PRINTED: 08/10/2021 FORM APPROVED OMB NO. 0938-0391

| TATEMENT OF DEFICIENCIES |  | 1 ' '   | (X2) MULTIPLE CONSTRUCTION  A, BUILDING |       |  | (X3) DATE SURVEY<br>COMPLETED   |                    |
|--------------------------|--|---|---|-------|--|---|--------------------|
| AND PLAN OF              | CORRECTION   |   | 7,,,50,125                              |       |  | C   | 9/2021             |
|                          |  | 495391  | B. WING                                 |       | REET ADDRESS, CITY, STATE, ZIP CODE  | 07/2  | 9/2021             |
| NAME OF PR               | OVIDER OR SUPPLIER   | <del> </del>  |   |       | O1 LIBBIE AVE  |   |                    |
| GLENBUR                  | NIE REHAB & NURSING  | CENTER  |   |       | CHMOND, VA 23226   |   |                    |
|                          | SLIMMARY ST  | ATEMENT OF DEFICIENCIES   | ID                                      |       |  | N<br>BE   | (X5)<br>COMPLETION |
| (X4) ID<br>PREFIX<br>TAG | /EACH DEFICIENC  | Y MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)  | PREF<br>TAG                             |       | CROSS-REFERENCED TO THE APPROPR<br>DEFICIENCY)   | IATE  | DATE               |
| E 000                    | Initial Comments   |   | E                                       | 000   |  |   |                    |
| F 000                    | survey was conducted or/29/2021. The fact compliance with 42 Requirement for Lor INITIAL COMMENT.  An unannounced M survey was conduct 7/29/2021. Correction compliance with 42 Term Care requirem survey/report will for 0/400050669- substitution.   | edicare/Medicaid standard ed 7/27/2021 through ons are required for CFR Part 483 Federal Long ments. The Life Safety Code stantiated with deficiency, | F                                       | : 000 | Glenburnie Rehabilitation Nursing Center provides to of correction without adm denying the validity or exiof the alleged deficiencies plan of correction is prepared as evidence comply with the requirem participation and effort to high quality resident cent care.   | his plan itting or stence s. The ared to ents of provide  |                    |
|                          | (VA00050669- substantiated with deficiency, VA00051556- substantiated without deficiency, VA00049849- unsubstantiated and VA00050230- unsubstantiated), were investigated during the survey.  The census in this 125 certified bed facility was 117 at the time of the survey. The survey sample consisted of 49 resident reviews.  Resident Rights/Exercise of Rights  CFR(s): 483.10(a)(1)(2)(b)(1)(2)  §483.10(a) Resident Rights.  The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section.  §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's |   |   | F 550 | F550: Residents Rights/Exerce Rights  1. Resident #104 continues to refacility and the catheter collect has been placed on the back of wheelchair below the level of the bladder.  2. All residents leaving facility appointments/outings have the to be affected by this alleged depractice. Audit conducted by management to ensure all residents a foley catheter collection bag placed below the bladder and it discrete location as possible.  3. DON or designee will re-edenursing staff that all residents foley catheter collection bag a below the bladder and in a dislocation as possible. | eside in ion bag I the he for potential eficient ursing lents with are ucate all with a re placed | 1                  |

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.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION |   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   | ` '  | LE CONSTRUCTION   | (X3) DATE SURVEY<br>COMPLETED    |                            |
|--|---|---|--|---|----------------------------------|----------------------------|
|  |   |   | R WING   |   | C<br>07/29/2024                  |                            |
|  |   | 495391  | B. WING  |   | 07/29/2021                       |                            |
| NAME OF P  | ROVIDER OR SUPPLIER   |   |  | STREET ADDRESS, CITY, STATE, ZIP CODE   |                                  |                            |
| GLENBURNIE REHAB & NURSING CENTER                |   |   | 1901 LIBBIE AVE  |   |                                  |                            |
| GLENBUI  | KNIE KEHAB & NUKSING  | CENTER  |  | RICHMOND, VA 23226  |                                  |                            |
| (X4) ID<br>PREFIX<br>TAG                         | PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL  |   | ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIAT |   |                                  | (X5)<br>COMPLETION<br>DATE |
| 140  |   |   |  | DEFICIENCY)   |                                  |                            |
| F 550  | individuality. The facil promote the rights of \$483.10(a)(2) The facil access to quality care severity of condition, must establish and mapractices regarding triprovision of services residents regardless of \$483.10(b) Exercise of The resident has the rights as a resident of or resident of the Unit \$483.10(b)(1) The facility.  \$483.10(b)(2) The resident can exercise interference, coercion from the facility.  \$483.10(b)(2) The resident can exercise interference, coercion from the facility.  \$483.10(b)(1) The facility free of interference, coercion from the facility.  \$483.10(b)(1) The resident can exercise of the facility in the facility in the facility in the facility document of the facility document of the facility document of the facility document of the facility of the facility staff place. | ity must protect and the resident.  cility must provide equal regardless of diagnosis, or payment source. A facility aintain identical policies and ansfer, discharge, and the under the State plan for all of payment source.  of Rights.  right to exercise his or her of the facility and as a citizen ded States.  cility must ensure that the his or her rights without and discrimination, or reprisal sident has the right to be oercion, discrimination, and the interest of the facility in the rights as required under this is not met as evidenced and, resident interview, staff ument review and clinical determined that the facility in a resident's dignity by | F 55   | 4. DON or designee will audit reswith a foley catheter collection be appropriate placement below the bladder and in a discrete location promote Resident's dignity week times 4 and monthly times 2 to erresidents have on appropriate out when leaving facility on appointments/outings. Any identifies will be immediately correct Results will be reported to Qualit Assurance committee for analysis revision x 3 months.  5. Date of compliance will be Au 20, 2021. | to to sy sure erwear fied ted. y |                            |

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION |  | CONTROL TION AND FOR  |                   | TIPLE CONSTRUCTION  |                                   | (X3) DATE SURVEY COMPLETED |  |
|---|--|---|-------------------|---|-----------------------------------|----------------------------|--|
|   | 495391 B. WING   |   |                   |   | C<br>07/29/2021                   |                            |  |
| ,   | NAME OF PROVIDER OR SUPPLIER  GLENBURNIE REHAB & NURSING CENTER  |   |                   | STREET ADDRESS, CITY, STATE, ZIP (<br>1901 LIBBIE AVE<br>RICHMOND, VA 23226 | CODE                              |                            |  |
| (X4) ID<br>PREFIX<br>TAG                            | (EACH DEFICIENC)   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)   | ID<br>PREF<br>TAG |   | TION SHOULD BE<br>THE APPROPRIATE | (X5)<br>COMPLETION<br>DATE |  |
| F 550   | diagnoses that include Parkinson's disease    Resident # 104's modata set), an admission (assessment reference coded Resident # 10 brief interview for me of 0 - 15, 11 - being recognition for making 104 was coded as reof one staff member for Under section H "Blaton 104 was coded under indwelling catheter and Cobservations of Resion 107/27/21 at 11:45 a.r. p.m., revealed the repower wheelchair. Or revealed the catheter on the front of the composition bag reveal Resident # 104's naw their wheelchair. Obstabling revealed that # 104's thighs, then in wheelchair and into the composition of the composition of the composition bag reveal Resident # 104's naw their wheelchair. Obstabling revealed that # 104's thighs, then in wheelchair and into the composition of the comp | admitted to the facility with led but were not limited to: [1] and multiple sclerosis [2].  Set recent MDS (minimum on assessment with an ARD oce date) of 07/08/2021, 4 as scoring an 11 on the intal status (BIMS) of a score moderately impaired of daily decisions. Resident # quiring extensive assistance or activities of daily living. dder and Bowel" Resident # r "H0100" as having an ind an external catheter.  Ident # 104 conducted on m., 1:05 p.m., and at 2:05 sident was sitting in their ibservation of the wheelchair in collection bag was hanging introl arm of power observation of the catheter end that it was at the height of well while they were sitting in servation of the catheter it was draped over Resident rose over the arm of the | F                 | 550   |                                   |                            |  |

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION |   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   | (X2) MULTIPLE CONSTRUCTION A, BUILDING |   | (X3) DATE SURVEY<br>COMPLETED |                            |
|---|---|---|--|---|-------------------------------|----------------------------|
|   |   | 495391  | B, WING                                |   |                               | C<br>/29/2021              |
| NAME OF F   | PROVIDER OR SUPPLIER  |   | -                                      | STREET ADDRESS, CITY, STATE, ZIP CODE   | 1 077                         | 25/2021                    |
| GLENBURNIE REHAB & NURSING CENTER                   |   | CENTER  | · · · · · · · · · · · · · · · · · · ·  | 1901 LIBBIE AVE<br>RICHMOND, VA 23226   |                               |                            |
| (X4) ID<br>PREFIX<br>TAG                            | (EACH DEFICIENCY  | ATEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SCIDENTIFYING INFORMATION)   | ID<br>PREFI<br>TAG                     | PROVIDER'S PLAN OF CORRECTION  (EACH CORRECTIVE ACTION SHOULD B  CROSS-REFERENCED TO THE APPROPRIA  DEFICIENCY) |                               | (X5)<br>COMPLETION<br>DATE |
|   | on the front of the corwheelchair. Further of collection bag revealed Resident # 104's nave their wheelchair. Obset tubing revealed that it # 104's thighs, then rowheelchair and into the The POS [physician's 104 dated 07/28/2021 Catheter: Condom chaobstructed. Order Date obstructed. Order Date of the comprehensive can dated 07/05/2021 failed documentation to additional condom catheter.  On 07/27/21 at 12:50 conducted with Reside who placed the catheter of the wheelchair Resinurse." When asked if collection bag on the an Resident # 104 stated, On 07/28/2021 at 3:12 conducted with LPN [li 3, unit manager. After above observations of collection bag hanging arm of power wheelchair a dignity issue." | atrol arm of power observation of the catheter of that it was at the height of el while they were sitting in ervation of the catheter was draped over Resident ose over the arm of the e collection bag.  Order sheet] for Resident # documented, "Urinary ange PRN [as needed] if the: 07/28/2021."  For early are plan for Resident # 104 of the evidence of the eress Resident # 104 of the eresident # 104 of the eress Resident # 104 of the eresident # 104 | F                                      | 550   |                               |                            |

|   | OF DEFICIENCIES<br>OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   | (X2) MULT<br>A. BUILDIN | PLE CONSTRUCTION<br>G  | (X3) DATE SURVEY<br>COMPLETED  |                 |  |
|---|---|---|-------------------------|--|--|-----------------|--|
|   |   | 495391  | B. WING _               |  |  | C<br>07/29/2021 |  |
| NAME OF PROVIDER OR SUPPLIER  GLENBURNIE REHAB & NURSING CENTER |   |   |                         | STREET ADDRESS, CITY, STATE, ZIP CODE 1901 LIBBIE AVE RICHMOND, VA 23226 |  | 100 E 1         |  |
| (X4) ID<br>PREFIX<br>TAG  | SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PRECEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION)  |   |                         | ,  | (EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE |                 |  |
| F 558<br>SS=D   | and access to persons outside the facility."  On 07/28/2021 at app [administrative staff m clinical services, ASM ASM # 4, medical dire the above concern.  No further information  References: [1] A type of movemer information was obtain https://www.nlm.nih.go sease.html.  [2] A nervous system brain and spinal cord. sheath, the material th your nerve cells. This blocks messages between body, leading to the syinformation was obtain https://medlineplus.go Reasonable Accommod CFR(s): 483.10(e)(3)  §483.10(e)(3) The righ services in the facility of accommodation of respreferences except when danger the health or other residents.  This REQUIREMENT by: | proximately 5:00 p.m., ASM member] #1, director of #2, director of nursing and ector, were made aware of was presented prior to exit.  Int disorder. This med from the website: pov/medlineplus/parkinsonsdi disease that affects your lit damages the myelin mat surrounds and protects damage slows down or ween your brain and your remptoms of MS. This med from the website: pov/multiplesclerosis.html. dations Needs/Preferences with reasonable ident needs and men to do so would resafety of the resident or is not met as evidenced president interview, staff | F 55                    | F558: Reasonable Accommodations Needs/Preferences                        | th ioned to be   |                 |  |

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  | (X2) MULTIPLE CONSTRUCTION (X3) DATE:  A. BUILDING |   |  |  |
|---|--|--|--|---|--|--|
|   |  |  |  |   | С  |  |
|   |  | 495391   | B. WING _  |   | 07/29/2021   |  |
| NAME OF P   | ROVIDER OR SUPPLIER  |  |  | STREET ADDRESS, CITY, STATE, ZIP CODE   |  |  |
| GLENBUR   | RNIE REHAB & NURSING   | CENTER   |  | 1901 LIBBIE AVE<br>RICHMOND, VA 23226   |  |  |
| (X4) ID SUMMARY STATEMENT OF DEFICIENCIES   |  | T 15   | PROVIDER'S PLAN OF CORRECTION                      | (V5)  |  |  |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIENCY   | MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG                                | 4   | BE COMPLÉTION  |  |
| F 558   | Continued From page  | 5  | F 5  |   |  |  |
|   | accommodation of retwo of 49 residents, R #91.  The facility staff failed Resident #45 and 91 maintained within reach the findings include:  1. Resident #45 was a diagnoses that include atrial fibrillation (1) and Resident #45's most reset), an admission asset (assessment reference Resident #45 as scorif for mental status (BIM impaired for making da coded Resident #45 as assistance of one staff personal hygiene. See Resident #45 not having upper extremities.  The comprehensive can dated 5/28/2021 documented in part, " articles within easy reach and the side of | cicility staff failed to ensure sident needs maintain for esident #45 and Resident to ensure the call bells for were positioned and ch.  Idmitted to the facility with ed but were not limited to dimyocardial infarction (2). escent MDS (minimum data essment with an ARD ed date) of 6/4/2021, codeding a 6 on the brief interview S) scale, 6- being severely ally decisions. Section G is requiring extensive immember for toilet use and stion G further documented and any impairment in the series plan for Resident #45 mented in part, "At risk for alance/poor coordination, s. Date Initiated: terventions/Tasks" itHave commonly used ch" | F 5  | management to verify the current residents had their call bells with reach.  3.DON or designee will educate is staff that call bells for Residents; be positioned and maintained wit reach.  4.DON or designee will audit 5 Residents call bell placement 3 ti week for 4 weeks and monthly tint to ensure call bells are positioned maintained within reach. Any ide issues will be immediately correct Results will be reported to Qualit Assurance committee for analysis revision x 3 months.  5.Date of compliance will be Aug 2021. | facility must hin mes a mes 2 and ntified ted. y s and |  |
|   | observation was made room. Resident #45 wa   | ximately 11:43 a.m., an of Resident #45 in their as observed lying in bed d on the top right corner of of the call bell with the   |  |   |  |  |

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION |   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | (X2) MUL<br>A. BUILD |     | E CONSTRUCTION   | (X3) DATE SURVEY<br>COMPLETED |                            |
|---|---|--|----------------------|-----|--|-------------------------------|----------------------------|
| 495391  |   | 495391   | B. WING              |     |  | C<br>07/29/2021               |                            |
|   | NAME OF PROVIDER OR SUPPLIER  GLENBURNIE REHAB & NURSING CENTER   |  |                      |     | STREET ADDRESS, CITY, STATE, ZIP CODE<br>1901 LIBBIE AVE<br>RICHMOND, VA 23226                               | 1                             |                            |
| (X4) ID<br>PREFIX<br>TAG                            | (EACH DEFICIENC)  | ATEMENT OF DEFICIENCIES<br>/ MUST BE PRECEDED BY FULL<br>.SC IDENTIFYING INFORMATION)  | ID<br>PREF<br>TAG    |     | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | E                             | (X5)<br>COMPLETION<br>DATE |
| F 558   | corner of the bed fran interview was attempt When asked if they co Resident #45 stated, Additional observation revealed the call bell I documented above. Con 7/28/2021 at 8:35 clipped to the sheet we resident use located behand.  On 7/28/2021 at approinterview was conduct nursing assistant) #5. bell should be clipped residents clothing. Che purpose of this was to stated that if the call lighthe mattress the residenterview was conduct practical nurse) #4. LF bell should be placed does not fall off. LPN applacement was checked and nurses.  On 7/28/2021 at approinterview was conduct practical nurse) #4. LF bell should be placed does not fall off. LPN applacement was checked and nurses.  On 7/28/2021 at approinterview was conduct stated that the staff cheach time they rounded stated that the call bell bell the call bell bell was a stated that the call bell bell the call bell | ent use was observed  If the bed at the top right he. At this time, an ted with Resident #45.  Bould reach their call bell, I'd don't know."  Ins on 7/27/2021 at 2:30 p.m.  Illocated in the position as Disservation of the call bell a.m. revealed the call bell with the press button for Deside Resident #45's right  Desimately 11:15 a.m., an ted with CNA (certified CNA #5 stated that the call to the sheet or the | F                    | 558 |  |                               |                            |

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION             |   | IDENTIFICATION AND IMPED  |  | TIPLE CONSTRUCTION |                                | (X3) DATE SURVEY<br>COMPLETED |  |
|---|---|---|--|--------------------|--------------------------------|-------------------------------|--|
|   |   |   | A. BOILE   |                    |                                | С                             |  |
|   | 495391 B. WING  |   |  | 07/29/2021         |                                |                               |  |
| NAME OF PROVIDER OR SUPPLIER  GLENBURNIE REHAB & NURSING CENTER |   |   | STREET ADDRESS, CITY, STATE, ZIP CC<br>1901 LIBBIE AVE<br>RICHMOND, VA 23226 | DE                 |                                |                               |  |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIENC)  | ATEMENT OF DEFICIENCIES<br>/ MUST BE PRECEDED BY FULL<br>.SC IDENTIFYING INFORMATION)   | ID<br>PREFI<br>TAG   |                    | ON SHOULD BE<br>BE APPROPRIATE | (X5)<br>COMPLETION<br>DATE    |  |
|   | #7 was informed of th Resident #45 during of 7/27/2021. LPN #7 state would not have been location.  On 7/28/2021 at appropriet was made to a member) #1, the regionservices for the facility placement.  The facility policy, "Be documented in part, "/equipped with a resideresidents to call for state directed to either a state centralized work area.  On 7/28/2021 at appropriet (administrative staff medirector of clinical services of nursing, and ASM #4 were made aware of the No further information of the No further information of the Aproblem with the special problem with the special problem. This information website: <a href="https://www.nlm.nih.go"></a> (a Myocardial infarction of the No further information of the website: <a href="https://www.nlm.nih.go"></a> (a Myocardial infarction of the No further information of the website: <a href="https://www.nlm.nih.go"></a> (a Myocardial infarction of the No further information of the website: <a href="https://www.nlm.nih.go"></a> (a Myocardial infarction of the No further information of the No | e call bell location for bservations conducted on ated that Resident #45 able to reach it in that eximately 5:45 p.m., a ASM (administrative staff and director of clinical policy on call bell drooms" dated May 2017 All resident rooms are ent call system that allows aff assistance. Calls are aff member or to a"  eximately 5:30 p.m., ASM ember) #1, the regional fices, ASM #2, the director in above concern.  was presented prior to exit.  eed or rhythm of the ation was obtained from wy/medlineplus/atrialfibrillat in art attacks are caused by a | F  | 558                |                                |                               |  |

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

| F DEFICIENCIES<br>CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: A, BUILDING  |   |  |   | E SURVEY<br>PLETED   |   |
|--|--|---|--|---|--|---|
|  | 495391   | B. WING   | B. WING  |   | C<br>07/29/2021  |   |
| NAME OF PROVIDER OR SUPPLIER  GLENBURNIE REHAB & NURSING CENTER  |  |   | 19   | 901 LIBBIE AVE  |  |   |
| (EACH DEFICIENCY   | MUST BE PRECEDED BY FULL   | ID<br>PREFI<br>TAG  |  | ,   |  | (X5)<br>COMPLETION<br>DATE  |
| arteries. The coronary by graph to the heart. If the heart is starved of This information was on the property of the heart is starved of This information was on the property of the heart is starved of This information was on the property of the heart is starved of the h | arteries bring blood and the blood flow is blocked, oxygen and heart cells die. obtained from the website: v/ency/article/000195.htm.  Idmitted to the facility with ed but were not limited to and dementia (2). Excent MDS (minimum data ament with an ARD ed date) of 6/25/2021, coded severely impaired for a Section G coded ing extensive assistance of collet use and totally imember for personal ther documented Resident tent in the upper extensive assistance of collet use and totally imember for personal ther documented Resident tent in the upper extensive assistance of collet use and totally imember for personal ther documented Resident tent in the upper extensive assistance of collet use and totally imember for personal ther documented Resident and the formal and  | F   | 558  |   |  |   |
|  | DVIDER OR SUPPLIER  SUMMARY STA  (EACH DEFICIENCY REGULATORY OR L  Continued From page arteries. The coronary oxygen to the heart. If the heart is starved of This information was of attest.//medlineplus.go  2. Resident #91 was a diagnoses that include terebral infarction (1) Resident #91's most re tet), a quarterly assess assessment reference resident #91 as being making daily decisions resident #91 as requir the staff member for tr tependent of one staff ygiene. Section G fur 45 having an impairm xtremities on one side the comprehensive ca atted 5/26/2021 docur alls due to impaired ba tensory deficit. Date In the comprehensive ca atted 5/26/2021 docur alls due to impaired ba tensory deficit. Date In the comprehensive ca atted 5/26/2021 docur alls due to impaired ba tensory deficit. Date In the comprehensive ca atted 5/26/2021 docur atted 5/26/2021 docur the comprehensive ca atted 5/26/2021 docur atted 5/26/2021 docur the comprehensive ca atted 5/26/2021 docur the comprehensive ca atted 5/26/2021 docur the comprehensive ca atted 5/26/2021 docur atted 5/26/2021 docur the comprehensive ca attention of the comprehensive the comprehensive ca attention of the comprehensive the comprehensive ca attention of the comprehensive th | A95391  DVIDER OR SUPPLIER  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 8 arteries. The coronary arteries bring blood and boxygen to the heart. If the blood flow is blocked, the heart is starved of oxygen and heart cells die. This information was obtained from the website: antips://medlineplus.gov/ency/article/000195.htm.  A. Resident #91 was admitted to the facility with diagnoses that included but were not limited to be the rebral infarction (1) and dementia (2). Resident #91's most recent MDS (minimum data tel), a quarterly assessment with an ARD assessment reference date) of 6/25/2021, coded Resident #91 as being severely impaired for making daily decisions. Section G coded Resident #91 as requiring extensive assistance of the staff member for toilet use and totally ependent of one staff member for personal yielene. Section G further documented Resident 45 having an impairment in the upper xtremities on one side.  The comprehensive care plan for Resident #91 ated 5/26/2021 documented in part, "At risk for alls due to impaired balance/poor coordination, tensory deficit. Date Initiated: 05/26/2021."  Inder "Interventions/Tasks" it documented in part, "Have commonly used articles within easy | DONIDER OR SUPPLIER  SUBMARRY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 8  arteries. The coronary arteries bring blood and boxygen to the heart. If the blood flow is blocked, he heart is starved of oxygen and heart cells die. This information was obtained from the website: https://medlineplus.gov/ency/article/000195.htm.  C. Resident #91 was admitted to the facility with liagnoses that included but were not limited to be be serebral infarction (1) and dementia (2). Resident #91's most recent MDS (minimum data set), a quarterly assessment with an ARD assessment reference date) of 6/25/2021, coded Resident #91 as being severely impaired for naking daily decisions. Section G coded Resident #91 as requiring extensive assistance of one staff member for toilet use and totally ependent of one staff member for personal ygiene. Section G further documented Resident 45 having an impairment in the upper xtremities on one side.  The comprehensive care plan for Resident #91 ated 5/26/2021 documented in part, "At risk for alls due to impaired balance/poor coordination, ensory deficit. Date Initiated: 05/26/2021." Inder "Interventions/Tasks" it documented in art, " Have commonly used articles within easy each"  In 7/27/2021 at approximately 11:59 a.m., an observation was made of Resident #91 in their inform. Resident #91 was observed lying in bed ith the call bell located in the floor to the left side ithe bed near the privacy curtain. At this time, in interview was attempted with Resident #91.  Then asked if they could reach their call bell, esident #91 stated, "Yes." Resident #91 then | DONDER OR SUPPLIER  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 8 arteries. The coronary arteries bring blood and boxygen to the heart. If the blood flow is blocked, he heart is starved of oxygen and heart cells die. This information was obtained from the website: https://medlineplus.gov/ency/article/000195.htm.  2. Resident #91 was admitted to the facility with liagnoses that included but were not limited to be preceding infarction (1) and dementia (2). Resident #91's most recent MDS (minimum data bet), a quarterly assessment with an ARD assessment reference date) of 6/25/2021, coded Resident #91 as being severely impaired for making daily decisions. Section G coded Resident #91 as requiring extensive assistance of one staff member for toilet use and totally ependent of one staff member for personal yglene. Section G further documented Resident 45 having an impairment in the upper xtremities on one side.  The comprehensive care plan for Resident #91 ated 5/26/2021 documented in part, "At risk for alls due to impaired balance/poor coordination, ensory deficit. Date Initiated: 05/26/2021."  Inder "Interventions/Tasks" it documented in art, "Have commonly used articles within easy each"  In r/127/2021 at approximately 11:59 a.m., an observation was made of Resident #91 in their incom. Resident #91 was observed lying in bed ith the call bell located in the floor to the left side if the bed near the privacy curtain. At this time, in interview was attempted with Resident #91.  Then asked if they could reach their call bell, esident #91 stated, "Yes." Resident #91 then | DOUDER OR SUPPLIER  ### A BANURSING CENTER  ### A BANURSING CENTER  ### A BANURSING CENTER  ### A BANURSING CENTER  ### BANURSING CE | A BUILDING  A95391  B. WING  STREET ADDRESS, CITY, STATE, ZIP CODE  1991 LIBBIE AVE  RICHMOND, VA 23226  RICHMOND, VA 23226  RICHMOND, VA 23226  SUMMARY STATEMENT OF DEFICIENCIES  SUMMARY STATEMENT OF DEFICIENCY  (EACH DEPTICENCY) WIST BE PERCORDED BY PULL  REGULATORY OR LISC IDENTIFYING INFORMATION)  PROVIDERS RIAN OF CORRECTION  TAG  CONDITIONED FROM LISC IDENTIFYING INFORMATION)  F 558  arteries. The coronary arteries bring blood and  anygen to the heart. If the blood flow is blocked,  he heart is starved of oxygen and heart cells die.  This information was obtained from the website:  titps://medlineplus.gov/ency/article/000195.htm.  Resident #915 most recent MDS (minimum data  web), a quarterly assessment with an ARD  assessment reference date) of 6/25/2021, coded  (seeident #915 as being severely impaired for  naking daily decisions. Section G coded  (seeident #915 as being severely impaired for  naking daily decisions. Section G coded  (seeident #915 as being severely impaired for  naking daily decisions. Section G coded  (seeident #915 as being severely impaired for  naking daily decisions. Section F personal  yolene. Section 6 further documented Resident  45 having an impairment in the upper  xtremities on one side.  he comprehensive care plan for Resident #91  ated 5/26/2021 documented in part. "At risk for  Ills due to impaired balance/poor coordination,  ensory defici. Date initiated: SE/26/2021."  nater "Interventions/Tasks" it documented in  art. "Have commonly used articles within easy  arch"  n 7/27/2021 at approximately 11:59 a.m., an  seervation was made of Resident #91 in their  one. Resident #91 shape severed lying in bed  this the call bell located in the floor to the left side  the bed near the privacy currain. At this time,  n interview was attempted with Resident #91.  Here asked if they could reach their call bell,  solidant #91 stated, "Yes". Resident #91 then |

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION             |  | IDENTIFICATION NUMBER   |  | TIPLE CONSTRUCTION         |            | (X3) DATE SURVEY<br>COMPLETED |  |
|---|--|---|--|----------------------------|------------|-------------------------------|--|
|   |  | 495391  | :  | B. WING                    |            | C<br>7/29/2021                |  |
| NAME OF PROVIDER OR SUPPLIER  GLENBURNIE REHAB & NURSING CENTER |  |   | STREET ADDRESS, CITY, STATE, ZIP CODE 1901 LIBBIE AVE RICHMOND, VA 23226 |                            | 11/29/2021 |                               |  |
| (X4)<br>PREF<br>TAG   |  |   | D BE   | (X5)<br>COMPLETION<br>DATE |            |                               |  |
| F 5   | asked where it was.  On 7/27/2021 at approbservation was made Resident #91's room to Additional observation and 7/28/2021 at 8:37 located in the floor to the privacy curtain.  On 7/28/2021 at approinterview was conduct nursing assistant) #5. bell should be clipped residents clothing. CN purpose of this was to stated that the call bel floor. CNA #5 stated the may be dropped to the them during rounds an reach before they left to On 7/28/2021 at approinterview was conducted practical nurse) #4. LP bell should be placed of does not fall off. LPN # placement was checked and nurses.  On 7/28/2021 at approinterview was conducted that the staff chee ach time they rounded stated that the call bell their lap so it was acces #7 was informed of the | eximately 12:10 a.m., an exist of a staff member entering to provide care.  Its on 7/27/2021 at 2:30 p.m. a.m. revealed the call bell the left side of the bed near eximately 11:15 a.m., an exist of the sheet or the A #5 stated that the call to the sheet or the A #5 stated that the be within reach. CNA #5 should never be left in the exist at times the call bell of floor but they checked and made sure they were in the room.  In the bed with the call bell of the bed with LPN (licensed N #4 stated that the call bell of the the during rounds by CNA's eximately 11:21 a.m., an exist of the call bell of during rounds by CNA's eximately 11:21 a.m., an exist of the call bell placement of the call bell placement of the call bell placement of the call bell placed across existed to the resident. LPN | F  | 558                        |            |                               |  |

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING \_ С 495391 B. WING 07/29/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1901 LIBBIE AVE **GLENBURNIE REHAB & NURSING CENTER** RICHMOND, VA 23226 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID COMPLETION DATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PREFIX TAG. REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) Continued From page 10 F 558 7/27/2021 and 7/28/2021. LPN #7 stated that Resident #91 would not have been able to reach it on the floor. On 7/28/2021 at approximately 5:30 p.m., ASM (administrative staff member) #1, the regional director of clinical services, ASM #2, the director of nursing, and ASM #4, the medical director were made aware of the above concern. No further information was presented prior to exit. References: 1. Cerebrovascular disease, infarction or accident A stroke. When blood flow to a part of the brain stops. A stroke is sometimes called a "brain attack," If blood flow is cut off for longer than a few seconds, the brain cannot get nutrients and oxygen. Brain cells can die, causing lasting damage. This information was obtained from the website: https://medlineplus.gov/ency/article/000726.htm. 2. Dementia F584: Reasonable Accommodations A loss of brain function that occurs with certain diseases. It affects memory, thinking, language, Needs/Preferences judgment, and behavior. This information was obtained from the website: 1. The windowsill in Room 122 was https://medlineplus.gov/ency/article/000739.htm. F 584 observed with peeling paint and large Safe/Clean/Comfortable/Homelike Environment F 584

SS=D

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

chips of paint peeled up on the surface.

Windowsill paint was immediately

PRINTED: 08/10/2021

|                          | OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   |                     | E CONSTRUCTION  | (X3) DATE SURVEY<br>COMPLETED   |  |
|--------------------------|--|---|---------------------|---|---|--|
|                          |  | 495391  | B. WING             |   | С   |  |
| NAME OF F                | DROVIDER OF CURRIER  | 490391  | 1                   | OTDEET ADDRESS OFFI OTATE TO SOLE   | 07/29/2021  |  |
|                          | PROVIDER OR SUPPLIER  RNIE REHAB & NURSING   |   |                     | STREET ADDRESS, CITY, STATE, ZIP CODE 1901 LIBBIE AVE RICHMOND, VA 23226  |   |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)   | ATEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL  .SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)  |   |  |
|                          | supports for daily livin  The facility must provi §483.10(i)(1) A safe, of homelike environment use his or her personal possible. (i) This includes ensur receive care and serve physical layout of the filter independence and do (ii) The facility shall exthe protection of the re- or theft.  §483.10(i)(2) Houseke services necessary to and comfortable interior §483.10(i)(3) Clean be- in good condition;  §483.10(i)(4) Private of resident room, as specified in all areas;  §483.10(i)(5) Adequate levels in all areas;  §483.10(i)(6) Comfortat levels. Facilities initially 1990 must maintain a transition 81°F; and  §483.10(i)(7) For the maintain §483.10(i)(7) For the maintain and §48 | de- clean, comfortable, and t, allowing the resident to al belongings to the extent ring that the resident can ices safely and that the facility maximizes resident es not pose a safety risk. cercise reasonable care for esident's property from loss reping and maintenance maintain a sanitary, orderly, or; and and bath linens that are |                     | corrected by Maintenance staff up notification.  2. All rooms have the potential to affected by this alleged deficient practice. An Audit was conducted maintenance of residents' room for peeling and chipping of paint on the windowsills to assess need for repulation and the windowsills to assess | be I by or he pair. ility eeling pair. gnee wsills kly 2. ill be on x 3 |  |

|   | OF DEFICIENCIES<br>F CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   |                    | TIPLE CONSTRUCTION   |      | (X3) DATE SURVEY<br>COMPLETED |  |
|---|---|---|--------------------|--|------|-------------------------------|--|
|   |   | 495391  | B, WING            |  |      | C<br>07/29/2021               |  |
| NAME OF PROVIDER OR SUPPLIER  GLENBURNIE REHAB & NURSING CENTER |   | CENTER  |                    | STREET ADDRESS, CITY, STATE, ZIP CODE 1901 LIBBIE AVE RICHMOND, VA 23226 |      | 112312021                     |  |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIENCY  | ATEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)  | ID<br>PREFI<br>TAG |  | D BE | (X5)<br>COMPLETION<br>DATE    |  |
|   | staff failed to maintain one of 126 resident ro 122). The window sill observed with peeling paint peeled up on the The findings include:  On 7/27/2021 at approphered a window over conditioning unit on the window was approximated inches deep. A flower One-quarter of the surrobserved with large chaint exposing the she additional areas approwere observed on the and peeling paint. The from the surface of the Additional observations and 7/28/2021 11:15 a as described above.  On 7/28/2021 at approximate inches deep. A flower observed on the additional areas approwere observed on the and peeling paint. The from the surface of the Additional observations and 7/28/2021 at approximaterview was conducted in the additional concern maintenance for repaired peeling paint was not hereported to be repaired called maintenance on | a homelike environment in loms in the facility, (room in resident room 122 was paint and large chips of a surface.  Eximately 11:40 a.m., an a for of resident rooms in the m 122, observation for the heating/air e wall. The sill of the lately 48 inches wide and 12 pot was on the window sill, face of the window sill, was ipped areas of peeling letrock underneath. Four eximately six inches in size window sill with cracked paint chips were raised up window sill.  Is on 7/27/2021 at 2:30 p.m.  Im. revealed the findings  Eximately 11:15 a.m., an and with CNA (certified CNA #5 stated that any is were reported to so that omelike and should be considered. CNA #5 stated that they the telephone and put in a found any concerns that | F                  | 584  |      |                               |  |

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION |   | (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: A. BUILDING  |                     |  | TE SURVEY<br>MPLETED |                            |
|---|---|--|---------------------|--|----------------------|----------------------------|
|   |   | 495391   | B, WING_            |  | 0.                   | C<br>7/29/2021             |
|   | ROVIDER OR SUPPLIER RNIE REHAB & NURSING  | CENTER   |                     | STREET ADDRESS, CITY, STATE, ZIP CODE<br>1901 LIBBIE AVE<br>RICHMOND, VA 23226                               |                      |                            |
| (X4) ID<br>PREFIX<br>TAG                            | (EACH DEFICIENCY  | ATEMENT OF DEFICIENCIES<br>MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION ( (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPION DEFICIENCY) | BE                   | (X5)<br>COMPLETION<br>DATE |
|   | hallway with the reside frequently. LPN #7 observed to maintenance underneath and stated reported to maintenance on 7/28/2021 at approximately were not aware of resident room 122. OS window sill in resident paint exposing the sheet stated that they would stated that they would stated that the window the room homelike.  On 7/28/2021 at approximately approximately with the window the room homelike.  On 7/28/2021 at approximately approximately #1, the region services for the facility phomelike environment.  The facility policy, "Quality policy, "Quality policy, "Quality policy, "Quality policy, "Residents are procomfortable and homelity phomelike environment" dated Maioart, "Residents are procomfortable and homelity phomelike extent possible" | red with LPN (licensed PN #7 stated that they of any environmental em or putting in work that they worked on the ent room in question served the window sill in a the peeling paint and sing the sheetrock that it should have been be for repairs.  It with the common that it is should have been be for repairs.  It with OSM (other staff or of maintenance, and the common that is any repairs needed in the room 122 with peeling etrock underneath and take care of it. OSM #7 stall condition did not make the common that is any repairs needed in the room 122 with peeling etrock underneath and take care of it. OSM #7 stall condition did not make the common that is a condition of the common that is a condition of the common that is a condition that is a condition of the common that is personal belongings to the common that is personal belongings to common that the common that is personal belongings to the common that the common that is personal belongings to the common that the common that the common that is personal belongings to the common that the c | F 5                 | 884  |                      |                            |

|               | T OF DEFICIENCIES<br>OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   | (X2) MULTIF         | PLE CONSTRUCTION   | (X3) DATE SURVEY<br>COMPLETED                       |                            |  |
|---------------|---|---|---------------------|--|---|----------------------------|--|
|               |   |   |                     |  | C   |                            |  |
|               |   | 495391  | B. WING             |  |   | 07/29/2021                 |  |
|               | PROVIDER OR SUPPLIER  JRNIE REHAB & NURSING   |   |                     | STREET ADDRESS, CITY, STATE, ZIP CODE 1901 LIBBIE AVE RICHMOND, VA 23226   |   | , 2021                     |  |
| PREFIX<br>TAG | (EACH DEFICIENCY  | ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)   | BE C  | (X5)<br>COMPLETION<br>DATE |  |
|               | with clean, comfortable meet federal and state  On 7/28/2021 at approduction (administrative staff medirector of clinical servitor of nursing, and ASM #4 were made aware of the No further information of No further information of Transfer and Discharge CFR(s): 483.15(c)(1)(i)(i)(i)(i)(i)(i)(i)(i)(i)(i)(i)(i)(i) | e and safe bedrooms that requirements"  eximately 5:30 p.m., ASM ember) #1, the regional ces, ASM #2, the director in the above concern.  eximately 5:30 p.m., ASM ember) #1, the regional ces, ASM #2, the director in the above concern.  eximately 5:30 p.m., ASM ember) #1, the regional ces, ASM #2, the director in the same resident to exit.  eximately 5:30 p.m., ASM ember) #1, the medical director in exit.  eximately 5:30 p.m., ASM ember) #1, the regional ces, as presented prior to exit.  eximately 5:30 p.m., ASM ember) #1, the regional ces, as presented prior to exit.  eximately 5:30 p.m., ASM ember) #1, the regional ces, as presented prior to exit.  eximately 5:30 p.m., ASM ember) #1, the regional ces, as presented prior to exit.  eximately 5:30 p.m., ASM ember) #1, the regional ces, as presented prior to exit.  eximately 5:30 p.m., ASM ember) #1, the regional ces, as presented prior to exit.  eximately 5:30 p.m., ASM ember) #1, the regional ces, as presented prior to exit.  eximately 5:30 p.m., ASM ember) #1, the regional ces, as presented prior to exit.  eximately 5:30 p.m., ASM ember) #1, the regional ces, as presented prior to exit.  eximately 5:30 p.m., ASM ember) #1, the regional ces, as presented prior to exit.  eximately 5:30 p.m., ASM ember) #1, the regional ces, as presented prior to exit.  example #1, the regional ces, as presented prior to exit.  example #1, the regional ces, as presented prior to exit.  example #1, the regional ces, as presented prior to exit.  example #1, the regional ces, as presented prior to exit.  example #1, the regional ces, as presented prior to exit.  example #1, the regional ces, as presented prior to exit.  example #1, the regional ces, as presented prior to exit.  example #1, the regional ces, as presented prior to exit.  example #1, the regional ces, as presented prior to exit.  example #1, the regional ces, as presented prior to exit.  example #1, the regional ces, as presented prior to exit.  example #1, the regional ces, as presented prior to exit.  example #1, t |                     | F622: Transfer and Discharge Requirements  1.Residents #101, #80, #15, #23, #52 continue to reside in facility. Residents #83, and #114 continuereside in facility.  2.All residents have the potential transfected by this alleged deficient practice. Audit by nursing manage conducted on residents from Augusto verify that the transfer form and comprehensive care plan goals we sent with resident upon transfer to another health care institution.  3.DON or designee will educate mustaff on ensuring that the transfer frand comprehensive care plan goals sent with Resident's that are being transferred to another health care institution and communicated with receiving health care institution and communicated with receiving health care institution and | es to  to be  ement ast 1st  tre  arsing form s are |                            |  |
| 1             | Nonpayment applies if the submit the necessary pare payment or after the third Medicare or Medicaid, de   | perwork for third party<br>d party, including   | t<br>t              | appropriate documentation in the E<br>LDON or designee will audit Resignate that transfer to another health care a stitution have a transfer form.   | EHR.  |                            |  |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION |  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   | (X2) MULTIPI<br>A. BUILDING | LE CONSTRUCTION   | (X3) DATE SURVEY<br>COMPLETED            |                            |
|--|--|---|-----------------------------|---|--|----------------------------|
|  | 495391   |   | B. WING                     |   | 1  | C<br>29/2021               |
|  | PROVIDER OR SUPPLIER RNIE REHAB & NURSING  | CENTER  |                             | STREET ADDRESS, CITY, STATE, ZIP CODE<br>1901 LIBBIE AVE<br>RICHMOND, VA 23226  | •  |                            |
| (X4) ID<br>PREFIX<br>TAG                         | (EACH DEFICIENC)   | ATEMENT OF DEFICIENCIES<br>'MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG         | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD B<br>CROSS-REFERENCED TO THE APPROPRIA<br>DEFICIENCY)   | BE                                       | (X5)<br>COMPLETION<br>DATE |
|  | resident who becomes admission to a facility resident only allowable or (F) The facility ceases (ii) The facility may no resident while the app § 431.230 of this chap exercises his or her rig discharge notice from 431.220(a)(3) of this condischarge or transfer or safety of the resider facility. The facility muthat failure to transfer of the facility transfer to the facility transfer to the facility transfer to the facility muthat failure to transfer of the facility transfer of the facility or provider.  (i) Documentation in the facility or provider.  (ii) Of this section.  (b) In the case of paragesection, the specific response met, facility attempts facility to meet the need facility attempts facility to meet the need facility to meet the need facility to meet the need facility attempts facility attempts facility to meet the need facility attempts facility attempts facility attempts facility attempts facility to meet the need facility attempts facility a | y for his or her stay. For a seligible for Medicaid after the facility may charge a charges under Medicaid; to operate. It transfer or discharge the eal is pending, pursuant to ter, when a resident that to appeal a transfer or the facility pursuant to § napter, unless the failure to would endanger the health at or other individuals in the st document the danger or discharge would pose.  Intation.  Fers or discharges a ne circumstances specified A) through (F) of this set ensure that the transfer ented in the resident's propriate information is exceiving health care  The resident's medical record ansfer per paragraph (c)(1)  Figraph (c)(1)(i)(A) of this ident need(s) that cannot is to meet the resident available at the receiving le(s).  Frequired by paragraph (c) is be made by- | F 622                       | comprehensive care plan goals see communicated, and documented is weekly times 4 weeks and month times 2. Any identified issues will immediately corrected. Results were ported to Quality Assurance committee for analysis and revision months.  5.Date of compliance will be Aug 2021 | in EHR<br>ly<br>l be<br>ill be<br>on x 3 |                            |

|           | OF DEFICIENCIES<br>F CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:     | (X2) MULT<br>A. BUILDII | FIPLE CONSTRUCTION NG  | C        | (X3) DATE SURVEY<br>COMPLETED |            |  |
|-----------|---------------------------------|---|-------------------------|--|----------|-------------------------------|------------|--|
|           |                                 | 495391  | B. WING                 |  |          |                               | С          |  |
| <u> </u>  |                                 | 495391  | D. WING                 |  |          | 07                            | /29/2021   |  |
| NAME OF P | ROVIDER OR SUPPLIER             |   |                         | STREET ADDRESS, CITY, STATE, ZIP CODE  |          |                               |            |  |
| GLENBU    | RNIE REHAB & NURSING            | CENTER  |                         | 1901 LIBBIE AVE  |          |                               |            |  |
|           |                                 | CLIVIEN   |                         | RICHMOND, VA 23226   |          |                               |            |  |
| (X4) ID   |                                 | ATEMENT OF DEFICIENCIES                                   | ID                      | PROVIDER'S PLAN OF CORRE   | CTION    |                               | (X5)       |  |
| PREFIX    |                                 | ' MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION) | PREFIX                  |  |          |                               | COMPLETION |  |
| TAG       | NEODENIONI ONE                  | SCIDENTIFFING INFORMATION)                                | TAG                     | CROSS-REFERENCED TO THE APPL<br>DEFICIENCY)  | ROPRIATE |                               | DATE       |  |
|           |                                 |   |                         |  |          |                               |            |  |
| F 622     | Continued From page             | 16  | F6                      | 200  |          |                               |            |  |
|           | , ,                             |   | "0                      | 022  |          |                               |            |  |
|           | (A) or (B) of this section      | y under paragraph (c) (1)                                 |                         |  |          |                               |            |  |
|           |                                 | transfer or discharge is                                  |                         | 1  |          |                               |            |  |
|           |                                 | graph (c)(1)(i)(C) or (D) of                              |                         |  |          |                               |            |  |
|           | this section.                   | graph (c)(1)(1)(O) or (D) or                              | Ī                       | (  |          |                               |            |  |
|           |                                 | ed to the receiving provider                              |                         |  |          |                               |            |  |
|           | must include a minimu           |   |                         |  |          |                               |            |  |
|           | (A) Contact informatio          |   |                         |  |          |                               |            |  |
|           | responsible for the car         |   |                         |  |          |                               |            |  |
|           | (B) Resident represent          | tative information including                              |                         |  |          |                               |            |  |
|           | contact information             |   |                         |  |          |                               |            |  |
|           | (C) Advance Directive           |   |                         |  |          | -                             |            |  |
|           | (D) All special instructi       | •   |                         |  |          |                               |            |  |
|           | ongoing care, as appro          |   |                         |  |          |                               |            |  |
|           | (E) Comprehensive ca            |   |                         |  |          |                               | 1          |  |
|           |                                 | y information, including a                                |                         |  |          |                               | 1          |  |
|           | copy of the resident's o        |   |                         |  |          |                               |            |  |
|           |                                 | 1(c)(2) as applicable, and                                |                         |  |          |                               |            |  |
| 1         | a safe and effective tra        | on, as applicable, to ensure                              |                         |  |          | 1                             |            |  |
|           |                                 | is not met as evidenced                                   |                         |  |          |                               |            |  |
|           | by:                             | is not met as evidenced                                   |                         |  |          |                               |            |  |
|           | · ·                             | w, facility document review                               |                         | ľ  |          |                               |            |  |
|           |                                 | ew, it was determined that                                |                         | K.   |          |                               |            |  |
|           | the facility staff failed to    |   |                         |  |          |                               |            |  |
|           |                                 | ocumentation for seven of                                 |                         | T and the second |          |                               |            |  |
|           | 49 residents in the sun         |   |                         |  |          | 1                             |            |  |
|           | #101, #83, #114, #80, ;         | #15, #23 and #52.   |                         |  |          | 1                             |            |  |
|           |                                 |   |                         |  |          |                               |            |  |
|           | The facility staff failed t     |   |                         |  |          |                               |            |  |
|           | comprehensive care pl           |   |                         |  |          |                               |            |  |
|           | #101, #83, #114, #80, #         |   |                         | W.   |          |                               |            |  |
|           | provided and communic           |   |                         |  |          |                               |            |  |
|           | health care institution u       | pon transfer to the                                       |                         |  |          |                               |            |  |
|           | hospital.                       |   |                         |  |          |                               |            |  |
| ].        | The findings include:           |   |                         |  |          |                               |            |  |
|           | me mungs menue:                 |   |                         |  |          |                               | ıl'        |  |
| h .       | 1. The facility staff failed    | d to provide evidence that                                |                         |  |          |                               |            |  |

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION |   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  |                    |  |                        | E SURVEY<br>IPLETED        |
|---|---|--|--------------------|--|------------------------|----------------------------|
|   | <b>495391</b> B. WING   |  |                    | 07   | C<br>// <b>29/2021</b> |                            |
|   | PROVIDER OR SUPPLIER  RNIE REHAB & NURSING  | CENTER   | •                  | STREET ADDRESS, CITY, STATE, ZIP CODE<br>1901 LIBBIE AVE<br>RICHMOND, VA 23226 | •                      |                            |
| (X4) ID<br>PREFIX<br>TAG                            | (EACH DEFICIENCY  | ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)   | ID<br>PREFI<br>TAG | ,  | BE                     | (X5)<br>COMPLETION<br>DATE |
|   | all required information goals) was provided to Resident #101 was tra 6/15/21.  Resident #101 was ac 5/18/07. Resident #10 were not limited to muland high blood pressu quarterly minimum dat assessment reference resident's cognitive ski making as severely im  Review of Resident #1 revealed the resident whospital on 6/15/21 be blue in the face, foamin presented with rapid la review of Resident #10 including nurses' notes 6/15/21, failed to revea staff provided the resid plan goals to the receiving Con 7/28/21 at 12:27 p.1 conducted with LPN (lict LPN #4 stated she sen sheet, list of medication tests] results and a list residents are transferred stated she has never set hospital when residents.  On 7/28/21 at 4:52 p.m. | in (comprehensive care plan on hospital staff when considered to the hospital on the insterred instead of 7/6/21, seizures a set assessment with an date of 7/6/21, coded the ills for daily decision paired.  On's clinical record was transferred to the cause the resident was no out of the mouth and bored breathing. Further on's clinical record, and a transfer form dated il evidence that the facility ent's comprehensive care no hospital staff.  In., an interview was been denoted in the interview was considered in the interview was been decided in the interview was been decided in the interview was at the interview was been decided in the interview wa | F                  | 622  |                        |                            |

|                          | OF DEFICIENCIES<br>F CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER;  |                     | PLE CONSTRUCTION  G  | (X3) DATE SURVEY<br>COMPLETED |                            |
|--------------------------|---|--|---------------------|--|-------------------------------|----------------------------|
|                          |   | 495391   | B. WING _           |  | 1                             | C<br>/29/2021              |
| NAME OF P                | ROVIDER OR SUPPLIER   |  |                     | STREET ADDRESS, CITY, STATE, ZIP CODE  | 07.                           | 12312021                   |
| GLENBU                   | RNIE REHAB & NURSING  | CENTER   | ]                   | 1901 LIBBIE AVE  |                               |                            |
|                          |   |  |                     | RICHMOND, VA 23226   |                               |                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY  | ATEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY) |                               | (X5)<br>COMPLETION<br>DATE |
|                          | The facility policy titled Emergency" documen necessary to make an discharge to a hospital our facility will implement procedures: d. Prepare with the resident" The exact information that the No further information of the Emergence:  (1) Multiple Sclerosis is disease that affects the This information was on https://vsearch.nlm.nih.meta?v%3Aproject=medlineplus-bundle&quest.727485085.1627513122  2. The facility staff failed comprehensive care plathospital upon Resident hospital on 6/1/2021.  Resident #83 was adm | d, "Transfer or Discharge, ted, "4. Should it become emergency transfer or or or other related institution, ent the following e a transfer form to send he policy did not specify the will be provided.  was presented prior to exit.  a a nervous system brain and spinal cord brain and spinal cord brained from:  gov/vivisimo/cgi-bin/query-edlineplus&v%3Asources=ery=ms&_ga=2.16826909  122-1380714373.1627513  d to provide the an goals to the receiving #83's transfer to the | F 62                |  |                               |                            |
| i                        | diagnoses that included urinary tract infection, s in which hemorrhage or vessels of the brain leadesulting symptoms - su   | I but were not limited to: troke (abnormal condition blockage of the blood ds to oxygen lack and idden loss of ability to arm or parts of the face],   |                     |  |                               |                            |
| C                        | death) (1), and cancer of the most recent MDS (   | of the colon.  |                     |  |                               |                            |
|                          | assessment, a Medicare  |  |                     |  |                               |                            |

|                          |  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | A, BUILDI           | MULTIPLE CONSTRUCTION JILDING   |                                  |  | (X3) DATE SURVEY<br>COMPLETED |  |
|--------------------------|--|--|---------------------|---|----------------------------------|--|-------------------------------|--|
|                          |  | 495391   | B, WING_            |   |                                  |  | C<br>// <b>29/2021</b>        |  |
|                          | NAME OF PROVIDER OR SUPPLIER  GLENBURNIE REHAB & NURSING CENTER  |  |                     | STREET ADDRESS, CITY, STATE, ZIP (<br>1901 LIBBIE AVE<br>RICHMOND, VA 23226     | CODE                             |  |                               |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)   | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF<br>( (EACH CORRECTIVE ACT<br>CROSS-REFERENCED TO DEFICIENCE) | TION SHOULD BE<br>THE APPROPRIAT |  | (X5)<br>COMPLETION<br>DATE    |  |
|                          | coded Resident #83 a (brief interview for me the resident was mod daily cognitive decision coded as requiring ex of his activities of daily which he was coded a assistance was provided assistance wa | eference date of 6/24/2021, as scoring a "9" on the BIMS intal status) score, indicating erately impaired to make ons. Resident #83 was tensive assistance for most y living except eating in as independent after set up ded.  6/1/2021 at 11:11 a.m. sident left the facility via cortation with 2 attendants. Inted. He was clean. No iscomfort. MD (medical onsible party) aware."  record failed to evidence are plan goals were sent transfer to the hospital on income a transfer form, face ons, recent lab results and a residents are transferred 4 stated she has never on the hospital when eed. | F 6                 | 22  |                                  |  |                               |  |

|                          | OF DEFICIENCIES<br>OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  |                     | TIPLE CONSTRUCTION   |          | (X3) DATE SURVEY<br>COMPLETED |  |
|--------------------------|---|--|---------------------|--|----------|-------------------------------|--|
|                          |   | 495391   | B. WING             | B. WING  |          | C<br>07/29/2021               |  |
|                          | PROVIDER OR SUPPLIER<br>RNIE REHAB & NURSING  | CENTER   |                     | STREET ADDRESS, CITY, STATE, ZIP CODE<br>1901 LIBBIE AVE<br>RICHMOND, VA 23226             |          | 0112912021                    |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY  | ATEMENT OF DEFICIENCIES<br>'MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY) | HOULD BE | (X5)<br>COMPLETION<br>DATE    |  |
|                          | care plan in all of her y An interview was cond 7/29/2021 at 09:10 a.r #83 was sent to the he had abnormal labs (la day before, his WBC (i 62.4 and his potassiur decided to transfer hin error that I didn't document to the hospital."  ASM (administrative si regional director of clin the director of nursing, above findings on 7/28  No further information of References: (1) Barron's Dictionary Non-Medical Reader, 5 Chapman, page 114.  3. The facility staff faile comprehensive care pl. hospital upon Resident hospital on 7/1-5/2021.  Resident # 114 was ad 5/27/2021 with a recent with diagnoses that inc to: end stage renal dise hemodialysis (a proced conditions and renal [ki wastes and impurities a blood by a special mack | ducted with LPN #3 on in, regarding why Resident ospital. LPN #3 stated he coratory) test results the white blood cell count) was in was high. The doctor in that morning. It's my ment the reason why he staff member) #1, the ical services, and ASM #2, were made aware of the ideal services, and ASM #2, were made aware of the ideal services, and the ideal Terms for the ideal the edition, Rothenberg and ideal to provide the an goals to the receiving #114's transfer to the intending in the ideal to the facility on readmission on 7/9/2021, luded but were not limited the energy failure, in which are removed from the | F                   | 522  |          |                               |  |

|                          | T OF DEFICIENCIES<br>OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  |                     | TIPLE CONSTRUCTION<br>ING  | (X3) DATE SURVEY<br>COMPLETED |
|--------------------------|---|--|---------------------|--|-------------------------------|
|                          |   | 495391   | B. WING             |  | C<br>07/29/2021               |
|                          | PROVIDER OR SUPPLIER  JRNIE REHAB & NURSING   | CENTER   |                     | STREET ADDRESS, CITY, STATE, ZIP CODE 1901 LIBBIE AVE RICHMOND, VA 23226 | 3112312321                    |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY  | ATEMENT OF DEFICIENCIES<br>'MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG |  | BE COMPLETION                 |
|                          | term for chronic, nonre is usually a combination chronic bronchitis) (2) anxiety disorder (state apprehension, often we resulting in body chan heartbeat and sweat).  The most recent MDS assessment, a quarter assessment reference Resident # 114 as soo (brief interview for mentithe resident was moded aily cognitive decision coded as limited assist for most of her activitie.  A nurse's note dated, 7 documented, "Writer caby the resident, who state to get dialysis there. Si for 3 hours versus 4 ho informed the resident to and we will try to up he center contacted and the changed to 2:45 p.m. We resident room with anot resident was noted to he lay bed, eyes closed, lethal cannula at 4 liters going (temperature) 101; O2 silters, BP (blood pressu | eversible lung disease that on of emphysema and high blood pressure and of mild to severe ithout specific cause, ges such as quickened (3)  (minimum data set) by assessment, with an date of 7/15/2021, coded ring a "12" on the BIMS stall status) score, indicating trately impaired to make as. The resident was cance of one staff member is of daily living.  (75/2021 at 8:42 a.m. alled into the resident room ated she needed to go to dishe felt full and wanted the also mentioned running turns at the dialysis center. I be day was her dialysis day or chair time. Dialysis are resident chair time was writer back into the there are an acute change. It will be a compared to the compared to | F                   | 522  |                               |

|                          | OF DEFICIENCIES<br>F CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   |                     | PLE CONSTRUCTION   | (X3) DATE SURVEY<br>COMPLETED |  |
|--------------------------|--|--|---------------------|--|-------------------------------|--|
|                          |  | , January Company  | A. BUILDIN          |  |                               |  |
|                          |  | 495391   | B. WING             | ·  | C<br>07/29/2021               |  |
| NAME OF P                | ROVIDER OR SUPPLIER  |  |                     | STREET ADDRESS, CITY, STATE, ZIP CODE  |                               |  |
| CI ENDIII                | RNIE REHAB & NURSING   | CENTER   |                     | 1901 LIBBIE AVE  |                               |  |
| GLENBU                   | RINE REMAD & NUKSING   | CENTER   |                     | RICHMOND, VA 23226   |                               |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY   | ATEMENT OF DEFICIENCIES<br>'MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY) |                               |  |
| F 622                    | Continued From page distress."  Review of the clinical if the comprehensive cawith the resident upon An interview was concepted from the comprehensive of the comprehensive was concepted from the comprehensive of the com | record failed to evidence are plan goals were sent a transfer to the hospital.  ducted with LPN (licensed to unit manager, on the plan goals with the documents ansferred to the hospital. The plan goals with the exact plan goals aware of the exact plan goals were provided to the Resident # 80's | F 62                | DEFICIENCY)  |                               |  |
|                          | Resident#80 was adm  | nitted to the facility with  |                     |  |                               |  |

|                          | OF DEFICIENCIES OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   |                    | TIPLE CONSTRUCTION ING   | (X3) DATE SURVEY<br>COMPLETED |                            |
|--------------------------|---|---|--------------------|--|-------------------------------|----------------------------|
|                          |   | 495391  | B. WING            |  |                               | C<br>/ <b>29/2021</b>      |
|                          | PROVIDER OR SUPPLIER  RNIE REHAB & NURSING  | CENTER  |                    | STREET ADDRESS, CITY, STATE, ZIP CODE 1901 LIBBIE AVE RICHMOND, VA 23226 | 1 077                         | 729/2021                   |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY  | ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)  | ID<br>PREFI<br>TAG |  | _                             | (X5)<br>COMPLETION<br>DATE |
|                          | diagnoses included but disease and stroke. Resident # 80's most is set), a quarterly assess (assessment reference coded Resident # 80 a brief interview for men of 0 - 15, nine - being a cognition for making diseases of the set of the bed, eating his dat the foot of the bed. To oriented. Writer went to bed. The resident was nated to bed. The resident refus and neck hurt. This write resident was on the floor the facility. Upon enteresident was on the floor to the facility. Upon enteresident was on the floor the facility. Upon enteresident was and the floor the facility of the floor the facility of the floor | recent MDS (minimum data ment with an ARD edate) of 06/22/2021, as scoring a nine [9] on the tal status (BIMS) of a score moderately impaired of aily decisions.  O's clinical record evealed a nurse's note 15 p.m., which writer called to resident nursing assistant]. The pelying on the left side of ith a pillow under his head, seen sitting up on the side inner. His wheelchair was the resident in to ed, stating his lower back per tried to talk with the past I was going to do, the use my assistance stating, ital' 911 called and arrived ering the room, the per on his left side. He is wheelchair and it he complained to the ical technicians] his lower resident left the facility stretcher. The resident No protective equipment and to [Name of Hospital] | F                  | 522  |                               |                            |

|                          | OF DEFICIENCIES<br>F CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  | (X2) MUL<br>A. BUILD | TIPLE CONSTRUCTION ING   |         | (X3) DATE SURVEY<br>COMPLETED |  |
|--------------------------|--|--|----------------------|--|---------|-------------------------------|--|
|                          |  | 495391   | B. WING              |  |         | C<br>07/29/2021               |  |
|                          | ROVIDER OR SUPPLIER  | CENTER   |                      | STREET ADDRESS, CITY, STATE, ZIP CODE 1901 LIBBIE AVE RICHMOND, VA 23226 |         |                               |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY   | ATEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)   | ID<br>PREFI<br>TAG   |  | OULD BE | (X5)<br>COMPLETION<br>DATE    |  |
|                          | Review of the EHR [e the paper clinical reco to evidence that the cogoals were sent to the of Resident # 80's hose.  On 7/28/21 at 12:27 p conducted with LPN [I regarding documentate transfer. LPN #4 state form, face sheet, list or results and a list of diatransferred to the hose has never sent care plead when residents are transferred to the hose has never sent care plead when residents are transferred to the hose has never sent care plead when residents are transferred to the hose has never sent care plead when residents are transferred to the hose has never sent care plead when residents are transferred to the hose has never sent care plead when residents are transferred to the hose has never sent care plead when residents are transferred to the hose has never set for the above concern.  No further information to the facility staff failed comprehensive care plead the receiving facility for transfer of Resident # 15 was addiagnoses that include altered mental status, a Resident # 15's most reset], a quarterly assessing (assessment reference coded Resident # 15 as interview for mental statis, and the paper of the receiving facility for transfer of Resident # 15 as interview for mental statis, and the paper of the receiving facility for transfer of Resident # 15 as interview for mental statis, and the paper of the receiving facility for transfer of Resident # 15 as interview for mental statis, and the paper of the receiving facility for transfer of Resident # 15 as interview for mental statis, and the paper of the receiving facility for transfer of Resident # 15 as interview for mental statis, and the paper of the receiving facility for transfer of Resident # 15 as interview for mental statis, and the paper of the receiving facility for transfer of Resident # 15 as interview for mental statis, and the paper of the receiving facility for transfer of Resident # 15 as interview for mental statis, and the paper of the receiving facility for transfer of Resident # 15 as interview for mental statis. | lectronic health record] and ord for Resident # 80 failed comprehensive care plan receiving facility at the time spital transfer.  .m., an interview was idensed practical nurse] #4 ion sent for a resident d she sends a transfer f medications, recent lab gnoses when residents are poital. LPN #4 stated she an goals to the hospital insferred.  roximately 5:00 p.m., ASM rember] #1, director of #2, director of nursing and ctor, were made aware of was presented prior to exit.  ed to evidence that the an goals were provided to a facility-initiated hospital 15, on 05/18/2021.  Initted to the facility with d but were not limited to: and diabetes mellitus [1]. Recent MDS [minimum data ment with an ARD | F                    | 622  |         |                               |  |

|                          | OF DEFICIENCIES<br>F CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   | 1 ' '             |     | PLE CONSTRUCTION   |          | (X3) DATE SURVEY<br>COMPLETED |  |
|--------------------------|--|---|-------------------|-----|--|----------|-------------------------------|--|
|                          |  | 495391  | B. WING           |     |  | 07       | C                             |  |
|                          | ROVIDER OR SUPPLIER  |   |                   |     | STREET ADDRESS, CITY, STATE, ZIP CODE 1901 LIBBIE AVE RICHMOND, VA 23226                                     | <u> </u> | /29/2021                      |  |
| (X4) ID<br>PREFIX<br>TAG | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)   |   | ID<br>PREF<br>TAG |     | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) |          | (X5)<br>COMPLETION<br>DATE    |  |
|                          | received a call from [N stating MD [medical d Doctor] would like for the ER [emergency ro elevated sodium of 16 [responsible party] wa had spoken with the M the MD. She would lik out. 911 called."  Review of the EHR [el the paper clinical reco to evidence that the cogoals were sent to the of Resident # 15's faci.  On 7/28/21 at 12:27 p. conducted with LPN [li regarding documentati transfer. LPN #4 states form, face sheet, list of results and a list of diag transferred to the hosp has never sent care plawhen residents are transfer. LPN #4, medical direction of the shown of the shown concern.  No further information we References: | Resident # 15 dated m., documented, "Writer lame of Nurse Practitioner], octor], [Name of Medical the resident to be sent to om] via [by] 911 due to 0. The resident RP s called. She stated she ID and is in agreement with e for her mom to be sent  ectronic health record] and rd for Resident # 15 failed omprehensive care plan receiving facility at the time lity-initiated transfer.  m., an interview was censed practical nurse] #4 on sent for a resident d she sends a transfer f medications, recent lab gnoses when residents are ital. LPN #4 stated she an goals to the hospital nsferred.  oximately 5:00 p.m., ASM | F                 | 622 |  |          |                               |  |

| STATEMENT OF DEFICIENCIES (X1) AND PLAN OF CORRECTION  | ) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  | 1                  | TIPLE CONSTRUCTION  NG  | (X3) DATE SURVEY<br>COMPLETED |  |
|--|---|--------------------|---|-------------------------------|--|
|  | 495391  | B. WING            |   | C<br>07/29/2021               |  |
| NAME OF PROVIDER OR SUPPLIER   | - Year  | -                  | STREET ADDRESS, CITY, STATE, ZIP CODE   | 0112312021                    |  |
| CLENDUDNIE DELIAD & MUDSING CEN  | NITED   |                    | 1901 LIBBIE AVE   |                               |  |
| GLENBURNIE REHAB & NURSING CEN   | NIER  |                    | RICHMOND, VA 23226  |                               |  |
| PREFIX (EACH DEFICIENCY MUS  | MENT OF DEFICIENCIES<br>IST BE PRECEDED BY FULL<br>DENTIFYING INFORMATION)  | ID<br>PREFI<br>TAG | PROVIDER'S PLAN OF CORRECTION  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY) | DATE                          |  |
| regulate the amount of su goal of treatment at first is blood glucose level. Long-prevent complications. Th to treat and manage type active and eating healthy f was obtained from the we https://medlineplus.gov/en  6. The facility staff failed to documentation was provided facility upon transfer of Reshospital on 5/21/21.  Resident #23 was admitted 1/10/20, discharged to hor readmitted to the facility or had the diagnoses of but requadriplegia, aphasia, diath blood pressure, COVID-19. The admission / 5-day MD with an ARD (Assessment 1/19/21 coded the resident impaired in ability to make The resident was coded as all areas of activities of dail.  A review of the clinical reconote dated 5/21/21 that do resident room by nursing swith respiratory distress, bloop (cardio pulmonary resucalled, MD (medical doctor (responsible party) notified suctioned several times, renormal, vital signs within noemt's (emergency medical facility, resident is at baseli | agar in the blood. The s to lower your high g-term goals are to he most important way 2 diabetes is by being foods. This information ebsite:  Incy/article/000313.htm.  It o evidence what, if any, ded to the receiving esident #23 to the  Bed to the facility on one on 6/1/21 and on 7/13/21. The resident not limited to a stroke, abetes, anxiety, high 9, and contractures.  DS (Minimum Data Set) Reference Date) of the as moderately edaily life decisions. Its requiring total care for all limits at the time of the contraction initiated, 911 or called, rp d. Resident (Sic.) espirations returned to normal limits at the time of technician arrived to | F                  | 522   |                               |  |

|                          | OF DEFICIENCIES<br>F CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | 1 ' '             |     | LE CONSTRUCTION  |   | SURVEY<br>PLETED           |
|--------------------------|---|--|-------------------|-----|--|---|----------------------------|
|                          |   |  | A, BUILD          | ING |  | İ | С                          |
|                          |   | 495391   | B, WING           | _   |  |   | /29/2021                   |
| NAME OF P                | ROVIDER OR SUPPLIER   |  | -                 |     | STREET ADDRESS, CITY, STATE, ZIP CODE  |   |                            |
| OL ENDU                  | DAME DELLA DO AMADOMO   | CENTED   |                   |     | 1901 LIBBIE AVE  |   |                            |
| GLENBUR                  | RNIE REHAB & NURSING  | CENTER   |                   |     | RICHMOND, VA 23226   |   |                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY  | ATEMENT OF DEFICIENCIES<br>MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREF<br>TAG |     | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) |   | (X5)<br>COMPLETION<br>DATE |
| F 622                    | Continued From page   | 27   | F                 | 622 | 2  |   |                            |
|                          | evaluations, rp will me (emergency room)."  | eet resident at er   |                   |     |  |   |                            |
|                          | The resident was read 5/26/21.  | lmitted to the facility on   |                   |     |  |   |                            |
|                          | female with significant Patient was sent to EL d/t (due to) respiratory admitted to (name of lairway, found to have infection) w/ (with) Extreated with IV (intraversity)   | ent #23) is a 69-year-old t past medical history. D (emergency department) o distress. Resident was nospital) for aspiration into a UTI (urinary tract Coli (Escherichia coli) and   |                   |     |  |   |                            |
|                          | contact information (C) Advance Directive (D) All special instructiongoing care, as appro (E) Comprehensive ca (F) All other necessary copy of the resident's cany other documentations a safe and effective on 7/28/21 at 12:27 p. | f what, if any, ovided to the receiving not limited to: n of the practitioner re of the resident. tative information including information ons or precautions for opriate. re plan goals r information, including a discharge summary, and on, as applicable, to ctive transition of care. |                   |     |  |   |                            |
|                          | LPN #4 stated she ser   | censed practical nurse) #4.  nds a transfer form, face  ns, recent lab (laboratory   |                   |     |  |   |                            |

|                          | OF DEFICIENCIES<br>F CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  |                    |     | E CONSTRUCTION  | (X3) DATE SURVEY<br>COMPLETED |                            |
|--------------------------|--|--|--------------------|-----|---|-------------------------------|----------------------------|
|                          |  | 495391   | B. WING            |     |   | С                             |                            |
| NAME OF P                | ROVIDER OR SUPPLIER  | 433331   | D. WING            | _   | STREET ADDRESS, CITY, STATE, ZIP CODE   | 07                            | 7/29/2021                  |
| GLENBIN                  | RNIE REHAB & NURSING   | CENTER   |                    |     | 1901 LIBBIE AVE   |                               |                            |
| GLENBUI                  | KINE KEHAB & NUKSING   | CENTER   |                    |     | RICHMOND, VA 23226  |                               |                            |
| (X4) ID<br>PREFIX<br>TAG |  |  | ID<br>PREFI<br>TAG |     | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) |                               | (X5)<br>COMPLETION<br>DATE |
|                          | stated she has never hospital when residen  An interview was conc practical nurse) #3, the 7/28/2021 at 2:28 p.m. goes to the hospital, we resident, LPN #3 states summary, DNR (do not facesheet." When asked plan goals with the resident has never sent the care on 7/28/21 at 10:40 All with a list that included what documents were Resident #23 was tran 5/21/21 Nothing was paurvey.  On 7/29/21 at 8:45 AM services, Director of Noirector (Administratives #2, and #3 respectively findings. No further inforthe end of the survey.  7. The facility staff faile comprehensive care platter receiving facility upo #52 to the hospital on 5 were surved. | to f diagnoses when led to the hospital. LPN #4 sent care plan goals to the sent care plan goals to the stare transferred.  Itucted with LPN (licensed e unit manager, on When asked if a resident as documents go with the dashe sends the order of tresuscitate), and led if she sends the care lident, LPN #3 stated she led plan in all of her years.  If the facility was provided a request for evidence of sent to the hospital when sferred to the hospital on rovided by the end of the last facility was provided by the end of the last facility was provided by the end of the last facility was provided by the end of the last facility was provided by the end of the last facility was provided by the end of the last facility was provided by the end of the last facility was provided by the end of the last facility was provided by the end of the last facility readmitted to the led diagnoses of but not less, stroke, dysphasia, | F                  | 622 |   |                               |                            |

|                          | OF DEFICIENCIES<br>F CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  | (X2) MULTIPLE (     | CONSTRUCTION   | (X3) DATE S |                            |
|--------------------------|--|--|---------------------|--|-------------|----------------------------|
|                          |  | 495391   | B. WING             |  | 07/2        | 29/2021                    |
|                          | ROVIDER OR SUPPLIER  | CENTER   | 190                 | REET ADDRESS, CITY, STATE, ZIP CODE<br>OI LIBBIE AVE<br>CHMOND, VA 23226   |             |                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY   | ATEMENT OF DEFICIENCIES<br>' MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BI<br>CROSS-REFERENCED TO THE APPROPRIA<br>DEFICIENCY) |             | (X5)<br>COMPLETION<br>DATE |
|                          | and COVID-19. The repair of Data Set) was a quark with an ARD (Assessm 6/9/21. The resident viseverely cognitively in daily life decisions. The requiring total care for assistance for hygiene transfers; and supervious A review of the clinical following nurses notes 5/24/21 at 2:42 PM: "Cresident c/o (complain dizziness, BP 98/57 (complain dizziness, BP 98/57 (complain dizziness, dialysis cente (power of attorney) award dialysis, dialysis cente (power of attorney) awas 5/24/21 at 5:35 PM: "Asigns 91/53 (blood pre Temperature 100.7 96 RA (room air). Patient was alert to sel was assisted to room visite RP (responsible party) practitioner) were mad conditions."  5/24/21 at 8:15 PM: "Motified of resident low elevated temp (temper level. Writer place residiters nasal cannula). Rootified of change in contified in contified of change in contified in contified in contif | enal disease, pacemaker, most recent MDS (Minimum erly / 5-day assessment ment Reference Date) of was coded as being apaired in ability to make the resident was coded as bathing; extensive to tolleting, dressing, and the sion for eating.  The cord revealed the the the control of the part of th | F 622               |  |             |                            |

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

| CENTERS FOR MEDICARE & MEDICAID SERVICES |   |  | OMB NO. 0938-0391 |     |  |    |                            |  |
|--|---|--|-------------------|-----|--|----|----------------------------|--|
|  | OF DEFICIENCIES<br>F CORRECTION                     | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:                             |                   |     | LE CONSTRUCTION  |    | E SURVEY<br>PLETED         |  |
|  |   |  |                   |     |  |    | С                          |  |
|  |   | 495391   | B. WING           | _   |  | 07 | /29/2021                   |  |
| NAME OF P                                | ROVIDER OR SUPPLIER                                 |  |                   |     | STREET ADDRESS, CITY, STATE, ZIP CODE  |    |                            |  |
| GLENBUI                                  | RNIE REHAB & NURSING                                | CENTER   |                   |     | 1901 LIBBIE AVE  |    |                            |  |
|  |   |  |                   | L   | RICHMOND, VA 23226   |    |                            |  |
| (X4) ID<br>PREFIX<br>TAG                 | (EACH DEFICIENCY                                    | ATEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION) | ID<br>PREF<br>TAG |     | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) |    | (X5)<br>COMPLETION<br>DATE |  |
| = 000                                    |   |  |                   |     |  |    |                            |  |
| F 622                                    |   |  | F                 | 622 | 2  |    |                            |  |
|  | hospital) for observation                           | on."   | 1                 |     |  |    |                            |  |
|  | A physician's progress                              | s note dated 6/6/21  |                   |     |  |    |                            |  |
|  |   | recently admitted to the   |                   |     |  |    |                            |  |
|  |   | sis session since his blood  |                   |     |  |    |                            |  |
|  |   | very low and he had a  |                   |     |  |    |                            |  |
|  |   | and oxygen saturation was  |                   |     |  |    |                            |  |
|  |   | hospital led to diagnosis of   |                   |     |  |    |                            |  |
|  | sepsis from line infecti                            | e endocarditis He will be  | l l               |     |  |    | 1                          |  |
|  | _   | ious) cefazolin (2) 3 times  |                   |     |  |    |                            |  |
|  |   | during dialysis sessions.  |                   |     |  |    |                            |  |
|  |   | ultures dated 5/29/2021  |                   |     |  |    |                            |  |
|  |   | ous disease is following   |                   |     |  |    |                            |  |
|  | closely "   |  |                   |     |  |    |                            |  |
|  | Further review failed to                            | reveal any evidence that   |                   |     |  |    |                            |  |
|  |   | re plan goals were sent to   |                   |     |  | -  |                            |  |
|  | the receiving facility up                           | oon transfer.  |                   |     |  |    |                            |  |
|  | The "SNE / NE to Hose                               | oital Transfer Form" dated   |                   |     |  |    |                            |  |
|  |   | This form documented   |                   |     |  |    |                            |  |
| 1  | resident demographic                                |  |                   |     |  |    |                            |  |
|  | information, allergies,                             |  |                   |     |  |    | i i                        |  |
|  | status, treatments, pre                             |  |                   |     |  | 1  | 1                          |  |
|  | immunizations. Howev                                | ·  |                   |     |  |    |                            |  |
|  |   | comprehensive care plan  |                   |     |  | 1  |                            |  |
|  | goals were provided to                              | the receiving nospital.  |                   |     |  |    |                            |  |
|  | On 7/28/21 at 12:27 p.                              | m., an interview was   |                   |     |  |    |                            |  |
|  |   | censed practical nurse) #4.  |                   |     |  |    |                            |  |
|  |   | ds a transfer form, face   |                   |     |  |    |                            |  |
|  |   | ns, recent lab results and a   |                   |     |  |    |                            |  |
|  |   | residents are transferred  |                   |     |  |    |                            |  |
|  | to the hospital. LPN #4                             |  |                   |     |  |    |                            |  |
|  | sent care plan goals to<br>residents are transferre |  | 1                 |     |  |    |                            |  |
|  | TOURDING AID HAIISIDITE                             | 754 s  |                   |     |  |    |                            |  |
|  | An interview was condu                              | ucted with LPN (licensed   |                   |     |  |    |                            |  |

|                          | OF DEFICIENCIES<br>F CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  | (X2) MUL<br>A. BUILD |         | E CONSTRUCTION   |    | K3) DATE SURVEY<br>COMPLETED |  |
|--------------------------|--|--|----------------------|---------|--|----|------------------------------|--|
|                          |  | 495391   |                      | B. WING |  | 07 | C<br><b>07/29/2021</b>       |  |
|                          | ROVIDER OR SUPPLIER  RNIE REHAB & NURSING  | CENTER   | ·                    | 1:      | TREET ADDRESS, CITY, STATE, ZIP CODE<br>901 LIBBIE AVE<br>RICHMOND, VA 23226   |    |                              |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY   | ATEMENT OF DEFICIENCIES<br>' MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREF<br>TAG    |         | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BI<br>CROSS-REFERENCED TO THE APPROPRIA<br>DEFICIENCY) |    | (X5)<br>COMPLETION<br>DATE   |  |
| F 623                    | goes to the hospital, we resident, LPN #3 states summary, DNR (do not facesheet." When ask plan goals with the resident has never sent the care on 7/28/21 at 10:40 At with a list that included what documents were Resident #52 was trans Nothing identifying that goals were provided to 5/25/21 was provided.  On 7/29/21 at 8:45 AM services, Director of Not (Administrative Staff M #3 respectively) were resured to and fever.  Information obtained from the survey.  (1) Tylenol - is used to and fever.  Information obtained from the survey of the surv | e unit manager, on . When asked if a resident was documents go with the ed she sends the order of resuscitate), and ed if she sends the care sident, LPN #3 stated she re plan in all of her years.  M the facility was provided do a request for evidence of sent to the hospital when isferred on 5/24/21. It comprehensive care plan to the receiving hospital on | F6                   | 622     |  |    |                              |  |

|                          | OF DEFICIENCIES<br>F CORRECTION                      | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:                                | (X2) MUL <sup>-</sup><br>A. BUILDI |      | ECONSTRUCTION   |          | SURVEY<br>PLETED           |
|--------------------------|--|--|------------------------------------|------|---|----------|----------------------------|
|                          |  |  | , wooled                           | _    |   |          | С                          |
|                          |  | 495391   | B. WING                            |      |   |          | /29/2021                   |
| NAME OF P                | ROVIDER OR SUPPLIER                                  |  |                                    | S    | TREET ADDRESS, CITY, STATE, ZIP CODE  |          |                            |
| CLENBIL                  | RNIE REHAB & NURSING                                 | CENTER   | ]                                  | 19   | 901 LIBBIE AVE  |          |                            |
| GELNEO                   | THE KEHAD & NORSING                                  | CENTER   |                                    | R    | RICHMOND, VA 23226  |          |                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY                                     | ATEMENT OF DEFICIENCIES<br>' MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION) | ID<br>PREFIX<br>TAG                |      | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BI<br>CROSS-REFERENCED TO THE APPROPRIA'<br>DEFICIENCY) |          | (X5)<br>COMPLETION<br>DATE |
|                          |  |  |                                    |      | F623: Notice Requirements Bef   | ore      |                            |
| F 623                    | Continued From page                                  | 32   | F6                                 | 323  | Transfer/Discharge  |          |                            |
|                          | §483.15(c)(3) Notice I                               |  |                                    | - 1  | 1.Residents #101, #15, #23, and #   | 52       |                            |
|                          | Before a facility transf                             |  |                                    | - 1  | continue to reside in facility. Resi  |          |                            |
|                          | resident, the facility m                             |  | 1                                  |      | #83 and #114 have discharged fro  |          |                            |
|                          | (i) Notify the resident a                            | e transfer or discharge and  |                                    |      | facility.   | 111 1110 |                            |
|                          | the reasons for the mo                               | 0  |                                    | - 1  | 2.All residents have the potential  | to he    |                            |
|                          | language and manner                                  | •  |                                    |      | affected by this alleged deficient  | ,0 00    |                            |
|                          | facility must send a co                              |  |                                    |      | practice. Audit was conducted by  | Casia1   |                            |
|                          | representative of the C                              |  |                                    | - 1  | •   | - 1      |                            |
|                          | Long-Term Care Omb                                   |  |                                    |      | Service on resident discharged sin  | .ce      |                            |
|                          | (ii) Record the reasons discharge in the reside      |  |                                    | - 1  | 8/1/2021 have notification to the   |          |                            |
| 1                        |  | graph (c)(2) of this section;  |                                    | - 1  | Ombudsman, resident and RP.   |          |                            |
|                          | and  |  |                                    | - 1  | 3.Administrator or designee will educate nursing staff, social worke  |          |                            |
|                          |  | e the items described in   |                                    |      |   |          |                            |
|                          | paragraph (c)(5) of this                             | s section.   |                                    |      | and admissions team that any resid  |          |                            |
|                          | \$492 45/a)/4) Timing a                              | of the nation  |                                    |      | that is transferred and discharged  |          |                            |
| 1                        | §483.15(c)(4) Timing of                              | in paragraphs (c)(4)(ii) and   |                                    |      | the facility must have a notification   |          |                            |
|                          | (c)(8) of this section, the                          |  |                                    |      | writing to the Ombudsman, Reside  | ent      |                            |
|                          |  | der this section must be   |                                    | 0.10 | and RP.   | 1        | 1                          |
|                          |  | least 30 days before the   |                                    | 4    | 1. Social Service or designee will a  | ıudit    |                            |
|                          | resident is transferred                              | -  |                                    | t    | ransfers and/or discharges weekly   | ,        |                            |
|                          | (ii) Notice must be made<br>before transfer or disch | le as soon as practicable  |                                    | t    | imes 4 weeks and monthly times  | 2 to     |                            |
|                          |  | duals in the facility would  |                                    | e    | ensure that written notification of   | the      | 1                          |
|                          |  | paragraph (c)(1)(i)(C) of  |                                    | t    | ransfers/dischargers were provide   | d to     |                            |
|                          | this section;  | 3  |                                    |      | he Ombudsman, Resident and/or   |          | 1                          |
|                          |  | duals in the facility would  |                                    | - 1  | Any identified issues will be   |          | F                          |
|                          |  | paragraph (c)(1)(i)(D) of  |                                    | 100  | mmediately corrected. Results wi  | ll be    |                            |
|                          | this section;  | th improved quifficiently to   |                                    |      | eported to Quality Assurance  |          |                            |
|                          |  | th improves sufficiently to e transfer or discharge,                                 |                                    |      | committee for analysis and revisio  | n x 3    |                            |
|                          | under paragraph (c)(1)                               |  |                                    | - 1  | nonths.   | - 1. 2   |                            |
|                          | (D) An immediate trans                               |  |                                    |      | 5.Date of compliance will be Augu   | 1st 20   |                            |
|                          | required by the residen                              | t's urgent medical needs,  |                                    |      | 2021.   | .01 20,  | 1                          |
|                          | under paragraph (c)(1)                               |  |                                    | 12   | 021.  |          |                            |
| 1                        | (E) A resident has not r                             | esided in the facility for 30  |                                    |      |   |          |                            |

| NAME OF PROVIDER OR SUPPLIER  GLENBURNIE REHAB & NURSING CENTER  SIRRET ADDRESS, CITY, STATE, ZIP CODE  1991 LIBER ATE  RICHMOND, VA 23226  DESCRIPTION OF PROVIDER OR SUPPLIED FROM THE PROCEEDED BY PLU. PREFIX REGISTRATION OF PROPERTIES AND THE PROPERTIES OF PLU. TAG  F 623 Continued From page 33 days.  \$483,15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (ii) The effective date of transfer or discharge; (iii) The offective date of transfer or discharge; (iii) The offective date of transfer or discharge; (iii) The following: (iv) A statement of the resident is transferred or discharge; (iv) The name, address (mailing and email), and telephone number of the office of the State learning request; (v) The name, address (mailing and email) and tolephone number of the office of the State Long-Term Care Orthodosman; (vi) For nursing facility residents with intellectual and developmental disabilities exhibitises to under Part C of the Developmental Disabilities exhibitions to a disabilities of the specific proposal of the protection and advocacy of individuals with a mental disorder or related disabilities, the mailing and email address and telephone number of the office of the agency responsible for the protection and advocacy of individuals with a mental disorder or related disabilities, the mailing and email address and telephone number of the protection and advocacy of individuals with a mental disorder or related disabilities, the mailing and email address and telephone number of the specific or the protection and advocacy of individuals with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder or related disabilities of the protectio |           | OF DEFICIENCIES<br>F CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | (X2) MUL<br>A. BUILDI | TIPLE CONSTRUCTION  |      | (3) DATE SURVEY<br>COMPLETED |  |
|---|-----------|--|--|-----------------------|---|------|------------------------------|--|
| MAME OF PROVIDER OR SUPPLIER  GLENBURNIE REHAB & NURSING CENTER  BUMMARY STATEMENT OF DEFOSISCIES  (EACH OPERICAN MUST BE PRECEDED BY PILL REGULATORY OR LSC IDENTIFYING INFORMATION)  F 623  Continued From page 33  days.  \$443.15(c)(5) Contents of the notice, The written notice specified in paragraph (c)(3) of this section must include the following: (ii) The reason for transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident is transferred or discharged; (iv) A statement of the remaining and email), and telephone number of the office of the State Long-Term Care Ormbudsman; (vi) For nursing facility residents with a mental disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder or related disabilities or the mailing and email address and telephone number of the agency and (vii) For nursing facility residents with a mental disorder or related disabilities or the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder or related disabilities or the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder or related disabilities or the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.  §483.15(c)(6) Changes to the notice.   | 1         |  |  |                       |   |      | С                            |  |
| SLENBURNIEREHAB & NURSING CENTER   1991 LIBBLE AVE RICHMOND, VA 22226   10   PREFIX (EACH DERICISMO'N SIZE PRECEDED BY PILL REGULATORY OR I.S.C IDENTIFY NO INFORMATION)   TAG   PROVIDER'S PLAN OF CORRECTION (SACUE DERICISMO'N SIZE PRECEDED BY PILL REGULATORY OR I.S.C IDENTIFY NO INFORMATION)   TAG   PROPERTY TAG   PROVIDER'S PLAN OF CORRECTION (SACUE DERICISMO'N)   TAG   PROPERTY TAG   PROVIDER'S PLAN OF CORRECTION (PLAN OF TAG   PROVIDER'S PLAN OF CORRECTION (PLAN    |           |  | 495391   | B. WING               |   | 0.   | 7/29/2021                    |  |
| GLEMBURNIE REMAB & NURSING CENTER   RICHMOND, VA 23226  | NAME OF P | ROVIDER OR SUPPLIER  |  |                       | STREET ADDRESS, CITY, STATE, ZIP CODE                             |      |                              |  |
| (A4)ID PREFIX TAG  SUMMARY STATEMENT OF DEFICIENCIES PREFIX TAG  CACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  F 623  Continued From page 33 days.  \$483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (iii) The location to which the resident is transferred or discharges (iii) The location to which the resident is transferred or discharges (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402; codified at 42 U.S.C. 15001 et seq.), and (vii) For nursing facility residents with a mental disorder estabilished under the Protection and advocacy for individuals with a gency responsible for the protection and advocacy of individuals with a mental disorder estabilished under the Protection and advocacy for individuals Act.  S483.15(c)(6) Changes to the notice.   | CLEMBUR   |  | CENTER   |                       | 1901 LIBBIE AVE   |      |                              |  |
| PRÉRIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  F 623  Continued From page 33 days.  \$483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:  (i) The effective date of transfer or discharge; (ii) The ocation to which the resident is transferred or discharge; (iii) The location to which the resident is transferred or discharge; (iii) The location to which the resident is transferred or discharge; (iv) A statement of the retilty which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email), and telephone number of the office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L, 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder or related disabilities the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder related disabilities the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and advocacy for individuals with a mental disorder established under the Protection and advocacy of individuals with a mental disorder.  | GLENBUR   | RNIE REMAB & NURSING   | CENTER   |                       | RICHMOND, VA 23226  |      |                              |  |
| days.  §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:  (i) The reason for transfer or discharge; (ii) The location to which the resident is transferred or discharged; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities and to the protection and advocacy of rindividuals with agency responsible for the protection and advocacy of individuals with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the agency responsible for the protection and advocacy of individuals with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally III Individuals Act.   | PREFIX    | (EACH DEFICIENCY   | MUST BE PRECEDED BY FULL   | PREFI                 | X (EACH CORRECTIVE ACTION SHOUL<br>CROSS-REFERENCED TO THE APPROF | ) BE | COMPLETION                   |  |
| if the information in the notice changes prior to   |           | days.  §483.15(c)(5) Content notice specified in paramust include the follow (i) The reason for trar (ii) The effective date (iii) The location to what transferred or discharge (iv) A statement of the including the name, and telephone number receives such request to obtain an appeal for completing the form an hearing request; (v) The name, address telephone number of the Long-Term Care Ombi (vi) For nursing facility and developmental disabilities, the mailing telephone number of the protection and advice developmental disability C of the Developmental and Bill of Rights Act of codified at 42 U.S.C. 1 (vii) For nursing facility disorder or related disability disorder or rela | ts of the notice. The written agraph (c)(3) of this section wing: usfer or discharge; of transfer or discharge; ich the resident is ged; resident's appeal rights, ddress (mailing and email), r of the entity which s; and information on how rm and assistance in nd submitting the appeal s (mailing and email) and he Office of the State udsman; residents with intellectual sabilities or related and email address and he agency responsible for ocacy of individuals with ities established under Part I Disabilities Assistance f 2000 (Pub. L. 106-402, 5001 et seq.); and residents with a mental abilities, the mailing and phone number of the the protection and s with a mental disorder Protection and Advocacy als Act. | F                     | 623   |      |                              |  |

|                          | OF DEFICIENCIES<br>F CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   | 1                  | TIPLE CONSTRUCTION   | (X3) DATE SURVEY<br>COMPLETED |                            |  |
|--------------------------|---|---|--------------------|--|-------------------------------|----------------------------|--|
|                          |   | 495391  | B, WING            |  | Į.                            | C<br><b>07/29/2021</b>     |  |
|                          | ROVIDER OR SUPPLIER RNIE REHAB & NURSING  | CENTER  |                    | STREET ADDRESS, CITY, STATE, ZIP CODE<br>1901 LIBBIE AVE<br>RICHMOND, VA 23226 |                               |                            |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY  | ATEMENT OF DEFICIENCIES<br>/ MUST BE PRECEDED BY FULL<br>.SC IDENTIFYING INFORMATION)   | ID<br>PREFI<br>TAG |  |                               | (X5)<br>COMPLETION<br>DATE |  |
|                          | effecting the transfer of must update the recip as practicable once the becomes available.  §483.15(c)(8) Notice is In the case of facility of the administrator of the written notification prict to the State Survey Ag State Long-Term Care the facility, and the residual to the state survey Ag State Long-Term Care the facility, and the residual to the state survey Ag State Long-Term Care the facility, and the residual to the state survey Ag State Long-Term Care the facility, and the residual to the facility and the residual to the facility staff intervies and clinical record reviet facility staff failed to notification of transfer representative for six of sample, Residents #10 #52. | or discharge, the facility ients of the notice as soon are updated information  In advance of facility closure closure, the individual who is a facility must provide or to the impending closure gency, the Office of the e Ombudsman, residents of sident representatives, as a transfer and adequate ents, as required at §  is not met as evidenced  ew, facility document review iew, it was determined that | F                  | 623  |                               |                            |  |
|                          | on 6/15/21. The facility written notification of the  |   |                    |  |                               |                            |  |
|                          | were not limited to mul<br>and high blood pressur<br>quarterly minimum data   | 1's diagnoses included but tiple sclerosis, seizures  |                    |  |                               |                            |  |

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

|               | OF DEFICIENCIES<br>F CORRECTION                       | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER: | 1 ' '         |    | CONSTRUCTION   |    | SURVEY<br>PLETED   |
|---------------|---|---|---------------|----|--|----|--------------------|
|               |   |   | 71. 201231    |    |  | С  |                    |
|               |   | 495391  | B. WING       |    |  | 07 | /29/2021           |
|               | ROVIDER OR SUPPLIER                                   | CENTER  |               | 19 | TREET ADDRESS, CITY, STATE, ZIP CODE<br>901 LIBBIE AVE<br>ICHMOND, VA 23226          |    |                    |
| (X4) ID       | SUMMARY STA   | ATEMENT OF DEFICIENCIES                               | ID            | _  | PROVIDER'S PLAN OF CORRECTION  |    | (X5)               |
| PREFIX<br>TAG |   | MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)   | PREFIX<br>TAG | `  | (EACH CORRECTIVE ACTION SHOULD B<br>CROSS-REFERENCED TO THE APPROPRIA<br>DEFICIENCY) |    | COMPLÉTION<br>DATE |
| F 623         | Continued From page                                   |   | F 6           | 23 |  |    |                    |
|               | resident's cognitive sk<br>making as severely im      | -   |               |    |  |    |                    |
|               | Review of Resident #                                  |   |               |    |  |    |                    |
|               | revealed the resident                                 | was transferred to the ecause the resident was        |               |    |  |    |                    |
|               |   | ing out of the mouth and                              |               |    |  |    |                    |
|               | presented with rapid la<br>review of Resident #1      | abored breathing, Further                             |               |    |  |    |                    |
|               |   | s and a transfer form dated                           |               |    |  |    |                    |
|               | · ·   | resident's representative                             |               |    |  |    | 1                  |
|               | that written notification                             | nsfer but failed to reveal<br>of the transfer was     |               |    |  |    | ,                  |
|               | provided to Resident #                                | f101's representative.                                |               |    |  |    |                    |
|               | On 7/28/21 at 12:27 p. conducted with LPN (li         | .m., an interview was<br>censed practical nurse) #4.  |               |    |  |    |                    |
|               | LPN #4 stated she pro                                 | vides representatives with                            |               |    |  |    | l.                 |
|               | but does not provide w<br>transfers.                  | nt transfers to the hospital<br>rritten notice of the |               |    |  |    |                    |
|               |   | n., ASM (administrative                               |               |    |  |    |                    |
|               | staff member) #1 (the r<br>services) and ASM #2 (     | regional director of clinical                         |               |    |  |    |                    |
|               | were made aware of th                                 | · — ·   |               | I  |  |    |                    |
|               |   | , "Transfer or Discharge,                             |               |    |  |    |                    |
|               | Emergency" document<br>necessary to make an           | ed, "4. Should it become emergency transfer or        |               |    |  |    |                    |
|               | discharge to a hospital                               | or other related institution,                         |               |    |  |    |                    |
|               | our facility will impleme<br>procedures: e. Notify th | ent the following<br>re representative (sponsor)      |               |    |  |    |                    |
|               | or other family member                                |   |               |    |  |    |                    |
| 1             | No further information v                              | vas presented prior to exit.                          |               |    |  |    |                    |
| - 1           | Reference:<br>(1) Multiple Sclerosis is               | a nervous system                                      |               |    |  |    |                    |

|                          | OF DEFICIENCIES<br>F CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  |                    | TIPLE CONSTRUCTION  | (X3) DATE SURVEY<br>COMPLETED |                            |
|--------------------------|---|--|--------------------|---|-------------------------------|----------------------------|
|                          |   | 495391   | B, WING            |   |                               | C                          |
|                          | ROVIDER OR SUPPLIER   |  |                    | STREET ADDRESS, CITY, STATE, ZIP CODE 1901 LIBBIE AVE RICHMOND, VA 23226                                  | 1 07                          | 7/29/2021                  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)  | ATEMENT OF DEFICIENCIES<br>/ MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFI<br>TAG | PROVIDER'S PLAN OF CORRECTIC X (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY) | BE                            | (X5)<br>COMPLETION<br>DATE |
|                          | disease that affects the This information was on https://vsearch.nlm.nih meta?v%3Aproject=m medlineplus-bundle&qu 5.727485085.1627513122 2. The facility staff failmotification to Resident responsible party for the sent to the hospital.  Resident #83 was adm 5/3/2021 with a readm diagnoses that include urinary tract infection, in which hemorrhage of vessels of the brain lear resulting symptoms - sent to speak, paralysis of death) (1), and cancer.  The most recent MDS assessment, a Medical with an assessment reflected the resident as as (brief interview for ment the resident was mode daily cognitive decision as requiring extensive a activities of daily living was independent after approvided. | brain and spinal cord. botained from: n.gov/vivisimo/cgi-bin/query- nedlineplus&v%3Asources= nery=ms&_ga=2.16826909 8122-1380714373.1627513  ed to provide a written tt #83 and/or the ne reason the resident was  nitted to the facility on ission on 6/17/2021, with d but were not limited to: stroke (abnormal condition or blockage of the blood ads to oxygen lack and udden loss of ability to on arm or parts of the face], weakness or if severe, of the colon.  (minimum data set) re five day assessment, ference date of 6/24/2021, scoring a "9" on the BIMS tal status) score, indicating rately impaired to make s. The resident was coded assistance for most of his except eating in which he set up assistance was  , 6/1/2021 at 11:11 a.m. | F                  | 523   |                               |                            |
| 1                        |   | ortation with 2 attendants.  |                    |   |                               |                            |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION |   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   |                    |  |           | (X3) DATE SURVEY<br>COMPLETED |                            |  |
|--|---|---|--------------------|--|-----------|-------------------------------|----------------------------|--|
|  |   | 495391  | B, WING            | B, WING  |           |                               | C<br>07/29/2021            |  |
|  | OF PROVIDER OR SUPPLIER<br>BURNIE REHAB & NURSING   | CENTER  |                    | STREET ADDRESS, CITY, STATE, ZIP CODE 1901 LIBBIE AVE RICHMOND, VA 23226 |           |                               | 23/2021                    |  |
| (X4) I<br>PREF<br>TAG                            | X (EACH DEFICIENC)  | ATEMENT OF DEFICIENCIES<br>/ MUST BE PRECEDED BY FULL<br>.SC IDENTIFYING INFORMATION)   | ID<br>PREFI<br>TAG |  | SHOULD BE |                               | (X5)<br>COMPLETION<br>DATE |  |
| F 6.   | complaint of pain or didoctor) and RP (response Review of the clinical that a written notification resident was transferr provided to the resident for the hospital transfer.  An interview was conceptation practical nurse and/or the responsible as to the reason the rest the hospital, LPN #6 sonursing, maybe social nursing does not do the An interview was conceptational nurse at 2:28 p.m. resident or the responsible at 2:28 p.m. resident or the responsible party but diviting.  ASM (administrative st regional director of clinithe director of nursing, above findings on 7/28.  No further information of References:  (1) Barron's Dictionary | record failed to evidence on of the reason the ed to the hospital was nt and/or responsible party or on 6/1/2021.  ducted with LPN (licensed 7/28/2021 at 12:17 p.m. or provide the resident party something in writing esident was transferred to tated, "That's not on services does that but at."  ducted with LPN (licensed e unit manager, on provide the resident was transferred to tated, "That's not on services does that but at."  ducted with LPN (licensed e unit manager, on providing the sible party a written the resident is being pointal. LPN #3 stated they ident and/or their on't give them anything in aff member) #1, the ideal services, and ASM #2, were made aware of the | F                  | 623  |           |                               |                            |  |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |  | (X2) MULTIPLE CONSTRUCTION A. BUILDING   |         |  | (X3) DATE SURVEY<br>COMPLETED   |   |                            |
|---|--|--|---------|--|---|---|----------------------------|
|   |  | 495391   | B. WING |  |   | _ | C<br>/29/2021              |
|   | ROVIDER OR SUPPLIER<br>RNIE REHAB & NURSING  | CENTER   |         | 19   | TREET ADDRESS, CITY, STATE, ZIP CODE<br>901 LIBBIE AVE<br>ICHMOND, VA 23226 |   | 123/2021                   |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIENCY   | ATEMENT OF DEFICIENCIES<br>/ MUST BE PRECEDED BY FULL<br>.SC IDENTIFYING INFORMATION)  |         | ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROPR DEFICIENCY) |   |   | (X5)<br>COMPLETION<br>DATE |
| F 623   | Continued From page  | 38   | F       | 623  |   |   |                            |
|   | 3. The facility staff failed to provide a written notification to Resident #114 and/or the responsible party for the reason the resident was sent to the hospital.   |  |         |  |   |   |                            |
|   | 5/27/2021 with a recer with diagnoses that into: end stage renal dishemodialysis (a proce conditions and renal [I wastes and impurities blood by a special macobstructive pulmonary term for chronic, nonre is usually a combination chronic bronchitis) (2) anxiety disorder (state apprehension, often w | dure used in toxic kidney] failure, in which are removed from the chine) (1), chronic disease (COPD - general eversible lung disease that on of emphysema and high blood pressure and of mild to severe ithout specific cause, ges such as quickened |         |  |   |   |                            |
|   | Resident #114 as scor<br>(brief interview for men<br>the resident was mode<br>daily cognitive decision   | ly assessment, with an date of 7/15/2021, coded ing a "12" on the BIMS tal status) score, indicating rately impaired to make is. The resident was ance of one staff member   |         |  |   |   |                            |
| 1   | by the resident, who state the hospital. She state   | 7/5/2021 at 8:42 a.m. alled into the resident room ated she needed to go to d she felt full and wanted he also mentioned running   |         |  |   |   |                            |

|                          | OF DEFICIENCIES<br>CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  |                    | TIPLE CONSTRUCTION   |    | TE SURVEY<br>MPLETED       |
|--------------------------|---|--|--------------------|--|----|----------------------------|
|                          |   | 495391   | B. WING            |  |    | C<br>7/20/2024             |
|                          | ROVIDER OR SUPPLIER RNIE REHAB & NURSING  |  |                    | STREET ADDRESS, CITY, STATE, ZIP CODE 1901 LIBBIE AVE RICHMOND, VA 23226 |    | 7/29/2021                  |
| (X4) ID<br>PREFIX<br>TAG | FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL   |  | ID<br>PREFI<br>TAG |  | BE | (X5)<br>COMPLETION<br>DATE |
|                          | informed the resident and we will try to up he center contacted and to changed to 2:45 p.m. resident room with and resident was noted to lead to she was noted to be lead to she was she was she was taken to she was to she was to the reason the resident was the hospital, LPN #6 standard to the was the was conducted in the was | cours at the dialysis center. I today was her dialysis day er chair time. Dialysis the resident chair time was Writer back into the other team member. The have an acute change. aying on her right side in argic, oxygen via nasal Ig. VS (vital signs) T sat (saturation) 89% on 4 ure) 155/90, P (pulse) 77. otified and 911 called, the requesting to be of hospital). The resident hospital) for respiratory  ecord failed to evidence on of the reason the red to the hospital was at and/or responsible party on 7/5/2021.  For provide the resident party something in writing sident was transferred to ated, "That's not on services does that but at."  Incred with LPN (licensed unit manager, on regarding providing the lible party a written in resident is being | F                  | 523  |    |                            |

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

|                          | STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  |  | (X2) MULTIPLE CONSTRUCTION A. BUILDING |                                       |        | (X3) DATE SURVEY<br>COMPLETED |  |
|--------------------------|--|--|--|---------------------------------------|--------|-------------------------------|--|
|                          |  | 495391   | B. WING                                |                                       |        | C                             |  |
| NAME OF P                | ROVIDER OR SUPPLIER  | 455551   | 15                                     | STREET ADDRESS, CITY, STATE, ZIP CODE |        | 07/29/2021                    |  |
|                          |  |  |  | 1901 LIBBIE AVE                       |        |                               |  |
| GLENBU                   | RNIE REHAB & NURSING   | CENTER   |  | RICHMOND, VA 23226                    |        |                               |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY   | ATEMENT OF DEFICIENCIES<br>' MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFI<br>TAG                     |                                       | JLD BE | (X5)<br>COMPLETION<br>DATE    |  |
|                          | verbally inform the rest responsible party but of writing.  ASM (administrative stregional director of clirithe director of nursing above findings on 7/28 No further information  References: (1) Barron's Dictionary Non-Medical Reader, 8 Chapman, page 266. (2) Barron's Dictionary Non-Medical Reader, 8 Chapman, page 124. (3) Barron's Dictionary Non-Medical Reader, 8 Chapman, page 43. 4. The facility staff failed 15 and Resident # 15 statistication of a facility-Resident #15 on 05/18.  Resident # 15 was addiagnoses that included altered mental status, a Resident # 15's most reset], a quarterly assessing (assessment reference coded Resident # 15 as interview for mental statis interview for mental statis interview for mental statis regions a statistical part of the sta | sident and/or their don't give them anything in taff member) #1, the pical services, and ASM #2, were made aware of the 3/2021 at 5:07 p.m.  was provided prior to exit.  of Medical Terms for the 5th edition, Rothenberg and of Medical Terms for the 5th edition, Rothenberg and of Medical Terms for the 5th edition, Rothenberg and of Medical Terms for the 5th edition, Rothenberg and ed to provide Resident # a representative written einitiated transfer of /2021.  Initted to the facility with do but were not limited to: and diabetes mellitus [1]. Event MDS [minimum data ment with an ARD date) of 05/01/2021, as scoring a 15 on the brief tus (BIMS) of a score of 0 ely intact for making daily | F                                      | 623                                   |        |                               |  |
| 1                        | 05/18/2021 at 5:06 p.m.  |  |  |                                       |        |                               |  |

|                          | T OF DEFICIENCIES<br>OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  |                     | IPLE CONSTRUCTION<br>NG  | (X3) DATE SURVEY<br>COMPLETED |                            |
|--------------------------|---|--|---------------------|--|-------------------------------|----------------------------|
|                          |   | 495391   | B. WING             |  | C                             |                            |
| NAME OF                  |   | 490391   | B. WING             |  | 07                            | /29/2021                   |
|                          | PROVIDER OR SUPPLIER  JRNIE REHAB & NURSING   | CENTER   |                     | STREET ADDRESS, CITY, STATE, ZIP CODE  1901 LIBBIE AVE  RICHMOND, VA 23226                                   |                               |                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY  | ATEMENT OF DEFICIENCIES<br>'MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | 3E                            | (X5)<br>COMPLETION<br>DATE |
| F 623                    | received a call from [N stating MD [medical d Doctor] would like for the ER [emergency ro elevated sodium of 16 [responsible party] wa had spoken with the M the MD. She would lik out. 911 called."  Review of the clinical (electronic health reco to evidence that a writt was provided to the rerepresentative for the 05/18/2021 for Reside  On 7/28/21 at 12:27 p. conducted with LPN (liregarding written notifithe resident's representative resident transfers to the provide written notice of the above concern.  No further information was References: [1] A chronic disease in regulate the amount of goal of treatment at firs blood glucose level. Lo | lame of Nurse Practitioner], octor], [Name of Medical the resident to be sent to om] via [by] 911 due to 0. The resident RP is called. She stated she ID and is in agreement with the for her mom to be sent record and the EHR in the form of the for | F6                  | 23   |                               |                            |

|                          | TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA ND PLAN OF CORRECTION IDENTIFICATION NUMBER:   |   | (X2) MULTIPLE CONSTRUCTION A. BUILDING |   |          | ATE SURVEY<br>OMPLETED     |
|--------------------------|---|---|--|---|----------|----------------------------|
|                          |   | 495391  | B, WING                                |   |          | C<br>07/29/2021            |
|                          | ROVIDER OR SUPPLIER   | CENTER  |  | STREET ADDRESS, CITY, STATE, ZIP CODE 1901 LIBBIE AVE RICHMOND, VA 23226                            |          | 0112312021                 |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)  | ATEMENT OF DEFICIENCIES<br>' MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG                    | PROVIDER'S PLAN OF CORR<br>(EACH CORRECTIVE ACTION SH<br>CROSS-REFERENCED TO THE APF<br>DEFICIENCY) | IOULD BE | (X5)<br>COMPLETION<br>DATE |
|                          | to treat and manage to active and eating heal was obtained from the https://medlineplus.go 5. The facility staff fail written notice of a hos to the responsible part transfer to the hospital Resident #23 was adr 1/10/20, discharged to readmitted to the facility had the diagnoses of a quadriplegia, aphasia, blood pressure, COVII The admission / 5-day with an ARD (Assessm 7/19/21 coded the resident was code all areas of activities of the resident was code all areas of activities of A review of the clinical note dated 5/21/21 that resident room by nursi with respiratory distress cpr (cardio pulmonary in called, MD (medical do (responsible party) not several times, respirativital signs within normal (emergency medical te resident is at baseline, | thy foods. This information website:  v/ency/article/000313.htm. ed to evidence that a pital transfer was provided by upon Resident #23's and 5/21/21.  mitted to the facility on a home on 6/1/21 and by on 7/13/21. The resident put not limited to a stroke, diabetes, anxiety, high 0-19, and contractures.  MDS (Minimum Data Set) ent Reference Date) of dent as moderately aske daily life decisions, and as requiring total care for a faily living.  record revealed a nurse's todout down the food one staff, resident noted so, blue tinge color to skin, resuscitation) initiated, 911 potor) called, rpuffied, resident suctioned one returned to normal, all limits at the time emt's chnician) arrived to facility, emt's decided on taking any room) for evaluations, er (emergency room)." | F 62                                   | 23  |          |                            |

|                     | STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:   |  |                    | TIPLE CONSTRUCTION<br>ING  | (X3) DATE SURVEY<br>COMPLETED |                            |
|---------------------|---|--|--------------------|--|-------------------------------|----------------------------|
|                     |   | 495391   | B. WING            |  | 07/2                          | )<br>29/2021               |
|                     | DF PROVIDER OR SUPPLIER BURNIE REHAB & NURSING  | CENTER   |                    | STREET ADDRESS, CITY, STATE, ZIP CODE<br>1901 LIBBIE AVE<br>RICHMOND, VA 23226 |                               |                            |
| (X4)<br>PREF<br>TAG | IX (EACH DEFICIENCY   | ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)  | ID<br>PREFI<br>TAG | ,  |                               | (X5)<br>COMPLETION<br>DATE |
| F                   | female with significan Patient was sent to El d/t (due to) respiratory admitted to (name of airway, found to have infection) w/ (with) E. treated with IV (intrave therapy), stabilized, di (facility)"  Further review of the creveal any evidence the hospital transfer was provened in the folial transfer was provened with LPN (lith LPN #4 stated she proverbal notice of resides but does not provide with transfers.  An interview was conditional provides the resident of written notification as to transferred to the hospiverbally inform the residence on 7/28/21 at 10:40 AM | ent #23) is a 69-year-old to past medical history.  O (emergency department) or distress. Resident was mospital) for aspiration into a UTI (urinary tract)  Coli (Escherichia coli) and enous) ABT (antibiotic scharged, and returned to enous) ABT (antibiotic scharged, and returned to enous) and enous) ABT (antibiotic scharged, and returned to enous) and enous) ABT (antibiotic scharged, and returned to enous) and enous | F                  | 623  |                               |                            |

|                          | OF DEFICIENCIES<br>F CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  |                     | (X2) MULTIPLE CONSTRUCTION A. BUILDING   |       |                            |  |
|--------------------------|---|--|---------------------|--|-------|----------------------------|--|
|                          |   | 495391   | B. WING             |  | 0.    | C<br>07/29/2021            |  |
| 3                        | ROVIDER OR SUPPLIER RNIE REHAB & NURSING  | CENTER   |                     | STREET ADDRESS, CITY, STATE, ZIP CODE<br>1901 LIBBIE AVE<br>RICHMOND, VA 23226                             |       |                            |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)  | ATEMENT OF DEFICIENCIES<br>/ MUST BE PRECEDED BY FULL<br>.SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECT<br>(EACH CORRECTIVE ACTION SHOU<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY) | LD BE | (X5)<br>COMPLETION<br>DATE |  |
|                          | 5/21/21. Nothing was On 7/29/21 at 8:45 AN Director of Nursing an (Administrative Staff N #3 respectively) were No further information the survey.  6. The facility staff fails written notice of a hosy to the responsible part on 5/24/21 for Resider  Resident #52 was most facility on 6/4/21 with to limited to sepsis, diabed dysphagia, insomnia, sepressure, end stage re and COVID-19. The m Data Set) was a quarte with an ARD (Assessme 6/9/21. The resident we severely cognitively im daily life decisions. The requiring total care for assistance for hygiene transfers; and supervis  A review of the clinical of following nurses notes: 5/24/21 at 2:42 PM: "Ciresident c/o (complain of dizziness, BP 98/57 (b) (medical doctor) aware dialysis, dialysis center | when the Administrator, and Medical Director Members (ASM) #1, #2, and made aware of the findings. was provided by the end of the en | F 6:                | 23   |       |                            |  |

|                          | STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:   |  | (X2) MULTIPLE CONSTRUCTION A. BUILDING |  |           | (X3) DATE SURVEY<br>COMPLETED |                            |
|--------------------------|---|--|--|--|-----------|-------------------------------|----------------------------|
|                          |   |  |  |  |           | С                             |                            |
|                          |   | 495391   | B, WING                                |  |           | 07                            | /29/2021                   |
|                          | ROVIDER OR SUPPLIER  RNIE REHAB & NURSING   | CENTER   |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br>1901 LIBBIE AVE<br>RICHMOND, VA 23226 |           |                               | j                          |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY  | ATEMENT OF DEFICIENCIES<br>'MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFI<br>TAG                     |  | SHOULD BE |                               | (X5)<br>COMPLETION<br>DATE |
|                          | 5/24/21 at 5:35 PM: "signs 91/53 (blood pre Temperature 100.7 96 was given Tylenol (1). with confusion. Patien girlfriend at bedside. FNP (nurse practitioner patients conditions."  5/24/21 at 8:15 PM: "Notified of resident low elevated temp, low O2 place resident on O2 A cannula). RP (responsichange in condition and ED (emergency depart for observation."  A physician's progress documented, "was rehospital after his dialys pressure was running vitemperature of 100.3 at 83evaluation in the his sepsis from line infection diagnosed with infection continuing IV cefazolin weeks during dialysis is blood cultures dated 5/2 Infectious disease is follower than the sepsital transfer was preveal any evidence that hospital transfer was prevented to the septial transfer to the septial transfer to the septial transfer to the s | Assessed patient. Vital essure) pulse 81 1% on RA (room air). Patient Patient was alert to self to was assisted to room with RP (responsible party) and were made aware of MD (medical doctor) Pal/P (blood pressure), Pal/P ( | F                                      | 623  |           |                               |                            |

|                          | OF DEFICIENCIES<br>F CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  |                     | IPLE CONSTRUCTION  | (X3) DATE<br>COMP | SURVEY<br>PLETED           |
|--------------------------|---|--|---------------------|--|-------------------|----------------------------|
|                          |   | 495391   | B. WING             |  |                   | C                          |
| NAME OF P                | ROVIDER OR SUPPLIER   | 40001  |                     | STREET ADDRESS, CITY, STATE, ZIP CODE  | 077               | 29/2021                    |
| GLENBUI                  | RNIE REHAB & NURSING  | CENTER   |                     | 1901 LIBBIE AVE<br>RICHMOND, VA 23226  |                   |                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY  | ATEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROPRI<br>DEFICIENCY) | BE                | (X5)<br>COMPLETION<br>DATE |
|                          | documented resident of contact information, a functional status, treat immunizations. However documentatition that a hospital transfer was proceeded with LPN (little LPN #4 stated she proverbal notice of reside but does not provide with transfers.  An interview was conditionally provided and practical nurse) #3, the resident or the responsible party but diviting.  On 7/28/21 at 10:40 AN with a list that included written notification to the transfer when the resident of the resident or the | vas reviewed. This form demographic information, llergies, code status, ments, precautions, and ver, there was no written notification of a provided to the RP.  .m., an interview was censed practical nurse) #4. wides representatives with not transfers to the hospital written notice of the ucted with LPN (licensed a unit manager, on When asked if she give ponsible party a written note resident is being ital, LPN #3 stated they dent and/or their on't give them anything in the facility was provided a request for evidence of e RP of the hospital ent was transferred on er provided.  The Administrator, Medical Director | F 62                | 23   |                   |                            |

| A95391  NAME OF PROVIDER OR SUPPLIER  GLENBURNIE REHAB & NURSING CENTER  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  F 623  Continued From page 47  (1) Tylenol - is used to treat mild to moderate pain and fever. Information obtained from https://medlineplus.gov/druginfo/meds/a681004.html  (2) Cefazolin - is an antibiotic. Information obtained from https://medlineplus.gov/druginfo/meds/a682731.html  F 625  Notice of Bed Hold Policy Before/Upon Trnsfr  F 625  Notice of Bed Hold Policy Before/Upon Trnsfr  A95391  STREET ADDRESS, CITY, STATE, ZIP CODE 1901 LIBBIE AVE RICHMOND, VA 23226  STREET ADDRESS, CITY, STATE, ZIP CODE 1901 LIBBIE AVE RICHMOND, VA 23226  F 623  F 625  Notice of Bed Hold Policy Before/Upon Transfer  1. Residents #80, #15, #23, and #52  TRESIDENT AND ADDRESS, CITY, STATE, ZIP CODE 1901 LIBBIE AVE RICHMOND, VA 23226  F 625  STREET ADDRESS, CITY, STATE, ZIP CODE 1901 LIBBIE AVE RICHMOND, VA 23226  F 625  F 625  F 625  STREET ADDRESS, CITY, STATE, ZIP CODE 1901 LIBBIE AVE RICHMOND, VA 23226  F 626 PROVIDER SHAN OF CORRECTION (EACH OERRICIVE ACTION SHOULD BE CROSS-REFERINCED TO THE APPROPRIATE DEFICIENCY)  F 623  F 623  F 625  F 625  F 625  Notice of Bed Hold Policy Before/Upon Transfer  1. Residents #80, #15, #23, and #52  T A STREET ADDRESS, CITY, STATE, ZIP CODE 1901 LIBBIE AVE RICHMOND, VA 23226  F 625  F 625  F 625  F 625 |               | OF DEFICIENCIES<br>OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | (X2) MULTIP | PLE CONSTRUCTION   | (X3) DATE SURVEY<br>COMPLETED  |                            |
|--|---------------|---|--|-------------|--|--|----------------------------|
| NAME OF PROVIDER OR SUPPLIER  GLENBURNIE REHAB & NURSING CENTER    STREET ADDRESS, CITY, STATE, ZIP CODE   |               |   | 495391   |             |  |  |                            |
| F 623  Continued From page 47 (1) Tylenol - is used to treat mild to moderate pain and fever. Information obtained from https://medlineplus.gov/druginfo/meds/a681004.html  (2) Cefazolin - is an antibiotic. Information obtained from https://medlineplus.gov/druginfo/meds/a682731.html  Notice of Bed Hold Policy Before/Upon Trnsfr  F 625  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  F 623  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  F 623  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  F 623  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)   |               |   |  |             | 1901 LIBBIE AVE  |  | 12912021                   |
| (1) Tylenol - is used to treat mild to moderate pain and fever. Information obtained from https://medlineplus.gov/druginfo/meds/a681004.html  (2) Cefazolin - is an antibiotic. Information obtained from https://medlineplus.gov/druginfo/meds/a682731.html  F 625 Notice of Bed Hold Policy Before/Upon Trnsfr  F 625 Notice of Bed Hold Policy Before/Upon Trnsfr  F 625 Notice of Bed Hold Policy Before/Upon Trnsfr   | PREFIX        | (EACH DEFICIENCY  | Y MUST BE PRECEDED BY FULL   | PREFIX      | (EACH CORRECTIVE ACTION SHOULD E<br>CROSS-REFERENCED TO THE APPROPRIA  | BE .   | (X5)<br>COMPLETION<br>DATE |
| SS=E CFR(s): 483.15(d)(1)(2)  §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section.  §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing  | F 625<br>SS=E | (1) Tylenol - is used to and fever. Information obtained th https://medlineplus.go tml  (2) Cefazolin - is an ar Information obtained fhttps://medlineplus.go tml  (2) Cefazolin - is an ar Information obtained fhttps://medlineplus.go tml  Notice of Bed Hold Po CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of be sursing facility transfer the resident goes on the nursing facility must provide the resident or resident specifies— (i) The duration of the sany, during which the return and resume resifacility; (ii) The reserve bed paplan, under § 447.40 of (iii) The nursing facility' bed-hold periods, which paragraph (e)(1) of this resident to return; and (iv) The information specifies section.  §483.15(d)(2) Bed-hold the time of transfer of a | treat mild to moderate pain from hydruginfo/meds/a681004.h  httibiotic. from hydruginfo/meds/a682731.h  licy Before/Upon Trnsfr 2)  hed-hold policy and return- hefore transfer. Before a rs a resident to a hospital or herapeutic leave, the hovide written information to her representative that  state bed-hold policy, if resident is permitted to hidence in the nursing  yment policy in the state f this chapter, if any; s policies regarding h must be consistent with he section, permitting a  hecified in paragraph (e)(1) | F 625       | F625: Notice of Bed Hold Police Before/Upon Transfer  1. Residents #80, #15, #23, and #5 continue to reside in facility. Resi #83 and #114 have discharged frofacility.  2. All residents have the potential affected by this alleged deficient practice. Audit by Admissions on residents transferred and currently hospital will be conducted to verification received Notice of Bed H Policy  3. Administrator or designee will educate nursing, social workers, a admissions staff that any resident transferred from the facility must provided bed hold notification to the Resident and/or RP.  4. Admission staff or designee will transfers and/or discharges weekly times 4 weeks and monthly times ensure that any Resident that is | idents om the to be to be in the fy if fold  and that is be the l audit y 2 to |                            |

| I  | STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION |  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  | (X2) MULTIPLE CONSTRUCTION  A. BUILDING |     | (X3) DATE SURVEY<br>COMPLETED   |                             |                            |
|----|---|--|--|---|-----|---|-----------------------------|----------------------------|
| I  |   |  | 495391   | B. WING                                 |     |   | C<br>07/29/2021             |                            |
| ŀ  | NAME OF P   | ROVIDER OR SUPPLIER  |  |   | _   | TREET ADDRESS OF COLUMN   | 07                          | 729/2021                   |
| l  | TO MALE OF T  | NOVIDEN ON GOL LEEN  |  |   |     | STREET ADDRESS, CITY, STATE, ZIP CODE   |                             |                            |
| l  | GLENBU  | RNIE REHAB & NURSING   | CENTER   |   |     | 901 LIBBIE AVE  |                             |                            |
| l. |   |  |  |   | F   | RICHMOND, VA 23226  |                             |                            |
|    | (X4) ID<br>PREFIX<br>TAG                            | (EACH DEFICIENCY   | NTEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)   | ID<br>PREFI<br>TAG                      |     | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIA'<br>DEFICIENCY)   |                             | (X5)<br>COMPLETION<br>DATE |
|    |   | Based on staff intervier and clinical record revise facility staff failed to provide the survey #15, #23 and #52.  The findings include:  1. The facility staff failed and/or responsible paranotification prior to and hospital on 6/1/2021.  Resident #83 was admitional facility facility for the survey and the survey for the brain least resulting symptoms - surveysels of the brain least resulting symptoms - surveysels with an assessment, a Medicard with an assessment reference of the provided Resident #83 as brief interview for mention the resident was moderated and the provided Resident was moderated Resident Re | e written notice which of the bed-hold policy h (d)(1) of this section. is not met as evidenced ew, facility document review ew, it was determined the ovide a notice of bed hold ansfer for six of 49 example, #83, #114, #80, as a sample, #83, #114, #80, as a six with a bed hold or upon a transfer to the ditted to the facility on ssion on 6/17/2021, with a but were not limited to: troke (abnormal condition or blockage of the blood didden loss of ability to a rarm or parts of the face], reakness or if severe, of the colon.  The day assessment, erence date of 6/24/2021, scoring a "9" on the BIMS all status) score, indicating | F                                       | 625 | bed hold notification to the Reside and/or RP. Any identified issues immediately corrected. Results wireported to Quality Assurance committee for analysis and revision months.  5.Date of compliance will be Aug 2021. | will be<br>ill be<br>on x 3 |                            |

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION |  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   | (X2) MUL<br>A. BUILD |     | CONSTRUCTION  | (X3) DATE SURVEY<br>COMPLETED |                            |  |
|---|--|---|----------------------|-----|---|-------------------------------|----------------------------|--|
|   |  | 495391  | B, WING              |     |   | 07                            | C<br>/ <b>29/2021</b>      |  |
|   | ROVIDER OR SUPPLIER  | CENTER  |                      | 190 | REET ADDRESS, CITY, STATE, ZIP CODE  1 LIBBIE AVE CHMOND, VA 23226  |                               |                            |  |
| (X4) ID<br>PREFIX<br>TAG                            | (EACH DEFICIENC)   | ATEMENT OF DEFICIENCIES<br>/ MUST BE PRECEDED BY FULL<br>.SC IDENTIFYING INFORMATION)   | ID<br>PREF<br>TAG    |     | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD B<br>CROSS-REFERENCED TO THE APPROPRIA<br>DEFICIENCY) | E                             | (X5)<br>COMPLETION<br>DATE |  |
|   | provided.  The nurse's note date documented, "The resonance mergency transperson the was alert and oried complaint of pain or doctor) and RP (responsible paint of the clinical bed hold notice was pand/or responsible paint ansfer to the hospital on 7/28/21 at 12:27 piconducted with LPN (ILPN #4 stated the nurpolicy with residents with the hospital but they do that this is done.  An interview was conceptational nurse) #3, the 7/28/2021 at 2:28 p.m. provide the resident or the bed hold policy, LF is unable to talk about responsible party to see bed. When asked whe information, LPN #3 st documented in the nur The facility policy, "Transfered to the bed hold."  The facility policy, "Bed readily pol | and, 6/1/2021 at 11:11 a.m. sident left the facility via cortation with 2 attendants. Inted. He was clean. No iscomfort. MD (medical consible party) aware."  Trecord failed to evidence a rovided to the resident rity prior to and or upon I on 6/1/2021.  I.m., an interview was idensed practical nurse) #4. It is seen send the bed hold when they are transferred to o not document evidence a unit manager, on it. When asked if they responsible party notice of PN #3 stated if the resident it, she reaches out to the see if they want to hold the re staff document this ated it should be se's note. | F                    | 625 |   |                               |                            |  |

|                          | OF DEFICIENCIES<br>F CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  | A. BUILD           | TIPLE CONSTRUCTION  ING               |    | E SURVEY<br>PLETED         |
|--------------------------|--|---|--------------------|---------------------------------------|----|----------------------------|
|                          |  |   |                    | · ·                                   |    | С                          |
| NAME OF P                | ROVIDER OR SUPPLIER  | 495391  | B. WING            | STREET ADDRESS, CITY, STATE, ZIP CODE | 07 | //29/2021                  |
|                          | RNIE REHAB & NURSING   | CENTER  |                    | 1901 LIBBIE AVE RICHMOND, VA 23226    |    |                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY   | ATEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)  | ID<br>PREFI<br>TAG |                                       | BE | (X5)<br>COMPLETION<br>DATE |
|                          | information will be giv resident representativ. The rights and limitative garding bed-holds; it policy as indicated by residents); c. The facil hold a bed (non-Medic bed beyond the state residents); d. The deta Notice of Transfer)."  ASM (administrative s regional director of clirithe director of nursing above findings on 7/28 No further information.  References: (1) Barron's Dictionary Non-Medical Reader, 8 Chapman, page 114.  2. The facility staff faile and/or the responsible notification upon transity/2/2021.  Resident # 114 was ac 5/27/2021 with a recen with diagnoses that incite end stage renal dischemodialysis (a proced conditions and renal [k wastes and impurities a blood by a special mac obstructive pulmonary | en to the resident and the les that explains in detail: a. lons of the resident b. The reserve bed payment the state plan (Medicaid lity per diem rate required to caid residents) or to hold a bed=hold period (Medicaid ails of the transfer (per the lical services, and ASM #2, were made aware of the 8/2021 at 5:07 p.m. was provided prior to exit.  of Medical Terms for the oth edition, Rothenberg and led to provide Resident #114 party with a bed hold fer to the hospital on  dmitted to the facility on t readmission on 7/9/2021, cluded but were not limited lease requiring dure used in toxic lidney] failure, in which lare removed from the lethine) (1), chronic disease (COPD - general liversible lung disease that | F                  | 625                                   |    |                            |

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 08/10/2021 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER: A. BUILDING COMPLETED С 495391 B. WING NAME OF PROVIDER OR SUPPLIER 07/29/2021 STREET ADDRESS, CITY, STATE, ZIP CODE GLENBURNIE REHAB & NURSING CENTER 1901 LIBBIE AVE RICHMOND, VA 23226 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION DATE PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 625 Continued From page 51 F 625 chronic bronchitis) (2) high blood pressure and anxiety disorder (state of mild to severe apprehension, often without specific cause, resulting in body changes such as quickened heartbeat and sweat). (3) The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 7/15/2021, coded Resident # 114 as scoring a "12" on the BIMS (brief interview for mental status) score, indicating the resident was moderately impaired to make daily cognitive decisions. The resident was coded as limited assistance of one staff member for most of her activities of daily living. A nurse's note dated, 7/5/2021 at 8:42 a.m. documented, "Writer called into the resident room by the resident, who stated she needed to go to the hospital. She stated she felt full and wanted to get dialysis there. She also mentioned running for 3 hours versus 4 hours at the dialysis center. I informed the resident today was her dialysis day and we will try to up her chair time. Dialysis center contacted and the resident chair time was changed to 2:45 p.m. Writer back into the

respiratory distress."

resident room with another team member. The resident was noted to have an acute change. She was noted to be laying on her right side in bed, eyes closed, lethargic, oxygen via nasal cannula at 4 liters going. VS (vital signs) T (temperature) 101; O2 sat (saturation) 89% (percent) on 4 liters, BP (blood pressure) 155/90, P (pulse) 77. MD (medical doctor) notified and 911 called, the resident left the facility, requesting to be transported to (initials of hospital). The resident was taken to (name of hospital) for

| ENT OF DEFICIENCIES<br>AN OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | 1 ' '              | TIPLE CONSTRUCTION<br>ING             | (X3) DATE SURVE<br>COMPLETED |                          |
|---|--|--------------------|---------------------------------------|------------------------------|--------------------------|
|   |  |                    |                                       | С                            |                          |
|   | 495391   | B. WING            |                                       | 07/29/20                     | )21                      |
| OF PROVIDER OR SUPPLIER   |  |                    | STREET ADDRESS, CITY, STATE, ZIP CODE |                              |                          |
| BURNIE REHAB & NURSIN   | G CENTER   |                    | 1901 LIBBIE AVE                       |                              |                          |
| DOTATIL REFINE G HOROM  | o other th   |                    | RICHMOND, VA 23226                    |                              |                          |
| IX (EACH DEFICIENC  | TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)   | ID<br>PREFI<br>TAG |                                       | E COM                        | (X5)<br>IPLETION<br>DATE |
| bed hold notice was pand/or the responsible transfer to the hospital transfer to the hospital transfer to the hospital conducted with LPN (LPN #4 stated the nupolicy with residents the hospital but they that this is done.  An interview was compractical nurse) #3, the 7/28/2021 at 2:28 p.m. provide the resident of the bed hold policy, L is unable to talk abour responsible party to seed. When asked whe information, LPN #3 seed documented in the number of the director of clir the director of nursing above findings on 7/2:  No further information  References:  (1) Barron's Dictionary Non-Medical Reader, Chapman, page 266.  (2) Barron's Dictionary Non-Medical Reader, Chapman, page 124.  (3) Barron's Dictionary | record failed to evidence a provided to Resident #114 le party prior to and or upon al on 7/5/2021.  p.m., an interview was (licensed practical nurse) #4. It is sessed the bed hold when they are transferred to do not document evidence  ducted with LPN (licensed the unit manager, on the manager, on the manager, on the way are responsible party notice of PN #3 stated if the resident to the the eight of the the stated it should be the ere staff document this stated it should be the stated it should be the stated it should be the stated it services, and ASM #2, the were made aware of the | F                  | 525                                   |                              |                          |

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION |  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  | (X2) MULTIPLE CONSTRUCTION  A, BUILDING |                                       | (X3) DATE SURVEY<br>COMPLETED |                            |
|---|--|--|---|---------------------------------------|-------------------------------|----------------------------|
|   |  |  |   |                                       | С                             |                            |
|   |  | 495391   | B. WING                                 |                                       | 07/                           | 29/2021                    |
| NAME OF F   | ROVIDER OR SUPPLIER  |  |   | STREET ADDRESS, CITY, STATE, ZIP CODE | -                             |                            |
| CLENDIII  | RNIE REHAB & NURSING   | CENTED   |   | 1901 LIBBIE AVE                       |                               |                            |
| GLENBU  | KINIE KEITAD & NUKSING   | CENTER   |   | RICHMOND, VA 23226                    |                               |                            |
| (X4) ID<br>PREFIX<br>TAG                            | (EACH DEFICIENCY   | ATEMENT OF DEFICIENCIES<br>/ MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFI<br>TAG                      |                                       |                               | (X5)<br>COMPLETION<br>DATE |
|   | Chapman, page 43.  3. The facility staff fai copy of the bed hold p Resident #80 at the til 06/01/2021.  Resident #80 was ad diagnoses included budisease and stroke. Resident #80's most is set), a quarterly assess (assessment reference coded Resident #80 a brief interview for men of 0 - 15, nine - being cognition for making description for ma | led to provide or send a policy to the hospital with me of transfer on mitted to the facility with at were not limited to: heart recent MDS (minimum data sment with an ARD edate) of 06/22/2021, as scoring a nine [9] on the stall status (BIMS) of a score moderately impaired of aily decisions.  Ident #80 dated noted and the food of the bed pillow esident was noted to be lying on an on the floor, with a pillow esident was last seen of the bed, eating his dinner. The foot of the bed. The idented. Writer went to do assessment to assist the resident refused, stating sk hurt. This writer tried to and explain what I was not continue to refuse my ant to go to the hospital' to the facility. Upon resident was on the floor ed, 'he went to get in his from under him.' He is [emergency medical] | F                                       | 625                                   |                               |                            |

|                          | OF DEFICIENCIES<br>F CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  | ` '                | TIPLE CONSTRUCTION ING                |        | (X3) DATE SURVEY<br>COMPLETED |  |
|--------------------------|--|---|--------------------|---------------------------------------|--------|-------------------------------|--|
|                          |  |   | A. BOILD           |                                       |        | С                             |  |
|                          |  | 495391  | B. WING            | <del></del>                           |        | 07/29/2021                    |  |
| NAME OF P                | ROVIDER OR SUPPLIER  |   |                    | STREET ADDRESS, CITY, STATE, ZIP CODE |        | *                             |  |
| GLENBUR                  | RNIE REHAB & NURSING   | CENTER  |                    | 1901 LIBBIE AVE                       |        |                               |  |
|                          |  |   | ,                  | RICHMOND, VA 23226                    |        |                               |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY   | ATEMENT OF DEFICIENCIES  'MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)   | ID<br>PREFI<br>TAG |                                       | ULD BE |                               |  |
|                          | No protective equipme called to [Name of Hospital State Review of the EHR [ethe paper clinical recoto evidence document was provided to Resideresponsible party in rehospital on.  On 7/28/21 at 12:27 p conducted with LPN (li LPN #4 stated the numpolicy with residents with the hospital but they dithat this is done.  On 07/28/2021 at application of the services, ASM ASM #4, medical direction above concern.  No further information of the services of the bed hold portion of the services of the services of the time of the services of the serv | nt was alert and oriented. ent was noted. Report spital] ER and given to ff Member]."  lectronic health record] and ord for Resident # 80 failed ation that a bed hold policy ent # 80 or Resident # 80's egard to the transfer to the  .m., an interview was idensed practical nurse) #4. ses send the bed hold when they are transferred to o not document evidence  reximately 5:00 p.m., ASM ember] #1, director of # 2, director of nursing and otor, were made aware of  was presented prior to exit.  ed to provide or send a olicy to the hospital with | F                  | 625                                   |        |                               |  |
|                          | set], a quarterly assessi<br>(assessment reference   |   |                    |                                       |        |                               |  |

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION |  | IDENTIFICATION NUMBER:   |                     | MULTIPLE CONSTRUCTION UILDING |  |    | (X3) DATE SURVEY<br>COMPLETED |  |
|---|--|--|---------------------|-------------------------------|--|----|-------------------------------|--|
|   |  |  | A. BOILDI           | ING                           |  |    | С                             |  |
|   |  | 495391   | B. WING             |                               |  | 07 | /29/2021                      |  |
| NAME OF PI  | ROVIDER OR SUPPLIER  |  |                     |                               | STREET ADDRESS, CITY, STATE, ZIP CODE  |    |                               |  |
| GLENBUR   | RNIE REHAB & NURSING   | CENTER   |                     |                               | 1901 LIBBIE AVE<br>RICHMOND, VA 23226  |    |                               |  |
| (X4) ID<br>PREFIX<br>TAG                            | (EACH DEFICIENCY   | ATEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)   | ID<br>PREFII<br>TAG |                               | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) |    | (X5)<br>COMPLETION<br>DATE    |  |
|   | interview for mental st - 15, 15 - being cognit decisions.  The nurse's note for F 05/18/2021 at 5:06 p.r received a call from [N, stating MD [medical Doctor] would like for the ER [emergency ro elevated sodium of 16 [responsible party] wa had spoken with the M the MD. She would like out. 911 called."  Review of the EHR [el the paper clinical reco to evidence documents was provided to Residiresponsible party in rehospital on 05/18/2021 on 7/28/21 at 12:27 p. conducted with LPN (li LPN #4 stated the nurspolicy with residents with hospital but they dethat this is done.  On 07/28/2021 at appr [administrative staff medical services, AS and ASM # 4, medical of the above concern. | as scoring a 15 on the brief atus (BIMS) of a score of 0 ively intact for making daily desident # 15 dated m., documented, "Writer lame of Nurse Practitioner] doctor], [Name of Medical the resident to be sent to om] via [by] 911 due to 0. The resident RP s called. She stated she ID and is in agreement with the for her mom to be sent ectronic health record] and red for Resident # 15 failed ation that a bed hold policy ent # 15 or Resident # 15's gard to the transfer to the I. m., an interview was censed practical nurse) #4. | F                   | 625                           |  |    |                               |  |
|   | 11.1   |  |                     |                               |  |    | 1                             |  |

|                          | OF DEFICIENCIES<br>F CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | (X2) MULT           | TIPLE CONSTRUCTION   | (X3) DATE<br>COMP | SURVEY                     |
|--------------------------|--|--|---------------------|--|-------------------|----------------------------|
| 1                        |  |  | A. BOILD            |  | [ ,               | С                          |
|                          |  | 495391   | B. WING             |  | 07/               | /29/2021                   |
| NAME OF P                | ROVIDER OR SUPPLIER  |  |                     | STREET ADDRESS, CITY, STATE, ZIP CODE  1901 LIBBIE AVE   |                   |                            |
| GLENBU                   | RNIE REHAB & NURSING   | CENTER   |                     | RICHMOND, VA 23226   |                   |                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY   | ATEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)   | ID<br>PREFI)<br>TAG | PROVIDER'S PLAN OF CORRECTION X (EACH CORRECTIVE ACTION SHOULD IS CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) | BE                | (X5)<br>COMPLETION<br>DATE |
|                          | regulate the amount of goal of treatment at fir blood glucose level. L prevent complications to treat and manage ty active and eating healt was obtained from the https://medlineplus.go/  5. The facility staff failt written bed hold notice responsible party upor to the hospital on 5/21  Resident #23 was adm 1/10/20, discharged to readmitted to the facilith had the diagnoses of be quadriplegia, aphasia, blood pressure, COVID The admission / 5-day with an ARD (Assessm 7/19/21 coded the resi impaired in ability to make the total areas of activities of A review of the clinical note dated 5/21/21 that resident room by nursification with respiratory distress cpr (cardio pulmonary realled, MD (medical do (responsible party) notis suctioned several times normal, vital signs with | n which the body cannot of sugar in the blood. The st is to lower your high ong-term goals are to . The most important way ype 2 diabetes is by being thy foods. This information website: v/ency/article/000313.htm.  ed to evidence that a ewas provided to the natural transfer of Resident #23 /21.  nitted to the facility on whome on 6/1/21 and try on 7/13/21. The resident but not limited to a stroke, diabetes, anxiety, high D-19, and contractures.  MDS (Minimum Data Set) ent Reference Date) of dent as moderately ake daily life decisions. It does not as requiring total care for faily living.  record revealed a nurse 's to documented, "called to ng staff, resident noted s, blue tinge color to skin, resuscitation) initiated, 911 notor) called, rp | Fé                  | 525  |                   |                            |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION |  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   |                    |     |  | (X3) DATE SURVEY<br>COMPLETED |                            |
|--|--|--|--------------------|-----|--|-------------------------------|----------------------------|
|  |  |  | - NINO             |     |  |                               | С                          |
| NAMEOF   | DROVINER OR CLIODI IER   | 495391   | B. WING            |     | STREET ADDRESS, CITY, STATE, ZIP CODE  | 07                            | /29/2021                   |
| NAME OF F  | PROVIDER OR SUPPLIER   |  |                    |     | 1901 LIBBIE AVE  |                               |                            |
| GLENBU   | RNIE REHAB & NURSING   | CENTER   |                    |     | RICHMOND, VA 23226   |                               |                            |
| (X4) ID<br>PREFIX<br>TAG                         | (EACH DEFICIENCY   | ATEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)   | ID<br>PREFI<br>TAG |     | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) |                               | (X5)<br>COMPLETION<br>DATE |
| F 625  | facility. resident is at be taking resident to er (revaluations, rp will me (emergency room)."  The resident was read 5/26/21.  A physician's progress documented, "(Reside female with significant Patient was sent to ED d/t (due to) respiratory admitted to (name of hairway, found to have infection) w/ (with) E. treated with IV (intrave therapy), stabilized, di (facility)"  Further review of the creveal any evidence the was provided to the RI transfer of Resident #25/21/21.  On 7/28/21 at 12:27 p. conducted with LPN (li LPN #4 stated the nurspolicy with residents we the hospital but they dethat this is done.  An interview was cond practical nurse) #3, the 7/28/2021 at 2:28 p.m. provide the resident or the bed hold policy, LP | passeline, emt's decided on emergency room) for eet resident at er dimitted to the facility on some manager, on each resident at er dimitted to the facility on some manager, on eet resident at er decided to the facility on some manager, on each resident was no spital) for aspiration into a UTI (urinary tract Coli (Escherichia coli) and enous) ABT (antibiotic scharged, and returned to some manager, on enough the facility of the hospital on enough the facility of the hospital on end document evidence enough the facility of the hospital on end document evidence enough the facility of the hospital on end document evidence enough the facility of the facility of the hospital on end document evidence enough the facility of the faci | F                  | 625 |  |                               |                            |

|                          | OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   | 1 ` ′              | TIPLE CONSTRUCTION ING  |                 | SURVEY<br>PLETED           |
|--------------------------|--|---|--------------------|---|-----------------|----------------------------|
|                          |  | 495391  | B. WING            |   | C<br>07/29/2021 |                            |
| NAME OF F                | PROVIDER OR SUPPLIER   | 40001   | 1                  | STREET ADDRESS, CITY, STATE, ZIP CODE   | 07              | /29/2021                   |
| OLEMBIA                  |  | ATNEED  |                    | 1901 LIBBIE AVE   |                 |                            |
| GLENBU                   | RNIE REHAB & NURSING   | CENTER  |                    |   |                 |                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY   | ATEMENT OF DEFICIENCIES<br>' MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFI<br>TAG | PROVIDER'S PLAN OF CORRECTION  (EACH CORRECTIVE ACTION SHOULD B  CROSS-REFERENCED TO THE APPROPRIA  DEFICIENCY) | E               | (X5)<br>COMPLETION<br>DATE |
| 72                       | responsible party to so bed. When asked when #3 stated it should be note.  On 7/28/21 at 10:40 A with a list that included a written bed hold notion upon transfer of Resid 5/21/21. Nothing was On 7/29/21 at 8:45 AM Services, Director of N Director (Administrative, #2, and #3 respectively findings. No further infection the end of the survey.  6. The facility staff fails written bed hold notice responsible party upon to the hospital on 5/24/ Resident #52 was mos facility on 6/4/21 with the limited to sepsis, diabed dysphagia, insomnia, sepressure, end stage reand COVID-19. The modula Set) was a quarte with an ARD (Assessme 6/9/21. The resident was cognitively impaired in a decisions. The resident total care for bathing; expressions in the service of the service o | ee if they want to hold the ere that is documented, LPN documented in the nurse's  M the facility was provided d a request for evidence of ce being provided to the RP lent #23 to the hospital on provided.  M, the Director of Clinical lursing and Medical e Staff Members (ASM) #1, y) were made aware of the ormation was provided by  ed to evidence that a was provided by  ed to evidence that a was provided to the transfer of Resident #52.  It recently readmitted to the ne diagnoses of but not tes, stroke, dysphasia, eizures, high blood and disease, pacemaker, ost recent MDS (Minimum erly / 5-day assessment ent Reference Date) of as coded as severely ability to make daily life was coded as requiring xtensive assistance for | F                  | DEFICIENCY)   |                 |                            |
|                          |  | sing, and transfers; and  |                    |   |                 |                            |

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION |   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:      | (X2) MUL <sup>-</sup><br>A. BUILDI | TIPLE CONS<br>NG | (X3) DATE SURVEY<br>COMPLETED                    |    |                 |
|---|---|--|------------------------------------|------------------|--|----|-----------------|
|   |   | 495391   |                                    |                  |  |    | С               |
|   |   | 495391   | B. WING                            |                  |  | 07 | //29/2021       |
| NAME OF P   | ROVIDER OR SUPPLIER                           |  |                                    | STREET           | ADDRESS, CITY, STATE, ZIP CODE                   |    |                 |
| GLENBU  | RNIE REHAB & NURSING                          | CENTER   |                                    | 1901 LIE         | BBIE AVE   |    |                 |
|   |   |  |                                    | RICHM            | OND, VA 23226                                    |    |                 |
| (X4) ID   |   | ATEMENT OF DEFICIENCIES                                    | ID                                 |                  | PROVIDER'S PLAN OF CORRECTION                    |    | (X5)            |
| PREFIX<br>TAG                                       |   | / MUST BE PRECEDED BY FULL<br>.SC IDENTIFYING INFORMATION) | PREFIX                             | <                | (EACH CORRECTIVE ACTION SHOULD B                 |    | COMPLETION DATE |
| IAG   | NEGODATORT ORE                                | SO IDENTIFY PRO INFORMATION)                               | TAG                                |                  | CROSS-REFERENCED TO THE APPROPRIA<br>DEFICIENCY) | 15 |                 |
|   |   |  | -                                  | _                |  |    |                 |
| F 625   | Continued From page                           | . 50   | F6                                 | 25               |  |    |                 |
|   | A review of the clinical                      |  |                                    | ,23              |  |    |                 |
|   | following nurses notes                        |  |                                    | 1                |  |    |                 |
|   | Tollowing hurses notes                        | 5.   | 1                                  |                  |  |    |                 |
|   | 5/24/21 at 2:42 PM: "(                        | Change of condition noted,                                 |                                    |                  |  |    | 1               |
|   |   | of) being lightheaded,                                     |                                    |                  |  |    | 1               |
|   | dizziness, BP 98/57 (b                        |  | 1                                  |                  |  |    | 1               |
|   | (medical doctor) awar                         |  |                                    | 1                |  |    | 1               |
|   |   | r aware before arrival, POA                                |                                    |                  |  |    |                 |
|   | (power of attorney) aw                        | are, agree with care plan."                                |                                    |                  |  |    | 1               |
|   |   |  |                                    |                  |  |    | 1               |
|   |   | Assessed patient. Vital                                    |                                    |                  |  |    |                 |
|   | signs 91/53 (blood pre                        |  |                                    |                  |  | 1  | 1               |
|   |   | % on RA (room air). Patient                                |                                    |                  |  |    |                 |
| 1   |   | Patient was alert to self                                  |                                    |                  |  |    |                 |
|   |   | t was assisted to room with                                |                                    |                  |  |    |                 |
|   |   | RP (responsible party) and                                 |                                    |                  |  |    |                 |
| 1   | NP (nurse practitioner) patients conditions." | ) were made aware of                                       |                                    |                  |  |    |                 |
|   | patients conditions.                          |  |                                    |                  |  | 1  |                 |
|   | 5/24/21 at 8:15 PM: "N                        | ID (medical doctor)  |                                    |                  |  |    |                 |
|   | notified of resident low                      |  |                                    |                  |  |    |                 |
|   | elevated temp, low O2                         |  |                                    | 1                |  |    |                 |
|   |   | T 2 LNC (two liters nasal                                  |                                    |                  |  |    |                 |
|   | cannula). RP (respons                         | ible party) notified of                                    |                                    |                  |  |    |                 |
| 1   | change in condition an                        | d MD order to transfer to                                  |                                    |                  |  |    | 6               |
|   | ED (emergency depart                          | ment) (name of hospital)                                   |                                    | A .              |  | 1  |                 |
|   | for observation."                             |  |                                    |                  |  |    | 1               |
|   | A physician!                                  | 10 - A 0 - A - A - A - C   C   C   C                       |                                    |                  |  |    |                 |
|   | A physician's progress                        |  |                                    |                  |  |    |                 |
|   | documented, "was re                           | is session since his blood                                 |                                    |                  |  |    |                 |
|   | pressure was running v                        |  |                                    |                  |  |    | 1               |
|   |   | nd oxygen saturation was                                   |                                    |                  |  |    |                 |
|   |   | ospital led to diagnosis of                                |                                    |                  |  |    |                 |
|   | sepsis from line infectio                     |  |                                    |                  |  |    |                 |
|   |   | e endocarditis He will be                                  |                                    |                  |  |    |                 |
|   | =   | (2) 3 times per week for 3                                 |                                    |                  |  |    |                 |
|   |   | essions. Recent repeat                                     |                                    |                  |  |    |                 |
|   |   | 29/2021 were negative.                                     |                                    |                  |  |    |                 |

|                          | OF DEFICIENCIES<br>OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   |                     | LE CONSTRUCTION  |   | SURVEY<br>PLETED           |
|--------------------------|---|---|---------------------|--|---|----------------------------|
|                          |   | 495391  | B. WING             |  | 1 | C<br>/29/2021              |
|                          | PROVIDER OR SUPPLIER RNIE REHAB & NURSING   | CENTER  |                     | STREET ADDRESS, CITY, STATE, ZIP CODE  1901 LIBBIE AVE  RICHMOND, VA 23226                                   |   | 12312021                   |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY  | ATEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) |   | (X5)<br>COMPLETION<br>DATE |
|                          | Infectious disease is for Further review of the or reveal any evidence the was provided to the R transfer of Resident #5/24/21.  A review of the "SNF / Form" dated 5/24/21 vertical documented resident of contact information, all functional status, treat immunizations. However documentation that a vertical provided to the RP.  On 7/28/21 at 12:27 p. conducted with LPN (ling LPN #4 stated the nurse policy with residents were the hospital but they do that this is done.  An interview was conditional practical nurse) #3, the 7/28/2021 at 2:28 p.m. provide the resident or the bed hold policy, LP is unable to talk about it responsible party to see bed. When asked when #3 stated it should be conote.  On 7/28/21 at 10:40 AN with a list that included a written bed hold notice. | clinical record failed to nat a written bed hold notice P (responsible party) upon 52 to the hospital on  NF to Hospital Transfer was reviewed. This form demographic information, lergies, code status, ments, precautions, and wer, there was no written bed hold notice was censed practical nurse) #4. Sees send the bed hold hen they are transferred to o not document evidence e ucted with LPN (licensed e unit manager, on | F 62:               |  |   |                            |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |   | (X2) MULTIPI<br>A. BUILDING  | (X3) DATE SURVEY<br>COMPLETED |   |                                   |                            |
|---|---|--|-------------------------------|---|-----------------------------------|----------------------------|
|   |   |  | 7001250                       |   | С                                 |                            |
|   |   | 495391   | B. WING                       |   | 07/29                             | 9/2021                     |
| NAME OF P   | ROVIDER OR SUPPLIER   |  |                               | STREET ADDRESS, CITY, STATE, ZIP CODE   |                                   |                            |
| GLENBU  | RNIE REHAB & NURSING  | CENTER   |                               | 1901 LIBBIE AVE   |                                   |                            |
| GEENBO!   | WE KEINS & HOROWO   | OLIVIER .  |                               |   |                                   |                            |
| (X4) ID<br>PREFIX<br>TAG  | FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL   |  | ID<br>PREFIX<br>TAG           | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)  |                                   | (X5)<br>COMPLETION<br>DATE |
| F 625   | On 7/29/21 at 8:45 AN<br>Clinical Services, Dire  | 61  Nothing was provided.  In the Regional Director of ctor of Nursing and Medical re Staff Members (ASM) #1,  | F 625                         | 5   |                                   |                            |
|   | #2, and #3 respective findings. No further interest the end of the survey.  | y) were made aware of the ormation was provided by   |                               |   |                                   |                            |
|   | and fever. Information obtained fi https://medlineplus.gov tml  (2) Cefazolin - is an an  | //druginfo/meds/a681004.h<br>tibiotic.   |                               |   |                                   |                            |
|   | Information obtained fr<br>https://medlineplus.gov<br>tml   | om<br>//druginfo/meds/a682731.h  |                               |   |                                   |                            |
|   | Accuracy of Assessme<br>CFR(s): 483.20(g)   | nts  | F 641                         | <b>F641:</b> Accuracy of Assessments 1. Residents #104 continues to resi  | de in                             |                            |
|   | by: Based on staff intervier review, it was determined failed to ensure the assereflected the status of cresidents, (Resident #1) The facility staff failed the Resident #104's bladdassessment MDS (minimum) | is not met as evidenced we and clinical record ed that the facility staff sessment accurately one of 49 sampled 04).  o accurately code er status on the admission |                               | facility.  2. All residents have the potential taffected by this alleged deficient practice. Audit on current resident MDS staff to verify accuracy of cofor foley catheters and bowel and bladder coded accurately  3. Regional Director MDS or desig will educate MDS staff on comple accurate assessments to include bulimited to any Foley Catheters (int and external) along with Bowel an | s by oding gnee ting at not ernal |                            |

|                          | OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   |                     | IPLE CONSTRUCTION  |  | E SURVEY<br>IPLETED        |
|--------------------------|--|--|---------------------|--|--|----------------------------|
|                          |  | 495391   | B, WING_            |  | 0.                                     | C<br>7/29/2021             |
| NAME OF F                | PROVIDER OR SUPPLIER   |  |                     | STREET ADDRESS, CITY, STATE, ZIP CODE  | 1 0                                    | 112912021                  |
| CLENBU                   | DNIE DELLA D. 8. NUDOING   | OCHTER   | 1                   | 1901 LIBBIE AVE  |  |                            |
| GLENBU                   | RNIE REHAB & NURSING   | CENTER   |                     | RICHMOND, VA 23226   |  |                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)   | ATEMENT OF DEFICIENCIES<br>/ MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORREC'<br>(EACH CORRECTIVE ACTION SHOU<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY)   | D BE                                   | (X5)<br>COMPLETION<br>DATE |
| F 641                    | g and a second page  | 62   | F 6                 | Bladder Function recorded<br>appropriately on the MDS asso<br>4.MDS or designee will audit<br>residents MDS assessments to   | 5<br>ensure                            |                            |
|                          | diagnoses that include Parkinson's disease [1] Resident # 104's most data set) assessment, with an ARD (assessm 07/08/2021, coded Re 11 on the brief intervie of a score of 0 - 15, 11 impaired of cognition of Resident # 18 was cod assistance of one staff daily living. Under sect Resident # 104 was cod having an indwelling ocatheter. Under section Incontinence" Residen number 1 [one] - "Occathan 7 [seven] episode The POS [physician's counter that the post of t | sident # 104 as scoring an ew for mental status (BIMS)  - being moderately or making daily decisions. ded as requiring extensive free member for activities of tion H "Bladder and Bowel" oded under "H0100" as atheter and an external in H0300 "Urinary transparent transpar |                     | accurate coding of foley cathe bowel and bladder weekly tim weeks and monthly times 2. A identified issues will be immer corrected. Results will be repo Quality Assurance committee analysis and revision x 3 mont 5.Date of compliance will be A 2021. | ers and es 4 ny liately ted to for ns. |                            |
|                          | dated 07/05/2021 failed documentation to address condom catheter.  On 07/28/2021 at 1:30 conducted with LPN [Lie   | p.m., an interview was<br>censed practical nurse] #<br>ter reviewing Resident #  |                     |  |  |                            |

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |   |   |                    |                                       |           | SURVEY<br>PLETED |                            |  |  |
|--|---|---|--------------------|---------------------------------------|-----------|------------------|----------------------------|--|--|
|  |   | 495391  | B. WING            |                                       |           | ]                | C                          |  |  |
| NAME OF  | PROVIDER OR SUPPLIER  |   |                    | STREET ADDRESS, CITY, STATE, ZIP COD  | E         | [ 07             | /29/2021                   |  |  |
| GLENB  | URNIE REHAB & NURSING   | CENTER  |                    | 1901 LIBBIE AVE<br>RICHMOND, VA 23226 | 26        |                  |                            |  |  |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIENC)  | ATEMENT OF DEFICIENCIES<br>/ MUST BE PRECEDED BY FULL<br>.SC IDENTIFYING INFORMATION)   | ID<br>PREFI<br>TAG |                                       | SHOULD BE |                  | (X5)<br>COMPLETION<br>DATE |  |  |
| F 655<br>SS=D  | 07/08/2021, LPN # 5 "Bladder and Bowel" that Resident # 104 s for a catheter. LPN # H0100 and H0300 aut on the CNAs [certified documentation of the of Daily Living]. LPN # Resident # 104 did no for the catheter at the sections H0100 and H taken out and when th 104 would be coded for On 07/28/2021 at app [administrative staff m clinical services, ASM ASM # 4, medical dire the above concern.  No further information References: [1] A type of movemen information was obtain https://www.nlm.nih.go sease.html.  [2] A nervous system d brain and spinal cord. I sheath, the material that your nerve cells. This content is the syour nerve cells. | stated that section H was not correctly coded and hould not have been coded 5 stated that sections comatically populates based I nursing assistants] resident's ADLs [Activities 5 further stated that It have a physician's order time of admission therefore 10300 should have been here is an order Resident # for H0100.  roximately 5:00 p.m., ASM hember] #1, director of #2, director of nursing and ctor, were made aware of  was presented prior to exit.  It disorder. This hed from the website: hymedlineplus/parkinsonsdi  isease that affects your that surrounds and protects lamage slows down or heen your brain and your mptoms of MS. This hed from the website: hymultiplesclerosis.html. | F 65               | 55                                    |           |                  |                            |  |  |

|                          | OF DEFICIENCIES<br>F CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  | 1 ' '              |   | E CONSTRUCTION  | (X3) DATE SURVEY<br>COMPLETED                              |                            |
|--------------------------|---|--|--------------------|---|---|--|----------------------------|
|                          |   |  | 7. 50125           |   |   |  | С                          |
|                          |   | 495391   | B. WING            |   |   | 07   | /29/2021                   |
|                          | ROVIDER OR SUPPLIER   | OFNERD   |                    |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br>1901 LIBBIE AVE  |  |                            |
| GLENBUI                  | RNIE REHAB & NURSING  | CENTER   |                    | F | RICHMOND, VA 23226  |  |                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY  | ATEMENT OF DEFICIENCIES<br>' MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFI<br>TAG |   | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIA<br>DEFICIENCY)  |  | (X5)<br>COMPLETION<br>DATE |
|                          | §483.21 Comprehens Planning §483.21(a) Baseline C §483.21(a)(1) The faci implement a baseline that includes the instru- effective and person- that meet professiona The baseline care plat (i) Be developed within admission. (ii) Include the minimu necessary to properly including, but not limite (A) Initial goals based (B) Physician orders. (C) Dietary orders. (C) Dietary orders. (C) Dietary services. (E) Social services. (F) PASARR recomme §483.21(a)(2) The faci comprehensive care plat care plan if the compre (i) Is developed within admission. (ii) Meets the requirem (b) of this section (excel this section). §483.21(a)(3) The faci resident and their repre- of the baseline care plat limited to: (i) The initial goals of the | care Plans ility must develop and care plan for each resident uctions needed to provide tentered care of the resident I standards of quality care. In must- In 48 hours of a resident's Immediate the tentered to- on admission orders.  It way develop a tentered to- te | F                  |   | F655: Baseline Care Plan  1.Resident #23 continues to reside facility. Resident #421 has been discharged from the facility.  2.All residents newly admitted to facility have the potential to be affective by this alleged deficient practice. Nursing Management will audit as verify current residents have basel care plan.  3.DON or designee will educate a nurses that a baseline care plan modeveloped for each resident within hours of admission to the facility a separate from the comprehensive oplan, and that the baseline care plan must address the care to meet the resident's immediate needs.  4.DON or designee will audit new admits weekly times 4 weeks and monthly times 2 to ensure resident have a baseline care plan present a developed within 48 hours. Any identified issues will be immediate corrected. Results will be reported Quality Assurance committee for analysis and revision x 3 months.  5.Date of compliance will be August 2021. | the fected and line ll ust be a 48 and is care and lely to |                            |

|                          | STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   |  | 1 ` ′             | (X2) MULTIPLE CONSTRUCTION  A. BUILDING |   |      | (X3) DATE SURVEY<br>COMPLETED |  |
|--------------------------|--|--|-------------------|---|---|------|-------------------------------|--|
|                          |  | 495391   | B. WING           |   |   | L    | C<br>// <b>29/202</b> 1       |  |
|                          | ROVIDER OR SUPPLIER  | CENTER   |                   |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br>1901 LIBBIE AVE<br>RICHMOND, VA 23226  | 1 01 | 12912021                      |  |
| (X4) ID<br>PREFIX<br>TAG |  |  | ID<br>PREF<br>TAG |   | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BI<br>CROSS-REFERENCED TO THE APPROPRIA'<br>DEFICIENCY) |      | (X5)<br>COMPLETION<br>DATE    |  |
|                          | on behalf of the facility (iv) Any updated inforr of the comprehensive This REQUIREMENT by:  Based on observation document review, and was determined that the develop a baseline car residents in the survey and #421.  The facility staff failed plan for the use of an afor the use of bed rails failed to develop a base the physician ordered in upon admission for Retailed to the facility had the diagnoses of beguadriplegia, aphasia, oblood pressure, COVID The admission / 5-day with an ARD (Assessme 7/19/21 coded the residence of the management of the management of the side of all areas of activities on 7/27/21 at 3:37 PM, observed in bed, with the side of the companies of the management of the side | treatments to be cility and personnel acting //. mation based on the details care plan, as necessary, is not met as evidenced of the staff interview, facility clinical record review, it me facility staff failed to re plan for two of 49 sample, Residents #23 to develop a baseline care inti-anxiety medication and for Resident #23 and eline care plan to address indwelling urinary catheter sident #421.  Idmitted to the facility on home on 6/1/21 and y on 7/13/21. The resident ut not limited to a stroke, diabetes, anxiety, high interest of the strong materials with the strong materials and contractures.  MDS (Minimum Data Set) intractures as moderately sike daily life decisions, das requiring total care of daily living. | F                 | 655                                     |   |      |                               |  |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPL IDENTIFICATION N |  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:                            |                     | IPLE CONSTRUCTION  | (X3) DATE SURVEY<br>COMPLETED |                            |
|--|--|--|---------------------|--|-------------------------------|----------------------------|
|  |  | 495391   | B. WING             |  | С                             |                            |
| NAME OF P  | ROVIDER OR SUPPLIER  | 453351   | J B. WING _         | STREET ADDRESS SITE OF THE STREET  | 07/2                          | 9/2021                     |
|  | RNIE REHAB & NURSING   | CENTER   |                     | STREET ADDRESS, CITY, STATE, ZIP CODE 1901 LIBBIE AVE RICHMOND, VA 23226                                     |                               |                            |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIENCY   | ATEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) |                               | (X5)<br>COMPLETION<br>DATE |
| F 655  |  | 66   | F 6                 | 55   |                               |                            |
|  | bed up on both sides.  |  |                     |  |                               |                            |
|  | A review of the clinical following:  | record revealed the  |                     |  |                               |                            |
|  | A physician's order data admission) for "1/4 bila functional mobility."                                |  |                     |  |                               |                            |
|  | use of Bed Rails" whic<br>risks signed by the res<br>addition, a "Resident E<br>7/13/21 included a sec | tion for "Bed Rail<br>uation included an item that<br>nendationsBed rail(s)      |                     |  |                               |                            |
|  | (1) 0.5 mg, Give 1 table   | ed 7/13/21 for "Lorazepam<br>et via PEG [Percutaneous<br>y (2)]-Tube at bedtime" |                     |  |                               |                            |
|  | dates, for different prob  |  |                     |  |                               |                            |
| r  |  | Registered Nurse, the unit hat the resident should be of side rails and          |                     |  |                               |                            |
| c  | On 7/29/21 at 10:48 AM<br>conducted with LPN #7<br>Nurse). She stated that                             | (Licensed Practical  |                     |  |                               |                            |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |  | (X2) MULTIPLE CONSTRUCTION A. BUILDING   |                     |                                       | (X3) DATE SURVEY<br>COMPLETED |                            |
|---|--|--|---------------------|---------------------------------------|-------------------------------|----------------------------|
|   |  |  | A. BUILDI           | ING                                   |                               | С                          |
|   |  | 495391   | 91 B. WING          |                                       |                               | 07/29/2021                 |
| NAME OF P   | ROVIDER OR SUPPLIER  |  |                     | STREET ADDRESS, CITY, STATE, ZIP CODE |                               |                            |
| GLENBU  | RNIE REHAB & NURSING   | CENTER   |                     | 1901 LIBBIE AVE                       |                               |                            |
| GEENBOI   | THE REHAB & NOROMO   | CENTER   |                     | RICHMOND, VA 23226                    |                               |                            |
| (X4) ID<br>PREFIX<br>TAG  | X (EACH DEFICIENCY MUST BE PRECEDED BY FULL  |  | ID<br>PREFII<br>TAG |                                       | D BE                          | (X5)<br>COMPLETION<br>DATE |
|   | nurse who does the a baseline care plan.  A review of the facility Baseline" documented resident's immediate of maintained, a baseline developed within forty resident's admission. Will review the health of (e.g., dietary needs, more treatments, etc.) and in plan to meet the reside including but not limited on admission orders; the Clinical Services, Director (Administrative #2, and #3 respectivel findings. No further information obtained from the brain to allow for resident in the limited of the survey.  References:  (1) Lorazepam is used Lorazepam is in a class benzodiazepines. It would be the brain to allow for resident in the limited formation obtained from the survey in the brain to allow for resident in the limited from the survey.  (2) PEG tube: feeding stomach. This information website: | rese of side rails and ons. LPN #7 stated that the dmission usually does the dmission usually does the discourage of the care plan will be reight (48) hours of the care plan will be reight (48) hours of the the care practitioner's orders redications, routine mplement a baseline care ent's immediate care needs at to: a. Initial goals based of the care for the care for the care made aware of the formation was provided by the formation was provided by the sof medications called orks by slowing activity in elaxation. | Fe                  | 655                                   |                               |                            |

|                          | STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:   |  | (X2) MULTIPLE CONSTRUCTION |                    |   |   | (X3) DATE SURVEY<br>COMPLETED |  |
|--------------------------|---|--|----------------------------|--------------------|---|---|-------------------------------|--|
| ,                        |   | ,  | A. BUILDI                  | NG_                | -   |   | С                             |  |
|                          |   | 495391   | B. WING                    | _                  |   | j | /29/2021                      |  |
| NAME OF P                | ROVIDER OR SUPPLIER   |  |                            | S                  | STREET ADDRESS, CITY, STATE, ZIP CODE   |   |                               |  |
| CLEMBII                  | RNIE REHAB & NURSING  | CENTER   |                            | 1                  | 901 LIBBIE AVE  |   |                               |  |
| GLENBU                   | RIVE REHAD & NORSING  | CENTER   |                            | RICHMOND, VA 23226 |   |   |                               |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)  | ATEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)   | ID<br>PREFI<br>TAG         | X                  | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD B<br>CROSS-REFERENCED TO THE APPROPRIA<br>DEFICIENCY) |   | (X5)<br>COMPLETION<br>DATE    |  |
| F 655                    | Continued From page   | 68   | F                          | 355                |   |   |                               |  |
|                          | 2. Resident #421 was 7/19/21 with diagnosis limited to: left knee re replacement) (1), hyp persistently above 140 (2) and COPD [chronidisease] (chronic, non (3).  The most recent MDS assessment, a five data  | s admitted to the facility on so that included but were not placement (artificial joint ertension (blood pressure 0/90 millimeters of mercury) ic obstructive pulmonary a-reversible lung disease)  6 (minimum data set) by Medicare assessment,   |                            |                    |   |   |                               |  |
|                          | with an ARD (assessm 7/26/21, coded Reside of 15 on the BIMS (br status) score, indicatin cognitively intact. A re G-functional status co requiring extensive as hygiene/bathing, limite ambulation, locomotio for eating. A review of and Bladder coded Reoccasionally incontine indwelling catheter for | ent reference date) of<br>ent #421 as scoring a 15 out<br>ief interview for mental<br>ing the resident was<br>eview of the MDS Section<br>ided Resident #421 as<br>esistance for transfer,<br>ed assistance for<br>in and dressing; supervision<br>if MDS Section H- Bowel<br>esident #421 as<br>ent for bowel and as having<br>bladder. |                            |                    |   |   |                               |  |
|                          | failed to evidence any  | ne care plan dated 7/23/21<br>documentation addressing<br>and the care required for  |                            |                    |   |   |                               |  |
|                          |   | an's orders dated 7/19/21,<br>Foley catheter 16 french".   |                            |                    |   |   |                               |  |
|                          | PM with LPN (licensed<br>MDS coordinator. Whe<br>indwelling catheter on<br>#421, LPN #5 stated, '   | ducted on 7/28/21 at 3:30<br>d practical nurse) #5, the<br>en asked about the<br>the care plan for Resident<br>'I know she had a Foley<br>. I do not see any progress  |                            |                    |   |   |                               |  |

|                          | OF DEFICIENCIES<br>F CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   | 1 ' '              |             | E CONSTRUCTION  |      | E SURVEY<br>PLETED         |  |
|--------------------------|---|---|--------------------|-------------|---|------|----------------------------|--|
|                          |   | 495391  | B. WING            | A. BUILDING |   |      | С                          |  |
| NAME OF D                | ROVIDER OR SUPPLIER   | 43331   | D. WINO            | =           | OTDEET ADDRESS OF STATE 210 CODE  | ] 07 | /29/2021                   |  |
| NAME OF P                | ROVIDER OR SUPPLIER   |   |                    |             | STREET ADDRESS, CITY, STATE, ZIP CODE   |      | ()                         |  |
| GLENBU                   | RNIE REHAB & NURSING  | CENTER  |                    |             | 1901 LIBBIE AVE   |      |                            |  |
|                          |   |   |                    |             | RICHMOND, VA 23226  |      |                            |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY  | ATEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)   | ID<br>PREFI<br>TAG |             | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD B<br>CROSS-REFERENCED TO THE APPROPRIA<br>DEFICIENCY) |      | (X5)<br>COMPLETION<br>DATE |  |
| F 655                    | Continued From page   | 69  | F                  | 655         | 5   |      |                            |  |
|                          | on 7/26/21. It should<br>Nursing is responsible<br>and I do the comprehe  | for the baseline care plan<br>ensive care plan."  | 1                  |             |   |      |                            |  |
|                          | PM with LPN #2. Whe responsible for the base  | ducted on 7/28/21 at 3:45<br>in asked who is<br>seline care plan, LPN #2<br>ponsible. When asked to   |                    |             |   |      |                            |  |
|                          | review Resident #421  | s care plan for indwelling<br>d, "It is not on there and it   |                    |             |   |      |                            |  |
|                          | ASM (administrative st  | as followed in the facility,  |                    |             |   |      |                            |  |
|                          | director of clinical serv   | I, ASM #1, the regional<br>ices, ASM #2, the director<br>, the Medical Director were<br>icern.  |                    |             |   |      |                            |  |
|                          | Non-Medical Reader, 5<br>Chapman, page 319.<br>(2) Barron's Dictionary<br>Non-Medical Reader, 5<br>Chapman, page 282.<br>(3) Barron's Dictionary<br>Non-Medical Reader, 5<br>Chapman, page 120. | of Medical Terms for the of the edition, Rothenberg and of Medical Terms for the the edition, Rothenberg and of Medical Terms for the the edition, Rothenberg and |                    |             |   |      |                            |  |
|                          | Develop/Implement Co<br>CFR(s): 483.21(b)(1)  | mprehensive Care Plan   | F 6:               | 56          |   |      |                            |  |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  |  | (X2) MULTI<br>A. BUILDIN   | PLE CONSTRUCTION    | (X3) DATE SURVEY<br>COMPLETED  |              |  |  |
|--|--|--|---------------------|--|--------------|--|--|
|  |  |  |                     |  | С            |  |  |
|  |  | 495391   | B. WING _           |  | 07/29/2021   |  |  |
| NAME OF P  | ROVIDER OR SUPPLIER                                    |  |                     | STREET ADDRESS, CITY, STATE, ZIP CODE  |              |  |  |
| GLENBU   | RNIE REHAB & NURSING                                   | CENTER   |                     | 1901 LIBBIE AVE  |              |  |  |
|  | ,  |  |                     | RICHMOND, VA 23226   |              |  |  |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIENCY                                       | ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | E COMPLETION |  |  |
| =  |  |  |                     | F656: Develop/Implement  |              |  |  |
| F 656  |  |  | F 68                | Comprehensive Care Plan  |              |  |  |
|  | §483.21(b) Comprehe                                    |  |                     | 1.Residents #40, #9, #172, #171,   | #104,        |  |  |
|  | §483.21(b)(1) The fac                                  | ensive person-centered   |                     | #11, #33, #62, #52 continue to res   |              |  |  |
|  |  | dent, consistent with the  |                     | facility and the care plan has been  | 1.17.        |  |  |
|  | resident rights set forth                              | n at §483.10(c)(2) and   |                     | reviewed to ensure comprehensiv  |              |  |  |
|  | §483.10(c)(3), that inc                                |  |                     | plan has been developed and  |              |  |  |
|  |  | mes to meet a resident's<br>mental and psychosocial                          |                     | implemented. Residents #372, #14   | 1 and        |  |  |
|  |  | ed in the comprehensive  |                     |  |              |  |  |
|  |  | orehensive care plan must  |                     | #59 have been discharged from the  | e            |  |  |
|  | describe the following                                 | _  |                     | facility.  |              |  |  |
|  |  | e to be furnished to attain  |                     | 2.All residents have the potential affected by this alleged deficient  | to be        |  |  |
|  | or maintain the resider                                | nt's highest practicable<br>psychosocial well-being as                       |                     |  |              |  |  |
| 1  |  | 4, §483.25 or §483.40; and   |                     | 11   |              |  |  |
|  |  | ould otherwise be required   | ľ                   | conduct an audit on current reside   | nts          |  |  |
|  |  | 5 or §483.40 but are not   |                     | with assistive devices, change in  | 1            |  |  |
|  |  | sident's exercise of rights  |                     | condition and verify care planned  | has          |  |  |
|  | under §483.10, includir treatment under §483.          |  |                     | been updated.  |              |  |  |
|  | (iii) Any specialized ser                              |  |                     | 3.DON or designee will educate a   | 11           |  |  |
|  | rehabilitative services t                              | he nursing facility will   |                     | nurses that care plans must be init  |              |  |  |
|  | provide as a result of P                               |  |                     | or updated for assistive devices an  |              |  |  |
|  | recommendations. If a findings of the PASARI           | facility disagrees with the  |                     | changes in condition.  | "            |  |  |
|  | rationale in the residen                               |  |                     | 4.DON or designee will audit 5   |              |  |  |
| 1.0  | (iv)In consultation with                               |  |                     |  | 4            |  |  |
|  | resident's representativ                               | re(s)-   |                     | residents care plans weekly times  |              |  |  |
|  | (A) The resident's goals                               | for admission and  |                     | weeks and a monthly time 2 to ens  | sure         |  |  |
| The second secon | desired outcomes,<br>(B) The resident's prefe          | erence and potential for   |                     | that care plans are updated with   |              |  |  |
|  | future discharge. Facilit                              |  |                     | assistive devices and change in  |              |  |  |
| ,  | whether the resident's o                               | desire to return to the  |                     | condition. Any identified issues w   |              |  |  |
|  | community was assess                                   |  |                     | immediately corrected. Results wi  | ll be        |  |  |
|  |  | and/or other appropriate   |                     | reported to Quality Assurance  |              |  |  |
|  | entities, for this purpose<br>(C) Discharge plans in t | he comprehensive care  |                     | committee for analysis and revisio   | n x 3        |  |  |
|  | plan, as appropriate, in                               |  |                     | months.  |              |  |  |
| 1.   | ,                |  |                     |  |              |  |  |

| ATEMENT OF DEFICIENCIES<br>ID PLAN OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  |                    | TIPLE CONSTRUCTION ING  |             | ATE SURVEY                 |  |
|---|--|--------------------|---|-------------|----------------------------|--|
|   |  |                    |   |             | С                          |  |
|   | 495391   | B. WING            |   |             | 07/29/2021                 |  |
| IAME OF PROVIDER OR SUPPLIER  SLENBURNIE REHAB & NURSING  | CENTER   |                    | STREET ADDRESS, CITY, STATE, ZIP CODE<br>1901 LIBBIE AVE<br>RICHMOND, VA 23226            |             |                            |  |
| PREFIX (EACH DEFICIENC)   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>.SC IDENTIFYING INFORMATION)  | ID<br>PREFI<br>TAG | PROVIDER'S PLAN OF COR  (EACH CORRECTIVE ACTION S  CROSS-REFERENCED TO THE A  DEFICIENCY) | SHOULD BE   | (X5)<br>COMPLETION<br>DATE |  |
| section. This REQUIREMENT by: Based on observation interviews, clinical red document review it was facility staff failed to dothe comprehensive caresidents in the survey #372, #9, #114, #172, #59, and #52.  The findings include:  1. The facility staff faile comprehensive fall can matt placement for Re  Resident #40 was addediagnoses that include cerebral infarction (1): Resident #40's most reset) assessment, a quantum ARD (assessment refectoded Resident #40 as assessment for mentation of 0 - 15, 15- being condition decisions. Section requiring extensive assessment for transfers, toilet use. Section J con having any falls since a assessment.  On 7/27/2021 at appropriate the section of the section of the section was made. | in in paragraph (c) of this  is not met as evidenced  in, resident interviews, staff cord reviews and facility as determined that the evelop and/or implement are plan for twelve of 49 y sample, Residents #40, #171, #104, #11, #33, #62,  ed to implement the re plan which included fall esident #40.  Initted to the facility with and hemiplegia (2). ecent MDS (minimum data earterly assessment with an erence date) of 5/28/2021, as scoring a 15 on the staff I status (BIMS) of a score gnitively intact for making in G coded Resident #40 sistance from one staff walking in the room and ided Resident #40 as not admission or the prior | F                  | 5.Date of compliance will 1 2021.   | pe August 2 | 20,                        |  |

|                          | TEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION DENTIFICATION NUMBER: A. BUILDING   |  |                     | (X3) DATE SURVEY<br>COMPLETED   |    |                            |
|--------------------------|---|--|---------------------|---|----|----------------------------|
|                          |   | 495391   | B. WING             |   | 0. | C<br>7/29/2021             |
|                          | ROVIDER OR SUPPLIER   |  |                     | STREET ADDRESS, CITY, STATE, ZIP CODE 1901 LIBBIE AVE RICHMOND, VA 23226                                  |    | 112312021                  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)  | ATEMENT OF DEFICIENCIES<br>MUST BE PRECEDED BY FULL<br>SCIDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION ( (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY) | BE | (X5)<br>COMPLETION<br>DATE |
|                          | place beside Residen interview was conduct Resident #40 stated to recent falls at the facil When asked about fall that he did not think he Additional observation 7/28/2021 8:41 a.m. a approximately 8:00 a.m. bed without fall mats be without fall mats be did 1/9/2020 docum falls due to impaired be dx (diagnosis) hx (hist accident) with hemiple 01/09/2020." Under "Indocumented in part, "Date Initiated: 06/02/201/21/2021"  The "Care Conference dated 3/19/2021 docum Discussed: Risk for Fall Risk Evaluation 1/24/2020 documented Risk; Score: 11.0"  The physician order's fevidence an order for the conference of the conference and the conference of the conf | all mats were observed in the 440's bed. At this time, and the with Resident #40. The had not had any ity and was doing well. I mats, Resident #40 stated the had any mats on the floor.  Is of Resident #40 on and 7/29/2021 at more revealed Resident #40 in the bed.  The plan for Resident #40 in the floor.   F6                  | 956   |    |                            |

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION |  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   | 1 ' '              |     | E CONSTRUCTION  | (X3) DATE SURVEY<br>COMPLETED |                            |
|---|--|---|--------------------|-----|---|-------------------------------|----------------------------|
|   |  | 495391  | B. WING            |     |   | 07                            | C<br>7/29/2021             |
|   | ROVIDER OR SUPPLIER  | CENTER  |                    | 1   | STREET ADDRESS, CITY, STATE, ZIP CODE<br>1901 LIBBIE AVE<br>RICHMOND, VA 23226  |                               |                            |
| (X4) ID<br>PREFIX<br>TAG                            | (EACH DEFICIENC)   | ATEMENT OF DEFICIENCIES<br>' MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFI<br>TAG |     | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD B<br>CROSS-REFERENCED TO THE APPROPRIA<br>DEFICIENCY) |                               | (X5)<br>COMPLETION<br>DATE |
|   | comprehensive care particles assessment and determine the areas and particles and particle | plan was completed within er completion of the MDS. By looked at the CAAS (care to twere triggered from the lithe resident's diagnoses to pecific to the resident which ed. LPN #5 stated that the are plans in between the rely care plan reviews with alls or any new skin ated that staff were not en plan if fall mats were an replan and they were not in eximately 7:59 a.m., an ed with RN (registered er. RN #4 stated that the care that was provided for all departments. RN #4 an covered what care the and what their safety level at staff were not plan if fall mats were an explan and they were not in served Resident #40 in but the fall mats in place.  Eximately 11:15 a.m., ASM ing stated that the facility and procedures as their actice. | F                  | 656 |   |                               |                            |

|                          | NT OF DEFICIENCIES<br>OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   |                     | PLE CONSTRUCTION   | (X3) DATE SURVEY<br>COMPLETED | 001 |
|--------------------------|--|---|---------------------|--|-------------------------------|-----|
|                          |  | 405204  | D WING              |  | С                             |     |
| NAME OF                  | PROVIDER OR SUPPLIER   | 495391  | B. WING             |  | 07/29/2021                    |     |
| GLENB                    | URNIE REHAB & NURSING  |   |                     | STREET ADDRESS, CITY, STATE, ZIP CODE  1901 LIBBIE AVE  RICHMOND, VA 23226                                   |                               |     |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY   | ATEMENT OF DEFICIENCIES  'MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) |                               | ON  |
| F 65                     | The facility policy, "Ca Person-Centered" dat documented in part, ". person-centered care measurable objectives Describe the services attain or maintain the practicable physical, n well-being"  On 7/29/2021 at appro#1, the regional director of the above concern.  No further information of the above concern.  No further information of the brain stops. A stroke "brain attack." This info the website: https://medlineplus.gov  (2). Hemiplegia: Also of Paraplegia, and Quadri loss of muscle function happens when somethi way messages pass be muscles. Paralysis can can occur on one or bot can also occur in just or | re Plans, Comprehensive ed December 2016The comprehensive, plan will: a. Include and timeframes; b. that are to be furnished to resident's highest mental and psychosocial eximately 11:00 a.m., ASM or of clinical services and for nursing were made aware was provided prior to exit.  Itisease, infarction or en blood flow to a part of e is sometimes called a rmation was obtained from eximation was obtained from eximation was obtained from eximation was obtained from eximation was obtained from the part of your body. It is goes wrong with the tween your brain and be complete or partial. It is sides of your body. It is a rea, or it can be nation was obtained from eximation was obtained from the part of your body. It is a rea, or it can be nation was obtained from | F 65                |  |                               |     |

|                          | OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | 1                   | LE CONSTRUCTION   |    | SURVEY<br>PLETED           |
|--------------------------|--|--|---------------------|---|----|----------------------------|
|                          |  | 495391   | B. WING             |   | ł  | C                          |
| NAME OF F                | PROVIDER OR SUPPLIER   | 40001  | 15,,,,,,            | STREET ADDRESS, CITY, STATE, ZIP CODE   | 07 | /29/2021                   |
| GLENBU                   | RNIE REHAB & NURSING   | CENTER   |                     | 1901 LIBBIE AVE<br>RICHMOND, VA 23226   |    |                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY   | ATEMENT OF DEFICIENCIES<br>' MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD B<br>CROSS-REFERENCED TO THE APPROPRIA<br>DEFICIENCY) |    | (X5)<br>COMPLETION<br>DATE |
|                          | 2. The facility staff fail comprehensive care publich included use of wandering, exit-seekin (2).  Resident #372 was addiagnoses that included dementia with behavior fracture of left acetable.  Resident #372's most data set), a discharge an ARD (assessment re 6/10/2021, coded Reson the staff assessment of a score of 0 - 15, 8-for making daily decising Resident #372 display behaviors during the assection G coded Resident #372 display behaviors during the assection G coded Resident #372 as received an antidepressant mediassessment period.  Resident #372 no long and could not be obsersurvey. The deficiency investigation of an elop when Resident #372 we The comprehensive call | ed to develop a plan for Resident #372 wandergaurd (1) and g behaviors and elopement  mitted to the facility with d but were not limited to oral disturbance (3) and fulum (4).  recent MDS (minimum assessment with an with eference date) of ident #372 as scoring a 8 nt for mental status (BIMS) being moderately impaired ons. Section E coded ing rejection of care assessment timeframe. Ident #372 as requiring use, personal hygiene and Section M coded living an antipsychotic and lication 6 of 7 days in the  er resided at the facility wed during the dates of the was discovered during the mement which occurred as in the facility.  re plan for Resident #372 re plan which addressed mented wandering, | F 656               |   |    |                            |

|                          | OF DEFICIENCIES<br>F CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | (X2) MULTIPL<br>A. BUILDING | E CONSTRUCTION  |    | E SURVEY<br>IPLETED        |
|--------------------------|--|--|-----------------------------|---|----|----------------------------|
|                          |  | 495391   | B. WING                     | -   | 07 | C<br>7/29/2021             |
|                          | PROVIDER OR SUPPLIER RNIE REHAB & NURSING  |  | '                           | STREET ADDRESS, CITY, STATE, ZIP CODE<br>1901 LIBBIE AVE<br>RICHMOND, VA 23226  |    |                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY   | ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG         | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD E<br>CROSS-REFERENCED TO THE APPROPRIA<br>DEFICIENCY) | 3E | (X5)<br>COMPLETION<br>DATE |
|                          | The physician order's evidence an order for  The "Elopement Risk #372 dated 5/17/2021 risk for elopement (impunsafe wandering/exit plan updated and revise.  The progress notes for documented in part, - "1/8/2021 (18:53 (6:5) Refusing to remain in hwriter and bent her fingeducate her on why shroom to protect her from to protect her from the progress of the property and aware. pt (patient) sugar) check. pt proper repeatedly roams out in multiple occasions by significant refused show. I take will take it when I Charge nurse tried to the home for now and to phresident became agitate staff. Resident left along—"3/2/2021 12:59 (12:59 walking through halls for—"3/3/2021 16:39 (4:39 and verbal. Pt up and wands of shift"  "3/5/2021 18:02 (6:02 | for Resident #372 failed to use of a wandergaurd.  Evaluation" for Resident documented in part, "At plement plan of care for seeking behavior)Care seeking behavior)Pattempted to bite ger back when trying to eneeds to remain in her m virus."  35 p.m.) Note Text: effected on seeking se | F 656                       |   |    |                            |

|   |                   | OF DEFICIENCIES<br>OF CORRECTION                    | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER: | (X2) MULT<br>A. BUILDIN | IPLE CONSTRUCTION                           |                | ) DATE SURVEY<br>COMPLETED |
|---|-------------------|---|---|-------------------------|---|----------------|----------------------------|
| I |                   |   |   |                         |   |                | С                          |
|   |                   |   | 495391  | B. WING                 |   |                | 07/29/2021                 |
| l | NAME OF F         | PROVIDER OR SUPPLIER                                |   |                         | STREET ADDRESS, CITY, STATE, ZIP C          | ODE            |                            |
| l | GLENBU            | RNIE REHAB & NURSING                                | CENTER  | 1                       | 1901 LIBBIE AVE                             |                |                            |
| ŀ |                   | T   |   |                         | RICHMOND, VA 23226                          |                |                            |
| l | (X4) ID<br>PREFIX |   | ATEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL     | ID<br>PREFIX            | PROVIDER'S PLAN OF<br>(EACH CORRECTIVE ACTI |                | (X5)<br>COMPLETION         |
| ١ | TAG               |   | SC IDENTIFYING INFORMATION)                           | TAG                     | CROSS-REFERENCED TO T                       | HE APPROPRIATE | DATE                       |
| - |                   |   |   |                         | DEFICIENC                                   | Y)             | _ 1                        |
|   | E 050             |   |   |                         |   |                |                            |
|   | F 656             | - committee of the page                             |   | F 6                     | 56  |                | 1                          |
|   |                   | - "4/19/2021 23:42 (11                              |   | 1                       |   |                |                            |
|   |                   |   | lking through the unit this                           |                         | Y .   |                |                            |
|   |                   | evening"  | 10 m m NM ( T )                                       |                         |   |                |                            |
|   |                   |   | 19 p.m.) Note Text: resident                          |                         |   |                |                            |
|   |                   |   | d was verbally aggressive<br>to answer the question   |                         |   |                |                            |
|   |                   |   | er [Sic.] was chased from                             |                         | )   |                |                            |
|   |                   | the room."  | i [Olo.] was chased nom                               |                         |   |                |                            |
|   |                   | - "5/12/2021 23:11 (11:                             | 11 p.m.) Note Text:                                   |                         |   |                |                            |
|   |                   |   | rected several times this                             |                         |   |                |                            |
|   |                   |   | d many times during the                               |                         |   |                |                            |
|   |                   | shift that she is not allo                          |   |                         | 1   |                |                            |
|   |                   |   | I chairs but still continues                          |                         |   |                | 1                          |
|   | 1                 | to do so. When remind                               |   |                         |   |                |                            |
|   |                   | aggressive and comba                                |   |                         |   |                | 1                          |
|   |                   |   | 0 p.m.) Late Entry: Note                              |                         |   |                |                            |
|   |                   |   | all from nursing facility, that                       |                         | ř.  |                | 1 1                        |
|   |                   |   | esident, elopement initiated                          |                         |   |                | 1 1                        |
|   |                   |   | ey searched entire facility                           | ii .                    |   |                |                            |
|   |                   | 911 notified received in                            | nable to locate resident.                             |                         |   |                | 100                        |
|   |                   | located safe."                                      | ormanorresident was                                   |                         |   |                |                            |
|   |                   |   | 8 p.m.) Late Entry: Note                              |                         |   |                |                            |
|   |                   | Text: Elopement risk ev                             |   |                         |   |                |                            |
|   |                   |   | tive impairment present                               |                         |   |                |                            |
|   |                   | that effects decision ma                            | iking abilities. Able to                              |                         |   |                |                            |
|   |                   |   | ntly in the facility without                          |                         |   |                |                            |
|   | 1                 | assistance. Evaluation i                            | reveals a history of                                  |                         |   |                | 4                          |
|   |                   | elopement or elopemen                               |   |                         |   |                |                            |
|   |                   |   | attempting to leave facility                          |                         |   |                |                            |
|   |                   |   | ve a history of attempting                            |                         |   |                |                            |
|   |                   |   | notifying staff, [Resident                            |                         |   |                |                            |
|   |                   | #372] has not made any                              |   |                         |   |                |                            |
|   |                   | statements/verbalization                            |   |                         |   |                |                            |
|   |                   | penaviors indicating an<br>unsupervised. Wanderir   | intent to leave the facility                          |                         |   |                |                            |
|   |                   | unsupervised, vvanderir<br>Family/responsible party | •   |                         |   |                |                            |
|   |                   | concerns over likelihood                            |   |                         |   |                |                            |
|   |                   | center unattended or wit                            |   |                         |   |                |                            |
|   |                   |   | stail informouge.                                     |                         |   |                | 1                          |

| NAME OF PROVIDER OR SUPPLIER   STREET ADDRESS, CITY, STATE, ZIP CODE   1991 LIBBIE AVE   1992   19 | STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION |  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  | (X2) MUL | TIPLE CONSTRUCTION<br>NG  | (X3) DATE SURVEY<br>COMPLETED |            |
|--|---|--|--|----------|---|-------------------------------|------------|
| STREET ADDRESS, CITY, STATE, ZIP CODE  GLENBURNIER REHAB & NURSING CENTER  (A4) ID  SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PRECEDED BY PLI. REGULATORY OR LSC (DENTIFYING INFORMATION)  F 656  Continued From page 78  Based on evaluation [Resident #372] determined to be at risk for elopement. Care plan revised/updated based on evaluation."  - "5/17/2021 21:08 (9:08 p.m.). Late Entry: Note Text: MD (medical doctor) and rp (responsible party) was notified at time of event, head to toe skin assessment completed by writer no bruising or open areas noted. Resident was unable to say what happened, due to low bims score. Resident assisted by staff to be d to her room. Resident placed on 1:1 (one to one) monitoring for remainder of shift."  - "5/17/2021 0:002 (12:02 a.m.) Note Text: Upon entering residents room to obtain HS (bedtime) blood sugar, writer observed that this resident was not in her room. Building was searched, DON (director of nursing) and Administrator were notified. Police were notified, Police were notified and dispatcher informed writer that the resident went to Walgreens and staff there called the police, DON and ADON (assistant director of nursing) went to retrieve resident. MD and RP [responsible party] were notified that resident and been able to leave the building with wander guard on her ankle.  Upon her return, full skin assessment was done and no open area/wounds were found. Staff will continue monitoring resident and observing behaviors."  - "5/18/2021 10:58 (10:58 a.m.) Physician progress note! am seeing her today for an incidence of wandering behaviors."  |   |  | 495391   |          |   | 0.7                           |            |
| CAMPID   C | NAME OF P   | ROVIDER OR SUPPLIER  |  |          | STREET ADDRESS, CITY, STATE, ZIP CODE                           | 1 07                          | 129/2021   |
| (A) ID PRETIX SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC (DENTIFYNO NFORMATION)  F 656  Continued From page 78  Based on evaluation [Resident #372] determined to be at risk for elopement. Care plan revised/updated based on evaluation, and revised/updated based on evaluation or progress noted. Resident was unable to say what happened, due to low birns score. Resident assisted by staff to bed to her room. Resident placed on 1:1 (one to one) monitoring for remainder of shift."  - "5/17/2021 0:002 (12:02 a.m.) Note Text: Upon entering residents room to obtain HS (bedtime) blood sugar, writer observed that this resident was not in her room. Building was searched. DON (director of nursing) and Administrator were notified. Police were notified and dispatcher informed writer that the resident went to Walgreens and staff there called the police. DON and ADON (assistant director of nursing) went to retrieve resident. MD and RP [responsible party] were notified that resident had been able to leave the building with wander guard on her ankle. Upon her return, full skin assessment was done and no open area/wounds were found. Staff will continue monitoring resident and observing behaviors."  - "5/18/2021 10:58 (10:58 a.m.) Physician progress note I am seeiing her today for an incidence of wandering behavior. Patient had gone out of the facility and walked up to the   | GI ENDIE  | DAILE DELIAD & AUTOONO   | CENTER   | - 1      | 1901 LIBBIE AVE   |                               |            |
| FREEKY TAG    (EACH DEFICENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  F 656  Continued From page 78  Based on evaluation [Resident #372] determined to be at risk for elopement. Care plan revised/updated based on evaluation,"  - "5/17/2021 21:08 (9:08 p.m.) Late Entry: Note Text: MD (medical doctor) and rp (responsible party) was notified at time of event, head to toe skin assessment completed by writer no bruising or open areas noted. Resident was unable to say what happened, due to low bims score. Resident assisted by staff to bed to her room. Resident placed on 1:1 (one to one) monitoring for remainder of shift."  - "5/17/2021 00:02 (12:02 a.m.) Note Text: Upon entering residents room to obtain HS (bedtime) blood sugar, writer observed that this resident was not in her room. Building was searched, DON (director of nursing) and Administrator were notified. Police were notified. Police were notified. Police were notified. Police were notified and dispatcher informed writer that the resident twent to Walgreens and staff there called the police, DON and ADON (assistant director of nursing) went to retrieve resident. MD and RP [responsible party] were notified that resident had been able to leave the building with wander guard on her ankle.  Upon her return, full skin assessment was done and no open area/wounds were found. Staff will continue monitoring resident and observing behaviors."  - "5/18/2021 10:58 (10:58 a.m.) Physician progress note I am seeing her today for an incidence of wandering behavior. Patient had gone out of the facility and walked up to the  | GLENBUR   | THE REMAB & NURSING  | CENTER   | 1        | RICHMOND, VA 23226  |                               |            |
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| Walgreens. She was found by the police and brought back to the facilityThe daughters tell me that she has had this wandering behavior all her life since she likes to walk a lot. The patient has advancing dementia and due to her wandering behavior she might need a locked dementia unit facility"   |   | Based on evaluation [I to be at risk for elopen revised/updated based – "5/17/2021 21:08 (9:0 Text: MD (medical doc party) was notified at the skin assessment comport or open areas noted. For what happened, due to assisted by staff to be placed on 1:1 (one to come remainder of shift." – "5/17/2021 00:02 (12 entering residents room blood sugar, writer obstands and the staff the and ADON (director of nursin notified. Police were not informed writer that the Walgreens and staff the and ADON (assistant directive resident. MD at were notified that reside the building with wanded upon her return, full skin and no open area/wound continue monitoring residence of wandering gone out of the facility at Walgreens. She was for orought back to the facility at Walgreens. She was for orought back to the facility at wandering behavior she wandering behavior she wandering behavior she | Resident #372] determined nent. Care plan don evaluation."  08 p.m.) Late Entry: Note etcr) and rp (responsible ime of event, head to toe pleted by writer no bruising Resident was unable to say to low bims score. Resident done) monitoring for  102 a.m.) Note Text: Upon monitoring for  102 a.m.) Note Text: Upon monitoring for  103 a.m.) Note Text: Upon monitoring for  104 a.m.) Note Text: Upon monitoring for  105 a.m.) Note Text: Upon monitoring for  106 a.m.) Note Text: Upon monitoring for  107 a.m.) Note Text: Upon monitoring for  108 a.m.) Note Text: Upon monitoring for  109 and Administrator were expected and dispatcher for an able to leave expected and been able to leave expected and several form of the series of the several form of the series of | F6       | 956   |                               |            |

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION |  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   |                     | PLE CONSTRUCTION  G   | (X3) DATE SURVEY<br>COMPLETED |                            |
|---|--|--|---------------------|---|-------------------------------|----------------------------|
|   |  | 495391   | B. WING             |   |                               | C<br>// <b>29/2021</b>     |
|   | ROVIDER OR SUPPLIER  | CENTER   |                     | STREET ADDRESS, CITY, STATE, ZIP CODE<br>1901 LIBBIE AVE<br>RICHMOND, VA 23226                          |                               |                            |
| (X4) ID<br>PREFIX<br>TAG                            | (EACH DEFICIENC)   | ATEMENT OF DEFICIENCIES<br>MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY) | BE                            | (X5)<br>COMPLETION<br>DATE |
|   | repeats that she want Resident redirected n continues to monitor h - "6/10/2021 17:51 (5: Resident discharged their memory care unitheir memory care unitheir memory care unitherview was conducted practical nurse) #5, the #5 stated that an initiate the nursing staff on accomprehensive care p21 days or 7 days afted LPN #5 stated that the area assessment) that MDS assessment and determine the areas speed to be care planner nurses updated the care admission and quarter any new orders, any faconditions. LPN #5 stated that the area assessment and determine the areas speed to be care planner nurses updated the care admission and quarter any new orders, any faconditions. LPN #5 state seeking behaviors, was wandergaurd should have been used to be care plan for Reside elopement, a wanderg behaviors and wanderion on 7/29/2021 at approinterview was conducted staff member) #2, the order their was conducted staff member) #2, the order their was conducted to the property of the property of the property of their was conducted to the | c:22 p.m.) Note Text: coam from unit to unit and to go home to New Kent. umerous times. Staff ter movement." 51 p.m.) Note Text: co [Name of facility] today for t"  eximately 7:45 a.m., an ted with LPN (licensed to MDS coordinator. LPN I care plan was set up by lmission and the lan was completed within r completion of the MDS. y looked at the CAAS (care to were triggered from the the resident's diagnoses to the resident's diagnoses to the resident which the LPN #5 stated that the re plans in between the ly care plan reviews with ted that residents with exit ndering and wearing a tave a care plan addressing ked to provide a copy of tent #372 addressing the aurd, the exit seeking ng.  eximately 8:15 a.m., an d with ASM (administrative director of nursing. ASM t #372 had a wandergaurd pement on 5/17/2021. tetermine the date the | F 65                |   |                               |                            |

|                          | OF DEFICIENCIES OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  | (X2) MULTIPLE CONSTRUCTION |  |    | (X3) DATE SURVEY<br>COMPLETED |  |
|--------------------------|--|---|----------------------------|--|----|-------------------------------|--|
|                          |  |   | A. BUILDIN                 | IG   |    | C                             |  |
|                          |  | 495391  | B. WING _                  |  | 07 | 7/29/2021                     |  |
| NAME OF F                | PROVIDER OR SUPPLIER   | · · · · · · · · · · · · · · · · · · ·   |                            | STREET ADDRESS, CITY, STATE, ZIP CODE  |    |                               |  |
| GLENBU                   | RNIE REHAB & NURSING   | CENTER  |                            | 1901 LIBBIE AVE  |    |                               |  |
|                          | W  |   |                            | RICHMOND, VA 23226   |    |                               |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)   | ATEMENT OF DEFICIENCIES  ' MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG        | PROVIDER'S PLAN OF CORRECTIC<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROPE<br>DEFICIENCY) | BE | (X5)<br>COMPLETION<br>DATE    |  |
|                          | electronic medical recould not determine the was placed on Reside that Resident #372 diswarranted placing the elopement on 5/17/20 Resident #372's care was no care plan for twandergaurd.  On 7/29/2021 at approstated that there was resident #372's elopewandergaurd.  On 7/29/2021 at approstated that there was resident #372's elopewandergaurd.  On 7/29/2021 at approstated that there was resident #372's elopewandergaurd.  On 7/29/2021 at approstated that there was resident #372's elopewandergaurd.  The facility policy "Ward dated March 2019 door facility will identify residunsafe wandering and while maintaing the leafor residents. 1. If identify wandering, elopement, resident's care plan will interventions to maintate No further information was references:  1. Wandergaurd Patient tags transmit a seconds to enable conthospital-wide locating. | cord and stated that they are date the wandergaurd ent #372. ASM #2 stated splayed behaviors that wandergaurd prior to the 21. ASM #2 reviewed plan and stated that there are elopement or eximately 8:50 a.m., LPN #5 are care plan developed for elopement and use of the eximately 11:00 a.m., ASM or of clinical services and a finursing were made aware elopemented in part, "The dents who are at risk of strive to prevent harm est restrictive environment tified as at risk for or other safety issues, the I include strategies and in the resident's safety."  The status messages every 10 estatus messages every 10 | F 68                       | 56   |    |                               |  |

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION |  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  (X2) MULTIPLE CONSTRUCTION  A. BUILDING  |                     |  | (X3) DATE SURVEY<br>COMPLETED |                            |
|---|--|--|---------------------|--|-------------------------------|----------------------------|
|   |  | 495391   | B. WING _           |  |                               | C<br>07/29/2021            |
|   | ROVIDER OR SUPPLIER  RNIE REHAB & NURSING  | CENTER   |                     | STREET ADDRESS, CITY, STATE, ZIP CODE 1901 LIBBIE AVE RICHMOND, VA 23226                                 |                               |                            |
| (X4) ID<br>PREFIX<br>TAG                            | (EACH DEFICIENCY   | ATEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORREC<br>(EACH CORRECTIVE ACTION SHOI<br>CROSS-REFERENCED TO THE APPR<br>DEFICIENCY) | ULD BE                        | (X5)<br>COMPLETION<br>DATE |
|   | or loiter by an open do information was obtain https://www.stanleyhe s/protection/patients  2. Elopement- legally incapable of adequate who departs the health and undetected. This if from the website: https://psnet.ahrq.gov/=According%20to%20 0Center%20for%20Pa ave%2C%20but%20dont.%22  3. Dementia: A loss of with certain diseases. language, judgment, a information was obtain https://medlineplus.gov/4. Acetablumthe hip information was obtain https://medlineplus.gov/htm  3. The facility staff fail faccurate and person-caddress Resident #9's of address Resident #9 | ing when patients approach por/elevator. This pred from the website: althcare.com/hospital-clinic defined as a patient who is ally protecting himself, and a care facility unsupervised information was obtained deep web-mm/elopement#:~:text the%20VA%20National%2 tient,permitted%20to%20le dees%20so%20with%20inte defined from the website: affects memory, thinking, and behavior. This ded from the website: affects (acetabulum). This ded from the website: alled to develop an alled to deve | F 68                | 56   |                               |                            |

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION |   | IDENTIFICATION NUMBER.  |                                      | (X2) MULTIPLE CONSTRUCTION A. BUILDING                           |            |                            | (X3) DATE SURVEY<br>COMPLETED |  |
|---|---|---|--------------------------------------|--|------------|----------------------------|-------------------------------|--|
|   |   | 495391  | B, WING                              |  |            |                            | C<br>/ <b>29/2021</b>         |  |
|   | ROVIDER OR SUPPLIER   | CENTER  |                                      | STREET ADDRESS, CITY, STATE 1901 LIBBIE AVE RICHMOND, VA 23226   | , ZIP CODE | 1 01                       | 16316361                      |  |
| (X4) ID<br>PREFIX<br>TAG                            | EFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX   |   | X (EACH CORRECTIV<br>CROSS-REFERENCE | AN OF CORRECTION VE ACTION SHOULD B ED TO THE APPROPRIA ICIENCY) |            | (X5)<br>COMPLETION<br>DATE |                               |  |
|   | set), a quarterly asses (assessment reference Resident #9 as scorin for mental status (BIM cognitively intact for m Section G coded Resextensive assistance Section H coded Resindwelling urinary cathevidence documentation dialysis (4).  On 7/27/2021 at approasses (4).  On 7/27/2021 at approasses (4).  On 7/27/2021 at approasses (4).  The comprehensive cathevidence documented #9's uribag was observed lyindeside the bed.  The comprehensive cathevidence (4) approasses (4).  The comprehensive cathevidence (5) and (6) and (7) | ecent MDS (minimum data sment with an ARD e date) of 4/23/2021, coded g a 13 on the brief interview IS) scale, 13 - being naking daily decisions. dent #9 as requiring of one person for toilet use. dent #9 as having an neter. Section O failed to on of Resident #9 receiving of Area of Resident #9 in their nary catheter collection in g directly on the floor are plan dated 10/31/20, sufficiency related to a (diagnosis) bph (benign Date Initiated: 10/31/2020" rasks" it documented in insportation to and from a visit of a sufficiency related to a finite facility guidelines. Report clan. Date Initiated: h physician and/or dialysis ding changes in medication asage pre-dialysis as 10/31/2020, Coordinate fallysis treatment center. | F                                    | 356  |            |                            |                               |  |

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION |  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   |                   | TIPLE CO | NSTRUCTION  |      | E SURVEY<br>IPLETED        |
|---|--|--|-------------------|----------|---|------|----------------------------|
|   |  | 495391   | B. WING           |          |   | 07   | C<br>7/ <b>29/2021</b>     |
|   | PROVIDER OR SUPPLIER  RNIE REHAB & NURSING   | CENTER   |                   | 1901     | ET ADDRESS, CITY, STATE, ZIP CODE<br>LIBBIE AVE<br>HMOND, VA 23226  | 1 0/ | 723/2021                   |
| (X4) ID<br>PREFIX<br>TAG                            | (EACH DEFICIENCY   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREF<br>TAG |          | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD B<br>CROSS-REFERENCED TO THE APPROPRIA<br>DEFICIENCY) |      | (X5)<br>COMPLETION<br>DATE |
|   | The physician orders evidence documentated dialysis.  On 7/29/2021 at approinterview was conducted nurse) #5, th #5 stated that an initial the nursing staff on accomprehensive care particularly 21 days or 7 days after LPN #5 stated that the area assessment) that MDS assessment and determine the areas spreed to be care plannowere not sure if Reside would have to check.  On 7/29/2021 at approinterview was conducted that the care plan stated that the care plan resident required daily was. RN #4 stated that receive dialysis. RN #4 care plan was not accuminterventions documen be updated.  On 7/29/2021 at approviated that they had revel plan and had removed because Resident #9 don 7/27/2021 at approximations. | for Resident #9 failed to ion of Resident #9 receiving oximately 7:45 a.m., an ted with LPN (licensed e MDS coordinator. LPN all care plan was set up by dimission and the olan was completed within er completion of the MDS. By looked at the CAAS (care to twere triggered from the the resident's diagnoses to pecific to the resident that ed. LPN #5 stated that they ent #9 received dialysis and eximately 7:59 a.m., an ed with RN (registered er. RN #4 stated that the care that was provided for all departments. RN #4 an covered what care the and what their safety level to the Resident #9 did not all stated that Resident #9's urate with the dialysis ted on it and it needed to wimately 8:49 a.m., LPN #5 wiewed Resident #9's care the dialysis interventions | F                 | 656      |   |      |                            |

|                          | OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | 1 ' '               | E CONSTRUCTION  |    | E SURVEY                   |
|--------------------------|--|--|---------------------|---|----|----------------------------|
|                          |  | 495391   | B, WING             |   |    | C                          |
|                          | PROVIDER OR SUPPLIER RNIE REHAB & NURSIN   | ·  |                     | STREET ADDRESS, CITY, STATE, ZIP CODE 1901 LIBBIE AVE RICHMOND, VA 23226  | 07 | 7/29/2021                  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC  | TATEMENT OF DEFICIENCIES<br>CY MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROPR<br>DEFICIENCY) | BE | (X5)<br>COMPLETION<br>DATE |
|                          | nursing stated that the policies and procedured for practice.  On 7/28/2021 at apprequest was made to director of clinical set for comprehensive Comprehensi | roximately 5:45 p.m., a ASM #1, the regional roices for the facility policy are plans.  are Plans, Comprehensive sted December 2016 "The comprehensive, e plan will: a. Include es and timeframes; b. es that are to be furnished to resident's highest mental and psychosocial  coximately 11:00 a.m., ASM for of clinical services and of nursing were made aware  was provided prior to exit.  a condition in which you rine from your bladder. be acute-a sudden inability a gradual inability to bladder of urine. This ned from the website: gov/health-information/urol retention  perplasia: An enlarged | F 656               |   |    |                            |

|                          | OF DEFICIENCIES<br>F CORRECTION   | IDENTIFICATION NUMBER   |                     | FIPLE CONSTRUCTION NG   | (X3) DATE SURVEY<br>COMPLETED |
|--------------------------|---|---|---------------------|---|-------------------------------|
|                          |   |   |                     |   | C<br>07/29/2021               |
|                          | ROVIDER OR SUPPLIER RNIE REHAB & NURSING  | CENTER  |                     | STREET ADDRESS, CITY, STATE, ZIP CODE<br>1901 LIBBIE AVE<br>RICHMOND, VA 23226                |                               |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)  | ATEMENT OF DEFICIENCIES<br>'MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF COF<br>(EACH CORRECTIVE ACTION<br>CROSS-REFERENCED TO THE A<br>DEFICIENCY) | SHOULD BE COMPLETION          |
| ;<br>;<br>;              | from the website: https://medlineplus.go  3. Chronic kidney disc and can't filter blood a information was obtain https://medlineplus.go  I.  4. The facility staff faild #114's comprehensive pain medications per t physician ordered pain level ratings and the fa pain medication for pa severe pain.  Resident # 114 was ac 5/27/2021 with a recen with diagnoses that inc to: end stage renal disc hemodialysis (a procec conditions and renal [k wastes and impurities a blood by a special mac obstructive pulmonary term for chronic, nonre is usually a combination chronic bronchitis) (2) h anxiety disorder (state of apprehension, often with resulting in body chang neartbeat and sweat) (3  The most recent MDS ( assessment, a quarterly assessment reference of Resident # 114 as scori | is information was obtained  v/enlargedprostatebph.html ease: Kidneys are damaged  s they should. This  ned from the website:  v/chronickidneydisease.htm  ed to implement Resident  care plan to administer  the physician's orders. The  medication for severe pain  icility staff administered the  in scale ratings below  Imitted to the facility on  t readmission on 7/9/2021,  Iluded but were not limited  ease requiring  fure used in toxic  diney] failure, in which  are removed from the  hine) (1), chronic  disease (COPD - general  versible lung disease that  in of emphysema and  igh blood pressure and  of mild to severe  hout specific cause,  es such as quickened  is).  minimum data set)  v assessment, with an  date of 7/15/2021, coded | Fé                  | 556   |                               |

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

|                          | F CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  | A. BUILDING         | PLE CONSTRUCTION  |         | ATE SURVEY<br>OMPLETED     |
|--------------------------|--|---|---------------------|---|---------|----------------------------|
|                          |  | 495391  | B. WING             |   |         | C<br>07/29/2021            |
|                          | ROVIDER OR SUPPLIER  | G CENTER  |                     | STREET ADDRESS, CITY, STATE, ZIP CODE<br>1901 LIBBIE AVE<br>RICHMOND, VA 23226                |         |                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC  | TATEMENT OF DEFICIENCIES<br>DY MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY) | OULD BE | (X5)<br>COMPLETION<br>DATE |
|                          | the resident was mo daily cognitive decisicoded as limited ass for most of her activity. N - Medications, the receiving two days of during the look back. The comprehensive documented in part, dependence on renafluid overload, diseas "Interventions/Tasks" "Administer pain med Notify physician if part, worsening or of curres become ineffective."  The physician orders documented, "Hydroc Tablet (used to treat (milligrams) Give 1 target as needed for severe 6/1/2021, documented in pain, 8,9,10 = severe The July 2021 MAR (record) documented in for Hydrocodone - Acdocumented the medical service of the decimented of the medical service of the | derately impaired to make ions. Resident # 114 was istance of one staff member ties of daily living. In Section resident was coded as f an antianxiety medication period.  Care plan dated 6/25/2021 "Focus: Pain related to I dialysis, muscle weakness, se process." the 'documented in part, lication per physician orders. in frequency/intensity is ent analgesia regimen has  dated 6/23/2021 codone-Acetaminophen severe pain) (1) 5-325 MG blet by mouth every 6 hours pain." The order dated, d, "Pain Score every shift: 0 ild pain, 5, 6, 7 = moderate pain. every shift for pain."  medication administration the physician above order etaminophen. The MAR ication was administered on with pain scale ratings belowed by the physician as  1 pain level - 6 1 pain level - 7 1 pain level - 7 1 pain level - 6 | F 65                | 6   |         |                            |

|               | OF DEFICIENCIES<br>F CORRECTION                | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:         | (X2) MULT<br>A. BUILDIN | IPLE CONSTRUCTION                              | (X: | 3) DATE SURVEY<br>COMPLETED |
|---------------|--|--|-------------------------|--|-----|-----------------------------|
|               |  | 405004   |                         |  |     | С                           |
|               |  | 495391   | B WING _                |  |     | 07/29/2021                  |
| NAME OF P     | PROVIDER OR SUPPLIER                           |  |                         | STREET ADDRESS, CITY, STATE, ZIP CO            | ODE |                             |
| GLENBU        | RNIE REHAB & NURSING                           | GCENTER  |                         | 1901 LIBBIE AVE                                |     |                             |
|               |  |  | ]                       | RICHMOND, VA 23226                             |     |                             |
| (X4) ID       |  | FATEMENT OF DEFICIENCIES                                   | ID                      | PROVIDER'S PLAN OF                             |     | (X5)<br>COMPLETION          |
| PREFIX<br>TAG |  | Y MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION) | PREFIX<br>TAG           | (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TR |     | COMPLETION                  |
|               |  | ,  |                         | DEFICIENC                                      |     |                             |
|               |  |  |                         |  |     |                             |
| F 656         |  |  | F 6                     | 56   |     |                             |
|               | 7/17/2021 at 10:50 a.                          |  |                         |  |     |                             |
|               | 7/18/2021 at 5:54 a.n                          |  |                         |  |     |                             |
|               | 7/18/2021 at 9:09 p.n                          |  |                         |  |     |                             |
|               | 7/20/2021 at 10:15 p.                          |  |                         |  |     |                             |
|               | 7/21/2021 at 11:34 a.                          |  | 1                       |  |     |                             |
|               | 7/22/2021 at 1:26 a.m<br>7/23/2021 at 12:57 a. |  |                         |  |     |                             |
|               | 7/23/2021 at 12.57 a. 7/23/2021 at 9:30 a.m    |  |                         |  |     |                             |
|               | 7/24/2021 at 1:10 a.m                          |  |                         |  |     |                             |
|               | 7/26/2021 at 9:25 a.m                          |  |                         |  |     |                             |
|               |  |  |                         |  |     |                             |
|               |  | ducted with LPN (licensed                                  |                         |  |     |                             |
|               | practical nurse) #3, th                        |  |                         |  |     |                             |
|               |  | n., regarding the purpose of                               |                         | i i  |     |                             |
| 1             |  | are plan. LPN #3 stated it is                              | V.                      | 1  |     |                             |
|               |  | resident, also to guild use                                |                         |  |     |                             |
|               | plan of care."                                 | the resident needs. It's the                               |                         |  |     |                             |
|               | plan of care.                                  |  |                         | li .   |     |                             |
|               | ASM (administrative s                          | taff member) #1, the                                       |                         |  |     |                             |
|               |  | nical services, and ASM #2,                                | 1                       |  |     |                             |
|               | the director of nursing                        | , were made aware of the                                   | 1                       |  |     | 1                           |
|               | above findings on 7/29                         | 9/2021 at 10:41 a.m.                                       |                         |  |     |                             |
|               | No further information                         | was provided prior to exit.                                |                         |  |     |                             |
| 1             | Defenence                                      |  |                         |  |     |                             |
| 10            | References:                                    | as obtained from the                                       | 1                       |  |     |                             |
| 10            | (1) This information wa                        | as obtained from the                                       | 1                       |  |     | 1                           |
|               | following website:<br>https://medlineplus.gov  | //druginfo/meds/a614045.h                                  | 1                       |  |     |                             |
|               | tml  | //drugimo/meds/ao (4045.11                                 |                         |  |     |                             |
|               |  |  |                         |  |     |                             |
|               | 5. The facility staff faile                    | ed to implement the  |                         |  |     |                             |
|               |  | an related to respiratory                                  |                         |  |     |                             |
|               | care and services for F                        |  |                         |  |     |                             |
|               |  | w 1  |                         |  |     |                             |
|               |  | mitted to the facility on                                  |                         |  |     |                             |
| ١,            | or rorzoz i with diagnos                       | ses that included but were                                 |                         |  |     |                             |

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION |  | IDENTIFICATION NUMBER:  |                    | (2) MULTIPLE CONSTRUCTION BUILDING |   |   | (X3) DATE SURVEY<br>COMPLETED |  |  |
|---|--|---|--------------------|------------------------------------|---|---|-------------------------------|--|--|
|   |  | 495391  | B, WING            |                                    |   | 1 | C<br>7/ <b>29/2021</b>        |  |  |
|   | ROVIDER OR SUPPLIER  | CENTER  | •                  | 1901 Lii                           | ADDRESS, CITY, STATE, ZIP CODE BBIE AVE AOND, VA 23226  |   |                               |  |  |
| (X4) ID<br>PREFIX<br>TAG                            | (EACH DEFICIENC)   | ATEMENT OF DEFICIENCIES<br>/ MUST BE PRECEDED BY FULL<br>.SC IDENTIFYING INFORMATION)   | ID<br>PREFI<br>TAG | x                                  | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD B<br>CROSS-REFERENCED TO THE APPROPRIA<br>DEFICIENCY) |   | (X5)<br>COMPLETION<br>DATE    |  |  |
|   | disease (COPD -general nonreversible lung discombination of emphy bronchitis) (1), high blumorbid obesity (overwatchesis) (2), high blumorbid obesity (overwatchesis) (2), high blumorbid obesity (overwatchesis) (2), assessment, an admission assessment references Resident #172 as scorinterview for mental stresident was severely cognitive decisions. The requiring extensive as staff members for all of except eating in which after set up assistance O - Special Treatment Programs, the resident oxygen and having a Notentilator while a resident oxygen and having a Notentilator while a resident oxygen per physician of the physician order day documented, "Oxygen cannula every shift."  Observation was made a.m. observation revealed with her oxygen or two-prong tube that instance in the program of the physician or the phys | obstructive pulmonary prail term for chronic, sease that is usually a sease and deight).  (minimum data set) saion assessment, with an edate of 6/22/2021, coded ring a "2" on the BIMS (brief atus) score, indicating the impaired to make daily ne resident was coded as sistance of one or more of her activities of daily living she required supervision as provided. In Section so, Procedures, and the was coded as using son-invasive Mechanical dent at the facility.  The plan dated, 6/25/2021, focus: Has/at risk for related to COPD and diratory failure." The documented, "Administer order."  Inted, 7/2/2021, at 3 liters/minute via nasal section of the related that the facility is decided. The documented of the related that the facility is decided. The documented of the related to the | F                  | 656                                |   |   |                               |  |  |

|                          | OF DEFICIENCIES<br>F CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   | (X2) MUL<br>A. BUILD | TIPLE CONSTRUCTION  ING  |                              |      | SURVEY<br>PLETED           |  |
|--------------------------|--|---|----------------------|--|------------------------------|------|----------------------------|--|
|                          |  | 495391  | B. WING              |  |                              | 1    | C<br>07/29/2021            |  |
|                          | ROVIDER OR SUPPLIER  | CENTER  |                      | STREET ADDRESS, CITY, STATE, ZIP CO<br>1901 LIBBIE AVE<br>RICHMOND, VA 23226 | DE                           | 1 01 | ,20/2021                   |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY   | ATEMENT OF DEFICIENCIES<br>'MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFI<br>TAG   |  | ON SHOULD BE<br>HE APPROPRIA |      | (X5)<br>COMPLETION<br>DATE |  |
|                          | running. The oxygen of set at 4.5 LPM (liters probservation revealed was out of Resident # observation was made Resident #172 was in via a nasal cannula throxygen concentrator to Observation revealed flow meter was set with the 5 LPM line.  An observation was made 7/28/2021 at 12:07 p.m. practical nurse) #6. With resident's oxygen concentrator to the computer and via supposed to be on 3 Licomprehensive care pladminister oxygen as of was implemented, LPM When asked the purpose care plan, LPN #6 states the resident."  ASM (administrative states and in the director of nursing, above findings on 7/28/No further information with the director of Dictionary D | concentrator flow meter was beer minute). Further the oxygen concentrator 172's reach. A second on 7/28/2021 at 8:07 a.m. her bed with the oxygen on at was connected to an inat was running. The oxygen concentrator in the bottom of the ball on adde of Resident #172 on in., with LPN (licensed in asked to read the centrator, LPN #6 stated, is supposed to be on 3 b. LPN #6 proceeded to orders for Resident #172 perified the resident was PM. When asked if the an intervention to ordered by the physician 1 #6 stated, "No, Ma'am." see of the comprehensive ped, "It's the best care for aff member) #1, the call services, and ASM #2, were made aware of the | F                    | 656  |                              |      |                            |  |

|                          | OF DEFICIENCIES<br>F CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   | (X2) MUL<br>A. BUILD | TIPLE CONSTRUCTION   |       | ATE SURVEY<br>DMPLETED     |
|--------------------------|---|---|----------------------|--|-------|----------------------------|
|                          |   | 495391  | B. WING              |  |       | C<br>07/29/2021            |
| ļ.                       | ROVIDER OR SUPPLIER   | CENTER  |                      | STREET ADDRESS, CITY, STATE, ZIP CODE 1901 LIBBIE AVE RICHMOND, VA 23226 |       | 0112912021                 |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY  | ATEMENT OF DEFICIENCIES<br>MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFI<br>TAG   | · ·  | LD BE | (X5)<br>COMPLETION<br>DATE |
| F 656                    | Continued From page   | 90  | F                    | 656  |       |                            |
|                          |   | ed to implement the care tory care and services for   |                      |  |       |                            |
|                          | 7/14/2021 with diagnost not limited to: Cancer of muscular canal that tra   | ansports food from the<br>(1), Bipolar Disorder (a<br>sterized by episodes of   |                      |  |       |                            |
|                          | assessment reference<br>Resident #171 as scori<br>(brief interview for men-<br>the resident was capab<br>cognitive decisions. The | sion assessment, with an date of 7/20/2021, coded ng a "14" on the BIMS tal status) score, indicating le of making daily e resident was coded in atments, Procedures, and |                      |  |       |                            |
| į                        | documented, "Focus: H<br>impairment related to es   | e plan, dated, 7/27/2021,<br>as/at risk for respiratory<br>sophageal cancer." The<br>nted in part, "Administer<br>der."   |                      |  |       |                            |
| F<br>c<br>c<br>c         | Resident #171 was lying<br>oxygen in use via a nas<br>an oxygen concentrator  | al cannula connected to that was running. The w meter was set with the on the line for 2 LPM  |                      |  |       |                            |

|   |               | OF DEFICIENCIES<br>CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   |         | TPLE CONSTRU |   | (X3) DATE SURVEY<br>COMPLETED |                            |
|---|---------------|---|---|---------|--------------|---|-------------------------------|----------------------------|
|   |               |   | 495391  | B. WING |              |   | 07                            | C<br>7/ <b>29/2021</b>     |
| ľ | NAME OF P     | ROVIDER OR SUPPLIER   |   | -       | STREET ADD   | RESS, CITY, STATE, ZIP CODE   |                               |                            |
|   | GLENBUR       | RNIE REHAB & NURSING  | CENTER  |         | 1901 LIBBIE  |   |                               |                            |
| - | (X4) ID       | SUMMARY STA   | ATEMENT OF DEFICIENCIES   | ID ID   | RICHMONI     | D, VA 23226 PROVIDER'S PLAN OF CORRECTION   |                               |                            |
| L | PREFIX<br>TAG |   |   |         | (            | (EACH CORRECTION ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIADEFICIENCY) |                               | (X5)<br>COMPLETION<br>DATE |
|   |               | was lying in the bed. It nasal cannula connect concentrator that was concentrator flow mete of the ball sitting on the of the ball sitting on the On 7/28/2021 at 12:36 made of Resident #17 had oxygen in use via a to an oxygen concentrator (licensed practical nurse When asked the flow reflected that the flow reflected the line for the prostated the center of the intervention to administrative or the purpose of the plan, LPN #6 stated, "It resident."  ASM (administrative stated director of nursing, above findings on 7/28/No further information was References:  1) Barron's Dictionary of Chapman, page 208. 2) Barron's Dictionary of Chapman, page 208. | 9:04 a.m. Resident #171 He had oxygen in use via a ted to an oxygen running. The oxygen er was set with the bottom er was set with the bottom er line for 2 LPM.  I p.m. an observation was 1 was lying in his bed. He anasal cannula connected ator that was running. LPN se) #6 was in attendance, ate setting of Resident 6 stated, "Almost 3 LPM." and the oxygen escribed rate, LPN #6 prescribed rate should be not ball. When asked if the ter oxygen per physician's ensive care plan was stated, "No, Ma'am." When the comprehensive care is the best care for the call services, and ASM #2, were made aware of the | F       | 56           |   |                               |                            |

|                          | OF DEFICIENCIES<br>F CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  | 1                  | TIPLE CONSTRUCTION   |      | E SURVEY<br>IPLETED        |
|--------------------------|--|--|--------------------|--|------|----------------------------|
|                          |  | 495391   | B. WING            |  | 0:   | C<br>7/ <b>29/202</b> 1    |
|                          | ROVIDER OR SUPPLIER  RNIE REHAB & NURSING  | CENTER   |                    | STREET ADDRESS, CITY, STATE, ZIP CODE 1901 LIBBIE AVE RICHMOND, VA 23226 | 1 0/ | 1/23/2021                  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY   | ATEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)  | ID<br>PREFI<br>TAG |  | BE   | (X5)<br>COMPLETION<br>DATE |
|                          | 7. The facility staff fails comprehensive care p 104's condom cathete Resident # 104 was ad diagnoses that include Parkinson's disease [1 Resident # 104's most data set), an admission (assessment reference coded Resident # 104 brief interview for ment of 0 - 15, 11 - being mocognition for making da 18 was coded as required one staff member for Under section H "Bladd 104 was coded under "indwelling catheter and The POS [physician's of 104 dated 07/28/2021 of Catheter: Condom char obstructed. Order Date documentation to address condom catheter.  The facility's progress neated 07/02/2021 at 4:20 part, "Resident Evaluation to 107/28/2021 at 1:30 per conducted with LPN [Lice conducted with LP | ed to develop a lan to address Resident # r and care.  dmitted to the facility with ed but were not limited to: ] and multiple sclerosis [2].  recent MDS (minimum n assessment with an ARD e date) of 07/08/2021, as scoring an 11 on the eal status (BIMS) of a score oderately impaired of eally decisions. Resident # ring extensive assistance activities of daily living. der and Bowel" Resident # l'H0100" as having an an external catheter.  erder sheet] for Resident # documented, "Urinary nge PRN [as needed] if e: 07/28/2021."  re plan for Resident # 104 I to evidence ess Resident # 104 I to evidence | F                  | 656  |      |                            |

|                          | OF DEFICIENCIES<br>CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   | 1 ` ′              | (X2) MULTIPLE CONSTRUCTION A. BUILDING                                   |           |    | (X3) DATE SURVEY<br>COMPLETED |  |  |
|--------------------------|---|---|--------------------|--|-----------|----|-------------------------------|--|--|
|                          |   | 495391  | B. WING            |  |           | 07 | C<br>/ <b>29/2021</b>         |  |  |
|                          | ROVIDER OR SUPPLIER   | CENTER  |                    | STREET ADDRESS, CITY, STATE, ZIP CODE 1901 LIBBIE AVE RICHMOND, VA 23226 |           | 01 | 12312021                      |  |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY  | ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)  | ID<br>PREFI<br>TAG |  | SHOULD BE |    | (X5)<br>COMPLETION<br>DATE    |  |  |
|                          | 104's condom catheter "There was no order or didn't make it on the cacare plan should have address Resident # 10 stated yes.  On 7/29/2021 at approinterview was conducted that an initial can ursing staff on admission comprehensive care plant and the CAAS (can were triggered from the diagnosis to determine the diagnosis to determine the diagnosis to determine the diagnosis to determine the admission reviews with any new of conditions.  On 7/29/21 at approximaterview was conducted that the nurses upon the diagnosis of the diagnosis of the diagnosis of the diagnosis of the diagnosis to determine the admission reviews with any new of conditions.  On 7/29/21 at approximaterview was conducted that the nurse of the diagnosis of the diagnosis were updated even the diagnosis of the diagnosis were updated even the care that was provided the care that was provided all departments are plan covered what dially and what their safety. | care plan dated vas asked if the lan addressed Resident # r and care. LPN # 5 stated, n admission therefore it are plan." When asked if a been developed to lad's catheter care LPN # 5  eximately 7:45 a.m., an and with LPN # 5. LPN # 5 re plan was set up by the sion and the an was completed within completed of the MDS PN # 5 stated that they are area assessment) that be MDS assessment and nine areas specific to the be care planned. LPN # 5 updated the care plans in and quarterly care plan rders, falls or skin  attely 7:59 a.m., an d with RN (registered ber. RN # 4 stated that care bery three months and as and interventions put into at the care plan justified ded for the resident beta RN # 4 stated that the care the resident required bety level was. | F                  | 656  |           |    |                               |  |  |

PRINTED: 08/10/2021 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING С 495391 B. WING 07/29/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1901 LIBBIE AVE **GLENBURNIE REHAB & NURSING CENTER** RICHMOND, VA 23226 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX PREFIX** (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) F 656 Continued From page 94 F 656 clinical services, ASM #2, director of nursing and ASM # 4, medical director, were made aware of the above concern. No further information was presented prior to exit. References: [1] A type of movement disorder. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/parkinsonsdi sease.html. [2] A nervous system disease that affects your brain and spinal cord. It damages the myelin sheath, the material that surrounds and protects your nerve cells. This damage slows down or blocks messages between your brain and your body, leading to the symptoms of MS. This information was obtained from the website: https://medlineplus.gov/multiplesclerosis.html. 8. The facility staff failed to develop a comprehensive care plan to address Resident # 11's tracheostomy care. Resident # 11 was admitted to the facility with diagnoses that include but not limited to: skin

tracheostomy [4].

cancer of scalp and neck, respiratory failure with hypoxia [2], acquired absence of larynx [3] and

Resident # 11's most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 04/27/2021, coded Resident # 11 as scoring a 14 on the brief interview for mental status (BIMS) of a score of 0 - 15, 14 - being cognitively intact for making daily decisions. Section "O Special Treatments,

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION |  | IDENTIFICATION NUMBER:   |  | IPLE CONSTRUCTION  | (X3) DATE SURVEY<br>COMPLETED |  |
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|   |  | <b>495391</b> B.   |  |  | C<br>07/29/2021               |  |
|   | ROVIDER OR SUPPLIER  RNIE REHAB & NURSING  | CENTER   | STREET ADDRESS, CITY, STATE, ZIP CODE 1901 LIBBIE AVE RICHMOND, VA 23226 |  |                               |  |
| (X4) ID<br>PREFIX<br>TAG                            | (EACH DEFICIENCY   | ATEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG  | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIED (CROSS-REFERENCE)) | BE COMPLÉTION                 |  |
|   | for "Tracheostomy can The physician's order Resident # 11 docume and ambu [1] bag with The comprehensive can dated 04/21/2021 faile for tracheostomy care On 07/29/2021 at 7:30 conducted with LPN # LPN #3 reviewed Resicare plan dated 04/21/a care plan was develoned to tracheostomy care included to the conducted with LPN # 3 programmer includes the conducted with ASM [accomplete with a series of the conducted with ASM [accomplete] # 2, director of the conducted with ASM [accomplete] # 2, director of the conducted with a series of the conducted with a ser | rams" coded Resident # 11 re" while a resident.  dated 04/01/2021 for ented, "Keep a spare trach pt [patient] at all times."  are plan for Resident # 11 d to evidence interventions  a.m., an interview was 3, MDS coordinator. After dent # 11's comprehensive 2021, LPN #3 was asked if oped to address Resident # e. LPN # 3 stated no. At evided a corrected copy of ehensive care plan with uded.  a.m., an interview was dministrative staff of nursing. After ASM #2 1's comprehensive care , ASM #2 was asked if a ed for Resident # 11's M # 2 stated, "The ddress trach  eximately 5:00 p.m., ASM | F 68   | 56   |                               |  |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION |   | (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE C IDENTIFICATION NUMBER:  A. BUILDING   |                     |  |    | E SURVEY<br>MPLETED        |
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|  |   | 495391  | B. WING             |  | 0. | C<br>7/ <b>29/2021</b>     |
|  | PROVIDER OR SUPPLIER  RNIE REHAB & NURSING  | CENTER  | 190                 | REET ADDRESS, CITY, STATE, ZIP CODE<br>11 LIBBIE AVE<br>CHMOND, VA 23226   |    | 112312021                  |
| (X4) ID<br>PREFIX<br>TAG                         | (EACH DEFICIENC)  | ATEMENT OF DEFICIENCIES<br>/ MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTIC<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROPE<br>DEFICIENCY) | BE | (X5)<br>COMPLETION<br>DATE |
|  | References:  [1] A self-refilling bagged -1.5 liter capacity, use which, while suboptim patient, is effective for intubated patients, allow and artificial respiration obtained from the web https://medical-dictionambu+bag  9. The facility staff faile #33's comprehensive address the use of ant Resident #33 was adm 10/2/15. Resident #33 were not limited to dial difficulty swallowing. Reminimum data set assessment reference resident's cognition as N coded Resident #33 antipsychotic medication days. Section V coded a triggered care area as be care planned.  Review of Resident #33 a physician's order date 12.5 mg (milligrams) two Monday, Tuesday, Thu and Sunday for schizop | evalve-mask unit with a 1 and for artificial respiration all for the non-intubated ventilating and oxygenating owing both spontaneous in. This information was site:  ary.thefreedictionary.com/A and to develop Resident care plan to include and ipsychotic medication.  Initted to the facility on a diagnoses included but betes, heart failure and esident #33's annual essment with an date of 5/18/21, coded the severely impaired. Section as having received on six out of the last seven psychotropic drug use as and documented this would  B's clinical record revealed and 1/15/21 for Seroquel (1) to times a day every reday, Friday, Saturday hrenic effect disorder (1).  Intensive care plan revised ment information medication use. | F 656               |  |    |                            |

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION |   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   |                     | TIPLE CONSTRUCTION  |      | E SURVEY<br>IPLETED        |
|---|---|---|---------------------|---|------|----------------------------|
|   |   | 495391  | B. WING             |   | 07   | C<br>// <b>29/2021</b>     |
|   | NAME OF PROVIDER OR SUPPLIER  GLENBURNIE REHAB & NURSING CENTER   |   |                     | STREET ADDRESS, CITY, STATE, ZIP CODE 1901 LIBBIE AVE RICHMOND, VA 23226                                  | 1 01 | 12021                      |
| (X4) ID<br>PREFIX<br>TAG                            | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  |   | ID<br>PREFI)<br>TAG | PROVIDER'S PLAN OF CORRECTIO X (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY) | BE   | (X5)<br>COMPLETION<br>DATE |
|   | conducted with LPN (I (the MDS [minimum d #5 stated she is support psychotropic drug use receives an antipsyche psychotropic drug use the MDS. LPN #5 reviccomprehensive care pdid not have a care plated on 7/28/21 at 4:52 p.m. staff member) #1 (the new services) and ASM #2 were made aware of the The facility policy, "Car Person-Centered" dated documented in part, " person-centered care preson-centered c | icensed practical nurse) #5 ata set] coordinator). LPN beed to develop a care plan when a resident otic medication and triggers as a care area on ewed Resident #33's lan and stated the resident un for antipsychotic use.  a., ASM (administrative regional director of clinical (the director of nursing) he above concern.  e Plans, Comprehensive ed December 2016 .The comprehensive, olan will: a. Include and timeframes; b. hat are to be furnished to esident's highest ental and psychosocial  vas presented prior to exit.  let) tablets and eacting) tablets are used to | F                   | 556   |      |                            |

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION |  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  |                     | IPLE CONSTRUCTION  | (X3) DATE SURVEY<br>COMPLETED |  |
|---|--|--|---------------------|--|-------------------------------|--|
|   |  | 495391   | B, WING_            |  | C<br>07/29/2021               |  |
|   | CALCH DEFICIENCY MUST BE PRECEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION)  |  |                     | STREET ADDRESS, CITY, STATE, ZIP CODE 1901 LIBBIE AVE RICHMOND, VA 23226   | 0112312021                    |  |
| PREFIX  |  |  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTIOI<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROPRI<br>DEFICIENCY) | BE COMPLETION                 |  |
|   | 10. The facility staff fa #62's comprehensive address the use of ant Resident #62 was adm 1/20/17. Resident #62 were not limited to obsidisorder, major depresion. Resident #62's siminimum data set asseassessment reference resident as being cognicoded Resident #62 as antipsychotic medication days. Section V coded a triggered care area as be care planned.  Review of Resident #62's comprehence for many solution in the factor of the fac | iled to develop Resident care plan to include and ipsychotic medication.  Initted to the facility on a diagnoses included but bessive compulsive sive disorder and low back ignificant change in status essment with an date of 3/15/21, coded the itively intact. Section N is having received on six out of the last seven psychotropic drug use as and documented this would a solution and information medication use.  In a interview was eensed practical nurse) #5 is a set] coordinator). LPN ed to develop a sare plan when a resident ic medication and inggers as a care area on wed Resident #62's in and stated the resident for antipsychotic use. | F 68                |  |                               |  |

#### PRINTED: 08/10/2021 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING\_ COMPLETED C 495391 B. WING 07/29/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1901 LIBBIE AVE **GLENBURNIE REHAB & NURSING CENTER** RICHMOND, VA 23226 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION DATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 656 Continued From page 99 F 656 staff member) #1 (the regional director of clinical services) and ASM #2 (the director of nursing) were made aware of the above concern. No further information was presented prior to exit. Reference: (1) "Quetiapine (Seroquel) extended-release tablets are also used along with other medications to treat depression." This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a698019.h tml 11. The facility staff failed to develop the comprehensive care plan to include and address Resident #59's AV (arterial-venous) shunt care and dialysis. Resident #59 was admitted to the facility on 1/27/21 with diagnosis that included but were not limited to: diabetes mellitus (inability of insulin to function normally in the body) (1), ESRD [end stage renal

disease] (inability of the kidneys to excrete wastes and function in the maintenance of electrolyte balance) (2), heart failure (inability of the heart to pump enough blood to maintain

cerebrovascular accident (abnormal condition in which a hemorrhage or blockage of the blood vessels of the brain leads to a lack of oxygen) (4).

The most recent MDS (minimum data set) assessment, a Medicare 5 day assessment, with an ARD (assessment reference date) of 6/14/21, coded Resident #59 as scoring a 15 out of 15 on the BIMS (brief interview for mental status) score,

normal body requirements) (3) and

|                          | OF DEFICIENCIES<br>F CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  | (X2) MULTI<br>A. BUILDIN | PLE CONSTRUCTION<br>G  | (X3) DATE<br>COMP | SURVEY                     |
|--------------------------|--|--|--------------------------|--|-------------------|----------------------------|
|                          |  | 495391 B. WING   |                          |  | 29/2021           |                            |
|                          | NAME OF PROVIDER OR SUPPLIER  GLENBURNIE REHAB & NURSING CENTER  |  |                          | STREET ADDRESS, CITY, STATE, ZIP CODE 1901 LIBBIE AVE RICHMOND, VA 23226                                     | 1 0111            | 23/2021                    |
| (X4) ID<br>PREFIX<br>TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)   |  | ID<br>PREFIX<br>TAG      | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) |                   | (X5)<br>COMPLETION<br>DATE |
|                          | indicating the resident review of the MDS Se coded the resident as assistance for locomot dressing and bathing; for hygiene, transfer, a eating and dressing. Streatments and proced "Dialysis= yes."  A review of the physicial documented in part, "Evascular shunt-check in vascular shunt-check in the compression of the care plants of the | was cognitively intact. A ction G-functional status requiring extensive ion, limited assistance with supervision was required and bed mobility, walking, ection O: special tures, documented, an orders dated 6/10/21, bialysis: site of arterial wruit and thrill every shift."  hensive care plan dated any documentation sident #59's AV for a bruit or thrill and locumentation regarding for a bruit or thrill and locumentation regarding for the an. LPN #5 stated, "The in is to alert the staff on eath. For a dialysis of see the dialysis are the dialysis are the dialysis for bruit and thrill, remove and checking for bleeding. The infection due to monitor the signs and change dressing per ing that triggers from the ne care plan". When is or checking the AV | F 65                     |  |                   |                            |

|   |  |  |                     |  | OIVID I   | 0.0000.000                 |
|---|--|--|---------------------|--|-----------|----------------------------|
|   | OF DEFICIENCIES<br>F CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | 1                   | E CONSTRUCTION   |           | TE SURVEY<br>MPLETED       |
|   |  |  |                     |  |           | С                          |
|   | 495391 B. WING   |  |                     | 0  | 7/29/2021 |                            |
| NAME OF PROVIDER OR SUPPLIER  GLENBURNIE REHAB & NURSING CENTER |  |  | 1                   | STREET ADDRESS, CITY, STATE, ZIP CODE<br>1901 LIBBIE AVE<br>RICHMOND, VA 23226   |           |                            |
| (X4) ID<br>PREFIX<br>TAG  |  |  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BI<br>CROSS-REFERENCED TO THE APPROPRIA<br>DEFICIENCY) |           | (X5)<br>COMPLETION<br>DATE |
|   | don't see it. I will revision don't see it. I will revision 7/27/21 at 11:11 All standard of practice way ASM (administrative stand procedures."  According to the facilitic Comprehensive Person December 2016, which comprehensive, person incorporate identified procedures that are to be maintain the resident's physical, mental and psocial procedures. According to the facility Disease, Care of a Respendent's comprehensive sident's comprehensive sident's comprehensive sident's needs related for 1/28/21 at 5:30 PM, director of clinical servical for nursing and ASM #4, made aware of the conduction of further information was resident. See the conduction of th | lan, LPN #5 stated, "No, I e it."  M, when asked what as followed in the facility, aff member) #2, the ed, "We follow our policies  es "Care Plans, n-Centered" revised documents in part, "The n-centered care plan will: roblem areas, describe the furnished to attain or highest practicable ychosocial well-being."  Is "End-Stage Renal ident With" revised documents in part, "The rece care plan will reflect the rece care plan will reflect the research when the director were dern.  ASM #1, the regional res, ASM #2, the director the Medical Director were rem.  as provided prior to exit.  If Medical Terms for the medition, Rothenberg and the dedition, Rothenberg and medition, Rothenberg and medition, Rothenberg and | F 656               |  |           |                            |

|   |   | TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION OF CORRECTION (X3) MULTIPLE CONSTRUCTION OF CORRECTION (X4) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION OF CORRECTION (X4) PROVIDER/SUPPLIER/CLIA (X5) MULTIPLE CONSTRUCTION (X5) PROVIDER/SUPPLIER/CLIA (X5) MULTIPLE CONSTRUCTION OF CORRECTION (X5) PROVIDER/SUPPLIER/CLIA (X5) MULTIPLE CONSTRUCTION (X5) PROVIDER/SUPPLIER/CLIA (X5) MULTIPLE CONSTRUCTION (X5) PROVIDER/SUPPLIER/CLIA (X5) MULTIPLE CONSTRUCTION (X5) PROVIDER/SUPPLIER/CLIA (X5) PROVIDER/SUPPLIER/CLIA (X5) MULTIPLE CONSTRUCTION (X5) PROVIDER/SUPPLIER/CLIA (X5) PROVIDER/SUPPLIER/SUPPLIER/CLIA (X5) PROVIDER/SUPPLIER/SUPPLIER/CLIA (X5) PROVIDER/SUPPLIER/SUPPLIER/CLIA (X5) PROVIDER/SUPPLIER/ |  |                    |            |   | E SURVEY<br>MPLETED |                            |
|---|---|--|--|--------------------|------------|---|---------------------|----------------------------|
|   |   |  |  |                    |            | *   |                     | С                          |
| I |   |  | 495391   | B. WING            |            |   | 07                  | 7/29/2021                  |
|   | NAME OF PROVIDER OR SUPPLIER  GLENBURNIE REHAB & NURSING CENTER |  |  |                    | 1901 LIBBI | DRESS, CITY, STATE, ZIP CODE<br>E AVE<br>ID, VA 23226   |                     |                            |
|   | (X4) ID<br>PREFIX<br>TAG  | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)   |  | ID<br>PREFI<br>TAG |            | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIA'<br>DEFICIENCY) |                     | (X5)<br>COMPLETION<br>DATE |
|   |   | Chapman, page 259.  (4) Barron's Dictionary Non-Medical Reader, Chapman, page 111.  12. The facility staff fair comprehensive care pleadilysis care and serving between the facility and Resident #52 was most facility on 6/4/21 with the limited to sepsis, diable dysphagia, insomnia, sepressure, end stage reand COVID-19. The medical part of the comprehensive development of the comprehensive development of the comprehensive of the comprehensive of the comprehensive of fistula/graft included an intervention of Coordinate dialysis care reatment center."  A review of the clinical rephysician's order dated of the comprehensive of the clinical rephysician's order dated of the comprehensive of the clinical rephysician's order dated of the clini | of Medical Terms for the off hedition, Rothenberg and off hedition, Rothenberg and siled to implement the lan for the coordination of ces for Resident #52, do the dialysis center.  It recently readmitted to the he diagnoses of but not stes, stroke, dysphasia, reizures, high blood and disease, pacemaker, ost recent MDS (Minimum enty / 5-day assessment ent Reference Date) of as coded as being paired in ability to make a resident was coded as pathing; extensive toileting, dressing, and on for eating.  The hensive care plan and control of the complete in the dialysis  The dated 11/30/20 for the with the dialysis  The decord revealed a 6/28/21 for "Hemodialysis of the control of the dialysis of the dialysis of the control of the control of the dialysis of the dialysis of the control of the control of the dialysis of the dialysis of the control of the dialysis of the control of the dialysis of the control of the dialysis of the dialys | F                  | 56         |   |                     |                            |

PRINTED: 08/10/2021 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391

|   |                          | OF DEFICIENCIES<br>F CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  | (X2) MUL<br>A. BUILD | TIPLE CONSTRUCTION                    |         | DATE SURVEY                |
|---|--------------------------|--|---|----------------------|---------------------------------------|---------|----------------------------|
|   |                          | 495391   |   | B. WING              |                                       |         | C                          |
| ı | NAME OF P                | ROVIDER OR SUPPLIER  |   |                      | STREET ADDRESS, CITY, STATE, ZIP CODE |         | 07/29/2021                 |
|   | GLENBUF                  | RNIE REHAB & NURSING   | CENTER  |                      | 1901 LIBBIE AVE<br>RICHMOND, VA 23226 |         |                            |
|   | (X4) ID<br>PREFIX<br>TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)   |   | ID<br>PREFI<br>TAG   |                                       | OULD BE | (X5)<br>COMPLETION<br>DATE |
|   |                          | as applicable, for the dito performing dialysis, Vital signs, blood suga given, wound sites, speadditional comments.  The second half of the was to document for the return from dialysis the dialysis weight and vital weight and vital signs, comedications administer comments.  A review of the dialysis the following:  July 2, 2021 - there was documentation from eithluly 7, 2021 - the dialysis document on the commentation for the facility.  July 8, 2021 - the dialysis document on the dialysis do | e number, and by contact was  s communication log ch the facility was to alf the following information ialysis center review prior the following information: r, last pain medication ecial precautions,  form, the dialysis center e facility to review upon following information: Pre I signs, post dialysis duration of treatment, ed, and new orders or  log for July 2021 revealed  no communication log per facility to the other. is center did not unication log pertinent is center did not | F                    | 656                                   |         |                            |
|   | Մ<br>d<br>d<br>Ji<br>di  | ocument on the communication log pertinent ata for the facility.  uly 16, 2021 - the dialysis center did not ocument on the communication log pertinent ata for the facility.  uly 19, 2021 - there was no communication log ocumentation from either facility to the other.  uly 23, 2021 - the dialysis center did not ocument on the communication log pertinent  |   |                      |                                       |         |                            |

| 1                                 | OF DEFICIENCIES<br>OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   | (X2) MULTIPLE CONSTRUCTION A, BUILDING |  | (X3) DATE SURVEY<br>COMPLETED |                            |
|-----------------------------------|---|---|--|--|-------------------------------|----------------------------|
|                                   |   | 495391  | B, WING                                |  | 1                             | С                          |
| NAME OF F                         | PROVIDER OR SUPPLIER  | 455551  | 13:11110_                              | STREET ADDRESS, CITY, STATE, ZIP CODE  | 07.                           | /29/2021                   |
| GLENBURNIE REHAB & NURSING CENTER |   |   |  | 1901 LIBBIE AVE<br>RICHMOND, VA 23226  |                               |                            |
| (X4) ID<br>PREFIX<br>TAG          |   |   | ID<br>PREFIX<br>TAG                    | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | _                             | (X5)<br>COMPLETION<br>DATE |
|                                   | data for the facility. July 28, 2021 - the factor the communication log dialysis center.  On 7/29/21 at 10:44 A conducted with RN #4 asked about the purpose communication log, Rf document and report to change of condition, vialterations in relevant a stated that even if ther conditions or treatment the vital signs should be facilities.  On 7/29/21 at 10:48 Aff conducted with LPN #7 Nurse). When asked w dialysis communication it was for recording and resident's vital signs and dialysis center. When a left blank, and how eith vitals and weights were won't know." When ask coordinate dialysis care dialysis treatment center comprehensive care plabeling implemented if the were blank or incomplet was not.  On 7/29/21 at 8:45 AM, Services Director, Director (Admin ASM) #1, #2, and #3 recommunication in the plank or incomplet was not. | ility did not document on a pertinent data for the  M an interview was (Registered Nurse). When use of the dialysis N #4 stated it was to or from dialysis any tal signs, weights, or care and treatment. She were no changes in its, that at the very least, we documented by both  M an interview was (Licensed Practical hat the purpose of the book was, she stated that it communicating the id weight to and from the asked about logs that were er facility knew what the LPN #7 stated, "They ed if the intervention to and services with the er, on Resident #52's an dated 11/30/21, was e communication logs te, LPN #7 stated that it the Regional Clinical tor of Nursing and distrative Staff Members | F 65                                   |  |                               |                            |

| OF DEFICIENCIES<br>FCORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   |   |   |  | (X3) DATE SURVEY<br>COMPLETED  |  |
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|   | 495391 B. WIN   |   | ·   |  | С  |  |
| NAME OF PROVIDER OR SUPPLIER  |   | B, WING _   |   | 07   | /29/2021   |  |
|   | CENTER  |   | 1901 LIBBIE AVE   |  |  |  |
|   |   |   | RICHMOND, VA 23226  |  |  |  |
| (EACH DEFICIENCY  | MUST BE PRECEDED BY FULL  | ID<br>PREFIX<br>TAG   | (EACH CORRECTIVE ACTION SHOUL   | ) BE   | (X5)<br>COMPLETION<br>DATE   |  |
| F 656 Continued From page 105   |   | F 65  | 6   |  |  |  |
| dialysis communicatio   | n log was a problem. No   |   |   |  |  |  |
| Care Plan Timing and CFR(s): 483.21(b)(2)(i §483.21(b)(2) A compression of the comprehensive assignifications of the comprehensive assignification of the attending physical (a) The attending physical (b) A registered nurse of the comprehension of the comprehension of the comprehension of the comprehension of the comprehensive and their resident repression of the comprehensive and the comprehensive and quasissessments.  The comprehensive and quasissessments on the comprehensive and quasissessments.  This REQUIREMENT is the comprehensive and states on the comprehension of the comprehensive and quasissessments. | p-(iii)  Insive Care Plans Schensive care plan must Idays after completion of Scessment. Indisciplinary team, that ed to cian. Indisciplinary for the Indisciplinary team of the Indisciplinary team |   | 1. Residents #105, #9, and #82 of to reside in facility and the care been reviewed to ensure compresare plan has been updated and Resident #114 has been discharthe facility.  2. All residents have the potential affected by this alleged deficien practice. Nursing management we conduct audit care plans to verify plans initiated or updated for assidevices, psychotropic medication change in condition.  3. DON or designee will educate nurses that care plans must be in or updated to include assistive dipsychotropic medication and charcondition.  4. DON or designee will audit 5 resident's care plans weekly time weeks and monthly times 2 to enthat care plans are initiated or upfor change in condition, psychotromedications, and assistive devices medications, and assistive devices   | ontinue plan has chensive revised. ged from  I to be ci vill y care istive ns and  all itiated evices, ange in  es 4 sure dated copic s. Any   |  |  |
|   | ROVIDER OR SUPPLIER  SUMMARY STA  (EACH DEFICIENCY REGULATORY OR L.  Continued From page already been identified dialysis communicatio further information was survey.  Care Plan Timing and I CFR(s): 483.21(b)(2)(i) §483.21(b) Compreher §483.21(b)(2) A compre be- (i) Developed within 7 of the comprehensive ass (ii) Prepared by an intel includes but is not limit (A) The attending physi (B) A registered nurse was esident.  C) A nurse aide with re esident.  D) A member of food a E) To the extent praction the resident and the resident and their resident repre of practicable for the desident's care plan.  F) Other appropriate st isciplines as determine or as requested by the r isi)Reviewed and revise earm after each assessing comprehensive and qual ssessments. his REQUIREMENT is y: assed on observation, se   | A95391  ROVIDER OR SUPPLIER  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 105 already been identified that the completion of the dialysis communication log was a problem. No further information was provided by the end of the survey.  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 bee.  (ii) Developed within 7 days after completion of the comprehensive assessment.  (iii) Prepared by an interdisciplinary team, that includes but is not limited to—  (A) The attending physician.  B) A registered nurse with responsibility for the esident.  C) A nurse aide with responsibility for the esident.  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 needical record if the participation of the resident representative is determined of practicable for the development of the esident's care plan.  7) Other appropriate staff or professionals in isciplines as determined by the resident's needs r as requested by the resident.  ii) Reviewed and revised by the interdisciplinary sam after each assessment, including both the omprehensive and quarterly review sessessments.  his REQUIREMENT is not met as evidenced | ROVIDER OR SUPPLIER  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC (DENTIFYING INFORMATION)  Continued From page 105  already been identified that the completion of the dialysis communication log was a problem. No further information was provided by the end of the survey.  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 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 resident.  D) A member of food and nutrition services staff.  E) To the extent practicable, the participation of he resident and the resident's representative(s). An explanation must be included in a resident's nedical record if the participation of the resident representative is determined of practicable for the development of the resident's nedical record if the participation of the resident's nedical record if | A SULDING  A SURDING  A SURDING  A SURDING  STREET ADDRESS, CITY, STATE, ZIP CODE  1991 LIBBIE AVE  RICHMOND, VA 23226  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC DENTIFYING INFORMATION)  Continued From page 105  already been identified that the completion of the dialysis communication tog was a problem. No further information was provided by the end of the survey.  Care Plan Timing and Revision  CFR(s): 483.21(b)(2)(l)(lill)  \$483.21(b) Comprehensive Care Plans \$483.21(b)(2) A comprehensive care plan must been comprehensive assessment.  (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 esident.  C) A nurse aide with responsibility for the esident.  C) A nurse aide with responsibility for the esident and the resident for the development of the esident core plan.  T) Other appropriate staff or professionals in isolphines as determined of practicable for the development of the esident care plan.  T) Other appropriate staff or professionals in isolphines as determined on the propriate staff or professionals in isolphines as determined on the resident must be included in a resident and their resident each assessment, including both the omprehensive and quarterly review seessments.  B) A regulared nurse with responsibility for the esident.  C) A nurse aide with responsibility for the esident and the resident and the resident and the resident of the participation of the resident and the resident professionals in isolphines as determined on the professionals in isolphines are determined on the professional in including both the omprehensive and quarterly review seessments.  B) A registered nyse with responsibility for the esident and the r | A SULDING  A SURD STREET ADDRESS, CITY, STATE, ZIP CODE  SUMMARY STATEMENT OF DEPICEMENTS  CARD PROPERTY AND OF CORRECTION  PREFIX  TAG  PROVIDERS PLAN OF CORRECTION  FERSION  FROM DEPERS PLAN OF CORRECTION  FROM DEPERSON OF CORRECTION  FROM DEPERSON OF CORRECTION  FROM DEPERSON OF CORRECTION  FROM DEPERSON OF CORRECTION |  |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION |   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | (X2) MULTIPI        | LE CONSTRUCTION  | (X3) DATE SURVEY<br>COMPLETED | 501 |
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|  |   |  | A. BOILDING         |  | C                             |     |
| NAMEOS   |   | 495391   | B, WING             | <u></u>  | 07/29/2021                    |     |
|  | PROVIDER OR SUPPLIER  JRNIE REHAB & NURSING   | CENTER   |                     | STREET ADDRESS, CITY, STATE, ZIP CODE<br>1901 LIBBIE AVE<br>RICHMOND, VA 23226   |                               |     |
| (X4) ID  | SUMMARY STA   | ATEMENT OF DEFICIENCIES  |                     |  |                               |     |
| PREFIX<br>TAG                                    | EFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL  |  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BI<br>CROSS-REFERENCED TO THE APPROPRIA<br>DEFICIENCY) |                               | NC  |
| ,<br>,   | was determined that the review and/or revise the for four of 49 residents. Residents #105, #9, #1  The facility staff failed Resident #105's compression and revise Resident #9's compression and review and revise Resident #9's compression and review and revise Resident #82's comprehensive ause of antianxiety media physician.  The findings include:  1. The facility staff failed Resident #105's compression and revise and resident #105's compression and high blood pressured quarterly minimum data assessment reference desident's cognition as services of Resident #105's resident #105's resident's cognition as services of Resident #105's resident's reference desident's resident #105's resident #105's resident's resident #105's resident's resident #105's resident #105's resident's reference desident's resident #105's resident | the facility staff failed to be comprehensive care plan in the survey sample, and and Resident #82.  It and Resident #82.  It review and/or revise rehensive care plan for the oreview and revise lensive care plan to foley catheter and failed to dent #114's and Resident care plans to address the cation prescribed by the cation prescribed by the side of the facility on some side of the facilit | F 657               | Quality Assurance committee for analysis and revision x 3 months.  5.Date of compliance will be Aug 2021.              | ust 20,                       |     |
| 0  | On 7/27/21 at 11:35 a.m., Resident #105 was observed in bed with bilateral quarter bedrails.  |  |                     |  |                               |     |

|   |                                   |  | I STORED BEINGLO  |                     |   |                               | <u>vo. 0938-0391</u>       | 1 |
|---|-----------------------------------|--|---|---------------------|---|-------------------------------|----------------------------|---|
|   |                                   | OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   | , ,                 | LE CONSTRUCTION   | (X3) DATE SURVEY<br>COMPLETED |                            |   |
|   |                                   |  | 495391  | 495391 B. WING      |   | C<br>07/29/2021               |                            |   |
| ĺ | NAME OF F                         | PROVIDER OR SUPPLIER   |   | `                   | STREET ADDRESS, CITY, STATE, ZIP CODE   |                               | 112312021                  | - |
| I | GLENBURNIE REHAB & NURSING CENTER |  |   |                     | 1901 LIBBIE AVE   |                               |                            |   |
| ļ |                                   |  |   |                     | RICHMOND, VA 23226  |                               |                            | ı |
|   | (X4) ID<br>PREFIX<br>TAG          | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)   |   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD B<br>CROSS-REFERENCED TO THE APPROPRIA<br>DEFICIENCY) |                               | (X5)<br>COMPLETION<br>DATE |   |
|   | F 657                             | Continued From page  On 7/28/21 at 2:50 p.m. conducted with LPN (li LPN #3 stated care placare for residents. LPN plans should include themployees know they and not as a restraint.  On 7/28/21 at 4:52 p.m. staff member) #1 (the mover services) and ASM #2 (were made aware of the The facility policy titled, Comprehensive Person "8. The comprehensive Person "8. The comprehensive plan will: b. Describe the furnished to attain or mover highest practicable phy psychosocial well-being. No further information was a comprehensive plan will: b. The facility staff failed an indwelling urinary can indwelling urinary can indwelling urinary can calculate the benign prostatic hyperplarine (3).  Resident #9's most received, a quarterly assessment reference of assessment reference of the condition of the condit | n., an interview was censed practical nurse) #3. ans tell employees how to was are used to foster mobility  n., ASM (administrative regional director of clinical the director of nursing) re above concern.  "Care Plans, n-Centered" documented, reperson-centered care reservices that are to be aintain the resident's sical, mental, and g"  was presented prior to exit.  It to review and revise rensive care plan to include theter.  ed to the facility with put were not limited to asia (2) and retention of |                     | CROSS-REFERENCED TO THE APPROPRIA<br>DEFICIENCY)  |                               |                            |   |
|   |                                   | or mental status (BIMS)<br>cognitively intact for mak  |   |                     |   |                               |                            |   |

|                                   | N OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  (X2) MULTIPLE CONSTRUCTION  A. BUILDING   |   |                    | (X3) DATE SURVEY<br>COMPLETED         |                                  |     |                            |
|-----------------------------------|--|---|--------------------|---------------------------------------|----------------------------------|-----|----------------------------|
|                                   |  | 495391  | B. WING            | B WING                                |                                  | 1   | С                          |
| NAME OF                           | PROVIDER OR SUPPLIER   |   |                    | STREET ADDRESS, CITY, STATE, ZIP (    | CODE                             | 07. | /29/2021                   |
| GLENBURNIE REHAB & NURSING CENTER |  | CENTER  |                    | 1901 LIBBIE AVE<br>RICHMOND, VA 23226 |                                  |     |                            |
| (X4) ID<br>PREFIX<br>TAG          | (EACH DEFICIENCY   | ATEMENT OF DEFICIENCIES<br>' MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFI<br>TAG |                                       | TION SHOULD BE<br>THE APPROPRIAT |     | (X5)<br>COMPLETION<br>DATE |
|                                   | Section G coded Resi extensive assistance of Section H coded Resi indwelling urinary cath On 7/27/2021 at approphenesis observation was made bed. Resident #9's uring bag was observed lying beside the bed. At this conducted with Reside the urinary catheter con Resident #9 stated, "I had the urinary catheter of them all for me." With had the urinary catheter stated that he was not had it in for "a while" not had it in for "a while" not had it in for "a while" not compare the physician orders for documented in part, - "Catheter output even 05/06/2021."  - "Change Foley (cather Order Date: 01/22/2021 - "Urinary catheter: Hydrond ureteral calculous [166[sic] FR (french) ball centimeters) change Probstruction. Order Date: The comprehensive carfor Resident #9 failed to | dent #9 as requiring of one person for toilet use. dent #9 as having an eter.  eximately 2:18 p.m., an of Resident #9 in their frary catheter collection g directly on the floor time, an interview was ent #9. When asked about ellection bag on the floor, have so many tubes in me, em. The nurses take care free asked how long he er in place, Resident #9 sure of the exact date but ever.  er Resident #9  y shift. Order Date:  ter) bag PRN (as needed).  eter) bag PRN (as needed). | F                  | 657                                   |                                  |     |                            |

|                          | OF DEFICIENCIES<br>OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  |                     | TIPLE CONSTRUCTION<br>ING   | (X3) DATE SURVEY<br>COMPLETED |  |
|--------------------------|---|--|---------------------|---|-------------------------------|--|
|                          |   | 495391   | B. WING             |   | C                             |  |
|                          | PROVIDER OR SUPPLIER  RNIE REHAB & NURSING  |  |                     | STREET ADDRESS, CITY, STATE, ZIP CODE 1901 LIBBIE AVE RICHMOND, VA 23226  | 07/29/2021                    |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY  | ATEMENT OF DEFICIENCIES<br>/ MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION  (EACH CORRECTIVE ACTION SHOULD B  CROSS-REFERENCED TO THE APPROPRIA  DEFICIENCY) |                               |  |
|                          | the nursing staff on accomprehensive care part days or 7 days after LPN #5 stated that the area assessment) that MDS assessment and determine the areas spreed to be care plannaurses updated the care admission and quarter any new orders, any faconditions. LPN #5 states should be on the care on 7/29/2021 at appropriate was conducted nurse) #4, unit manage plans were updated eveneded with new orders place. RN #4 stated that the care that was provist through all departments care plan covered what daily and what their saff stated that urinary cath care plan.  On 7/29/2021 at approximate the regional director of of the above concern.  No further information was references: | dmission and the blan was completed within ar completion of the MDS. By looked at the CAAS (care to twere triggered from the the resident's diagnoses to be cific to the resident which ed. LPN #5 stated that the are plans in between the dry care plan reviews with alls or any new skin sted that urinary catheters plan.  In wimately 7:59 a.m., an ed with RN (registered er, RN #4 stated that care ery three months and as and interventions put into that the care plan justified ded for the resident so. RN #4 stated that the care the resident required fety level was. RN #4 eters should be on the cimately 11:00 a.m., ASM or of clinical services and nursing were made aware was provided prior to exit.  The see: Kidneys are damaged they should. This | F6                  | 357   |                               |  |

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION |   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   |                     | CONSTRUCTION  |      | E SURVEY                   |
|---|---|---|---------------------|---|------|----------------------------|
|   |   |   | <del></del>         |   | С    |                            |
| NAMEOES   | POVIDED OF GUIDRUIES  | 495391  | B. WING             | <del> </del>  | 07   | 7/29/2021                  |
|   | PROVIDER OR SUPPLIER  RNIE REHAB & NURSING  | CENTER  | 190                 | REET ADDRESS, CITY, STATE, ZIP CODE  Of LIBBIE AVE  CHMOND, VA 23226  |      |                            |
| (X4) ID<br>PREFIX<br>TAG                            | (EACH DEFICIENCY  | ATEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD E<br>CROSS-REFERENCED TO THE APPROPRIA<br>DEFICIENCY) | BE . | (X5)<br>COMPLETION<br>DATE |
| i<br>i<br>i<br>i<br>i<br>i<br>i<br>i                | 2. Benign prostatic hy prostate is also called hyperplasia (BPH). Thi from the website: https://medlineplus.gov.  3. Urinary retention is cannot empty all the ur Urinary retention can be to urinate, or chronic-a completely empty the beinformation was obtained https://www.niddk.nih.gogic-diseases/urinary-rufailure. It removes wast your kidneys can no lor information was obtained https://medlineplus.gov/20707.htm.  5. Hydronephrosis is the due to a build-up of urin obtained from the websintps://www.kidney.org/ais. | perplasia: An enlarged benign prostatic s information was obtained venlargedprostatebph.html a condition in which you ine from your bladder. e acute-a sudden inability gradual inability to bladder of urine. This ed from the website: ov/health-information/urol etention sis treats end-stage kidney e from your blood when iger do their job. This is defrom the website: ency/patientinstructions/0 he swelling of a kidney e. This information was te: itoz/content/hydronephros | F 657               | DEFICIENCY)   |      |                            |
| di<br>si<br>co<br>ol<br>ht                          | btained from the websit   | or both kidneys; the<br>ninerals or other<br>e. This information was  |                     |   |      |                            |

| RECTIVE ACTION SHOULD BE COMPI   | 21<br>(5)<br>LETION<br>LITE |
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| STATE, ZIP CODE  26  ET'S PLAN OF CORRECTION (X)  RECTIVE ACTION SHOULD BE COMPI  RENCED TO THE APPROPRIATE DA | (5)<br>LETION               |
| R'S PLAN OF CORRECTION (X) RECTIVE ACTION SHOULD BE COMPI  | LETION                      |
| RECTIVE ACTION SHOULD BE COMPI   | LETION                      |
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PRINTED: 08/10/2021 FORM APPROVED

| CTATEN | ENT OF DEFICIENCIES                        | ALL RESIDENCE STORY  |               |  | OWRIN | 10. 0938-039° | 1 |
|--------|--|--|---------------|--|-------|---------------|---|
|        | AN OF CORRECTION                           | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:         | (X2) MULTIPLE | CONSTRUCTION                                     |       | TE SURVEY     |   |
| 1      |  | I SELVIN TO ATTOMBER                                       | A. BUILDING   |  | COM   | MPLETED       |   |
|        |  |  |               |  |       | С             |   |
|        |  | 495391   | B. WING       |  | 0.    | 7/29/2021     |   |
| NAME   | OF PROVIDER OR SUPPLIER                    |  | ST            | REET ADDRESS, CITY, STATE, ZIP CODE              |       |               |   |
| GLEN   | BURNIE REHAB & NURSING                     | CENTER   | 190           | 01 LIBBIE AVE                                    |       |               |   |
|        |  | CENTER   | Rie           | CHMOND, VA 23226                                 |       |               |   |
| (X4)   | ID SUMMARY ST                              | ATEMENT OF DEFICIENCIES                                    | ID            | PROVIDER'S PLAN OF CORRECTION                    |       | (X5)          | - |
| PREF   | FIX (EACH DEFICIENC) REGULATORY OR I       | Y MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION) | PREFIX        | (EACH CORRECTIVE ACTION SHOULD B                 | E     | COMPLETION    |   |
| 17.0   | ,    | DENTI TING INFORMATION)                                    | TAG           | CROSS-REFERENCED TO THE APPROPRIA<br>DEFICIENCY) | TE    | DATE          |   |
|        |  |  |               |  |       |               | _ |
| F6     | 57 Continued From page                     | 112  | F 057         |  |       |               |   |
|        | pago                                       | 114  | F 657         |  |       |               |   |
|        | The comprehensive c                        | are plan for Resident #114                                 |               |  |       |               |   |
|        | dated 6/25/2021 doc                        | umented in part, "Focus: At                                | 1 1           |  |       |               |   |
|        | risk for adverse effects                   | s related to use of  |               |  |       |               | ı |
|        |  | cation." Review of the care                                | 1 1           |  |       | 1             | ı |
|        | plan failed to evidence                    | a care plan addressing the                                 |               |  |       |               |   |
|        | use of an anti-anxiety                     | medication   |               |  |       |               | ı |
|        |  |  | 1 1           |  |       |               |   |
|        | Review of the June 20                      | 21 MAR (medication   |               |  |       |               |   |
|        | administration record)                     | for Resident #114  | 1             |  |       |               | I |
|        | documented the above                       | physician order for Ativan.                                |               |  |       |               | ١ |
|        | The Ativan was docum                       | ented as administered on                                   |               |  |       |               | l |
|        | the following dates and                    |  |               |  |       |               | I |
|        | 6/16/2021 at 11:16 a.m                     |  |               |  | 1     |               | ı |
|        | 6/16/2021 at 8:09 p.m.                     |  |               |  |       |               | ı |
|        | 6/19/2021 at 10:22 p.m                     |  |               |  |       |               | ١ |
|        | 6/23/2021 at 12:48 p.m                     | ı.   |               |  | 1     |               | ı |
|        | 6/25/2021 at 3:37 a.m.                     |  | 1             |  |       |               | ı |
|        | 6/25/2021 at 10:51 a.m                     | •  |               |  |       |               | ı |
|        | 6/27/2021 at 10:48 a.m                     |  | # W           |  |       |               | 1 |
|        | 6/30/2021 at 11:40 a.m                     | -  |               |  |       |               |   |
|        | The July 2024 MAD for                      | D:   |               |  |       |               |   |
|        | The July 2021 MAR for documented the above |  |               |  |       |               |   |
|        | Ativan. The Ativan was                     |  |               |  | -     | 1             | ı |
|        | been administered on t                     |  | 1             |  |       |               |   |
|        | times:                                     | ne following dates and                                     |               |  |       | 1             |   |
|        | 7/1/2021 at 2:01 p.m.                      |  |               |  |       |               |   |
|        | 7/2/2021 at 10:46 p.m.                     |  |               |  |       | 1             |   |
|        | 7/4/2021 at 12:06 a.m.                     |  |               |  |       |               |   |
|        | 7/10/2021 at 4:14 a.m.                     |  |               |  |       |               |   |
|        | 7/11/2021 at 6:57 p.m.                     |  |               |  |       |               |   |
|        | 7/15/2021 at 7:29 p.m.                     |  |               |  |       |               |   |
|        | 7/16/2021 at 10:10 a.m.                    |  |               |  |       |               |   |
|        | 7/18/2021 at 11:16 a.m.                    |  | li li         |  |       | 1             |   |
|        | 7/18/2021 at 10:48 p.m.                    |  | 1             |  |       |               |   |
|        | 7/20/2021 at 11:02 a.m.                    |  | 1             |  | 4     | 1             |   |
|        | 7/21/2021 at 7:08 a.m.                     |  |               |  | 1     | 1             |   |
|        | 7/21/2021 at 6:42 p.m.                     |  |               |  | 1     |               |   |

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION |   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  | (X2) MULTIPLE CONSTRUCTION A. BUILDING |   | (X3) DATE SURVEY<br>COMPLETED |                            |
|---|---|--|--|---|-------------------------------|----------------------------|
|   |   | 495391 B. WING   |  |   | C                             |                            |
| GLENBU  | NAME OF PROVIDER OR SUPPLIER  GLENBURNIE REHAB & NURSING CENTER   |  |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br>1901 LIBBIE AVE<br>RICHMOND, VA 23226  | 1 07.                         | /29/2021                   |
| (X4) ID<br>PREFIX<br>TAG                            | (EACH DEFICIENCY  | NTEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD B<br>CROSS-REFERENCED TO THE APPROPRIA<br>DEFICIENCY) | E<br>TE                       | (X5)<br>COMPLETION<br>DATE |
| 2   | practical nurse) #5 on regarding developmen LON #5 stated the nursinterim care plan. She from the admission dat plan. When asked if a anti-anxiety medication planned, LON #5 stated care planned, the unit r (care plan). Resident # plan was reviewed with Resident #114's composite of the anti-anxiety medication would need to check on On 7/29/2021 at 8:20 a. stated there was no care anti-anxiety medication to the care plan.  SAM #1, the regional direct was made aware of the result of the resident was made aware of the result of the | ucted with LON (licensed 7/29/2021 at 7:45 a.m. tof resident care plans, ses, on admission, do the stated she had 21 days e to complete the care new physician order for an , should that be care d that yes, it should be nanager should update it 114's comprehensive care LON #5. After reviewing thensive care plan, LON are a care plan for the use cation. LON #5 stated this.  m., LON #5 returned and the plan for the use of the bout she would be adding it sector of clinical services, above findings on the distance of the edition, Rothenberg and for Medical Terms for the edition, Rothenberg and for Medical Terms for the edition, Rothenberg and | F 657                                  |   |                               |                            |

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION |  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  |                     | E CONSTRUCTION   | (X3) DA | TE SURVEY MPLETED          |  |
|---|--|--|---------------------|--|---------|----------------------------|--|
|   |  |  |                     |  |         | С                          |  |
| NAME OF   | DDOMEST OF SHIPP   | 495391   | B. WING             |  | 0       | 7/29/2021                  |  |
| 1   | NAME OF PROVIDER OR SUPPLIER  GLENBURNIE REHAB & NURSING CENTER  |  |                     | TREET ADDRESS, CITY, STATE, ZIP CODE<br>901 LIBBIE AVE<br>IICHMOND, VA 23226                                       |         |                            |  |
| (X4) ID<br>PREFIX<br>TAG                            | (EACH DEFICIENCY   | ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROPRI<br>DEFICIENCY) | BE      | (X5)<br>COMPLETION<br>DATE |  |
|   | Non-Medical Reader, Chapman, page 43.  (4) This information we following website: https://medlineplus.gov tml  4. The facility staff fail comprehensive care pan anti-anxiety medical prescribed by the physometric prescribed by the physometric particles and the facility with the diagnost chronic obstructive pulliblood pressure, diabeted chronic kidney disease. The most recent MDS (quarterly assessment will requiring extensive care assistance for transfers for dressing and hygien eating.  A review of the clinical redated 8/21/19 for Clonal (milligrams) once daily fidisorder. | as obtained from the  and to address the use of  and to address the use of  as of Resident #82  as of but not limited to  as of but not limited to  as obesity, migraines,  and anxiety disorder.  Minimum Data Set) was a  ath an ARD (Assessment  as paired in ability to make  and resident was coded as  as of or bathing; limited  and toileting; supervision  and independent for  accord revealed an order  are pam (1) 5 mg  or generalized anxiety  ensive care plan failed to  and ve care plan was  areflect and address the  a | F 657               |  |         |                            |  |

| STATEMENT<br>AND PLAN (  | FOF DEFICIENCIES OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   | (V2) MILL TIPLE CONCERNICATION |   | (X3) DA       | (X3) DATE SURVEY<br>COMPLETED |  |
|--------------------------|--|---|--------------------------------|---|---------------|-------------------------------|--|
|                          |  | 495391  | B. WING                        |   |               | C<br>7/20/2004                |  |
|                          | PROVIDER OR SUPPLIER   | CENTER  |                                | STREET ADDRESS, CITY, STATE, ZIP CODE 1901 LIBBIE AVE RICHMOND, VA 23226  | 1 0           | 7/29/2021                     |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY   | ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG            | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)   | =======<br>TE | (X5)<br>COMPLETION<br>DATE    |  |
| F 658<br>SS=D            | #4 (Registered Nurse) stated that the care pla revised to include the umedication.  On 7/29/21 at 8:45 AM Clinical Services, Director (Administrative #2, and #3 respectively findings. No further inforthe end of the survey.  (1) Clonazepam - is use seizures and to relieve Information obtained fro https://medlineplus.gov/tml  Services Provided Meet CFR(s): 483.21(b)(3)(i) \$483.21(b)(3) Comprehe | the unit manager, she an should have been use of an anti-anxiety  , the Regional Director of the for of Nursing and Medical e Staff Members (ASM) #1, e) were made aware of the formation was provided by the facility of panic attacks, and druginfo/meds/a682279.h  Professional Standards  Professional Standards  ensive Care Plans of arranged by the facility, rehensive care plan, endards of quality. The facility of |                                | F658: Services Provided Meet Professional Standards 1. Residents #421 and #82 no longe reside in the facility. 2. All residents have the potential to affected by this alleged deficient practice. Nursing management will audit current residents to validate physician orders have a prn pain scand nurses administered per the prn scale parameter. 3. DON or designee will educate all facility nurses to ensure that orders orn pain medications have a pain scand administered per the pain scale parameters. | ale pain      |                               |  |

|                       | ENT OF DEFICIENCIES<br>IN OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  | (X2) MULTIP         | PLE CONSTRUCTION  | (X3) DATE SURVEY<br>COMPLETED                        | _ |
|-----------------------|---|---|---------------------|---|--|---|
|                       |   | 495391  |                     |   | С  |   |
| NAME                  | OF PROVIDER OR SUPPLIER   | 495391  | B. WING             |   | 07/29/2021   |   |
|                       | BURNIE REHAB & NURSING  | CENTER  |                     | STREET ADDRESS, CITY, STATE, ZIP CODE 1901 LIBBIE AVE   |  |   |
|                       |   |   |                     | RICHMOND, VA 23226  |  |   |
| (X4)  <br>PREF<br>TAG | X (EACH DEFICIENCY  | ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD B<br>CROSS-REFERENCED TO THE APPROPRIA<br>DEFICIENCY)   |  | V |
| F 6                   | mg). The 7/20/21, physiciar administer Acetaminop mouth every 6 hours for total of 3900 milligram 24-hour period).  2. The facility staff fail physician orders for two medications to determ administer each as need to the findings include:  1. Resident #421 was a 7/19/21 with diagnosis limited to: left knee replacement ((6), hypertension (blood above 140/90 millimeted COPD [chronic obstruct (chronic, non-reversibled) The most recent MDS (assessment, a five day with an ARD (assessment 7/26/21, coded the resident 15 on the BIMS (brief in score, indicating the resintact. A review of the M stafus coded the resident assistance for ambulation dressing; supervision for | a order documented to men tablet, 975 mg by or pain (4 times a day for a of Acetaminophen per ed to clarify Resident #82's of as needed pain ne which and when to eded pain medication.  admitted to the facility on that included but were not eartificial joint replacement of pressure persistently resident of the facility on the facility on that included but were not eartificial joint replacement of pressure persistently resident of the facility on the facility on that included but were not eartificial joint replacement of pressure persistently resident of mercury) (7) and tive pulmonary disease] which is the facility of the facility |                     | 4.DON or designee will audit ords residents with prn pain medication verify the orders include the pain and the pain scale parameters wer followed that medication weekly the weeks and monthly times 2 to enfacility staff are following the pain parameter. Any identified issues with the pain parameter of the Quality Assurance committee for analysis and revision months.  5.Date of compliance will be August 2021. | ns to scale e imes nsure n scale will be ll be n x 3 |   |

| STATEMENT OF DEFICIENCIES (X1) PROVIDE IDENTIFICATION |  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  |                     | TIPLE CONSTRUCTION<br>NG   | (X3) DATE SURVEY<br>COMPLETED |
|---|--|--|---------------------|--|-------------------------------|
|   |  | 495391   | B. WING             |  | C<br>07/29/2021               |
|   | PROVIDER OR SUPPLIER  RNIE REHAB & NURSING   | CENTER   |                     | STREET ADDRESS, CITY, STATE, ZIP CODE 1901 LIBBIE AVE RICHMOND, VA 23226                                       | 0112312021                    |
| (X4) ID<br>PREFIX<br>TAG                              | (EACH DEFICIENCY   | ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)   | ID<br>PREFI)<br>TAG | PROVIDER'S PLAN OF CORRECTION  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) |                               |
|   | documented in part, "Flocation) related to left knee. INTERVENT to reposition frequently Notify physician if pain worsening or of current become ineffective. Pr family/patient related to A review of the physicial documented in part, "Tacetaminophen for a 2 exceed 3 grams (3000 A review of the physicial documented in part, "A 975 mg by mouth every A review of the MAR (mrecord), documented in 975 mg by mouth every A review of the MAR (mrecord), documented in 975 mg by mouth every 7/20/21 at 6:00 AM, 6:00 AM, 6:00 AM, 6:00 AM, 6:00 PM; 7/23/21 at 12:00 AM, 6:00 PM; 7/25/21 at 12:00 PM, 6:00 PM; 7/25/21 at 12:00 PM, 6:00 PM, 6:00 PM, 6:00 PM, 6:00 PM, 6:00 AM, 12:00 PM, 6:00 AM, 6:00 AM, 12:00 PM, 6:00 AM, 6: | FOCUS: Pain (specify FIONS: Encourage/assist / for comfort as needed. If requency/intensity is t analgesia regimen has ovide education to pain."  an orders dated 7/19/21, the maximum amount of 4 hour period should not mg)."  an orders dated 7/20/21, cetaminophen tablet, give / 6 hours for pain."  an edication administration part, "Acetaminophen / 6 hours administered 00 PM, 6:00 PM, 7/21/21 12:00 PM, 6:00 PM, 00 AM, 12:00 PM, 00 AM, 12:00 PM, 00 AM, 6:00 AM, 12:00 t 12:00 AM, 6:00 AM, 6/21 at 12:00 AM, 6/21 at 12:00 AM, 0 PM; 7/28/21 at 12:00 Acetaminophen 975 mg a day for a total of 3900 en per 24-hour period). e total maximum amount ed to be administered | Fé                  | 558  |                               |

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION  |  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   |                     | IPLE CONSTRUCTION  | (X3) D   | ATE SURVEY OMPLETED        |
|--|--|--|---------------------|--|----------|----------------------------|
|  |  | 405204   | B. MINO             |  |          | С                          |
| NAME OF F  | PROVIDER OR SUPPLIER   | 495391   | B. WING_            |  |          | 07/29/2021                 |
|  | RNIE REHAB & NURSING   | CENTER   |                     | STREET ADDRESS, CITY, STATE, ZIP CODE<br>1901 LIBBIE AVE<br>RICHMOND, VA 23226                     |          |                            |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIENCY   | ATEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORF<br>(EACH CORRECTIVE ACTION SI<br>CROSS-REFERENCED TO THE AP<br>DEFICIENCY) | HOULD BE | (X5)<br>COMPLETION<br>DATE |
| e de la companya de l | PM with LPN (licensed asked to review the acked to review to acked to review to acked the acked to review to refer sets when admitted to refer sets for new admitted to review the acked who register. When asked who verifying and following stated, "We do, the nur. An interview was conducted, "We do, the nur. An interview was conducted to receive the acked to represent the acked to receive the acked to review the acked to receive the acked to review the acked to receive the acked to review the a | ducted on 7/28/21 at 3:05 If practical nurse) #2. When betaminophen order for 2 stated, "975mg Tylenol mg. There is an order for 3000 mg daily. She een exceeding the 3000 the orders and there are ted. I think there are 18 hissions. I will call the order changed so it is to has the responsibility for physician orders, LPN #2 ses."  Lected on 7/28/21 at 3:15 Tasked to review the or Resident #421, LPN #6 To order sets on this new I's physicians order th every 6 hours. That may ones who order it like I, when asked what To followed in the facility, ff member) #2, the d, "We follow our policies The standard set of the medication To Attending Physician or To Attending Physician or | F 6                 | 58   |          |                            |

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION   | I IDENTIFICATION NUMBER:  |                     | TPLE CONSTRUCTION   | (X3) DATE SURVEY<br>COMPLETED |
|---|---|---------------------|---|-------------------------------|
|   | 495391  | B, WING _           |   | C<br>07/29/2021               |
| NAME OF PROVIDER OR SUPPLIER  GLENBURNIE REHAB & NURSING  | CENTER  |                     | STREET ADDRESS, CITY, STATE, ZIP CODE 1901 LIBBIE AVE RICHMOND, VA 23226                                | 07/29/2021                    |
| PREFIX (EACH DEFICIENCY)  | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPIDEFICIENCY) | D BE COMPLÉTION               |
| of nursing and ASM #4, made aware of the conditional References:  (6) Barron's Dictionary of Non-Medical Reader, 5th Chapman, page 319.  (7) Barron's Dictionary of Non-Medical Reader, 5th Chapman, page 282.  (8) Barron's Dictionary of Non-Medical Reader, 5th Chapman, page 120. | ASM #1, the regional ces, ASM #2, the director, the Medical Director were cern.  of Medical Terms for the the edition, Rothenberg and of Medical Terms for the chedition, Rothenberg and chedition.  It to clarify Resident #82's to as needed pain ewhich and when to led pain medication.  It do to the facility on ches of but not limited to conary disease, high chedition, and anxiety disorder. In the resident was an ARD (Assessment 21. The resident was ly impaired in ability to The resident was sive care for bathing; asfers and toileting; | F 68                |   |                               |

| STATEMENT<br>AND PLAN C  | OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  |                     | PLE CONSTRUCTION   | (X3) DA | TE SURVEY MPLETED          |  |
|--------------------------|--|--|---------------------|--|---------|----------------------------|--|
|                          |  | 405204   | P. WING             |  |         | С                          |  |
| NAME OF E                | PROVIDER OR SUPPLIER   | 495391   | B, WING             |  | 0       | 7/29/2021                  |  |
|                          | RNIE REHAB & NURSING   | CENTER   |                     | STREET ADDRESS, CITY, STATE, ZIP CODE  1901 LIBBIE AVE  RICHMOND, VA 23226                               |         |                            |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)   | ATEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY) | BE      | (X5)<br>COMPLETION<br>DATE |  |
|                          | A review of the physic dated 4/21/19 for Pair (acetaminophen) (1) 5 6 hours as needed for physician's orders reve for Oxycodone (2) 5 m give 2.5 mg by mouth chronic pain. Take at I scheduled morning do parameters such as foor a numeral pain ratin when each as needed given.  (Note: (1) Acetaminoph to treat mild to moderare is used to relieve moderate is used to rel | cian's orders revealed one in Relief Tab 100 mg, give 2 tablets every in pain. Further review of the aled one dated 10/11/19 ing (milligrams) capsule, once daily as needed for east 6 hours after the se. Neither order provided in moderate or severe and ing parameter for which and pain medication may be  the pain; and (2) Oxycodone derate to severe pain.)  hysician's orders revealed Pain Score every shift 0 = Pain; 5,6,7 = Moderate tain."  21 MAR (Medication revealed that a "0" was in score for each shift of any other number  21 MAR revealed that on the sident was administered the for a pain level of "2." the resident was the Pain Relief Tab for a  an interview was Registered Nurse, the unit | F 65                |  |         |                            |  |

| DEPAR                    | TMENT OF HEALTH AN  | ID HUMAN SERVICES   |                    |   |   | ED: 08/10/2021               |
|--------------------------|---|---|--------------------|---|---|------------------------------|
|                          | RS FOR MEDICARE & I   |   |                    |   |   | RM APPROVED<br>NO. 0938-0391 |
| STATEMEN                 | T OF DEFICIENCIES<br>OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   | 1 ` ′              | TIPLE CONSTRUCTION  | (X3) DA                                     | TE SURVEY<br>MPLETED         |
|                          |   | 495391  | B. WING            |   | 0   | C<br>7/29/2021               |
| NAME OF                  | PROVIDER OR SUPPLIER  |   |                    | STREET ADDRESS, CITY, STATE, ZIP CODE   |   |                              |
| GLENBU                   | JRNIE REHAB & NURSING   | CENTER  |                    | 1901 LIBBIE AVE<br>RICHMOND, VA 23226   |   |                              |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY  | ATEMENT OF DEFICIENCIES<br>'MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFI<br>TAG | PROVIDER'S PLAN OF CORRECTIVE ACTION SHO  | JLD BE                                      | (X5)<br>COMPLETION<br>DATE   |
|                          | have been clarified on could be given. RN #4 the oxycodone was not level of "2." She state making a determinatio parameters set by the On 7/29/21 at 8:45 AM Clinical Services, Director (Administrative #2, and #3 respectively findings. No further infective end of the survey.  (1) Tylenol - Information https://medlineplus.gov/tml  (2) Oxycodone - Information https://medlineplus.gov/tml  Free of Accident Hazard CFR(s): 483.25(d) (1)(2)  §483.25(d) Accidents.  The facility must ensure | what parameters each one stated that administering of appropriate for a pain d that nurses should not be in, that there should be physician.  If, the Regional Director of ctor of Nursing and Medical e Staff Members (ASM) #1, y) were made aware of the ormation was provided by n obtained from /druginfo/meds/a681004.h s/Supervision/Devices  If that - lent environment remains ands as is possible; and dent receives adequate nce devices to prevent |                    | F689: Free of Accident Hazards/Supervision/Devices 1. Resident #40 continues to res facility. Care plan has been upo 2. All residents have the potent affected by this alleged deficie practice. Nursing management conduct an audit on current res with fall mat orders and verify place and care planned. | side in the dated. all to be nt will idents |                              |

Based on observation, resident interview, staff

document review, it was determined that facility staff failed to the implement assistive device

interview, clinical record review, and facility

and care planned.

3.DON or designee will educate staff on

ensuring that fall mats must be in place

|                          | OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | (X2) MULTIPE<br>A. BUILDING | E CONSTRUCTION   | (X3) DA                                 | TE SURVEY<br>MPLETED       |
|--------------------------|--|--|-----------------------------|--|---|----------------------------|
|                          |  | 495391   | B. WING                     |  |   | С                          |
| NAME OF I                | PROVIDER OR SUPPLIER   | 1 433331   |                             | STREET ADDRESS, CITY, STATE, ZIP CODE  | 0                                       | 7/29/2021                  |
| GLENBU                   | RNIE REHAB & NURSING   | CENTER   | 1                           | 1901 LIBBIE AVE<br>RICHMOND, VA 23226  |   |                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY   | ATEMENT OF DEFICIENCIES<br>/ MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG         | PROVIDER'S PLAN OF CORRECTI<br>(EACH CORRECTIVE ACTION SHOUL<br>CROSS-REFERENCED TO THE APPROF<br>DEFICIENCY)  | D BE                                    | (X5)<br>COMPLETION<br>DATE |
|                          | of accident hazards for survey sample, Resided #40's fall mat on 7/26/27/28/21 and 7/29/21 prof care.  The findings include:  Resident #40 was admidiagnoses that included cerebral infarction (1) at the findings include  cerebral infarction (1) at the findings included cerebral infarction (1) at the findings included cerebral infarctions. Section assessment for mental of 0 - 15, 15- being cognically decisions. Section #40 requiring extensive member for transfers, which is the facility of the findings included composition was made to find the findings included the findings included the findings in the facility when asked about fall in the facility when asked a | insure an environment free or one of 49 residents in the ent #40.  Ito implement Resident 21, 7/27/21, the morning of er the comprehensive plan in the ent with an analysis of the end with an ARD date) of 5/28/2021, coded g a 15 on the staff status (BIMS) of a score nitively intact for making and Gocumented Resident assistance from one staff valking in the room and cumented Resident #40 and the end and the end in their is observed in bed with mats were observed in 40's bed. At this time, and with Resident #40, the had not had any |                             | 4.DON or designee will audit 5 Residents with fall mats to veri place and are care planned wee 4 weeks and monthly times 2. A identified issues will be immed corrected. Results will be repor Quality Assurance committee fa analysis and revision x 3 month 5. Date of compliance will be Ja 2021. | fy in kly times any iately ted to or s. | S                          |

|                          | OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  |                     | PLE CONSTRUCTION   | (X3) DA | ATE SURVEY<br>OMPLETED     |
|--------------------------|--|--|---------------------|--|---------|----------------------------|
| 1                        |  | 405204   | D Mana              |  |         | С                          |
| NAME OF                  | PROVIDER OR SUPPLIER   | 495391   | B. WING             | STREET ADDRESS, CITY, STATE, ZIP CODE  |         | 7/29/2021                  |
| GLENB                    | URNIE REHAB & NURSING  | CENTER   |                     | 1901 LIBBIE AVE<br>RICHMOND, VA 23226  |         |                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY   | ATEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRE<br>(EACH CORRECTIVE ACTION SHO<br>CROSS-REFERENCED TO THE APPF<br>DEFICIENCY) | OULD BE | (X5)<br>COMPLETION<br>DATE |
| F 689                    | Continued From page  | 123  | F 68                | 9  |         |                            |
|                          | The comprehensive cadated 1/9/2020 docum falls due to impaired by dx (diagnosis) hx (historaccident) with hemipley 01/09/2020." Under "Indocumented in part, " Date Initiated: 06/02/20 01/21/2021"  The "Care Conference dated 3/19/2021 documented 3/19/2021 documented Tisk for Fall Risk Evaluation 12/4/2020 documented Risk; Score: 11.0"  The physician order's forevidence an order for bion 7/29/2021 at approximaterview was conducted practical nurse) #5, the fill #5 stated that the nurses | nd 7/29/2021 at n. revealed Resident #40 in reside the bed.  are plan for Resident #40 ented in part, "At risk for alance/poor coordination. bry) CVA (cerebrovascular gia. Date Initiated: terventions/Tasks" it Fall Matt(s): Bilateral. 120. Revision on:  Note" for Resident #40 ented in part, "Topics ls/Safety"  on" for Resident #40 dated in part, " Category: High  r Resident #40 failed to lateral fall mats.  imately 7:45 a.m., an d with LPN (licensed MDS coordinator. LPN s updated the care plans n and quarterly care plan PN #5 stated that staff the care plan if fall mats |                     |  |         |                            |
|                          | On 7/29/2021 at approxir<br>interview was conducted  | nately 7:59 a.m., an<br>with RN (registered  |                     |  |         |                            |

| 1  |                               |  |   |                     |  |            | 10.0000-0001               |
|--|-------------------------------|--|---|---------------------|--|------------|----------------------------|
| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |                               | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  | (X2) MULTIPLE CONSTRUCTION A. BUILDING  |                     |  | ATE SURVEY |                            |
| l  |                               |  | 495391  | B MING              |  |            | С                          |
| ŀ  | NAME OF D                     | ROVIDER OR SUPPLIER  | 493391  | B. WING _           |  |            | 7/29/2021                  |
| -  |                               | ROVIDER OR SUPPLIER  | CENTER  |                     | STREET ADDRESS, CITY, STATE, ZIP CODE  1901 LIBBIE AVE RICHMOND, VA 23226                                    |            |                            |
|  | (X4) ID<br>PREFIX<br>TAG      | (EACH DEFICIENCY   | NTEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | 3E         | (X5)<br>COMPLETION<br>DATE |
|  | T F dd pp m C aa p w C # A of | nurses used the care president's daily routine was. RN #4 stated that every three months and were removed or revise into place. RN #4 state implementing the care intervention on the care place. RN #4 observed room in bed without the On 7/27/2021 at approx #2, the director of nursi followed their policies a nursing standard of practices for the facility policy, "Care Person-Centered" dated locumented in part, " Person-centered care planeasurable objectives and escribe the services that tain or maintain the restracticable physical, metrell-being" | er. RN #4 stated that the plan to determine a and what their safety level to care plans were updated do any resolved problems and new goals were put do that staff were not plan if fall mats were an aplan and they were not in Resident #40 in their aplan fall mats in place.  Simately 11:15 a.m., ASM and stated that the facility and procedures as their citice.  Simately 5:45 p.m., application of clinical olicy for implementing the plans, Comprehensive and will: a. Include and timeframes; b. at are to be furnished to sident's highest and psychosocial mately 11:00 a.m., ASM of clinical services and ursing were made aware | F 68                | 9  |            |                            |

| DEPARTMENT OF HEALTH A   |   |                     |  | PRINTED: 08/10/2021<br>FORM APPROVED |
|--|---|---------------------|--|--------------------------------------|
| CENTERS FOR MEDICARE &   |   |                     |  | OMB NO. 0938-0391                    |
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  |                     | IPLE CONSTRUCTION  | (X3) DATE SURVEY<br>COMPLETED        |
|  | 495391  | B. WING _           |  | C<br>07/29/2021                      |
| NAME OF PROVIDER OR SUPPLIER   |   |                     | STREET ADDRESS, CITY, STATE, ZIP CODE  | 0112912021                           |
| GLENBURNIE REHAB & NURSIN  | G CENTER  |                     | 1901 LIBBIE AVE<br>RICHMOND, VA 23226  |                                      |
| (X4) ID SUMMARY S  | TATEMENT OF DEFICIENCIES  |                     | The state of the s |                                      |
| PREFIX (EACH DEFICIENC   | Y MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)   |                                      |
| F 689 Continued From page  | e 125   | F 68                | 39   |                                      |
| References:  |   |                     |  |                                      |
| stops. A stroke is son attack." If blood flow i few seconds, the brai oxygen. Brain cells ca damage. This informat website: https://medlineplus.go  2. Hemiplegia Also called: Hemipleg Quadriplegia. Paralys function in part of your something goes wrong pass between your bracan be complete or pa both sides of your bod one area, or it can be information was obtain https://medlineplus.go  F 690 Bowel/Bladder Incontinentings/483.25(e) (1) -( §483.25(e) Incontinentings/483.25(e)(1) The facil resident who is contine admission receives ser maintain continence ur | If flow to a part of the brain netimes called a "brain s cut off for longer than a n cannot get nutrients and an die, causing lasting ation was obtained from the v/ency/article/000726.htm.  ia, Palsy, Paraplegia, is is the loss of muscle r body. It happens when g with the way messages ain and muscles. Paralysis rtial. It can occur on one or y. It can also occur in just widespread. This need from the website: v/paralysis.html. hence, Catheter, UTI 3)  ie. lity must ensure that nt of bladder and bowel on vices and assistance to aless his or her clinical is such that continence is n. | F 690               | F690: Bowel/Bladder Incontinent<br>Catheter, UTI  1. Residents #3, #9, and #104 contint<br>to reside in facility and the foley<br>catheters collection bags have been<br>placed below the level of the bladder<br>are attached to bed/chair/wheelchair<br>needed to prevent infection risk and<br>there is a Physicians order in place to<br>the Foley catheter.   | er,<br>r as                          |

|                          | OF DEFICIENCIES<br>F CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   | (X2) MULTIPI<br>A. BUILDING | LE CONSTRUCTION   | (X3) DATE SURVEY<br>COMPLETED       |
|--------------------------|---|---|-----------------------------|---|-------------------------------------|
|                          |   | 495391  | B, WING                     |   | C<br>07/29/2021                     |
| NAME OF P                | ROVIDER OR SUPPLIER   |   |                             | STREET ADDRESS, CITY, STATE, ZIP CODE   | 01/20/2021                          |
| GLENBU                   | RNIE REHAB & NURSING  | CENTER  |                             | 1901 LIBBIE AVE   |                                     |
|                          |   |   |                             | RICHMOND, VA 23226  |                                     |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY  | ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG         | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIAT<br>DEFICIENCY)   | TE DATE                             |
|                          | ensure that- (i) A resident who enter indwelling catheter is not resident's clinical condicatheterization was need (ii) A resident who enter indwelling catheter or so is assessed for removed as possible unless the demonstrates that cathe and (iii) A resident who is in receives appropriate the prevent urinary tract information continence to the external continence to the external continence, based on comprehensive assessment that a resident we receives appropriate the restore as much normal possible.  This REQUIREMENT is by:  Based on observation, interview, facility documer conditions are conditionally as a condition of a urinary catheter for the survey sample, Resident will resident with the survey sample, Resident will resident will resident will reside to ensure the appropriate that a resident will record review, it was detailed to ensure the appropriate that a resident will record review, and the propriate that a resident will record review, and the propriate that a resident will record review, and the propriate that a resident will record review, and the propriate that a resident will record review, and the propriate that a resident will record review, and the propriate that a resident will record review, and the propriate that a resident will record review, and the propriate that a resident will record review, and the propriate that a resident will record review.  The facility staff failed and well record review and the propriate that a resident will record review. | ers the facility without an and catheterized unless the lition demonstrates that cessary; ers the facility with an subsequently receives one all of the catheter as soon resident's clinical condition peterization is necessary; example of the catheter as soon resident's clinical condition peterization is necessary; example of the catheter as to fections and to restore at possible.  Sident with fecal the resident's ment, the facility must who is incontinent of bowel example and services to be at possible of the possible of the resident and services to be at possible of the facility must who is incontinent of bowel example of the facility staff the possible of the facility staff the facility | E S                         | 2.All residents with foley catheter the potential to be affected by this alleged deficient practice. Nursing management will audit current res with foley catheter to verify physicorder and observe for placement of foley catheter is below the level of bladder and has a catheter secure.  3.DON or designee will educate methat Residents with Foley Catheter have collection bags and are placed below the level of the bladder, are attached to bed/chair/wheelchair as needed to prevent infection risk and a Physicians order for the Foley catheter. The foley catheter has a catheter secure.  4.DON or designee will audit Resident's with Foley Catheters we simes 4 weeks and monthly times 2 tensure that the foley catheters colled to be ded/chair/wheelchair as needed to be ded/chair/wheelchair | idents cian f The arses s d s d has |
| 2                        | . The facility staff failed   | to maintain Kesident  |                             |   |                                     |

|                     | ENT OF DEFICIENCIES<br>AN OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   | 1                   | LE CONSTRUCTION   | (X3) DATI | E SURVEY                   |
|---------------------|--|---|---------------------|---|-----------|----------------------------|
|                     |  | 405204  | D WING              |   |           | С                          |
| NAME                | OF PROVIDER OR SUPPLIER  | 495391  | B. WING             |   | 07        | //29/2021                  |
|                     | BURNIE REHAB & NURSING   |   |                     | STREET ADDRESS, CITY, STATE, ZIP CODE<br>1901 LIBBIE AVE<br>RICHMOND, VA 23226  |           |                            |
| (X4)<br>PREF<br>TAC | IX (EACH DEFICIENC)  | ATEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD B<br>CROSS-REFERENCED TO THE APPROPRIA<br>DEFICIENCY) |           | (X5)<br>COMPLETION<br>DATE |
| F6                  | #9's urinary catheter be infection. The cathete on the floor during the 3. The facility staff fails 104's catheter collection their bladder to prever failed to obtain a physion of their bladder to prever failed to obtain a physion of the findings include:  1. Resident #3 was addiagnoses that include metabolic encephalops (2).  Resident #3's most received assessment, a qual ARD (assessment refered assessment and the finding daily decisions. Resident #3 as requiring one person for tollet ussection H coded Reside indwelling catheter.  On 7/28/2021 an observed assident #3 during would (licensed practical nurse Resident #3 was observed infection.) | rag in a manner to prevent r bag was observed lying dates of the survey.  The date of the survey of the backflow of urine and cian's order for a catheter.  The date of the facility with but were not limited to outly (1) and hypertension  The catheter of the date of | F 690               | 5.Date of compliance will be Aug<br>2021.   | ust 20,   |                            |

|                          | NT OF DEFICIENCIES<br>I OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   | 1                   | PLE CONSTRUCTION<br>IG   | (X3) DAT | TE SURVEY MPLETED          |
|--------------------------|--|---|---------------------|--|----------|----------------------------|
|                          |  | 495391  | B. WING             |  |          | С                          |
|                          | PROVIDER OR SUPPLIER  URNIE REHAB & NURSING  | CENTER  |                     | STREET ADDRESS, CITY, STATE, ZIP CODE 1901 LIBBIE AVE RICHMOND, VA 23226                                     | 1 07     | 7/29/2021                  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY   | ATEMENT OF DEFICIENCIES<br>MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | Ε        | (X5)<br>COMPLETION<br>DATE |
|                          | LPN #3 placed the uring tubing at the end of the hanging below. LPN # wound care. Upon state their right side, observed catheter was not secure leaked onto the sheets was visible where the econnection tubing were left hip/upper posterior.  The physician orders for documented in part, - "Urinary catheter: urin (french) balloon size: 10 needed) for obstruction 01/20/2021."  - "Change Foley cath [calong with Foley bag; si (milliliter) balloon every day(s) for to prevent info 02/16/2021."  The comprehensive cardated 4/22/2021 documindwelling urinary cathet IV pressure ulcer (4). Day on 7/28/2021 at approximaterview was conducted interview was conducted to the right of the end o | nary catheter collection bag e mattress with the bag 3 proceeded to provide ff turning Resident #3 to ation revealed the urinary red to the resident and had . A small skin indention urinary catheter and bag e underneath Resident #3's thigh prior to turning.  The Resident #3  ary retention size: 16FR change PRN (as . Order Date:  atheter] every 30 days are 16 French 10 ml evening shift every 30 ection. Order Date:  The plan for Resident #3 ented in part, "Use of the related to Stage III or ate Initiated: 04/22/2021."  mately 10:30 a.m., an I with LPN #3. LPN #3 for collection bags should for the bladder. LPN #3 I bag did not have a hook me so they had moved it is beside Resident #3's of the mattress until she stated that the purpose of the level of the bladder | F 69                |  |          |                            |

| STATEMEN<br>AND PLAN     | NT OF DEFICIENCIES<br>I OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  |                     | LE CONSTRUCTION   | (X3) DA | TE SURVEY<br>MPLETED      | 91 |
|--------------------------|--|--|---------------------|---|---------|---------------------------|----|
|                          |  | 495391   | B, WING             |   |         | C                         |    |
|                          | F PROVIDER OR SUPPLIER  URNIE REHAB & NURSING  | CENTER   |                     | STREET ADDRESS, CITY, STATE, ZIP CODE<br>1901 LIBBIE AVE<br>RICHMOND, VA 23226  | 1 0     | 7/29/2021                 |    |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY   | ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD E<br>CROSS-REFERENCED TO THE APPROPRIA<br>DEFICIENCY) | 3E      | (X5)<br>COMPLETIO<br>DATE | N  |
|                          | infection. LPN #3 state were anchored by usin device or by using tapper from pulling while proven that Resident #3's cath that the catheter should legs to allow it to drain the catheter should not resident because it coupressure ulcer from lay.  On 7/28/2021 at approximaterview was conducted stated that urinary cath to hang on the side of the drainage. LPN #7 states supposed to be anchored to keep from pulling and moving. LPN #7 stated. | ed that urinary catheters and a special attachment be to prevent the catheter iding care. LPN #3 stated leter was not anchored and do be placed between the freely. LPN #3 stated that it be located underneath a lid potentially cause a ing on it.  Eximately 11:21 a.m., an and with LPN #7. LPN #7 eter bags were supposed the bed to promote urine do that a urinary catheter is ed to the inside of the leg do to prevent it from that they had changed ection bag for Resident #3 and them it did not have a mately 11:15 a.m., ASM and go stated that the facility do procedures as their tice.  In a mately 5:45 p.m., a mately 5:45 p.m. | F 690               |   |         |                           |    |

| 1 |  | OF DEFICIENCIES<br>F CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  |                     | TIPLE CONSTRUCTION  |        | ATE SURVEY<br>OMPLETED     |  |
|---|--|---|--|---------------------|---|--------|----------------------------|--|
|   |  |   | 495391   | B. WING             |   |        | C<br>07/29/2021            |  |
|   |  | ROVIDER OR SUPPLIER  RNIE REHAB & NURSING   | CENTER   | •                   | STREET ADDRESS, CITY, STATE, ZIP CODE<br>1901 LIBBIE AVE<br>RICHMOND, VA 23226                    |        | VIII 2021                  |  |
|   | (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIENCY  | NTEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)   | ID<br>PREFII<br>TAG | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUT CROSS-REFERENCED TO THE APPR DEFICIENCY) | JLD BE | (X5)<br>COMPLETION<br>DATE |  |
|   | in the east of the | catheter. 3. The urinar held or positioned lower times to prevent the urinary drainage bag from flow bladder" The policy of sure the catheter tubing kept off the floorEnsurement at the insert tubing should be strapped the floorEnsurement at the insert tubing should be strapped the floor"  On 7/28/2021 at approximation of the regional director of nursimedical director of nursimedical director were neconcern.  No further information was disease that affects the rour brain. This information website https://www.healthline.com/lopathy.  Hypertension: High benformation was obtained. | the of kinks. 2. Unless of not apply a clamp to the y drainage bag must be er than the bladder at all ine in the tubing and ving back into the urinary further documented, "Be go and drainage bag are use the catheter remains pot to reduce friction and ion site. (Note: Catheter need to the resident's inner eximately 5:30 p.m., ASM of clinical services, ASM of and ASM #4, the nade aware of the above was provided prior to exit.  In general term describing a function or structure of tion is taken from the som/health/hepatic-enceph clood pressure. This dof from the website: medlineplus/highbloodpr | F                   | 590   |        |                            |  |

|                          | OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   | (X2) MULTIPLE C     |  | (X3) DA | NO. 0938-039  ATE SURVEY  MPLETED |
|--------------------------|--|---|---------------------|--|---------|-----------------------------------|
|                          |  | 495391  | B. WING             |  |         | С                                 |
|                          | PROVIDER OR SUPPLIER  RNIE REHAB & NURSING   |   | STR 190°            | EET ADDRESS, CITY, STATE, ZIP CODE I LIBBIE AVE HMOND, VA 23226  |         | 07/29/2021                        |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)   | ATEMENT OF DEFICIENCIES<br>/ MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECT<br>(EACH CORRECTIVE ACTION SHOU<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY) | LD BE   | (X5)<br>COMPLETION<br>DATE        |
|                          | degrees above the lever sometimes also elevary obtained from the web https://medical-dictions.  4. Pressure ulcer is an breaks down when soon pressing against the signouped by the severite the mildest stage. Stage A reddened, painful are turn white when pressure ulcer is forming or cool, firm or soft. Stage for the severe ulcer is forming an open sore. The may be red and irritate develops an open, sun The tissue below the slibe able to see body fat The pressure ulcer has there is damage to the sometimes to tendons a information was obtained https://medlineplus.gov/100740.htm. | t's bed is raised 30 to 90 /el, with the knees red. This information was red. This information was resite: ary.thefreedictionary.com/s  area of the skin that mething keeps rubbing or kin. Pressure sores are y of symptoms. Stage I is ge IV is the worst. Stage I: ea on the skin that does not red. This is a sign that a ng. The skin may be warm age II: The skin blisters or ne area around the sore d. Stage III: The skin now ken hole called a crater, kin is damaged. You may in the crater. Stage IV: become so deep that muscle and bone, and and joints. This red from the website: rency/patientinstructions/0 | F 690               |  |         |                                   |
| c<br>b                   | Resident #9 was adn<br>diagnoses that include to<br>penign prostatic hyperplurine (2).   |   |                     |  |         |                                   |
| s<br>(i                  | et), a quarterly assessmassessmassessment reference  | date) of 4/23/2021 coded<br>a 13 on the brief interview   |                     |  |         |                                   |

| STATEMEN                 | IT OF DEFICIENCIES  |  |                   |  |                                 | OWR M | <i>3.</i> 0938 <b>-</b> 039   | 91       |
|--------------------------|---|--|-------------------|--|---------------------------------|-------|-------------------------------|----------|
| AND PLAN                 | OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | 1                 | (X2) MULTIPLE CONSTRUCTION A. BUILDING |                                 |       | (X3) DATE SURVEY<br>COMPLETED |          |
|                          |   | 495391   | B. WING           | 3                                      |                                 | 07    | C<br>/29/2021                 |          |
| NAME OF                  | PROVIDER OR SUPPLIER  |  |                   | STREET ADDRESS, CITY, STATE, ZIP (     | ODE                             | - 0,  | 72372021                      | $\dashv$ |
| GLENBI                   | URNIE REHAB & NURSING   | CENTER   |                   | 1901 LIBBIE AVE<br>RICHMOND, VA 23226  |                                 |       |                               |          |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY  | ATEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)  | ID<br>PREF<br>TAG | IX (EACH CORRECTIVE ACT                | TON SHOULD BE<br>THE APPROPRIAT | E     | (X5)<br>COMPLETION<br>DATE    |          |
|                          | cognitively intact for m Section G coded Resi extensive assistance of Section H coded Reside indwelling catheter.  On 7/27/2021 at approabservation was made bed. Resident #9's urin bag was observed lying bed. At this time, an intwith Resident #9. Whe catheter collection bag stated, "I have so many up with them. The nurse for me."  Additional observations and 7/28/2021 at 9:24 at #9's urinary catheter confloor beside the bed.  The comprehensive car failed to evidence docur urinary catheter for Resident #9  The physician orders for documented in part, - "Catheter output every 05/06/2021." - "Change Foley (catheted Order Date: 01/22/2021. | aking daily decisions. dent #9 as requiring of one person for toilet use. dent #9 as having an  eximately 2:18 p.m., an of Resident #9 in their nary catheter collection g on the floor beside the terview was conducted on asked about the urinary on the floor, Resident #9 of tubes in me, I can't keep es take care of them all  on 7/27/2021 at 3:45 p.m. a.m. revealed Resident flection bag lying on the  re plan for Resident #9 mentation of an indwelling ident #9. The care plan, sted to chronic renal b) bph (benign prostatic ted: 10/31/2020" failed to on of an indwelling urinary  Resident #9 shift. Order Date:  er) bag PRN (as needed). " | F                 | 690                                    |                                 |       |                               |          |
|                          | - "Change Foley (cathete<br>Order Date: 01/22/2021.   | onephrosis (4) with renal  |                   |  |                                 |       |                               |          |

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 08/10/2021 FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING С 495391 B. WING 07/29/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1901 LIBBIE AVE **GLENBURNIE REHAB & NURSING CENTER** RICHMOND, VA 23226 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION DATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 690 Continued From page 133 F 690 166[sic] FR (french) balloon size 10 cc (cubic centimeters) change PRN for obstruction. Order Date: 7/26/2021." On 7/28/2021 at approximately 10:30 a.m., an interview was conducted with LPN (licensed practical nurse) #3. LPN #3 stated that urinary catheter collection bags should be placed below the level of the bladder. LPN #3 stated that the urinary catheter collection bag should be hooked onto the side of the bed to promote gravity drainage. On 7/28/2021 at approximately 11:21 a.m., an interview was conducted with LPN #7, LPN #7 stated that urinary catheter bags were supposed to hang on side of the bed to promote urine drainage. LPN #7 stated that urinary catheter collection bags were not supposed to be on the floor because it was unsanitary. LPN #7 observed Resident #9's urinary catheter collection bag on the floor beside their bed and stated that it should be hooked onto the bed. On 7/28/2021 at approximately 5:30 p.m., ASM #1, the regional director of clinical services, ASM #2, the director of nursing and ASM #4, the medical director were made aware of the above concern.

obtained from the website:

References:

No further information was provided prior to exit.

1. Benign prostatic hyperplasia: An enlarged prostate is also called benign prostatic hyperplasia (BPH). This information was

https://medlineplus.gov/enlargedprostatebph.html

|   | OF DEFICIENCIES<br>OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | (X2) MULTIPLE CONSTRUCTION A. BUILDING |   |        | (X3) DATE SURVEY<br>COMPLETED |                            |  |
|---|---|--|--|---|--------|-------------------------------|----------------------------|--|
|   |   | 495391   | B. WING                                | B. WING   |        | 0.                            | C<br><b>7/29/2021</b>      |  |
|   | ROVIDER OR SUPPLIER   | CENTER   |  | STREET ADDRESS, CITY, STATE, ZIP CODE 1901 LIBBIE AVE RICHMOND, VA 23226                          |        | U                             | 112912021                  |  |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIENCY  | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)  | ID<br>PREFI<br>TAG                     | PROVIDER'S PLAN OF CORREC  X (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY) | ULD BE |                               | (X5)<br>COMPLETION<br>DATE |  |
| :<br>:<br>:<br>:<br>:<br>:<br>:<br>:<br>:<br>:<br>:<br>:<br>:<br>:<br>:<br>:<br>:<br>:<br>: | cannot empty all the urinformation was obtain https://www.niddk.nih.gogic-diseases/urinary-fa. Chronic kidney diseand can't filter blood as information was obtaine https://medlineplus.gov.l.  4. Hydronephrosis is the to a build-up of urine. It cannot drain out from the from a blockage or obstican occur in one or both information was obtaine https://www.kidney.org/ais  5. Renal calculus: Kidnerenal stones or urinary separate that form in one stones are made up of recompounds found in uring obtained from the websinates://medlineplus.gov/gotones/  8. Resident # 104 was a with diagnoses that inclusion Parkinson's disease [2]. | a condition in which you ine from your bladder. This ed from the website: gov/health-information/urol etention  asse: Kidneys are damaged they should. This ed from the website: //chronickidneydisease.htm  as eswelling of a kidney due happens when urine he kidney to the bladder fruction. Hydronephrosis hidneys. This ed from the website: etoz/content/hydronephros  as ey stones (also called stones) are small, hard e or both kidneys; the ninerals or other he. This information was te: genetics/condition/kidney-dmitted to the facility ded but were not limited 1] and multiple sclerosis  event MDS (minimum inssessment with an ARD late) of 07/08/2021, | F                                      | 690   |        |                               |                            |  |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION |   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   |                    | TIPLE CONSTRUCTION<br>ING             |          | (X3) DATE<br>COMP | SURVEY                     |
|--|---|---|--------------------|---------------------------------------|----------|-------------------|----------------------------|
|  |   | 495391  | B. WING            |                                       |          |                   | 0                          |
| NAME OF F  | PROVIDER OR SUPPLIER  | 40001   |                    | STREET ADDRESS, CITY, STATE, ZIP CODE |          | 07/:              | 29/2021                    |
| GLENBU   | RNIE REHAB & NURSING  | CENTER  |                    | 1901 LIBBIE AVE<br>RICHMOND, VA 23226 |          |                   |                            |
| (X4) ID<br>PREFIX<br>TAG                         | (EACH DEFICIENCY  | ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)  | ID<br>PREFI<br>TAG |                                       | HOULD BE |                   | (X5)<br>COMPLETION<br>DATE |
| 1<br>1<br>1<br>1<br>1                            | brief interview for men of 0 - 15, 11 - being m cognition for making d 18 was coded as requ of one staff member fo Under section H "Blad 104 was coded under indwelling catheter and On 07/27/21 at 11:45 a 2:05 p.m., observation revealed the resident swheelchair. Observation revealed the catheter con the front of the cont wheelchair. Further observed their wheelchair. Observation revealed that it w # 104's thighs, then roswheelchair and into the On 07/28/21 at 1:30 p.r Resident # 104 revealed power wheelchair. Observed their wheelchair. Observed the catheter con the front of the control wheelchair. Further observed the catheter con the front of the control wheelchair. Further observed their wheelchair. Observed their wheelchair and into the wheelchair and into the wheelchair and into the wheelchair and into the | tal status (BIMS) of a score oderately impaired of aily decisions. Resident # iring extensive assistance r activities of daily living. der and Bowel" Resident # "H0100" as having an d an external catheter.  a.m., at 1:05 p.m and at soft Resident # 104 iriting in their power and of the wheelchair collection bag was hanging and arm of power servations of the catheter that it was at the height of while they were sitting in their evas draped over Resident the over the arm of the collection bag was hanging oil arm of power ervation of the wheelchair collection bag.  m., an observation of d they were sitting in their ervation of the catheter that it was at the height of while they were sitting in their ervation of the catheter that it was at the height of while they were sitting in vation of the catheter that it was at the height of while they were sitting in vation of the catheter as draped over Resident the over the arm of the collection bag.  der sheet] for Resident # ocumented, "Urinary | F                  | 590                                   |          |                   |                            |

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION |   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  | 1 ' '               | LE CONSTRUCTION  | (X3) DATE SURVEY<br>COMPLETED |                            |
|---|---|--|---------------------|--|-------------------------------|----------------------------|
|   |   | 495391   | B. WING             |  | C 07/26                       | 2/2024                     |
|   | PROVIDER OR SUPPLIER RNIE REHAB & NURSING   |  |                     | STREET ADDRESS, CITY, STATE, ZIP CODE 1901 LIBBIE AVE RICHMOND, VA 23226   | 07/28                         | 9/2021                     |
| (X4) ID<br>PREFIX<br>TAG                            | (EACH DEFICIENC)  | ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROPRI<br>DEFICIENCY) | BE                            | (X5)<br>COMPLETION<br>DATE |
|   | obstructed. Order Data The comprehensive ordated 07/05/2021 failed documentation to add condom catheter.  On 07/27/21 at 12:50 conducted with Reside who placed the cathete of the wheelchair Resinurse."  On 07/28/2021 at 3:12 conducted with LPN [ii 3, unit manager. LPN above observations of collection bag and tubical collection bag and tubical and would cause backs bladder. When asked if order for Resident # 10 reviewed the electronic the computer. After revistated that Resident # catheter and an order state time of their admission on 07/28/2021 at approfaministrative staff meclinical services, ASM # ASM # 4, medical direct the above concern. | are plan for Resident # 104 and to evidence ress Resident # 104's  p.m., an interview was ent # 104. When asked ar collection bag on the arm dent # 104 stated, "The  p.m. an interview was densed practical nurse] # #3 was informed of the Resident # 104's catheter ang LPN # 3 stated that the ang was positioned to high flow of urine into the f there was a physician's by's catheter, LPN # 3 a physician's order sheet on iewing the orders LPN # 3 a phys | F 690               |  |                               |                            |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |  | (X2) MULTIPLE CONSTRUCTION A. BUILDING  |                            |   | (X3) DATE SURVEY<br>COMPLETED |                            |  |
|--|--|---|----------------------------|---|-------------------------------|----------------------------|--|
|  |  | 495391  | B, WING                    |   |                               | С                          |  |
|  | F PROVIDER OR SUPPLIER BURNIE REHAB & NURSING  | CENTER  |                            | STREET ADDRESS, CITY, STATE, ZIP CODE 1901 LIBBIE AVE RICHMOND, VA 23226  | 1 07                          | 7/29/2021                  |  |
| (X4) IE<br>PREFI<br>TAG  | (EACH DEFICIENCY   | NTEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG        | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROPRI<br>DEFICIENCY)  | BE                            | (X5)<br>COMPLETION<br>DATE |  |
| F 698  | https://www.nlm.nih.go<br>sease.html.  [2] A nervous system of<br>brain and spinal cord.<br>sheath, the material the<br>your nerve cells. This of<br>blocks messages betwe<br>body, leading to the sy<br>information was obtained<br>https://medlineplus.gov<br>Respiratory/Tracheosto | isease that affects your at damages the myelin at surrounds and protects damage slows down or een your brain and your mptoms of MS. This ed from the website: /multiplesclerosis.html. omy Care and Suctioning tracheal suctioning. That a resident who including tracheostomy oning, is provided such offessional standards of sive person-centered goals and preferences, art. not met as evidenced staff interview, facility nical record review, it ity staff failed to provide he physician orders and are plan for three of 49 ample, Residents #172, | s<br>E<br>S<br>a<br>p<br>a | F695: Respiratory/Tracheostom Care and Suctioning 1. Residents #172, #171 and #11 continue to reside in facility and verification that residents have: - have appropriate supplies (i.e., ambubag, back up trach, and sucti kit) readily available at the bedsid - Equipment Masks (Bipap, Cpap, Nebulizer) are kept in a clean/appropriate bag for infection control and storage Residents on oxygen have the ox set appropriately per MD order 2. All residents requiring Respiratory/Tracheostomy care an auctioning have the potential to be affected by this alleged deficient bractice. Nursing management will udit current residents with oxygen rach and suctioning to verify: | oning<br>e.<br>ygen<br>d      |                            |  |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER   |   | (X2) MULTIPL<br>A. BUILDING | E CONSTRUCTION   | (X3) DATE                                  | SURVEY<br>LETED            |
|--|---|-----------------------------|--|--|----------------------------|
|  | 405004  |                             |  |  |                            |
| 11414  | 495391  | B. WING                     |  | 07/2                                       | 29/2021                    |
| NAME OF PROVIDER OR SUPPLIER  GLENBURNIE REHAB & NURSING CENT  | ER  | ] :                         | STREET ADDRESS, CITY, STATE, ZIP CODE<br>1901 LIBBIE AVE<br>RICHMOND, VA 23226   |  |                            |
| (X4) ID SUMMARY STATEMEN PREFIX (EACH DEFICIENCY MUST TAG REGULATORY OR LSC IDEN   | BE PRECEDED BY FULL   | ID<br>PREFIX<br>TAG         | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD E<br>CROSS-REFERENCED TO THE APPROPRIA<br>DEFICIENCY)  | BE   | (X5)<br>COMPLETION<br>DATE |
| Gontinued From page 138 disease (COPD) (1), high bl diabetes and morbid obesity  The most recent MDS (mining assessment, an admission assessment reference date and interview for mental status) or resident was severely impair cognitive decisions. The resident was severely impair cognitive decisions. The resident was severely impair cognitive decisions. The resident was requiring extensive assistant staff members for all of her and except eating in which she was requiring supervision after see provided. In Section O - Spee Procedures, and Programs, to coded as using oxygen and had Non-invasive Mechanical Ver resident at the facility.  On 7/27/2021 at 11:40 a.m., revealed, Resident #172 in he oxygen on via a nasal cannula that inserts into the nose), that an oxygen concentrator flow med LPM (liters per minute). Furth revealed the oxygen concentrator Resident #172's reach. On 7/2 a.m., a second observation realized that was connected to concentrator that was connected to concentrator that was running concentrator flow meter was sof the ball on the 5 LPM line.  An observation was made of F7/28/2021 at 12:07 p.m., with practical nurse) #6. When ask | mum data set) assessment, with an of 6/22/2021, coded "2" on the BIMS (brief score, indicating the red to make daily dent was coded as ce of one or more ctivities of daily living vas coded as et up assistance was cial Treatments, the resident was naving a ntilator while a  observation er bed with her a (a two-prong tube at was connected to was running. The ter was set at 4.5 er observation rator was out of 28/2021 at 8:07 evealed Resident n on via a nasal of an oxygen at with the bottom  Resident #172 on LPN (licensed |                             | have appropriate supplies (i.e., ambubag, back up trach, and suct kit) readily available at the bedsick. Equipment Masks (Bipap, Cpap Nebulizer) are kept in a clean/appropriate bag for infection control and storage. Residents on oxygen have the oxet appropriately per MD order. 3.DON or designee will educate Nursing Staff on standards of care suctioning and oxygen related to Respiratory and Tracheostomy Residents to include:  having appropriate supplies (i.e. ambubag, back up trach, and suctivity) readily available at the bedside Equipment Masks (Bipap, Cpap, Nebulizer) are kept in a clean/appropriate bag for infection control and storage  Residents on oxygen have the oxet appropriately per MD order appropriately p | de. , n xygen e for , oning e.  ygen dents |                            |

|   |                          | OF DEFICIENCIES<br>F CORRECTION                    | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  | (X2) MULTIPLE CONSTRUCTION  A. BUILDING |  | (X3) DATE<br>COMF | SURVEY<br>PLETED           |
|---|--------------------------|--|---|---|--|-------------------|----------------------------|
|   |                          |  | 495391  | B. WING                                 |  | 1                 | С                          |
| H | NAME OF D                | 00//050 00 0//05/150                               | 490091  | D. WING _                               |  | 07/               | /29/2021                   |
| ı | NAME OF P                | ROVIDER OR SUPPLIER                                |   |   | STREET ADDRESS, CITY, STATE, ZIP CODE  |                   |                            |
| ı | GLENBUR                  | RNIE REHAB & NURSING                               | CENTER  | İ                                       | 1901 LIBBIE AVE  |                   |                            |
| L |                          |  |   |   | RICHMOND, VA 23226   |                   |                            |
|   | (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY                                   | ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG                     | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) |                   | (X5)<br>COMPLETION<br>DATE |
|   |                          |  |   |   | - have appropriate supplies (i.e.,   |                   |                            |
|   | F 695                    | Continued From page                                | 139   | F 69                                    | ambubag, back up trach, and suct   | ioning            |                            |
|   |                          | resident's oxygen con-                             | centrator, LPN #6 stated,   |   | kit) readily available at the bedsic   |                   |                            |
|   |                          |  | e is supposed to be on 3  |   | T  |                   |                            |
|   |                          |  | ed to check the resident's  |   | - Equipment Masks (Bipap, Cpap   | ,                 |                            |
|   |                          |  | and verified the resident   |   | Nebulizer) are kept in a   |                   |                            |
|   |                          | was supposed to be or                              | n 3 LPM.  |   | clean/appropriate bag for infection  | n                 |                            |
|   | l l                      | The physician order da                             | ated 7/2/2021   |   | control and storage  |                   |                            |
|   |                          |  | at 3 liters/minute via nasal  |   | - Residents on oxygen have the ox  | zvoen             |                            |
|   | 1                        | cannula every shift."                              | at o moro/minute via nasai  |   |  | ygon              |                            |
|   |                          | ,  |   |   | set appropriately per MD order   | . 1               |                            |
|   |                          | Resident #172's TAR (                              | treatment administration  |   | weekly times 4 weeks and monthl  |                   |                            |
|   |                          | record) for July 2021 d                            |   |   | times 2. Any identified issues will  | be                |                            |
|   |                          | physician order. Further                           |   |   | immediately corrected. Results wi  | ill be            |                            |
|   |                          |  | gen was administered as   |   | reported to Quality Assurance  | 1                 |                            |
|   |                          |  | or the day shift and for the  |   | committee for analysis and revision  | n v 3             |                            |
|   |                          | day shift on 7/28/2021,                            | administration of oxygen,   |   | months.  | m x 3             |                            |
|   | - 1                      | the area for staff initials                        | , ,   |   |  |                   |                            |
|   |                          | are area for stair findate                         | was plantic   |   | 5.Date of compliance will be Aug   | ust 24,           |                            |
|   |                          | The comprehensive car                              | re plan dated, 6/25/2021,   |   | 2021.  |                   |                            |
|   |                          | documented in part, "F                             |   |   |  | 1                 |                            |
|   |                          | respiratory impairment                             | related to COPD and   |   |  |                   |                            |
|   |                          | acute and chronic resp                             |   |   |  |                   |                            |
|   |                          |  | ocumented, "Administer  |   |  |                   |                            |
|   |                          | oxygen per physician o                             | rder."  |   |  | Í                 |                            |
|   |                          | physician's order or fac<br>administrationSteps in | Verify that there is a s procedure. Review the ility protocol for oxygen the Procedure: 8. Turn erwise ordered, start the |   |  |                   |                            |
|   | r                        |  | cal services, and ASM #2, were made aware of the  |   |  |                   |                            |

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION   |  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   |                     | IPLE CONSTRUCTION  | (X3) DATE SURVEY<br>COMPLETED |
|---|--|---|---------------------|--|-------------------------------|
|   |  | 495391  | B. WING             |  | C                             |
|   | PROVIDER OR SUPPLIER  RNIE REHAB & NURSING   | CENTER  |                     | STREET ADDRESS, CITY, STATE, ZIP CODE 1901 LIBBIE AVE RICHMOND, VA 23226 | 07/29/2021                    |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIENCY   | ATEMENT OF DEFICIENCIES<br>'MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION  | BE COMPLETION                 |
|   | No further information References: (1) COPD or chronic of disease-general term flung disease that is us emphysema and chrorn Dictionary of Medical Transparence of the page 124.  1.b. The facility staff fa PAP, bi-level Positive A and tubing in a sanitary 172.  On 7/27/2021 at 11:40 are seen and tubing were something that the page 124 and tubing the page 124 an | bstructive pulmonary for chronic, nonreversible ually a combination of nic bronchitis. Barron's ferms for the Non-Medical othenberg and Chapman, liled to store a BiPap (Bi - uirway Pressure (1)), mask of manner for Resident #  a.m., observation revealed ed. An uncovered BiPap sitting on the resident's B/2021 at 8:07 a.m., a ealed, the BiPap mask | F 6:                |  |                               |
| i<br>i<br>i<br>i<br>i<br>i<br>i<br>i<br>i<br>i<br>i<br>i<br>i<br>i<br>i<br>i<br>i<br>i<br>i | made of Resident #172 practical nurse) #6. Whe uncovered items observed and, LPN #6 stated it is should be stored in a play hy it should be stored is stated to keep it clean and interview was conducted in the conduction of the conductin of the conduction of the conduction of the conduction of the co | p.m., an observation was with LPN (licensed en asked about the above ed on the residents night was a BiPap mask and it astic bag. When asked in a plastic bag, LPN #6 and to prevent infection.   |                     |  |                               |

|   |   | N OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING   |  |                    | (X3) DATE SURVEY<br>COMPLETED  |         | 1  |                            |  |
|---|---|---|--|--------------------|--|---------|----|----------------------------|--|
|   |   | i   | 495391   | B, WING            |  |         | С  |                            |  |
| l | NAME OF P                               | PROVIDER OR SUPPLIER  | 43331  | B. WING            |  |         | 07 | /29/2021                   |  |
|   |   | RNIE REHAB & NURSING  |  |                    | STREET ADDRESS, CITY, STATE, ZIP CODE  1901 LIBBIE AVE  RICHMOND, VA 23226 |         |    |                            |  |
|   | (X4) ID<br>PREFIX<br>TAG                | PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL  |  | ID<br>PREFI<br>TAG |  | OULD BE |    | (X5)<br>COMPLETION<br>DATE |  |
|   | 1 ( ) ( ) ( ) ( ) ( ) ( ) ( ) ( ) ( ) ( | and sitting on the night that is an infection con  The facility policy, "CP. documented in part, "G. Cleaning 7. Masks, n. Clean daily by placing is soaking/agitating for 5 detergent is recomment water and allow it to air facility policy failed to experience of the director of clinical the director of nursing, above findings on 7/28/  No further information was References:  (1) BiPap - Bi - PAP, bi-Pressure), mask and tuttor Resident # 172 is a recepte who are diagnose pap machine can be separeathing out pressure is was obtained from the fattps://medlineplus.gov/en.  2. The facility staff failed Resident #171 was adm. | sk should be uncovered stand, LPN #3 stated, "No, trol concern."  AP/BiPAP Support" General Guidelines for asal pillows and tubing: in warm, soapy water and minutes. Mild dish aded. Rinse with warm of the bipaper when not in the BiPAP when no | F                  | 695  |         |    |                            |  |

PRINTED: 08/10/2021 FORM APPROVED

OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING С 495391 B. WING. 07/29/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1901 LIBBIE AVE **GLENBURNIE REHAB & NURSING CENTER** RICHMOND, VA 23226 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 695 Continued From page 142 F 695 muscular canal that transports food from the mouth to the stomach) (1), Bipolar Disorder (a mental disorder characterized by episodes of mania and depression) (2), and muscle weakness. The most recent MDS (minimum data set) assessment, an admission assessment, with an assessment reference date of 7/20/2021, coded Resident #171 as scoring a "14" on the BIMS (brief interview for mental status) score, indicating the resident was capable of making daily cognitive decisions. The resident was coded in Section O - Special Treatments, Procedures, and Programs, as having used oxygen while a resident at the facility. On 7/27/2021 at 11:30 a.m., observation revealed Resident #171 lying in his bed with oxygen in use via a nasal cannula connected to an oxygen concentrator that was running. The oxygen concentrator flow meter was set with the bottom of the ball sitting on the line for 2 LPM (liters per minute). On 7/28/2021 at 9:04 a.m., a second observation revealed Resident #171 was lying in his bed. He had oxygen in use via nasal cannula connected to an oxygen concentrator that was running. The oxygen concentrator flow meter was set with the bottom of the ball sitting on the line for 2 LPM. On 7/28/2021 at 12:36 p.m. an observation made with LPN (licensed practical nurse) #6, revealed Resident #171 with oxygen in use via the nasal cannula connected to an oxygen concentrator that was running. LPN #6 was asked the flow rate setting of the resident's oxygen concentrator. LPN #6 stated, "Almost 3 LPM." When asked how to read the oxygen concentrator for the

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION |   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  |                     | PLE CONSTRUCTION   | (X3) DAT | E SURVEY<br>PLETED         |
|---|---|--|---------------------|--|----------|----------------------------|
|   |   | 495391   | B. WING             |  |          | С                          |
| NAME OF F   | PROVIDER OR SUPPLIER  | 40001  | B. WING             | STREET ADDRESS, CITY, STATE, ZIP CODE  | 07       | 7/29/2021                  |
| GLENBU  | RNIE REHAB & NURSING  | CENTER   |                     | 1901 LIBBIE AVE<br>RICHMOND, VA 23226  |          |                            |
| (X4) ID<br>PREFIX<br>TAG                            | (EACH DEFICIENCY  | ATEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD I<br>CROSS-REFERENCED TO THE APPROPRI<br>DEFICIENCY) | BE       | (X5)<br>COMPLETION<br>DATE |
| F 695   |   | 143<br>#6 stated the line for the  | F 69                | 5  |          |                            |
|   | prescribed rate should the ball.  | be through the center of   |                     |  |          |                            |
|   | The physician order da<br>documented, "Oxygen<br>cannula every shift."                                  | ated 7/22/2021<br>at 2 liters/minute via nasal   |                     |  |          |                            |
|   | the above physician or review of the TAR reve   | for July 2021 documented<br>der for oxygen. Further<br>aled documentation the<br>red per the physician order               |                     |  |          |                            |
|   | documented, "Focus: Himpairment related to e  | re plan, dated, 7/27/2021,<br>las/at risk for respiratory<br>sophageal cancer." The<br>nted in part, "Administer<br>rder." |                     |  |          |                            |
|   | manager, on 7/28/2021 how to read the oxygen resident's prescribed ox stated the nurse has to where the | ygen flow rate, LPN #3<br>get down to eye level.<br>ball should be, LPN #3<br>between the ball, not on                     |                     |  |          |                            |
| c<br>T<br>b<br>tt<br>o                              | oxygen concentrator, do<br>Furn the flowrate knob to<br>by your physician or the                        | o the setting prescribed rapist. To properly read prescribed flowrate line urn the flow knob until Now, center the ball on |                     |  |          |                            |

|                           | OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   | 1                  |     | LE CONSTRUCTION  |         | TE SURVEY                  |
|---------------------------|--|---|--------------------|-----|--|---------|----------------------------|
|                           |  | 495391  | B. WING            |     |  |         | С                          |
| NAME OF I                 | PROVIDER OR SUPPLIER   | 493091  | D. WING            | _   |  | 07      | 7/29/2021                  |
| TO WILL OF                | NOVIDER OR SUPPLIER  |   |                    |     | STREET ADDRESS, CITY, STATE, ZIP CODE  |         |                            |
| GLENBU                    | RNIE REHAB & NURSING   | CENTER  |                    | 1   | 1901 LIBBIE AVE  |         |                            |
|                           |  |   |                    |     | RICHMOND, VA 23226   |         |                            |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIENCY   | ATEMENT OF DEFICIENCIES<br>MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFI<br>TAG |     | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY) | :<br>(E | (X5)<br>COMPLETION<br>DATE |
| I se ( ) co iii - co F fo | ASM (administrative s regional director of clin the director of nursing, above findings on 7/28  No further information (1) Dictionary of Medical Reader, 5 Chapman, page 208. (2) Barron's Dictionary Non-Medical Reader, 5 Chapman, page 72.  3. The facility staff failed care was provided to R physicians orders.  A. the facility staff failed [1] at Resident # 11's be physician's orders.  Resident # 11 was admidiagnoses that include be cancer of scalp and need hypoxia [2], acquired ab tracheostomy [4].  Resident # 11's most received Resident # 11 as netrview for mental statu 15, 14 - being cognitive decisions. Section "O Sperocedures and Program or "Tracheostomy care" | taff member) #1, the ical services, and ASM #2, were made aware of the i/2021 at 5:07 p.m.  was provided prior to exit.  al Terms for the ith edition, Rothenberg and of Medical Terms for the th edition, Rothenberg and do to ensure tracheostomy esident #11 per the  maintain an Ambu bag and side according to ditted to the facility with bout not limited to: skin k, respiratory failure with sence of larynx [3] and dient MDS (minimum data sment with an ARD date) of 04/27/2021, scoring a 14 on the brief is (BIMS) of a score of 0 ly intact for making daily ecial Treatments, is coded Resident #11 while a resident. | F                  | 695 | DEFICIENCY)  |         |                            |
| T                         | he physician's order dat   | ed 04/01/2021 for   |                    |     |  |         | 1                          |

|                                       | OF DEFICIENCIES<br>F CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  |                     | PLE CONSTRUCTION   |      | E SURVEY<br>IPLETED        |
|---------------------------------------|---|---|---------------------|--|------|----------------------------|
|                                       |   | 495391  | B. WING _           |  |      | C                          |
|                                       | ROVIDER OR SUPPLIER   | CENTER  |                     | STREET ADDRESS, CITY, STATE, ZIP CODE 1901 LIBBIE AVE RICHMOND, VA 23226                                       | 1 07 | 7/29/2021                  |
| (X4) ID<br>PREFIX<br>TAG              | (EACH DEFICIENCY  | ATEMENT OF DEFICIENCIES<br>MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIAL DEFICIENCY) |      | (X5)<br>COMPLETION<br>DATE |
| i i i i i i i i i i i i i i i i i i i | The physician's order documented, "Keep a ambu bag with pt [patie Date: 07/28/2021."  The comprehensive cadated 04/21/2021 failed addressing Resident # tracheostomy care.  On 07/27/21 at 2:00 p. p.m., on 07/28/21 at 10 a.m., observations of R to evidence an ambu b  On 07/28/21 at approxiobservation of Resident Conducted with LPN [lick of the conducted with LPN # 2 and the bedside table at the room. When asked the room. When asked only is conducted with RN [regassistant director of number two physician's order for the stated no. | ented, "Keep a spare trach [patient] at all times."  for Resident # 11 spare lary tube [5] and ent] at all times. Revision  are plan for Resident # 11 d to evidence interventions 11's care needs for  m., on 07/28/21 at 8:02 0:15 a.m., and at 11:50 esident # 11's room failed ag.  mately 11:50 a.m., an tr # 11's room was rensed practical nurse] # or locate the ambu bag for all looked inside the closet and stated that it wasn't in if they were aware of the erambu bag, LPN # 1  a.m., an interview was istered nurse] # 2, sing. When asked about ers above, RN # 2 stated the term "Trach" to "Lary better description of the # 11 actually had. When a service is one whole tube | F 6:                | 95   |      |                            |

|                                      | OF DEFICIENCIES<br>F CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  |                     | LE CONSTRUCTION   | (X3) DATE | SURVEY<br>PLETED           |
|--------------------------------------|---|---|---------------------|---|-----------|----------------------------|
|                                      |   | 495391  | B. WING             |   |           | C                          |
|                                      | PROVIDER OR SUPPLIER  | CENTER  |                     | STREET ADDRESS, CITY, STATE, ZIP CODE 1901 LIBBIE AVE RICHMOND, VA 23226  | 1 07      | /29/2021                   |
| (X4) ID<br>PREFIX<br>TAG             | (EACH DEFICIENC)  | ATEMENT OF DEFICIENCIES<br>MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD I<br>CROSS-REFERENCED TO THE APPROPRI,<br>DEFICIENCY) | BE        | (X5)<br>COMPLETION<br>DATE |
| i<br>i<br>i<br>i<br>i<br>i<br>i<br>i | [administrative staff m of clinical services, AS and ASM # 4, medical of the above concern.  No further information  References:  [1] A self-refilling bag1.5 litre capacity, used which, while suboptima patient, is effective for intubated patients, allo and artificial respiration obtained from the webshttps://medical-dictional mbu+bag  [2] When not enough olungs into your blood. To obtained from the webshttps://www.nlm.nih.gov.ilure.html.  Hypoxia - Deficiency of tissues of the body. Thi obtained from the webshttps://www.merriam-webxia.  3] The larynx, or voice is and performs several into ody. The larynx is involved and performs several into ody. The larynx is involved and performs and voice provas obtained from the voice and performs and voice provas obtained from the voice and performs and voice provas obtained from the voice and performs and voice provas obtained from the voice and performs and voice provas obtained from the voice and performs and voice provas obtained from the voice and performs and voice provas obtained from the voice and performs and voice provas obtained from the voice pro | roximately 5:00 p.m., ASM ember] #1, regional director SM # 2, director of nursing director, were made aware was presented prior to exit.  Valve-mask unit with a 1 d for artificial respiration al for the non-intubated ventilating and oxygenating wing both spontaneous at This information was site:  ry.thefreedictionary.com/A  Exygen passes from your This information was site:  r/medlineplus/respiratoryfa  oxygen reaching the sinformation was ite:  ebster.com/dictionary/hyp  Dox, is located in the neck aportant functions in the lived in swallowing, oduction. This information | F 695               |   |           |                            |

|   |                          | OF DEFICIENCIES<br>F CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   |                    | TIPLE CONSTRUCTION<br>DING   |           | ) DATE SURVEY<br>COMPLETED |  |
|---|--------------------------|---|---|--------------------|--|-----------|----------------------------|--|
|   |                          |   | 495391  |                    |  |           | С                          |  |
| I | NAME OF D                | BOVIDED OF CURRIER  | 495591  | B, WING            |  |           | 07/29/2021                 |  |
|   |                          | ROVIDER OR SUPPLIER RNIE REHAB & NURSING  | CENTER  |                    | STREET ADDRESS, CITY, STATE, ZIP CODE 1901 LIBBIE AVE RICHMOND, VA 23226 |           |                            |  |
|   | (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY  | ATEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)   | ID<br>PREFI<br>TAG |  | SHOULD BE | (X5)<br>COMPLETION<br>DATE |  |
|   | F 695                    | Continued From page  [4] A surgical procedure through the neck into the tube is most often place provide an airway and the lungs. This tube is or trach tube This inform the website: https://medlineplus.gov/  [5] A lary tube is a flexing to maintain the stoman surgery. A lary tube is a and can be following a information was obtained https://patientslearn.uais/sites/95/2018/03/Lary  B. The facility staff failed the tracheostomy inner the physician's orders.  The POS [physician's orders. | re to create an opening the trachea (windpipe). A sed through this opening to to remove secretions from called a tracheostomy tube formation was obtained v/ency/article/002955.htm.  The silicone tube designed right after the laryngectomy used to maintain the airway laryngectomy. This ed from the website:  ms.edu/wp-content/upload v_Tube_Care.pdf  In the clean Resident # 11's cannula [1] according to the cumented, "Cleanse inner the build up, Trach to daily, and keep area dry preakdown. One (Sic.)  The Change trach dressing corder Date: 04/21/2021.  The eatment administration for Resident #11, |                    | I.   | PROPRIATE |                            |  |
|   | C C                      | eview of the eTAR reve<br>7/12/21, 07/16/21 and<br>on 07/28/21 at 11:33 a.  | m., an interview was<br>ensed practical nurse] #  |                    |  |           |                            |  |

|   |   |  |   |                     |   | CIVID I                       | NO. 0938-0391              |  |
|---|---|--|---|---------------------|---|-------------------------------|----------------------------|--|
|   |   | OF DEFICIENCIES<br>F CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   | ·                   | CONSTRUCTION  | (X3) DATE SURVEY<br>COMPLETED |                            |  |
|   |   | 19   | 495391  | B. WING             |   |                               | C                          |  |
| İ | NAME OF P   | ROVIDER OR SUPPLIER  |   | l s                 | TREET ADDRESS, CITY, STATE, ZIP CODE  | 1 0                           | 7/29/2021                  |  |
|   |   | RNIE REHAB & NURSING   |   | 19                  | 901 LIBBIE AVE<br>ICHMOND, VA 23226   |                               |                            |  |
|   | (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIENCY   | ITEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD B<br>CROSS-REFERENCED TO THE APPROPRIA<br>DEFICIENCY) | 3E                            | (X5)<br>COMPLETION<br>DATE |  |
|   | i<br>i<br>i<br>i<br>i<br>i<br>i<br>i<br>i<br>i<br>i<br>i<br>i<br>i<br>i<br>i<br>i<br>i<br>i | the eTAR, LPN # 3 state documented it wasn't of the above concern.  On 07/28/2021 at appropriate appro | After LPN # 3 reviewed ted, "If it wasn't done."  oximately 5:00 p.m., ASM ember] #1, regional director M # 2, director of nursing director, were made aware was presented prior to exit.  an inner tube inserted annula of the tracheostomy dividuals who require. The inner cannula of the tracheal tube lumen, and work of breathing. This are from the website: hyeducation.com  d to document the attheter [1] for Resident # according to the  der sheet] for Resident # cumented, "14 FR er every shift for ret Date: 05/14/2021."  atment administration for resident #11, hysician's order. Further aled blanks on 07/06/21, 6/21 and on 07/17/21 on a. shift; 07/03/21, | F 695               |   |                               |                            |  |

|                          | OF DEFICIENCIES<br>F CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   |                     | TIPLE CONSTRUCTION   | (X3) DATE<br>COMP | SURVEY                     |
|--------------------------|--|--|---------------------|--|-------------------|----------------------------|
|                          |  | 495391   | B, WING             |  | 1                 | C<br><b>/29/2021</b>       |
|                          | ROVIDER OR SUPPLIER  RNIE REHAB & NURSING  | CENTER   |                     | STREET ADDRESS, CITY, STATE, ZIP CODE 1901 LIBBIE AVE RICHMOND, VA 23226                                       | 077               | 29/2021                    |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY   | NTEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)   | ID<br>PREFII<br>TAG | PROVIDER'S PLAN OF CORRECTION X (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) |                   | (X5)<br>COMPLETION<br>DATE |
|                          | 07/28/21 on the 3:00 p 07/02/21, 07/10/21 and p.m. to 7:00 a.m. shift.  On 07/28/21 at 11:33 a conducted with LPN [L 3, unit manager, regard Resident # 11's eTAR. the eTAR, LPN # 3 sta documented it wasn't d  On 07/28/2021 at appr [administrative staff me of clinical services, ASI and ASM # 4, medical d of the above concern.  No further information v  References: [1]A catheter used to references: [1]A catheter used to reference to the website: https://medical-dictionar uction+catheter  D. The facility staff failed of humidified air [moist a tracheostomy care accorders.  The POS [physician's or | a.m., an interview was icensed practical nurse] # ding the blanks on After LPN # 3 reviewed ted, "If it wasn't lone."  oximately 5:00 p.m., ASM imber] #1, regional director M # 2, director of nursing director, were made aware was presented prior to exit.  move mucus and other er airway, trachea, and mation was obtained y.thefreedictionary.com/s  d to document the supply air] for Resident # 11's reding to the physician's reder sheet] for Resident # cumented, "Humidified air for tracheostomy 021." | F                   | 695  |                   |                            |

|                          | OF DEFICIENCIES OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  |                     | TPLE CONSTRUCTION  |      | E SURVEY<br>IPLETED        |
|--------------------------|--|---|---------------------|--|------|----------------------------|
|                          |  | 495391  | B, WING_            |  | 07   | C<br>'/ <b>29/2021</b>     |
|                          | PROVIDER OR SUPPLIER   | CENTER  |                     | STREET ADDRESS, CITY, STATE, ZIP CODE 1901 LIBBIE AVE RICHMOND, VA 23226   | 1 07 | 723/2021                   |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY   | ATEMENT OF DEFICIENCIES<br>'MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTIO<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROPR<br>DEFICIENCY) | BE   | (X5)<br>COMPLETION<br>DATE |
|                          | record] dated July 202 documented the physi above. Further review blanks on 07/06/21, 07 and on 07/17/21 on the shift; 07/03/21, 07/11/2 07/26/21 and on 07/28/11:00 p.m. shift; 07/02 07/24/21 on the 11:00 On 07/28/21 at 11:33 a conducted with LPN [L 3, unit manager, regard Resident # 11's eTAR. the eTAR, LPN # 3 states documented it wasn't documented it wasn't documented it wasn't do of the above concern.  No further information was above concern.  No further information was above concern.  The facility staff failed compressor setting of 2 tracheostomy care accorders.  The POS [physician's on 11 dated 04/21/2021 documented 04/21/2 | 21, for Resident #11, cian's order as stated of the eTAR revealed (711/21, 07/12/21, 07/16/21 e 7:00 a.m. to 3:00 p.m. 21, 07/19/21, 07/23/21, 6/21 on the 3:00 p.m. to /21, 07/10/21 and on p.m. to 7:00 a.m. shift.  a.m., an interview was idensed practical nurse] # ding the blanks on After LPN # 3 reviewed ted, "If it wasn't one."  Doximately 5:00 p.m., ASM mber] #1, regional director of #2, director of nursing director, were made aware was presented prior to exit. If to document the 8% for Resident # 11's ording to the physician's order sheet] for Resident # cumented, "Oxygen or via trach collar, every in Compressor settings art Date: 04/21/2021." | F 6                 | 95   |      |                            |

|   |                                       | OF DEFICIENCIES<br>F CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:                           | -                   | IPLE CONSTRUCTION<br>IG   |    | TE SURVEY<br>MPLETED       | • |
|---|---------------------------------------|--|--|---------------------|---|----|----------------------------|---|
|   |                                       |  | 495391   | B. WING             |   |    | C                          |   |
| I | NAME OF P                             | ROVIDER OR SUPPLIER  |  |                     | STREET ADDRESS, CITY, STATE, ZIP CODE   | 07 | 7/29/2021                  |   |
|   | GLENBUR                               | RNIE REHAB & NURSING   | CENTER   |                     | 1901 LIBBIE AVE<br>RICHMOND, VA 23226   |    |                            |   |
|   | (X4) ID<br>PREFIX<br>TAG              | (EACH DEFICIENCY   | ITEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIAT<br>DEFICIENCY) |    | (X5)<br>COMPLETION<br>DATE |   |
|   | f f f f f f f f f f f f f f f f f f f | 07/11/21, 07/12/21, 07/12/1, 07/11/21, 07/11/21, 07/19/21, 07/19/21, 07/19/21, 07/19/21, 07/19/21, 07/19/21, 07/19/21, 07/19/21, 07/19/21, 07/19/21, 07/19/21, 07/19/21, 07/19/21, 07/19/21, 07/19/21, 07/19/21, 07/19/21, 07/28/21 at 11:33 a conducted with LPN [Li 3, unit manager, regard Resident # 11's eTAR. the eTAR, LPN # 3 stated documented it wasn't documented i | realed blanks on 07/06/21, //16/21 and on 07/17/21 on one                    | F 69                | 95  |    |                            |   |

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

| AND PLAN                 | OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  |                    | TIPLE CONSTRUCTION  |                                    | E SURVEY<br>MPLETED        |
|--------------------------|---|--|--------------------|---|------------------------------------|----------------------------|
|                          |   | 495391   | B. WING            |   | 0.                                 | C<br>7/29/2021             |
|                          | PROVIDER OR SUPPLIER  URNIE REHAB & NURSING   | CENTER   | -1                 | STREET ADDRESS, CITY, STATE, ZIP CODE  1901 LIBBIE AVE  RICHMOND, VA 23226  |                                    | 7/29/2021                  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY  | ATEMENT OF DEFICIENCIES<br>MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFI<br>TAG |   | ) BE                               | (X5)<br>COMPLETION<br>DATE |
| F 698                    | 07/11/21, 07/19/21, 07/07/28/21 on the 3:00 p 07/02/21, 07/10/21 and p.m. to 7:00 a.m. shift.  On 07/28/21 at 11:33 a conducted with LPN [L 3, unit manager, regar Resident # 11's eTAR. the eTAR, LPN # 3 sta documented it wasn't con 07/28/2021 at appropriate appropriate staff me of clinical services, ASI and ASM # 4, medical cof the above concern.  No further information was region of the appropriate staff me of clinical services, ASI and ASM # 4, medical cof the above concern. | 7/23/21, 07/26/21 and on o.m. to 11:00 p.m. shift; d on 07/24/21 on the 11:00 a.m., an interview was icensed practical nurse] # ding the blanks on After LPN # 3 reviewed ted, "If it wasn't one."  Distinctly 5:00 p.m., ASM mber] #1, regional director of M # 2, director of nursing director, were made aware was presented prior to exit. | F                  | 595   |                                    |                            |
| SS=E                     | secretions during oral pl<br>information was obtaine  | that residents who uch services, consistent rds of practice, the rentered care plan, and preferences.  | F 69               | F698: Dialysis 1. Residents #64, #80 and #52 co to reside in facility and have app orders for dialysis, dialysis AV s being assessed each shift, and ac communication to and from the c center. Residents #114, #173, an have been discharged from the fa | nunt<br>curate<br>ialysis<br>d #59 |                            |

|  |  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   | 1                   | PLE CONSTRUCTION  | (X3) DATE SURVE<br>COMPLETED   | Υ                    |
|--|--|---|---------------------|---|--|----------------------|
|  |  | 495391  | B. WING             |   | С  |                      |
| NAME OF PROVIDER OR SUI  | PPLIER   |   | 1                   | STREET ADDRESS, CITY, STATE, ZIP CODE   | 07/29/20   | 21                   |
| GLENBURNIE REHAB &   |  |   |                     | 1901 LIBBIE AVE<br>RICHMOND, VA 23226   |  |                      |
| PREFIX (EACH)  | DEFICIENCY   | NTEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD B<br>CROSS-REFERENCED TO THE APPROPRIA<br>DEFICIENCY)   | E COMP   | (5)<br>LETION<br>ATE |
| review, clinic a complaint i facility staff farelated to dia survey sampl #59, and #52  The facility farecommunication for Resident # and failed to he #173 to receiv. #80's dialysis hassessed and shift according.  The findings in 1. The facility is communication for Resident #64 to 6/10/2021 with not limited to be hemodialysis (is conditions and wastes and implications and wastes and implications of the the most receives assessment, and assessment references | aff intervies al record nivestigation ailed to prove the process of the process o | ew, facility document review and in the course of on, it was determined the ovide care and services ix of 49 residents in the nts #64, #114, #173, #80, sure an ongoing s with the dialysis centers , #173, #80, #59 and #52, ysician order for Resident , failed to ensure Resident ovenous] shunt was for a Bruit and Thrill every sysician's orders. |                     | 2.All residents requiring Dialysis treatments have the potential to be affected by this alleged deficient practice. Nursing management with audit current resident's receiving dialysis to verify physician orders dialysis, assessing dialysis site with documentation. Audit the dialysis communication book documentation been reviewed to and from dialysis 3.DON or designee will educate Nursing Staff on obtaining dialysis orders, dialysis AV shunt being assessed each shift and documentation to and from the dialysis center for all resident receoutside Dialysis treatments.  4.DON or designee will audit residuallysis orders per physician, to dialysis AV shunt is being assessed each shift with documentation, and communication to and from the dialysis AV shunt is being assessed each shift with documentation, and communication to and from the dialysis AV shunt is dean assessed each shift with documentation, and communication to and from the dialecters are documented and review weekly times 4 weeks and monthly imes 2. Any identified issues will ammediately corrected. Results will eported to Quality Assurance committee for analysis and revision nonths. | for the on has selection electrons it is i |                      |

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| Control to the second of the control | EDIO/ (ID OLIVICE)   |                              |   | OMB N        | O. 0938-0391               |
|--|--|------------------------------|---|--------------|----------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION  | X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   | (X2) MULTIPLE<br>A. BUILDING | CONSTRUCTION  | , ,          | E SURVEY<br>MPLETED        |
|  | 495391   | B. WING                      | I I   | 0.7          | C<br>7/ <b>29/2021</b>     |
| NAME OF PROVIDER OR SUPPLIER  GLENBURNIE REHAB & NURSING C   | CENTER   | J                            | TREET ADDRESS, CITY, STATE, ZIP CODE<br>901 LIBBIE AVE  |              | 112312021                  |
|  |  | R                            | ICHMOND, VA 23226   |              |                            |
| PREFIX (EACH DEFICIENCY N  | EMENT OF DEFICIENCIES AUST BE PRECEDED BY FULL CIDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG          | PROVIDER'S PLAN OF COR<br>(EACH CORRECTIVE ACTION<br>CROSS-REFERENCED TO THE A<br>DEFICIENCY) | SHOULD BE    | (X5)<br>COMPLETION<br>DATE |
| F 698 Continued From page 1 resident was moderately cognitive decisions. In S Treatments, Procedures Resident #64 was coded while a resident at the fat The physician order date documented, "Hemodialy Time: MON (Monday), V FRIDAY Dialysis Center phone # (phone number The dialysis communicat #64 was located in the claurse's station. The sheet documented the date, vit notes to the dialysis cent place for the dialysis communicat following dates: 6/11/202-6/18/2021, 6/21/2021, 6/26/28/2021, 6/30/2021, 7/27/9/2021, 7/14/2021, and the physician orders for d Wednesday, and Friday, the dialysis dates and were moderated the state of the dialysis center moderated the state of the dialysis center moderated the state of the dialysis center staff.  The comprehensive care procumented in part, "Focumented in par | y impaired to make daily Section O - Special s, and Programs, d as receiving dialysis acility.  ed, 6/15/2021, ysis Dialysis Days and VED (Wednesday) (name of dialysis center) for the dialysis center).  tion book for Resident hart rack behind the ets in the book all signs, and a space for the from the facility and a ter to communicate with cumentation in Resident ation book for the 1, 6/14/2021, 6/25/2021, 6/25/2021, 7/26/2021, Based on lialysis on Monday, the following dates were missing documentation: 5/2021, 7/19/2021,  s notes for June and 64 failed to evidence cility staff provided egarding Resident # 64 | F 698                        | 5.Date of compliance will 2021.   | be August 20 |                            |

| STATEMENT<br>AND PLAN C           | OF DEFICIENCIES DEFICIENCIES  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   | (X2) MULTIPL<br>A. BUILDING | E CONSTRUCTION   | (X3) DAT | E SURVEY  MPLETED          |
|-----------------------------------|---|---|-----------------------------|--|----------|----------------------------|
|                                   |   | 495391  | B. WING                     |  |          | С                          |
|                                   | PROVIDER OR SUPPLIER  RNIE REHAB & NURSING  | CENTER  | 5                           | STREET ADDRESS, CITY, STATE, ZIP CODE  901 LIBBIE AVE  RICHMOND, VA 23226                                      | 1 07     | 7/29/2021                  |
| (X4) ID<br>PREFIX<br>TAG          | (EACH DEFICIENCY  | ATEMENT OF DEFICIENCIES<br>MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG         | PROVIDER'S PLAN OF CORRECTION  (EACH CORRECTIVE ACTION SHOULD E  CROSS-REFERENCED TO THE APPROPRI  DEFICIENCY) | BE       | (X5)<br>COMPLETION<br>DATE |
| t t t c c n n a a g g re si où be | documented, "Adminis physician order. Arran from dialysis center on access site for lack of infection, swelling or exfacility guidelines. Rep physician. Diet per physician interview was supposite the dialysis center) are award of the physician dialysis center) and the book should is senter between dialysis day order to be dialysis day order to communication in the book doesn't go a sheet communication in the book and interview was conducted an interview was conducted an interview was conducted an interview was conducted an interview was conducted an interview was conducted an interview was conducted an interview was conducted and | the "Interventions/Tasks" ster medications per tige for transportation to and dialysis days. Check thrill/bruit, evidence of excessive bleeding per ort abnormalities to existion orders."  Lucted with LPN (licensed 67/28/2021 at 12:30 p.m. explain the process staff bing to dialysis, LPN #1 book with him. They exposed to put things in nunication book)." When sed to document anything cation book, LPN #1 ng is to put anything are. We get tig his Vancomycin (an erious infections) (3) that minister." When asked if with Resident #64 for ed, LPN #1 stated, "If the should go. If there is no took, it wasn't sent or it italysis."  Leted with LPN #3, the unit at 2:22 p.m. When asked collows for a resident estated, "Before the should get a set of vital emperature, pulse and dialysis resident has a | F 698                       |  |          |                            |

|  | OF DEFICIENCIES OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   |                     | IPLE CONSTRUCTION IG   | (X3) DAT | TE SURVEY<br>MPLETED       |
|--|--|---|---------------------|--|----------|----------------------------|
|  |  | 495391  | B, WING _           |  |          | С                          |
|  | PROVIDER OR SUPPLIER   | CENTER  |                     | STREET ADDRESS, CITY, STATE, ZIP CODE 1901 LIBBIE AVE RICHMOND, VA 23226                                     | 07       | 7/29/2021                  |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIENCY   | ATEMENT OF DEFICIENCIES<br>MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPRI, DEFICIENCY) | 3E       | (X5)<br>COMPLETION<br>DATE |
| the state of the s | from dialysis, the book is any communication us (facility), if new med post set of vital signs a should note off on it." It sheets are kept, LPN # each individual resident communication sheets should call the dialysis LPN #3 was asked to fisheets for the dates midocumented above.  On 7/29/2021 at 11:30 a could not find any of the communication sheets.  The facility policy, "End-Care of a Resident with end-stag will be care for according standards of care. 4. Agracility and the contracted all aspects of how the remanaged, including: How developed and implement to exchanged between the director of nursing, we above concern on 7/29/2 No further information was References:  1) Barron's Dictionary of | s is looked at to see if there from the dialysis center to dications, orders, pre and and weights. The nurse When asked where the 13 stated in the binder for st. If they (dialysis and any of the missing sing communication as sa.m., LPN #3 stated she are missing dialysis and currently recognized greements between this and ESRD facility include asident's care will be with the care plan will be noted, how information will the facility."  If member) #1, the all services and ASM #2, were made aware of the 1021 at 10:41 a.m.  Its provided prior to exit. | F 69                | 98   |          |                            |

|                          | OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   | (X2) MUL <sup>*</sup> | TIPLE CONSTRUCTION NG   | (X3) DATE SURVEY<br>COMPLETED |                            | 1 |
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|                          |  | 495391  | B, WING               | 22  | 0.                            | C<br><b>7/29/2021</b>      |   |
| GLENBU                   | PROVIDER OR SUPPLIER  RNIE REHAB & NURSING   |   |                       | STREET ADDRESS, CITY, STATE, ZIP CODE<br>1901 LIBBIE AVE<br>RICHMOND, VA 23226                                      |                               | 172372021                  |   |
| (X4) ID<br>PREFIX<br>TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)   |   | ID<br>PREFIX<br>TAG   | PROVIDER'S PLAN OF CORRECTION ( (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION DEFICIENCY) | :<br>[E                       | (X5)<br>COMPLETION<br>DATE |   |
| ti da a a a a a F () th  | (2) Barron's Dictionary Non-Medical Reader, & Chapman, page 243. (3) This information was following website: https://medlineplus.gov.ml.  2. The facility staff faile communication process for Resident #114.  Resident #114 was add 5/27/2021 with a recent with diagnoses that include to: end stage renal dise hemodialysis (a proceduconditions and renal [kid wastes and impurities a blood by a special mach obstructive pulmonary diagram for chronic, nonrevisus usually a combination chronic bronchitis) (2) his anxiety disorder (state or apprehension) (3).  The most recent MDS (nessessment, a quarterly assessment reference dates and interest and interest and interest and interest and interest and interest | of Medical Terms for the 5th edition, Rothenberg and as obtained from the 1/druginfo/meds/a601167.ht d to have a swith the dialysis center mitted to the facility on readmission on 7/9/2021, uded but were not limited ase requiring ure used in toxic dney] failure, in which re removed from the nine) (1), chronic isease (COPD - general ersible lung disease that of emphysema and gh blood pressure and f mild to severe ninimum data set) assessment, with an ate of 7/15/2021, coded g a "12" on the BIMS I status) score, indicating tely impaired to make In Section O - Special and Programs, the aving received dialysis | F6                    | 98  |                               |                            |   |

| 1 | STATEMENT OF DEFICIENCIES                 |  | 0/40 == 0.45== 1-1-1-1-1  |                     |  | OIVID INO. 0938-0391 |                            |   |
|---|---|--|---|---------------------|--|----------------------|----------------------------|---|
|   |   | F CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   |                     | PLE CONSTRUCTION  G  |                      | TE SURVEY<br>MPLETED       |   |
|   |   |  | 495391  | B. WING             |  |                      | C<br>7/20/2024             |   |
| ľ | NAME OF P                                 | ROVIDER OR SUPPLIER  |   | - T                 | STREET ADDRESS, CITY, STATE, ZIP CODE  | 1 0                  | 7/29/2021                  | _ |
|   | GLENBUR                                   | RNIE REHAB & NURSING   |   |                     | 1901 LIBBIE AVE<br>RICHMOND, VA 23226  |                      |                            |   |
|   | (X4) ID<br>PREFIX<br>TAG                  | (EACH DEFICIENCY   | NTEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | BE.                  | (X5)<br>COMPLETION<br>DATE |   |
|   | F J d c c c c c c c c c c c c c c c c c c | dialysis days and time: up time: 3:00 p.m. (nar up time: 3:00 p.m. (nar (phone number of dialy Company: resident per every Mon, Wed, Fri [M Friday]."  The dialysis communic #114 was located in the nurse's station. The she documented the date, who the facility. There was different w | alysis Diagnosis: ESRD MON, WED, FRIDAY, pick me of dialysis center) //sis center) Transport sonal driver one time a day //onday, Wednesday,  ation book for Resident e chart rack behind the eets in the book rital signs, and a space for other from the facility and a enter to communicate with ocumentation in Resident cation book for the et, 6/25/2021, 6/16/2021, e/9/2021, 6/7/2021, Based on the physician's e every Monday, the following dialysis umentation: 5/28/2021, //28/2021, 7/16/2021, et's notes for June and #114 failed to evidence facility staff provided regarding Resident # 114 ff e plan dated 6/25/2021, cus: renal insufficiency or renal dialysis." The cumented in part, or and from dialysis Pick up time. (Number | F 69                | 8  |                      |                            |   |

| A. BUILDING  495391  B. WING  NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  1901 LIBBIE AVE   | COMPLETED  C 07/29/2021  (X5) COMPLETION |
|--|--|
| NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  | (X5)                                     |
| STREET ADDRESS, CITY, STATE, ZIP CODE  |  |
| RICHMOND, VA 23226   |  |
| (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION)  TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  | DATE                                     |
| Continued From page 159 company: Resident personal driver. Coordinate dialysis care with the dialysis treatment center. Dialysis: hemodialysis diagnosis: ESRD Dialysis days and time: Mon, Wed, Fr. Pick up time: 3:00 p.m. (name and address of dialysis center) (phone number of dialysis center) (phone number of dialysis center) Transport company: resident personal driver."  An interview was conducted with LPN #6 (licensed practical nurse) on 7/28/2021 at 12:14 p.m. When asked about the process followed when Resident #114 is sent to dialysis, LPN #6 stated she sends a brown bag snack and the communication book. When asked what's in the book, LPN #6 stated the top of the form list the vital signs, changes in the resident's condition, and medications given. LPN #6 stated the bottom of the form dialysis center will fill out. When asked if there should be a sheet with communication every time the resident goes to dialysis, LPN #6 stated, yes, the sheets are in the book.  An interview was conducted with LPN #3, the unit manager, on 7/28/2021 at 2:22 p.m. When asked about the process staff follows for a resident going to dialysis, LPN #3 stated, "Before the resident leaves the staff should get a set of vital signs (blood pressure, temperature, pulse and oxygen saturation). Each dialysis resident has a book and there are sheets in the book that the vital signs are written on. The book accompanies the resident to dialysis. When the resident returns from dialysis, the book is looked at to see if there is any communication from the dialysis center to us (facility), if new medications, orders, pre and post set of vital signs and weights. The nurse should note off on it." When asked where the sheets are kept, LPN #3 stated in the binder for |  |

|                          | ATEMENT OF DEFICIENCIES AD PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  |   | 1                   | TIPLE CONSTRUCTION<br>ING  |           | (X3) DATE SURVEY<br>COMPLETED |  |
|--------------------------|--|---|---------------------|--|-----------|-------------------------------|--|
|                          |  | 495391  | B. WING             |  |           | C<br>07/29/2021               |  |
|                          | PROVIDER OR SUPPLIER RNIE REHAB & NURSING  | CENTER  |                     | STREET ADDRESS, CITY, STATE, ZIP CODI<br>1901 LIBBIE AVE<br>RICHMOND, VA 23226 | E         | 0112312021                    |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY   | NTEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)  | ID<br>PREFI)<br>TAG | ( NOTION   | SHOULD BE | (X5)<br>COMPLETION<br>DATE    |  |
| 33 co co fo              | should call the dialysis LPN #3 was asked to f sheets for the dates mi documented above.  On 7/29/2021 at 9:07 a could not find any of the ASM (administrative staregional director of clinic the director of nursing, above concern on 7/28/No further information was References: (1) Barron's Dictionary of Non-Medical Reader, 5tl Chapman, page 266. (2) Barron's Dictionary of Non-Medical Reader, 5tl Chapman, page 124. (3) Barron's Dictionary of Non-Medical Reader, 5tl Chapman, page 43.  3. The facility staff failed order for dialysis and fail ommunication process wor Resident #173.  Resident #173 was admit 2/09/2020 with a readmith diagnoses that include end-stage renal disease emodialysis, atrial fibrillation. | ant. If they (dialysis) are not in the book we center to get it from them." ind any of the missing issing communication as a missing communication as a missing days.  The provided services, and ASM #2, were made aware of the 12021 at 5:07 p.m.  The provided prior to exit.  The medical Terms for the edition, Rothenberg and the edition, Rothenberg and the edition, Rothenberg and to obtain a physician ed to have a with the dialysis center a with the dialysis center tend to the facility on the dission on 12/26/2020 died but were not limited to requiring | F 6                 | 398  |           |                               |  |

| STATEMENT<br>AND PLAN (  | STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   | ĭ                   | E CONSTRUCTION   | (X3) DAT | TE SURVEY<br>MPLETED       |
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|                          |   | 495391  | B. WING             |  |          | С                          |
| 1                        | PROVIDER OR SUPPLIER  | CENTER  | 5                   | STREET ADDRESS, CITY, STATE, ZIP CODE 1901 LIBBIE AVE RICHMOND, VA 23226   | 1 07     | 7/29/2021                  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY  | ATEMENT OF DEFICIENCIES<br>MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTIO<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROPR<br>DEFICIENCY) | BE       | (X5)<br>COMPLETION<br>DATE |
| t a f f r s k k          | the atria of the heart of the ventricles and rest output and frequently of (1), high blood pressur reflux disease.  The most recent MDS assessment, a Medica assessment, a Medica assessment/discharge date of 12/28/2020 code scoring a "15" on the B mental status) score, in capable of making daily Section O - Special Tree Programs, coded the redialysis while a resident The review of the physisthe resident was in the reapplies of the clinical reapplies of the clinical reapplies of the clinical reapplies of the clinical reapplies of the clinical reapplies of the clinical reapplies of the clinical reapplies of the clinical reapplies of the clinical reapplies of the clinical received the clinical received the clinical received a dialysis order." Who cation of dialysis communication of dialysis | ausing irregular beats of alting in decreased heart clot formation in the atria) e, and gastroesophageal  (minimum data set) re five day assessment reference led Resident #173 as IMS (brief interview for adicating the resident was a cognitive decisions. In atments, Procedures and esident as receiving the ast the facility.  In a cord failed to evidence altysis for Resident #173.  Cord failed to evidence at the dialysis center for cord when a resident goes and the dialysis. ASM #2 was at #173's clinical record or dialysis. ASM #2 and stated, "I do not be a sked about the nunication for Resident couldn't find them in the | F 698               |  |          |                            |

| MAME OF PROVIDER OR SUPPLIER  CLEMBURNIE REHAB & NURSING CENTER  CLEMBURNIE REHAB & NURSING CENTER  SPECIAL MINMARY STATEMENT OF DEPOSITIONS BY PERCENT AND HER AND A STATEMENT OF DEPOSITIONS BY PERCENT AND HER AND A STATEMENT OF DEPOSITIONS BY PERCENT AND HER AND A STATEMENT OF DEPOSITIONS BY PERCENT AND HER AND A STATEMENT OF DEPOSITIONS BY PERCENT AND HER AND A STATEMENT OF DEPOSITIONS BY PERCENT AND HER AND A STATEMENT OF DEPOSITIONS BY PERCENT AND HER AND A STATEMENT OF DEPOSITIONS BY PERCENT AND HER AND A STATEMENT OF DEPOSITION BY PERCENT AND HER AND A STATEMENT OF THE ANY OFFICIAL STATEMENT OF THE ANY OFFI ANY |   | AND PLAN | NT OF DEFICIENCIES<br>OF CORRECTION                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER: | 1         | PLE CONSTRUCTION                      | (X3) DATE SURVEY<br>COMPLETED |            |   |
|--|---|----------|--|---|-----------|---------------------------------------|-------------------------------|------------|---|
| NAME OF PROVIDER OR SUPPLIER  GLENBURNIE REHAB & NURSING CENTER  SYMMARY STATEMENT OF DEPICENCIES  PRETRY TAG  SYMMARY STATEMENT OF DEPICENCIES  SYMMARY STATEMENT OF DEPICENCIES  FERRY TAG  SYMMARY STATEMENT OF DEPICENCIES  SYMMARY STATEMENT OF DEPICENCIES  FERRY TAG  SYMMARY STATEMENT OF DEPICENCIES  SYMMARY STATEMENT OF DEPICENCIES  FERRY TAG  CONTINUED FOR LIST OF THE APPROPRIATE  PRETRY TAG  CONTINUED FOR LIST OF THE APPROPRIATE  DEPICIENCY  References:  (1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 55.  4a. The facility staff failed to ensure Resident #80's dalysis AV Jerderovenous] shunt was assessed and checked for a Bruit and Thrill every shift according to the physician's orders.  Resident # 80's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 0822/2021, coded Resident # 80 as scoring a nine [9] on the brief interview for mental status (BMS) of a score of 0 - 15, nine - being moderately impaired of cognition for making daily decisions, Section "O Special Treatments, Procedures and Programs" coded Resident # 80 for "Dialysis" while a resident.  The POS (physician's order sheet) for Resident # 80 documental Chaplasis: Six for AV Jerterovenous] shunt Check Bruit [3] and Thrill [4] every shift. Start Date: 05/12/2021, The eTAR [electronic treatment administration record] for Resident # 80 dated June 2021  |   |          |  | A95301  |           |                                       |                               | С          |   |
| CLENBURNIER REHAB & NURSING CENTER  (M4) ID PREFEX TAG  SUMMARY STATEMENT OF DEPICIENCIES (EACH DEFICIENCY MUST REPRECEDED BY PILL)  PREFEX TAG  Continued From page 162 on 7729/2021 at 8:15 a.m.  No further information was provided prior to exit.  COMPLAINT DEFICIENCY  References:  (1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 55.  4a. The facility staff failed to ensure Resident #80's dialysis AV [arteriovenous] shunt was assessed and checked for a Bruit and Thrill every shift according to the physician's orders.  Resident # 80's most recent IMDS (minimum data set), a quarterly assessment with an ARD (assessment reference data) of 06/22/2021, coded Resident # 80 as scoring a nine [9] on the brief interview for mental status (BIMS) of a score of 0 - 15, nine - being moderately impaired of cognition for making daily decisions, Section "O Special Treatments, Procedures and Programs" coded Resident # 80 for "Dialysis" while a resident.  The POS [physician's order sheet] for Resident # 80 documented, "Dialysis: Site of AV [arteriovenous] shunt Check Bruit [5] and Thrill [4] every shift. Start Date: 06/412/2021.  The eTAR [electronic treatment administration record] for Resident # 80 dated June 2021   | 1 | NAME OF  | PROVIDER OR SUPPLIED                               | 433371  | B. WING _ |                                       | 0                             | 7/29/2021  |   |
| PRICE SHAPE A PURSING CENTER  SIBLIANT SYMERISM TO PERFICENCIES  (EACH DEFICIENCY MUST SEP PRECEDED BY PULL  REGULATORY OR LISC IDENTIFY AG INFORMATION)  F 698  Continued From page 162 on 7/29/2021 at 8:15 a.m.  No further information was provided prior to exit.  COMPLAINT DEFICIENCY  References: (1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 55, 4a. The facility staff falled to ensure Resident #80's dialysis AV [arteriovenous] shunt was assessed and checked for a Bruit and Thrill every shift according to the physician's orders.  Resident #80's most recent MDS (minimum data stage kidney disease [1], heart disease and stroke.  Resident #80's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 06/22/2021, coded Resident #80 as scoring a nine [9] on the brief interview for mental status (BIMS) of a score of 0 - 15, nine - being moderately impaired of cognition for making daily decisions, Section "O Special Treatments, Procedures and Programs" coded Resident #80 for "Dialysis" while a resident.  The POS [physician's order sheet] for Resident #80 documented, "Dialysis: Sile of AV larteriovenous] shunt Check Bruit [3] and Thrill [4] every shift. Start Date, 05/12/2021."   | İ |          | THOUBER ON SUFFEICH                                |   | 1         | STREET ADDRESS, CITY, STATE, ZIP CODE |                               |            |   |
| SUMMARY STATEMENT OF DESICIENCIES PREFEX TAG  SUMMARY STATEMENT OF DESICIENCIES PREFEX TAG  SUMMARY STATEMENT OF DESICIENCIES PREFEX TAG  CONLINUED FROM THE PROPERTY OF TAG  CROSS-REFERENCIENCY  References; (1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 55. 4a. The facility staff failed to ensure Resident #80's dialysis AV [arteriovenous] shunt was assessed and checked for a Bruit and Thrill every shift according to the physician's orders.  Resident #80's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 06/22/2021, coded Resident #80's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 08/22/2021, coded Resident #80's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 08/22/2021, coded Resident #80's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 08/22/2021, coded Resident #80's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 08/22/2021, coded Resident #80's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 08/22/2021, coded Resident #80's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 08/22/2021, coded Resident #80's for "Dialysis" while a resident.  The POS [physicins' order sheet] for Resident # 80 documented, "Dialysis: Site of AV [arteriovenous] shunt Check Bruit [3] and Thrill [4] every shift. Start Date: 05/12/2021.  The ETAR [electronic treatment administration record] for Resident #80 dated June 2021  | ı | GLENB    | URNIE REHAB & NURSING                              | CENTER  |           | 1901 LIBBIE AVE                       |                               |            |   |
| PREFIX TAG  TAG  REQULATORY OR LSC IDENTIFYING INFORMATION)  F 698  Continued From page 162 on 7/29/2021 at 8:15 a.m.  No further information was provided prior to exit.  COMPLAINT DEFICIENCY  References: (1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 55. 4a. The facility staff failed to ensure Resident #80's dalysis AV [arteriovenous] shunt was assessed and checked for a Bruit and Thrill every shift according to the physician's orders.  Resident #80's was admitted to the facility with diagnoses included but were not limited to end stage kidney disease [1], heart disease and stroke.  Resident #80's most recent MDS (minimum data set), a quarferly assessment reference date) of 06/22/2021, coded Resident #80 as scoring a nine [9] on the brief interview for mental status (BIMS) of a score of 0 - 15, nine - being moderately impaired of cognition for making daily decisions. Section "0 Special Treatments, Procedures and Programs" coded Resident #80 for "Dialysis' while a resident.  The POS [physician's order sheet] for Resident #80 documented, "Dialysis: Site of AV [arteriovenous] shunt Check Bruit [3] and Thrill [4] every shift. Start Date: 05/412/2021.  The aTAR [electronic treatment administration record] for Resident #80 dated June 2021  | ŀ |          |  |   |           | RICHMOND, VA 23226                    |                               |            |   |
| F 698  Continued From page 162 on 77/29/2021 at 8:15 a.m.  No further information was provided prior to exit.  COMPLAINT DEFICIENCY References: (1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 55. 4a. The facility staff failed to ensure Resident #80's dialysis AV [arteriovenous] shunt was assessed and checked for a Bruit land Thrill every shift according to the physician's orders.  Resident #80's admitted to the facility with diagnoses included but were not limited to end stage kidney disease [1], heart disease and stroke.  Resident #80's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 06/22/2021, coded Resident #80 as scoring a nine [9] on the brief interview for mental status (BIMS) of a score of 0 - 15, nine - being moderately impaired of cognition for making daily decisions, Section "O Special Treatments, Procedures and Programs" coded Resident #80 for "Dialysis" while a resident.  The POS [physician's order sheet] for Resident #80 documented, "Dialysis: Site of AV [arteriovenous] shunt Check Bruit [3] and Thrill [4] every shift. Start Date: 05/12/2021."  The aTAR [electronic treatment administration record] for Resident #80 dated June 2021   | l |          | SUMMARY STA  | TEMENT OF DEFICIENCIES                                |           | PROVIDER'S PLAN OF CORRECTION         |                               | (X5)       | - |
| F 698 Continued From page 162 on 7/29/2021 at 8:15 a.m.  No further information was provided prior to exit.  COMPLAINT DEFICIENCY References: (1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 55. 4a. The facility staff failed to ensure Resident #80's dialysis AV [arteriovenous] shunt was assessed and checked for a Bruit and Thrill every shift according to the physician's orders.  Resident #80 was admitted to the facility with diagnoses included but were not limited to end stage kidney disease [1], heart disease and stroke.  Resident #80's most recent MDS (minimum data set), a quarterly assessment with an APD (assessment reference date) of 06/22/2021, coded Resident #80 as scoring a nine [9] on the brief interview for mental status (BIMS) of a score of 0 - 15, nine - being moderately impaired of cognition for making daily decisions. Section *0 Special Treatments, Procedures and Programs" coded Resident #80 for "Dialysis" while a resident.  The POS [physician's order sheet] for Resident #80 documented, "Dialysis: Site of AV [arteriovenous] shunt Check Bruit [3] and Thrill [4] every shift. Start Date: 05/12/2021.*  The eTAR [electronic treatment administration record] for Resident #80 dated June 2021  |   |          | REGULATORY OR L                                    | SC IDENTIFYING INFORMATION)                           |           | (EACH CORRECTIVE ACTION SHOULD B      | E<br>TE                       | COMPLETION | 1 |
| on 7/29/2021 at 8:15 a.m.  No further information was provided prior to exit.  COMPLAINT DEFICIENCY  References:  (1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 55.  4a. The facility staff failed to ensure Resident #80's dialysis AV [arteriovenous] shunt was assessed and checked for a Bruit and Thrill every shift according to the physician's orders.  Resident # 80 was admitted to the facility with diagnoses included but were not limited to end stage kidney disease [1], heart disease and stroke.  Resident # 80's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 06/2/2/2021, coded Resident # 80 as scoring a nine [9] on the brief interview for mental status (BIMS) of a score of 0 - 15, nine - being moderately impaired of cognition for making daily decisions, Section "O Special Treatments, Procedures and Programs" coded Resident # 80 for "Dialysis" while a resident.  The POS [physician's order sheet] for Resident # 80 documented, "Dialysis: Site of AV [arteriovenous] shunt Check Bruit [3] and Thrill [4] every shift. Start Date: 05/12/2021.  The eTAR [electronic treatment administration record] for Resident # 80 dated June 2021   | ŀ |          |  |   |           |                                       |                               |            |   |
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| Resident # 80's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 06/22/2021, coded Resident # 80 as scoring a nine [9] on the brief interview for mental status (BIMS) of a score of 0 - 15, nine - being moderately impaired of cognition for making daily decisions. Section "O Special Treatments, Procedures and Programs" coded Resident # 80 for "Dialysis" while a resident.  The POS [physician's order sheet] for Resident # 80 documented, "Dialysis: Site of AV [arteriovenous] shunt Check Bruit [3] and Thrill [4] every shift. Start Date: 05/12/2021."  The eTAR [electronic treatment administration record] for Resident # 80 dated June 2021  |   |          |  | ], heart disease and                                  |           |                                       |                               |            | 1 |
| set), a quarterly assessment with an ARD (assessment reference date) of 06/22/2021, coded Resident # 80 as scoring a nine [9] on the brief interview for mental status (BIMS) of a score of 0 - 15, nine - being moderately impaired of cognition for making daily decisions. Section "O Special Treatments, Procedures and Programs" coded Resident # 80 for "Dialysis" while a resident.  The POS [physician's order sheet] for Resident # 80 documented, "Dialysis: Site of AV [arteriovenous] shunt Check Bruit [3] and Thrill [4] every shift. Start Date: 05/12/2021."  The eTAR [electronic treatment administration record] for Resident # 80 dated June 2021  |   |          | stroke.  |   |           |                                       |                               |            | l |
| set), a quarterly assessment with an ARD (assessment reference date) of 06/22/2021, coded Resident # 80 as scoring a nine [9] on the brief interview for mental status (BIMS) of a score of 0 - 15, nine - being moderately impaired of cognition for making daily decisions. Section "O Special Treatments, Procedures and Programs" coded Resident # 80 for "Dialysis" while a resident.  The POS [physician's order sheet] for Resident # 80 documented, "Dialysis: Site of AV [arteriovenous] shunt Check Bruit [3] and Thrill [4] every shift. Start Date: 05/12/2021."  The eTAR [electronic treatment administration record] for Resident # 80 dated June 2021  |   |          | Resident # 80's most re                            | cent MDS (minimum data                                |           |                                       |                               |            | l |
| coded Resident # 80 as scoring a nine [9] on the brief interview for mental status (BIMS) of a score of 0 - 15, nine - being moderately impaired of cognition for making daily decisions. Section "O Special Treatments, Procedures and Programs" coded Resident # 80 for "Dialysis" while a resident.  The POS [physician's order sheet] for Resident # 80 documented, "Dialysis: Site of AV [arteriovenous] shunt Check Bruit [3] and Thrill [4] every shift. Start Date: 05/12/2021."  The eTAR [electronic treatment administration record] for Resident # 80 dated June 2021  |   |          | set), a quarterly assessm                          | ent with an ARD                                       |           |                                       |                               |            |   |
| brief interview for mental status (BIMS) of a score of 0 - 15, nine - being moderately impaired of cognition for making daily decisions. Section "O Special Treatments, Procedures and Programs" coded Resident # 80 for "Dialysis" while a resident.  The POS [physician's order sheet] for Resident # 80 documented, "Dialysis: Site of AV [arteriovenous] shunt Check Bruit [3] and Thrill [4] every shift. Start Date: 05/12/2021."  The eTAR [electronic treatment administration record] for Resident # 80 dated June 2021   |   |          | (assessment reference                              | date) of 06/22/2021,                                  | 1         |                                       |                               |            | L |
| of 0 - 15, nine - being moderately impaired of cognition for making daily decisions. Section "O Special Treatments, Procedures and Programs" coded Resident # 80 for "Dialysis" while a resident.  The POS [physician's order sheet] for Resident # 80 documented, "Dialysis: Site of AV [arteriovenous] shunt Check Bruit [3] and Thrill [4] every shift. Start Date: 05/12/2021."  The eTAR [electronic treatment administration record] for Resident # 80 dated June 2021   |   |          | coded Resident # 80 as                             | scoring a nine [9] on the                             |           |                                       |                               |            |   |
| cognition for making daily decisions. Section "O Special Treatments, Procedures and Programs" coded Resident # 80 for "Dialysis" while a resident.  The POS [physician's order sheet] for Resident # 80 documented, "Dialysis: Site of AV [arteriovenous] shunt Check Bruit [3] and Thrill [4] every shift. Start Date: 05/12/2021."  The eTAR [electronic treatment administration record] for Resident # 80 dated June 2021  |   | 1        | brief interview for menta                          | I status (BIMS) of a score                            |           |                                       |                               |            |   |
| Special Treatments, Procedures and Programs" coded Resident # 80 for "Dialysis" while a resident.  The POS [physician's order sheet] for Resident # 80 documented, "Dialysis: Site of AV [arteriovenous] shunt Check Bruit [3] and Thrill [4] every shift. Start Date: 05/12/2021."  The eTAR [electronic treatment administration record] for Resident # 80 dated June 2021   |   |          | of 0 - 15, nine - being me                         | oderately impaired of                                 | 1         |                                       | -                             |            | ı |
| coded Resident # 80 for "Dialysis" while a resident.  The POS [physician's order sheet] for Resident # 80 documented, "Dialysis: Site of AV [arteriovenous] shunt Check Bruit [3] and Thrill [4] every shift. Start Date: 05/12/2021."  The eTAR [electronic treatment administration record] for Resident # 80 dated June 2021  |   | - 1      | cognition for making dail                          | y decisions. Section "O                               |           |                                       |                               |            | ı |
| resident.  The POS [physician's order sheet] for Resident # 80 documented, "Dialysis: Site of AV [arteriovenous] shunt Check Bruit [3] and Thrill [4] every shift. Start Date: 05/12/2021."  The eTAR [electronic treatment administration record] for Resident # 80 dated June 2021   |   |          |  |   |           |                                       |                               |            |   |
| The POS [physician's order sheet] for Resident # 80 documented, "Dialysis: Site of AV [arteriovenous] shunt Check Bruit [3] and Thrill [4] every shift. Start Date: 05/12/2021."  The eTAR [electronic treatment administration record] for Resident # 80 dated June 2021  |   | ľ        |  | Dialysis" while a                                     |           |                                       |                               |            |   |
| 80 documented, "Dialysis: Site of AV [arteriovenous] shunt Check Bruit [3] and Thrill [4] every shift. Start Date: 05/12/2021."  The eTAR [electronic treatment administration record] for Resident # 80 dated June 2021   |   |          |  | ,   |           |                                       |                               |            |   |
| [arteriovenous] shunt Check Bruit [3] and Thrill [4] every shift. Start Date: 05/12/2021."  The eTAR [electronic treatment administration record] for Resident # 80 dated June 2021  |   |          | The POS [physician's ord                           | der sheet] for Resident#                              |           |                                       |                               |            |   |
| every shift. Start Date: 05/12/2021."  The eTAR [electronic treatment administration record] for Resident # 80 dated June 2021   |   |          | 80 documented, "Dialysis                           | s: Site of AV   |           |                                       |                               |            |   |
| The eTAR [electronic treatment administration record] for Resident # 80 dated June 2021  |   |          | [arteriovenous] shunt Ch                           | eck Bruit [3] and Thrill [4]                          |           |                                       |                               |            |   |
| record] for Resident # 80 dated June 2021  |   |          | every shift. Start Date: 0                         | 5/12/2021."   |           |                                       |                               |            |   |
| record] for Resident # 80 dated June 2021  |   | 1        | The eTAR [electronic trea                          | atment administration                                 |           |                                       |                               |            |   |
| documented the above physician's order. Further  |   |          | record] for Resident # 80                          | dated June 2021                                       |           |                                       |                               |            |   |
|  |   | 1.       | documented the above pl                            | nysician's order. Further                             | 1         |                                       |                               |            |   |

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 08/10/2021 FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION. IDENTIFICATION NUMBER: A. BUILDING \_ COMPLETED 495391 B. WING 07/29/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1901 LIBBIE AVE **GLENBURNIE REHAB & NURSING CENTER** RICHMOND, VA 23226 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID ID PREFIX PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 698 Continued From page 163 F 698 review of the eTAR failed to evidence Resident # 80's bruit and thrill was checked on 06/05/21 and 06/06/21 on the 3:00 p.m. to 11:00 p.m. shift; 06/09/21, 06/12/21, 06/13/21, 06/17,21, 06/18/21 and on 06/26/21 on the 11:00 p.m. to 7:00 a.m. shift. The eTAR [electronic treatment administration record] for Resident # 80 dated July 2021 documented the above physician's order. Further review of the eTAR failed to evidence Resident # 80's bruit and thrill was checked on 07/04/21 and 07/05/21, 07/10/21, 07/12/21, 07/16/21, 07/21/21, 07/25/21 on the 3:00 p.m. to 11:00 p.m. shift; 07/04/21, 07/11/21, 07/16/21, and on 07/22,21 on the 11:00 p.m. to 7:00 a.m. shift. The facility's progress notes for Resident # 80 dated 06/01/21 through 07/27/2021 failed to evidence documentation that Resident # 80 bruit and thrill was check on the dates and times listed above on the eTARs for June and July 2021. On 07/28/21 at 11:33 a.m., an interview was conducted with LPN [licensed practical nurse] # 3, unit manager. After reviewing Resident # 80's

facilities."

eTARs dated June and July 2021, LPN # 3 was asked about the blanks on the on the dates and times listed above. LPN # 3 stated, "If it wasn't

According to the facility's "End-Stage Renal Disease, Care of a Resident With" revised September 2010, documents in part, "How information will be exchanged between the

On 07/28/2021 at approximately 5:00 p.m., ASM [administrative staff member] #1, director of

documented it wasn't done."

|                          | T OF DEFICIENCIES<br>OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   |         | PLE CONSTRUCTION  | (X3) DATE SURVEY<br>COMPLETED |                            |
|--------------------------|---|---|---------|---|-------------------------------|----------------------------|
|                          |   | 495391  | B. WING |   |                               | С                          |
| NAME OF                  | PROVIDER OR SUPPLIER  | 433331  | B. WING | STREET ADDRESS, CITY, STATE, ZIP CODE   | 07                            | 7/29/2021                  |
| GLENBU                   | IRNIE REHAB & NURSING   | CENTER  |         | 1901 LIBBIE AVE<br>RICHMOND, VA 23226   |                               |                            |
| (X4) ID<br>PREFIX<br>TAG | EFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL  |   |         | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD B<br>CROSS-REFERENCED TO THE APPROPRIA<br>DEFICIENCY) | E                             | (X5)<br>COMPLETION<br>DATE |
|                          | clinical services, ASM ASM # 4, medical dire the above concern.  No further information  References: [1] The last stage of ch is when your kidneys cobody's needs. This information the website: https://medlineplus.gov/ [2] Dialysis treats end-seremoves waste from your kidneys can no longer of (and other types of dialy of the kidneys when the information was obtained https://medlineplus.gov/00707.htm.  [3] & [4] There are two serial dialysis access site is fully staged your fingertips over a gentle vibration, which Another sign is when list a loud swishing noise we "bruit." If both of these serial normal, the graft is still information was obtained https://www.vascularheavisions/vascular-surgery-access/  4b. The facility staff failed | # 2, director of nursing and ctor, were made aware of was presented prior to exit.  ronic kidney disease. This an no longer support your armation was obtained  /ency/article/000500.htm.  stage kidney failure. It tur blood when your to their job. Hemodialysis /sis) does some of the job ey stop working well. This ed from the website: ency/patientinstructions/0  signs that indicate a inctioning well. When you in the site you should feel it is called a "thrill."  tening with a stethoscope ill be heard called a igns are present and in good condition. This is diffrom the website: Ithclinics.org/institutes-diand-medicine/dialysis-ac | F 69    | 3   |                               |                            |
| V                        | communication regarding with the dialysis center in and June 2021.  | Resident #80's care   |         |   |                               |                            |

| STATEMENT<br>AND PLAN C  | OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  | ŀ                   | PLE CONSTRUCTION  3  | (X3) DA | ATE SURVEY<br>OMPLETED     | - |
|--|--|--|---------------------|--|---------|----------------------------|---|
|  |  | 495391   | B. WING _           |  |         | C                          |   |
|  | PROVIDER OR SUPPLIER RNIE REHAB & NURSING  | CENTER   |                     | STREET ADDRESS, CITY, STATE, ZIP CODE 1901 LIBBIE AVE RICHMOND, VA 23226   |         | 07/29/2021                 |   |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIATE OF THE APPR | BE      | (X5)<br>COMPLETION<br>DATE |   |
| F b fa control of the | The POS [physician's of 80 documented, "Hemician ESRD Dialysis Days and Thursday and Saturday Dialysis Center: [Name Date: 05/13/2021."  The comprehensive candated 06/10/2020 documented 06/10/2020 documented of fistula/graff 04/16/2021." Under "Interest Dialysis three x's [times Dialysis Center and Add Thursday and Saturday 04/16/2021."  Review of facility's nurse 04/10/2021 through 07/04/20/21, 05/01/21, 05/00/26/26/21, 06/28/21 and congoing communication to the dialysis center state 04/20/21, 05/01/21, 05/01/21, 05/01/21, 05/01/21, 05/01/21, 06/26/21, 06/26/21 and concept of the dialysis of the di | order sheet] for Resident # odialysis [2] Diagnosis: and Time: Tuesday, y Pick up time: 9am of Dialysis Center]. Start  re plan for Resident #80's mented in part, "Renal chronic renal failure, cheatheter. Date Initiated: terventions/Tasks" ] a week at [Name of ress], Thursday, Date Initiated: e's notes dated 03/2021 failed to evidence facility staff provided regarding Resident #80 ff on 04/10/21, 04/17/21, 8/21, 05/11/21, 05/18/21, on 07/03/21.  s dialysis communication documentation from the s center on 04/10/21, /21, 05/08/21, 05/11/21, on 06/28/21. Further dialysis communication alysis communication tions for the facility staff 30's temperature, pulse, re, last pain medication | F 69                |  |         |                            |   |

|   |                                       | OF DEFICIENCIES<br>F CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   |                    | LTIPLE CONSTRUCTION<br>DING  |          |    | E SURVEY                   | Ì |
|---|---------------------------------------|--|--|--------------------|--|----------|----|----------------------------|---|
|   |                                       |  | 405004   |                    |  |          |    | С                          |   |
| I | NAME OF D                             | DO) (DED OF OURS) (==  | 495391   | B. WING            | B. WING  |          | 07 | /29/2021                   |   |
|   |                                       | ROVIDER OR SUPPLIER  RNIE REHAB & NURSING  | CENTER   |                    | STREET ADDRESS, CITY, STATE, ZIP CODE 1901 LIBBIE AVE RICHMOND, VA 23226 |          |    |                            |   |
|   | (X4) ID<br>PREFIX<br>TAG              | (EACH DEFICIENCY   | ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)   | ID<br>PREFI<br>TAG |  | HOULD BE |    | (X5)<br>COMPLETION<br>DATE |   |
|   | f f f f f f f f f f f f f f f f f f f | regarding the procedur communication forms. out the communication reviewing Resident #8 book for the missing dastated that the communication form dastated, "It should have asked who was respondialysis communication." The nurse taking care on 07/28/2021 at approcading the appropriate of the above concern.  No further information was the above concern.  No further information was the above concern.  Resident #59 was admit 1/27/21 with diagnoses the above concern with the desident #59.  Resident #59 was admit 1/27/21 with diagnoses the above concern with the desident #59.  Resident #59 was admit 1/27/21 with diagnoses the above concern with the desident #59.  Resident #59 was admit 1/27/21 with diagnoses the allowed the resident with the condition with the condition with the desident #59.  Resident #59 was admit 1/27/21 with diagnoses the allowed the resident with the condition with the condition with the condition with the condition with the diagnoses the allowed the resident with the condition with the con | refor a resident's dialysis LPN # 2 stated, "We fill sheet for each visit." After O's dialysis communication ates listed above, LPN # 2 nications sheets were not ed about the incomplete ated 07/03/21, LPN # 2 been completed." When sible for completing the forms, LPN # 2 stated, of the resident that day."  eximately 5:00 p.m., ASM mber] #1, director of 2, director of nursing and tor, were made aware of  tas presented prior to exit. It to evidence ongoing dialysis center for  ted to the facility on that included but were not itus (1), ESRD [end stage failure (inability of the lood to maintain normal and cerebrovascular  ninimum data set) 5 day assessment, with rence date) of 6/14/21, oring a 15 out of 15 on for mental status) score, | F                  | 698  |          |    |                            |   |

|                          | TATEMENT OF DEFICIENCIES<br>ND PLAN OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   |                     | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING  |     |                            |
|--------------------------|---|--|---------------------|---|-----|----------------------------|
|                          |   | 495391   |                     |   |     |                            |
|                          | PROVIDER OR SUPPLIER  RNIE REHAB & NURSING  | CENTER   |                     | STREET ADDRESS, CITY, STATE, ZIP CODE 1901 LIBBIE AVE RICHMOND, VA 23226  | 1 0 | 7/29/2021                  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY  | ATEMENT OF DEFICIENCIES<br>'MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROPR<br>DEFICIENCY) | BE  | (X5)<br>COMPLETION<br>DATE |
|                          | Section O: special tre was coded "Dialysis=  A review of the physicidocumented in part, "It Times: Tues [Tuesday Saturday pick up time dialysis."  A review was conducte "Dialysis Communicatidalysis binder at the nather forms in the binder 21 evidenced of the 21 6/10/21 through 7/27/2 missing forms for the dand 7/17/21.  An interview was conducted and 7/17/21.  An interview was conducted asked the purpose of the dialysis facility registed its to the dialysis facility registed with the fistula of symptoms of infection. It is back regarding any contreatment and weights."  On 7/27/21 at 11:11 AM standard of practice was ASM (administrative standirector of nursing stated and procedures." | atments and procedures: yes."  an orders dated 6/10/21, ESRD Dialysis Days and v], Thurs [Thursday], and 10:30 AM for 11:30 AM  and of Resident #59's on Forms" located in his ursing station. A review of from June 2021 and July dialysis treatments 1, there were three ates of 6/19/21, 6/26/21  acted on 7/28/21 at 11:40 practical nurse) #2. When the dialysis communication They provide information garding vital signs, any or shunt, any signs or They send information cerns during the dialysis  a, when asked what or followed in the facility, or followed in the facility, or follow our policies  ASM #1, the regional es, ASM #2, the director the Medical Director were | F 69                | 8   |     |                            |

|   | OF DEFICIENCIES<br>OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  | ,                   | PLE CONSTRUCTION   | (X3) DA | NO. 0938-039<br>TE SURVEY<br>MPLETED | ) [ |
|---|---|--|---------------------|--|---------|--------------------------------------|-----|
|   |   | 495391   | B. WING             |  |         | С                                    |     |
| NAME OF F                               | PROVIDER OR SUPPLIER  |  | -                   | STREET ADDRESS, CITY, STATE, ZIP CODE  | ] 0     | 7/29/2021                            | _   |
|   | RNIE REHAB & NURSING  |  |                     | 1901 LIBBIE AVE<br>RICHMOND, VA 23226  |         |                                      |     |
| (X4) ID<br>PREFIX<br>TAG                | (EACH DEFICIENCY  | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD I<br>CROSS-REFERENCED TO THE APPROPRI<br>DEFICIENCY) | 3E      | (X5)<br>COMPLETION<br>DATE           |     |
| ( ) ( ) ( ) ( ) ( ) ( ) ( ) ( ) ( ) ( ) | The facility policy, "End Care of a Resident with "Resident with end-sta will be care for according standards of care. 4. A facility and the contract all aspects of how the managed, including: He developed and impleme be exchanged between No further information with the facility and the contract of the standards of care. (1) Diabetes Mellitus - infunction normally in the of Medical Terms for the 5th edition, Rothenberg (2) End Stage Renal Diskidneys to excrete waste maintenance of electroly Dictionary of Medical Terms for the Reader, 5th edition, Rothenberg and Chapma (3) Heart failure: inability equirements. Barron's Efferms for the Non-Medical Requirements. Of the Non-Medical Reader, and Chapman, page 111. The facility staff failed | d-Stage Renal Disease, h," documented in part, ge renal disease (ESRD) ng to currently recognized agreements between this ted ESRD facility include resident's care will be ow the care plan will be ented, how information will the facility."  vas provided prior to exit.  ability of insulin to body. Barron's Dictionary e Non-Medical Reader, and Chapman, page 160. sease: inability of the es and function in the yte balance. Barron's rms for the Non-Medical henberg and Chapman, of the heart to pump n normal body Dictionary of Medical seal Reader, 5th edition, ean, page 259. Sent (CVA): abnormal corrhage or blockage of brain leads to a lack of ary of Medical Terms for 5th edition, Rothenberg .  to evidence | F 69                | 98   |         |                                      |     |
| a                                       | ommunication and coord<br>nd services for Resident  | dination of dialysis care #52 between the facility   |                     |  |         |                                      |     |

PRINTED: 08/10/2021 FORM APPROVED

|                          | STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  |   | (X2) MULTIF         | PLE CONSTRUCTION<br>G   | (X3) DAT       | (X3) DATE SURVEY<br>COMPLETED |  |
|--------------------------|---|---|---------------------|---|----------------|-------------------------------|--|
| 495391                   |   | B. WING   |                     | 07  | C<br>7/29/2021 |                               |  |
|                          | NAME OF PROVIDER OR SUPPLIER  GLENBURNIE REHAB & NURSING CENTER   |   |                     | STREET ADDRESS, CITY, STATE, ZIP CODE 1901 LIBBIE AVE RICHMOND, VA 23226  | 1 0,           | 72372021                      |  |
| (X4) IC<br>PREFIX<br>TAG | ( EACH DEFICIENCY   | ATEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD E<br>CROSS-REFERENCED TO THE APPROPRIA<br>DEFICIENCY) | E              | (X5)<br>COMPLETION<br>DATE    |  |
| F 69                     | and the dialysis center Resident #52 was most facility on 6/4/21 with the limited to sepsis, diabed dysphagia, insomnia, spressure, end stage reand COVID-19. The material Data Set) was a quarted with an ARD (Assessme 6/9/21. The resident was cognitively impaired in decisions.  A review of the clinical physician's order dated Diagnosis: ESRD (End Dialysis days and time: Friday. Pick up time: 11 (name, address, phone transportation company documented)."  A review of the dialysis revealed forms on which | st recently readmitted to the he diagnoses of but not bees, stroke, dysphasia, seizures, high blood and disease, pacemaker, oost recent MDS (Minimum berly / 5-day assessment been Reference Date) of as coded as severely ability to make daily life as coded as severely ability to make daily life as coded as severely ability to make daily life as coded as severely ability to make daily life arecord revealed a 6/28/21 for "Hemodialysis Stage Renal Disease). Monday, Wednesday, 1:30am. Dialysis Center: number, and contact was a communication log in the facility was to form the following information alysis center review prior ital signs, blood sugar, en, wound sites, special comments.  Form, the dialysis center facility to review upon blowing information: Presigns, post dialysis uration of treatment, | F 694               |   |                |                               |  |

| AND    | MENT OF DEFICIENCIES LAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  (X2) MULTIPLE CONSTRUCTION A. BUILDING  |   | (X3) DATE SURVEY<br>COMPLETED |   |                        |                            |
|--------|---|---|-------------------------------|---|------------------------|----------------------------|
| 495391 |   | B. WING _   |                               | 07  | C<br>// <b>29/2021</b> |                            |
|        | ME OF PROVIDER OR SUPPLIER  ENBURNIE REHAB & NURSING  |   |                               | STREET ADDRESS, CITY, STATE, ZIP CODE 1901 LIBBIE AVE RICHMOND, VA 23226  | 1 07                   | 12912021                   |
| PI     | REFIX (EACH DEFICIENC   | TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG           | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD E<br>CROSS-REFERENCED TO THE APPROPRIA<br>DEFICIENCY) | BE.                    | (X5)<br>COMPLETION<br>DATE |
| •      | Resident #52 revealed July 2, 2021 - there we documentation from each July 7, 2021 - the dial document on the commodata for the facility. July 8, 2021 - the dial document on the commodata for the facility. July 16, 2021 - the dial document on the commodata for the facility. July 19, 2021 - there we documentation from each July 23, 2021 - the dial document on the commodata for the facility. July 28, 2021 - the facility for the communication logically sis center.  On 7/29/21 at 10:44 All conducted with RN #4 (asked about the purpose communication log, she document and report to change of condition, vit | is log for July 2021 for d the following:  as no communication log sither facility to the other. It is senter did not munication log pertinent was center did not munication log pertinent was no communication log ther facility to the other. It is center did not munication log pertinent was no communication log ther facility to the other. It is center did not munication log pertinent was center did not munication log pertinent was Registered Nurse). When see of the dialysis estated it was to or from dialysis any al signs, weights, or are and treatment. RN #4 were no changes in set, that at the very least, endocumented by both an interview was (Licensed Practical out the purpose of the | F 69                          | 8   |                        |                            |

|    | EMENT OF DEFICIENCIES<br>PLAN OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  | (X2) MULTIPLE CONSTRUCTION A. BUILDING |  | (X3) DATE SURVEY<br>COMPLETED |  |
|----|--|---|--|--|-------------------------------|--|
|    | 495391   |   | B. WING                                | 0  |                               |  |
|    | E OF PROVIDER OR SUPPLIER  ENBURNIE REHAB & NURSING  | DER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  |  | 07/29/2021   |                               |  |
| PF | EFIX (EACH DEFICIENC)  | ATEMENT OF DEFICIENCIES<br>/ MUST BE PRECEDED BY FULL<br>.SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG                    | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)   |                               |  |
| F7 | dialysis center. When left blank, and how eit vitals and weights wer stated, "They won't kn A review of the comprevealed one dated 11 insufficiency related to presence of fistula/gra included an interventic "Coordinate dialysis catreatment center."  On 7/29/21 at 8:45 AM Clinical Services, Director (Administrative #2, and #3 respectively findings. ASM #1 state identified that the compcommunication log was information was provide survey.  Posted Nurse Staffing II CFR(s): 483.35(g)(1)-(4 §483.35(g)(1) Data required passis: (i) Facility name. (ii) The current date. | communicating the and weight to and from the asked about logs that were her facility knew what the e for Resident #52, LPN # 7 ow."  The ensive care plan /30/20 for "Renal chronic renal failure, ft/catheter." This care plan in dated 11/30/20 for are with the dialysis  The Regional Director of the dialysis as the facility were made aware of the dialytic approach to fail to fail the dialysis as a problem. No further end by the end of the information.  The facility information and adily discontinuously and the actual hours worked the sof licensed and | F 69                                   | F732: Posted Nurse Staff Inform  1. Facility staffing schedule has bee posted.  2. All residents have the potential to affected by this alleged deficient practice. Regional Director of Clin Services verified the staffing sched was posted during the duration of survey. | en be ical                    |  |

| NAME OF PROVIDER OR SUPPLIER  GLENBURNIE REHAB & NURSING CENTER    SUMMARY STATEMENT OF DEFICIENCIES   1901 LIBBIE AVE   RICHMOND, VA 23228  | STATEMENT<br>AND PLAN | EMENT OF DEFICIENCIES PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  (X2) MULTIPLE CONSTRUCTION A. BUILDING  |   | (X3) DATE SURVEY<br>COMPLETED |   |  |   |
|--|-----------------------|---|---|-------------------------------|---|--|---|
| STREET ADDRESS, CITY, STATE, 2IP CODE   1901 LIBBIE AVE   STREET ADDRESS, CITY, STATE, 2IP CODE   1901 LIBBIE AVE   RICHMOND, VA 23226   | 495391                |   | B. WING   |                               |   |  |   |
| SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG  |                       |   |   | 1                             | STREET ADDRESS SITV STATE 7/D CODE  | 07/29/2021   |   |
| FREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION)  F732  Continued From page 172 (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census.  \$483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors.  \$483.35(g)(3) Public access to posted nurse staffing data available to the public for review at a cost not to exceed the community standard.  \$483.35(g)(4) Facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.  This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and facility | GLENBU                | JRNIE REHAB & NURSING   | CENTER  |                               | 1901 LIBBIE AVE   |  |   |
| (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census.  §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors.  §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.  §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.  This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and facility               | PREFIX                | (EACH DEFICIENCY  | MUST BE PRECEDED BY FULL  | PREFIX                        | (EACH CORRECTIVE ACTION SHOULD E<br>CROSS-REFERENCED TO THE APPROPRIA   | BE COMPLETION  | 1 |
| facility staff failed to post nurse staffing information. The facility staff failed to post nurse staffing information on 7/27/21 and on 7/28/21, during the morning.  The findings include:  On 7/27/21 at 11:05 a.m., 7/27/21 at 3:25 p.m. and 7/28/21 at 8:01 a.m., a tour of the facility and observations including the lobby failed to reveal  |                       | (B) Licensed practical vocational nurses (as of (C) Certified nurse aide (iv) Resident census.  §483.35(g)(2) Posting (i) The facility must possible specified in paragraph daily basis at the begin (ii) Data must be poster (A) Clear and readable (B) In a prominent place residents and visitors.  §483.35(g)(3) Public actified at a the facility written request, make in available to the public for exceed the community services (B) (B) Facility direction and the facility and requirements. The facility posted daily nurse staffing the months, or as required is greater.  This REQUIREMENT is by:  Based on observation, services and services (B) (B) (B) (B) (B) (B) (B) (B) (B) (B) | nurses or licensed defined under State law). es.  requirements. st the nurse staffing data (g)(1) of this section on a ning of each shift. d as follows: format. e readily accessible to excess to posted nurse y must, upon oral or urse staffing data or review at a cost not to standard.  eata retention by must maintain the nig data for a minimum of each by State law, whichever not met as evidenced estaff interview and facility determined that the enurse staffing staff failed to post nurse (27/21 and on 7/28/21, 7/27/21 at 3:25 p.m. a tour of the facility and | F 73                          | educate Staffing Coordinator and present in facility, the backup statemember will post the staff schedular The staffing schedule must be postable and the staffing schedule must be postable at the front desk.  4. Administrator or designee will staffing assignment is posted a front desk weekly times 4 weeks amonthly times 2. Any identified is will be immediately corrected. Rewill be reported to Quality Assurate committee for analysis and revision months.  5. Date of compliance will be Aug | if not ff file. sted verify at the and ssues sults ance on x 3 |   |

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 08/10/2021 FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING COMPLETED 495391 B. WING 07/29/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1901 LIBBIE AVE **GLENBURNIE REHAB & NURSING CENTER** RICHMOND, VA 23226 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) COMPLETION **PREFIX** PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 732 Continued From page 173 F 732 posting of the nurse staffing information. On 7/28/21 at 9:11 a.m., an interview was conducted with OSM (other staff member) #5 (the staffing coordinator). OSM #5 stated each day when she comes to the facility, she is supposed to look at the schedule for the day, document information on the nurse staffing form and post the form in the front lobby. OSM #5 stated she did not arrive to the facility until 1:00 p.m. on 7/27/21 and did not post nurse staffing information that day. OSM #5 stated she arrived late to the facility on this date (7/28/21) and had completed the form but had not posted the form. OSM #5 stated there was not a backup person to complete this task when she is not in the facility. On 7/28/21 at 4:52 p.m., ASM (administrative staff member) #1 (the regional director of clinical services) and ASM #2 (the director of nursing) were made aware of the above concern. The facility policy titled, "Posting Direct Care Daily Staffing Numbers" documented, "Our facility will post, on a daily basis for each shift, the number of nursing personnel responsible for providing direct care to residents." No further information was presented prior to exit. F 755 Pharmacy Srvcs/Procedures/Pharmacist/Records F 755 F755: Pharmacy SS=E CFR(s): 483.45(a)(b)(1)-(3)

§483.45 Pharmacy Services

The facility must provide routine and emergency

drugs and biologicals to its residents, or obtain

§483.70(g). The facility may permit unlicensed personnel to administer drugs if State law

them under an agreement described in

Records

appropriately.

Services/Procedures/Pharmacist

1.Expired Medication has been removed

from medication rooms and disposed of

| STATEMENT<br>AND PLAN C  | OF DEFICIENCIES<br>F CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  | PLIER/CLIA (X2) MULTIPLE CONSTRUCTION NUMBER: A. BUILDING |  |  | (X3) DAT                    | E SURVEY<br>IPLETED        |
|--|--|--|---|--|--|-----------------------------|----------------------------|
|  | 495391   |  | B. WING   |  |  | 07                          | C                          |
|  | ROVIDER OR SUPPLIER RNIE REHAB & NURSING   | CENTER   |   | 1                                      | STREET ADDRESS, CITY, STATE, ZIP CODE 1901 LIBBIE AVE RICHMOND, VA 23226   | 07                          | 7/29/2021                  |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG                                       | <                                      | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)   | E<br>FE                     | (X5)<br>COMPLETION<br>DATE |
| is constitution of the con | sa licensed nurse.  §483.45(a) Procedures pharmaceutical service that assure the accurat dispensing, and adminibiologicals) to meet the §483.45(b) Service Comust employ or obtain the pharmacist whosaspects of the provision the facility.  §483.45(b)(1) Provides aspects of the provision the facility.  §483.45(b)(2) Establisher eccipt and disposition of sufficient detail to enable econciliation; and g483.45(b)(3) Determined and periods maintained and periods in security: | A facility must provide is (including procedures e acquiring, receiving, istering of all drugs and needs of each resident.  Insultation. The facility he services of a licensed  consultation on all of pharmacy services in es a system of records of of all controlled drugs in e an accurate  es that drug records are in not of all controlled drugs ically reconciled.  not met as evidenced  taff interview and facility determined the facility ired medication was lable for use in one of the Bradford unit | F 7   | 11 a a a a a a a a a a a a a a a a a a | 2.All residents have the potential affected by this alleged deficient practice. Nursing management will audit the expiration dates on medications in the medication roothe medication carts and will discard any identified expired.  3.DON or designee will educate all nursing staff on medications being discarded appropriately from Medicand/or Medicand room when expired.  4.DON or designee will audit Medicand Medicand rooms weekly times 4 we and monthly times 2 to ensure medication is not expired. Any dentified issues will be immediate orrected. Results will be reported quality Assurance committee for malysis and revision x 3 months.  Date of compliance will August 2021. | m and ard  Cart  Carts eeks |                            |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |   |   | TIPLE CONSTRUCTION NG | (X3) DATE SURVEY COMPLETED C   |    |                            |
|--|---|---|-----------------------|--|----|----------------------------|
|  |   |   |                       |  |    |                            |
| NAME OF PROVIDER OR SUPPLIER  GLENBURNIE REHAB & NURSING CENTER                                      |   |   | B. WING               |  | 07 | /29/2021                   |
|  |   |   |                       | STREET ADDRESS, CITY, STATE, ZIP CODE 1901 LIBBIE AVE RICHMOND, VA 23226                                       |    |                            |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIENCY  | ATEMENT OF DEFICIENCIES<br>MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG   | PROVIDER'S PLAN OF CORRECTION ( (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) |    | (X5)<br>COMPLETION<br>DATE |
| f * ( ) b h p ir O   | following medications refrigerator in the mediuse:  *2000 ml (milliliters) ba nutrition) solution - expresident on the label ha *Six bags of 100 cc (cu with Penicillin G (used by bacteria) (1) 4 mg (rexpired on 7/24/2021 still in the facility.  *Two bags of 100 cc of Meropenem (used to the (stomach area) infection of surround the brain and (grams)/100 ml - expired on 7/26/2021 - acility.  Three bags of 100 cc of expired on 7/26/2021 - acility.  Three bags of 100 cc of expired on 7/26/2021 - acility.  Three bags of 100 cc of expired on 7/26/2021 - acility.  Three bags of 100 cc of expired on 7/26/2021 - acility.  Three bags of 100 cc of expired on the label was still in the factoria including skin, the eart valve, respiratory incumonia], biliary tractifications.) (3) - expired on the label was still in the four bags of 0.9% Normal Meropenem 2 gm/100 million the label was still in the resident on the label on 7/29/2021 at 9:35 a.r. | e of the Bradford unit 29/2021 at 9:23 a.m. The were located in the cation room available for  g of TPN (total parental ired on 7/22/2021 -the ad been discharged. bic centimeter) of dextrose to treat infections caused milligrams) per 50 ml - Resident on the label was  10.9% Normal Saline with eat skin and abdominal as caused by bacteria and the membranes that spinal cord.) (2) 2 gm d on 7/23/2021. Resident the facility. dextrose with Penicillin G resident was still in the of dextrose with Cefazolin fections caused by pone, joint, genital, blood, tract [including tract [including tract and urinary tract the facility. mal Saline with al - expired on 7/25/2021. I was still in the facility. | F7                    |  |    |                            |
| L  | PN #6, LPN #2 and LPI   | N #9. When asked why  |                       | III  |    |                            |

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 08/10/2021 CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391

|        |  | OF DEFICIENCIES<br>F CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  |                            | TIPLE CONSTRUCTION ING   |      | (X3) DATE SURVEY<br>COMPLETED |  |
|--------|--|---|--|----------------------------|--|------|-------------------------------|--|
| 405204 |  |   |  | С                          |  |      |                               |  |
|        | NAME OF D  | DOVIDED OF GUIDBUIED  | 495391   | B. WING                    |  | 0    | 7/29/2021                     |  |
|        | GLENBU   | ROVIDER OR SUPPLIER RNIE REHAB & NURSING  |  |                            | STREET ADDRESS, CITY, STATE, ZIP CODE  1901 LIBBIE AVE  RICHMOND, VA 23226 | CODE |                               |  |
|        | (X4) ID<br>PREFIX<br>TAG   | REFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE  |  | (X5)<br>COMPLETION<br>DATE |  |      |                               |  |
|        | the state of the s | pharmacy sends them the refrigerator. LPN # normally sends extras about the process staf an IV medication, LPN rights of medication act the expiration date. Why process followed for repharmacy, LPN #3 state allows pick up of return Mondays and Thursday the amount of boxed up returned at one time, the the box is too heavy; the will not take it. LPN #2 drop the boxes of medicand was told they were LPN #9 stated this unit have many discharges many medications that charmacy.  The facility policy, "Stor documented in part, "4. discontinued, outdated, piologicals. All such drughed dispensing pharmacy.  ASM (administrative stategional director of clinic the director of nursing, valoue findings on 7/29/20. | pried IV (intravenous) rigerator, LPN #3 stated the and the staff throw them in the staff throw them in the staff throw them in the staff throw them in the staff throw them in the staff throw them in the staff throw them in the staff of them. When asked follows for administration the stated they do the six diministration and check for the asked about the the sturning medications to the ted the pharmacy only the medications on the pharmacy also limits the pharmacy staff member that stated she had offered to the cation off to the pharmacy the skilled unit and they the each day and there are so the need to be returned to the the staff member the facility shall not use or deteriorated drugs or the staff member to the staff member) #1, the the staff services and ASM #2, the staff staff throw the staff member) #1, the the staff services and ASM #2, the staff member of the | F                          | 755  |      |                               |  |
|        | 117  | COLOTORIOGS,  |  |                            |  |      | ı I                           |  |

(1) This information was obtained from the

FORM APPROVED

|   |                          | TEMENT OF DEFICIENCIES D PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  A. BUILDING   |  |                     | (X3) DATE SURVEY<br>COMPLETED   |                |                            |
|---|--------------------------|--|--|---------------------|---|----------------|----------------------------|
| NAME OF PROVIDER OR SUPPLIER  GLENBURNIE REHAB & NURSING CENTER |                          | 495391   | B. WING _  | 2                   | 07  | C<br>'/29/2021 |                            |
|   |                          |  | STREET ADDRESS, CITY, STATE, ZIP CODE 1901 LIBBIE AVE RICHMOND, VA 23226   |                     | , and , and an I  |                |                            |
| -   | (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY   | NTEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)   | E<br>TE        | (X5)<br>COMPLETION<br>DATE |
|   | SS=D                     | following website: https://medlineplus.gov tml (2) This information wa following website: https://medlineplus.gov tml (3) This information wa following website: https://medlineplus.gov tml Drug Regimen is Free f CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessar Each resident's drug re unnecessary drugs. An drug when used- §483.45(d)(1) In excess duplicate drug therapy); §483.45(d)(2) For exces §483.45(d)(3) Without a §483.45(d)(4) Without a g483.45(d)(5) In the pre | as obtained from the |                     | F757: Drug Regimen is Free from Unnecessary Drugs  1. Resident #27 continues to reside facility with the pain medication administration only after non-pharmacological interventions have been utilized and administered appropriately following MD order. Resident #114 has been discharged the facility.  2. All residents have the potential to affected by this alleged deficient practice. Nursing management will audit for non-pharmacological interventions implemented prior to administering prn pain medication.  3. DON or designee will educate all nursing staff on implementing non-pharmacological interventions prior administering prn pain medications | in the         |                            |

|                          | T OF DEFICIENCIES<br>OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   | (X2) MULTIPLE CONSTRUCTION A. BUILDING  B. WING |  | (X3) DATE SURVEY<br>COMPLETED   |
|--------------------------|---|---|---|--|---------------------------------|
|                          |   | 495391  |   |  | С                               |
| NAME OF                  | PROVIDER OR SUPPLIER  | 40001   |   | STREET ADDRESS, CITY, STATE, ZIP CODE  | 07/29/2021                      |
| GLENBL                   | IRNIE REHAB & NURSING   | CENTER  | 1   | 1901 LIBBIE AVE<br>RICHMOND, VA 23226  |                                 |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY  | ITEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG                             | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATION DEFICIENCY)  |                                 |
| i<br>i<br>c<br>e<br>e    | Based on staff intervie and review of facility d staff failed to ensure the two of 49 sampled resist Resident #27) was free medications.  1. The facility staff adminedication Hydrocodor Resident #114, for pair physician ordered para (8-10) and failed to atteinterventions prior to admedication.  2. Resident #27 receive 1% (topical analgesic) moderate pain, when pair moderate pain, when pair to include:  1. Resident # 114 was a 5/27/2021 with a recent with diagnoses that include: end stage renal disease hemodialysis (a proceduconditions and renal [kidwastes and impurities are blood by a special mach obstructive pulmonary dispersions. | ew, clinical record review occumentation the facility are medication regimen for dents (Resident #114, and exof unnecessary)  inistered the narcotic pain ne-Acetaminophen to a scale ratings below the meters of severe pain mpt non-pharmacological aministering the  d Diclofenac Sodium Gel nedication ordered for ain level was zero.  admitted to the facility on readmission on 7/9/2021, and but were not limited as requiring are used in toxic ney] failure, in which we removed from the aine) (1), chronic sease (COPD - general exible lung disease that of emphysema and and but to severe out specific cause, as such as quickened |   | 4.DON or designee will audit primedication administration to ensure non-pharmacological intervention, been implemented prior to administering the prime pain medical weekly times 4 weeks and monthly times 2. Any identified issues will immediately corrected. Results will reported to Quality Assurance committee for analysis and revision months.  5. Date of compliance will August 2021. | re s have tion y be ll be n x 3 |

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

| IDENTIFICATION NUMBER:  |  |   | TIPLE CONSTRUCTION<br>ING     | (X3) DATE SURVEY<br>COMPLETED  |                            |           |
|---|--|---|-------------------------------|--|----------------------------|-----------|
|   |  |   |                               | С  |                            |           |
| NAME  | DE PROVIDED OD SUDDUED   | 495391  | B. WING                       |  | 07                         | 7/29/2021 |
| NAME OF PROVIDER OR SUPPLIER  GLENBURNIE REHAB & NURSING CENTER  (X4) ID PREFIX TAG  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) |  | G CENTER  |                               | STREET ADDRESS, CITY, STATE, ZIP CODE  1901 LIBBIE AVE  RICHMOND, VA 23226 |                            |           |
|   |  | ID<br>PREFIX<br>TAG   | PROVIDER'S PLAN OF CORRECTION | RF.  | (X5)<br>COMPLETION<br>DATE |           |
| F 75  | The most recent MDS assessment, a quarte assessment reference Resident # 114 as soo (brief interview for men the resident was mode daily cognitive decisio coded as limited assis for most of her activities J - Health Conditions thaving no pain in the part The physician orders of documented, "Hydroco Tablet (used to treat se (milligrams) Give 1 table as needed for severe p6/1/2021, documented, = no pain, 1,2,3,4 - milo pain, 8,9,10 = severe pain, 8,9,10 = seve | s (minimum data set) rly assessment, with an e date of 7/15/2021, coded oring a "12" on the BIMS ntal status) score, indicating erately impaired to make ns. The resident was tance of one staff member es of daily living. In Section he resident was coded as east 5 days.  lated 6/23/2021 done-Acetaminophen evere pain) (3) 5-325 MG et by mouth every 6 hours eain." The order dated, "Pain Score every shift: 0 It pain, 5, 6, 7 = moderate eain. every shift for pain."  edication administration 14 documented the or Hydrocodone - AR documented the stered on the following ein scale ratings below the neters for severe pain as  pain level - 6 pain level - 7 - pain level - 7 | F 7                           | 757  |                            |           |

| I CTATELA    |  | I   |                     |  | OMB NO. 0938-0391 |                            |  |
|--------------|--|---|---------------------|--|-------------------|----------------------------|--|
|              | NT OF DEFICIENCIES<br>N OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  | (X2) MULTIP         | LE CONSTRUCTION  |                   | E SURVEY<br>MPLETED        |  |
|              |  | 495391  | B. WING             |  | 0;                | C<br>7/29/2021             |  |
| NAME C       | F PROVIDER OR SUPPLIER   |   |                     | STREET ADDRESS, CITY, STATE, ZIP CODE  |                   |                            |  |
| GLENI        | BURNIE REHAB & NURSING   | CENTER  | 1                   | 1901 LIBBIE AVE  |                   |                            |  |
| OLLIVI       | SOUTH INTERNAL OF MORSHING   | CENTER  | 1                   | RICHMOND, VA 23226   |                   |                            |  |
| (X4) II      | SUMMARY ST.  | ATEMENT OF DEFICIENCIES   |                     |  |                   |                            |  |
| PREFI<br>TAG | ( EACH DEFICIENCY  | MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | E                 | (X5)<br>COMPLETION<br>DATE |  |
| F 75         | 7/22/2021 at 1:26 a.m 7/23/2021 at 1:26 a.m 7/23/2021 at 2:37 a.m 7/24/2021 at 1:10 a.m 7/26/2021 at 9:25 a.m. Review of the nurses' revealed the following 7/13/2021 at 9:55 p.m. location of the pain or a interventions attempted administration of the Hydrocodone-Acetamin 7/15/2021 at 9:53 a.m. note or eMAR (electror administration record) assessment or non-pha attempted/provided doc 7/15/2021 at 7:29 p.m., 7/16/2021 at 9:03 p.m., each date and time, fail documented location of non-pharmacological in | a pain level - 6 a pain level - 2 a pain level - 5 a pain level - 0 a pain level - 0 a pain level - 7  Inotes for Resident #114 documentation: a did not document the lany non-pharmacological did/provided prior to the lany non-pharmacological did/provided prior to the land no pain larmacological interventions larmacological interventions larmacological interventions larmacological at 10:10 a.m., 7/17/2021 at 10:50 a.m., led to reveal any large treventions are to the administration of large was no nurse's pain assessment or large was no nurse's pain assessment or large was no nurse's pain assessment or large was no nurse large was no nurse large was no nurse large was no nurse large was no nurse large was no nurse large was no nurse large was no nurse large was no nurse large was no nurse large was no nurse large was no nurse large was no nurse la l | F 757               |  |                   |                            |  |

|                          | T OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA  | (X2) MU           | LTIPL | E CONSTRUCTION   |         | O. 0938-0391<br>E SURVEY   |
|--------------------------|--|--|-------------------|-------|--|---------|----------------------------|
| ANDFLAN                  | OF CORRECTION  | IDENTIFICATION NUMBER:   |                   |       |  |         | MPLETED                    |
|                          |  | 495391   | B. WING           | _     |  | 0.      | C<br>7/29/2021             |
|                          | PROVIDER OR SUPPLIER  IRNIE REHAB & NURSING  | CENTER   |                   | ı     | STREET ADDRESS, CITY, STATE, ZIP CODE  |         | 7.107.100.12               |
|                          |  |  |                   | F     | RICHMOND, VA 23226   |         |                            |
| (X4) ID<br>PREFIX<br>TAG |  |  | ID<br>PREF<br>TAG |       | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BI<br>CROSS-REFERENCED TO THE APPROPRIA<br>DEFICIENCY) | ≣<br>TE | (X5)<br>COMPLETION<br>DATE |
|                          | note or eMAR note. Note non-pharmacological is attempted/provided do administration of the Hydrocodone-Acetamin. The comprehensive cas documented in part, "Fidependence on renal of fluid overload, disease "Interventions/Tasks" of "Administer pain medic Notify physician if pain worsening or of current become ineffective."  An interview was condupractical nurse) #6 on 7 LPN #6 was asked to rephysician's order for Hy Acetaminophen. When should be given for a paseven, LPN #2 stated the requests which medicate asked according to the odocumentation of the pamedication be given for a below, LPN #2 stated, "Nan interview was conduction and the pamedication of the pamedication of the pamedication begiven for a seven the seven the above the pamedication of the pamed | o pain assessment or interventions cumented prior to the mophen.  It is plan dated 6/25/2021 focus: Pain related to flialysis, muscle weakness, process." the locumented in part, ation per physician orders. If frequency/intensity is analgesia regimen has frequency/intensity is analgesia regimen has focused with LPN (licensed f/28/2021 at 12:19 p.m. eview the above drocodone - location in level between one and he resident usually lon she wants. When order and the facility loin scale, should this a pain level of seven and No, I guess not."  Seted with LPN #3, the unit at 2:36 p.m., LPN #3 was we physician's order for loophen. LPN #3 was for physician's order for loophen. LPN #3 was for physician's level of eight, nine | F                 | 757   |  |         |                            |

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

| AND PLAN (                              | OF DEFICIENCIES DE CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   | 1                   | TIPLE CONSTRUCTION  NG   |    | E SURVEY                   |  |
|---|---|---|---------------------|--|----|----------------------------|--|
|   |   | 495391  | B. WING _           |  | 07 | C<br>7/29/2021             |  |
| GLENBU                                  | PROVIDER OR SUPPLIER RNIE REHAB & NURSING   |   |                     | STREET ADDRESS, CITY, STATE, ZIP CODE<br>1901 LIBBIE AVE<br>RICHMOND, VA 23226                                 |    | 12312021                   |  |
| (X4) ID<br>PREFIX<br>TAG                | (EACH DEFICIENCY  | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY) |    | (X5)<br>COMPLETION<br>DATE |  |
| ( ) ( ) ( ) ( ) ( ) ( ) ( ) ( ) ( ) ( ) | Medications" documen purpose of this procedu for assessing the resid administering analgesic Conduct a pain assess Evaluate and documen non-pharmacological in repositioning, warm or a Administer pain medical ASM (administrative staregional director of clinic the director of nursing, above concern on 7/28/No further information was References:  (1) Barron's Dictionary of Non-Medical Reader, 5th Chapman, page 266.  (2) Barron's Dictionary of Non-Medical Reader, 5th Chapman, page 124.  (3) Barron's Dictionary of Non-Medical Reader, 5th Chapman, page 43.  (4) This information was following website: https://medlineplus.gov/dml | atted in part, "Purpose: The ure is to provide guidelines ent's level of pain prior to pain medication3. ment as indicated5. It the effectiveness of atterventions (e.g.; cold compresses, etc.). 6. Actions as ordered."  Aff member) #1, the cal services and ASM #2, were made aware of the 2021 at 5:07 p.m.  Aff Medical Terms for the edition, Rothenberg and of Medical Terms for the edition, Rothenberg and obtained from the ruginfo/meds/a614045.h | F 7.                | 57   |    |                            |  |
| 5<br>  li<br>  fu                       | <ol> <li>Resident #27 was adm<br/>i/11/21 with diagnosis tha<br/>mited to: diabetes mellit<br/>unction normally in the bone<br/>nee amputation [BKA] (s</li> </ol>  | at included but were not<br>us (inability of insulin to<br>ody) (3), right below the  |                     |  |    | 0                          |  |

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

|  | OF DEFICIENCIES<br>OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   |                     | LE CONSTRUCTION  | (X3) DAT | TE SURVEY<br>MPLETED       | - |
|--|---|---|---------------------|--|----------|----------------------------|---|
|  | }   | 495391  | B. WING             |  |          | С                          |   |
|  | PROVIDER OR SUPPLIER  |   |                     | STREET ADDRESS, CITY, STATE, ZIP CODE 1901 LIBBIE AVE RICHMOND, VA 23226                                     | 07       | 7/29/2021                  |   |
| (X4) ID<br>PREFIX<br>TAG                   | (EACH DEFICIENCY  | NTEMENT OF DEFICIENCIES<br>MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | E        | (X5)<br>COMPLETION<br>DATE |   |
| f f a A A C C a a n n ttri irr 3 1 A F F F | limb) (4) and PTSD [podisorder] (mood disord traumatic event) (5).  The most recent MDS assessment, a five day with an ARD (assessment) (5).  The most recent MDS assessment, a five day with an ARD (assessment) (5)17/21, coded the resister of the BIMS (brief in score, indicating the resister of the conditional status coderequiring extensive assistransfer, locomotion and in eating and supervision Walking did not occur. All Habowel and Bladder of the care plant occumented in part, "For cight BKA, disease Proceed and the process of the physician requency/intensity is well and process. Notify physician requency/intensity is well analysis a regimen has been accommented in part, "Dick analysis are gimen has been accommented in part, "Dick apply to lower back topic moderate back pain, app | (minimum data set) (minimum data set) (Medicare assessment, ent reference date) of dent as scoring a 12 out of nterview for mental status) sident was moderately iew of the MDS Section ed the resident as istance for bed mobility, d dressing. Independence on for hygiene/bathing. A review of MDS Section coded the resident as or bowel and for bladder. INTERVENTIONS: cation per physician if pain orsening or of current pecome ineffective." In orders dated 7/14/21, clofenac Sodium Gel 1%, cally every 6 hours for ally 4 grams." A review of ed 7/19/21, documented by shift: 0=No pain, 1, 2, alloderate pain, 8, 9, hift for pain."  dication administration art, "Diclofenac Sodium | F 757               |  |          |                            |   |

| STATEMENT                   | OF DEFICIENCIES   | 040 55 51 51 55 55  | 1                   |  | OMB N   | <u>10. 0938-03</u>         | 91 |
|-----------------------------|---|---|---------------------|--|---------|----------------------------|----|
| AND PLAN C                  | F CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   | (X2) MULTIF         | PLE CONSTRUCTION   |         | TE SURVEY<br>MPLETED       |    |
| 11115 05 0                  |   | 495391  | B. WING             |  |         | C<br><b>7/29/2021</b>      |    |
|                             | ROVIDER OR SUPPLIER RNIE REHAB & NURSING  | CENTER  |                     | STREET ADDRESS, CITY, STATE, ZIP CODE  1901 LIBBIE AVE  RICHMOND, VA 23226                                     |         | 1,20,2021                  |    |
| (X4) ID<br>PREFIX<br>TAG    | (EACH DEFICIENCY  | ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY) | E<br>TE | (X5)<br>COMPLETION<br>DATE | N  |
| tt III AA F hh si pp "// th | pain level=0, 7/20/21 at 7/20/21 at 6:00 PM pain 12:00 AM pain level=0 12:00 PM pain level=0 7/22/21 6:00 AM pain level=0."  An interview was conding PM with LPN (licensed asked what does the zero means, LPN #2 stated, the way I think about it, is working." When asked #27's MAR, LPN #2 stated documented as 0 and the Sodium Gel 1% apply to every 6 hours for model grams." When asked if it is LPN #2 stated, "No, but he gel so he won't have book at it that way. I see the physician's order and it."  An interview was conducted in interview was conducted as orders for pain medic hould they receive the pain rating level is zero. According to the paramete gel if pain level is zero. According to the paramete gel if pain level is zero. Barron's Dictionary of on-Medical Reader, 5th hapman, page 319.  Barron's Dictionary of Barron's Dictionary of Barron's Dictionary of Barron's Dictionary of Barron's Dictionary of Barron's Dictionary of Barron's Dictionary of Barron's Dictionary of | at 6:00 AM pain level=0, in level=0. On 7/21/21, 6:00 AM pain level=0, 6:00 AM pain level=0. On evel=0, and 12:00 PM pain level=0. On evel=0, and 12:00 PM pain level=0. On evel=0, and 12:00 PM pain level=0, and is that the pain scale is that the pain medication level to review Resident level, "The pain scale is the order is for Diclofenace of lower back topically level back pain, apply 4 level is moderate pain, apply 4 level | F 757               |  |         |                            |    |
| 1 (0                        | , = = 11 or o Dictionally Of  | INICUIDAL LETTIS TOLLITE  | 11                  |  |         |                            | 1  |

| STATEMENT<br>AND PLAN C      | OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   | (X2) MULTIF  | PLE CONSTRUCTION  | (X3) DATE   | D. 0938-039<br>E SURVEY<br>PLETED | 1 |
|------------------------------|--|---|--|---|---|-----------------------------------|---|
|                              |  | 495391  | B. WING  |   | 1   | C                                 |   |
|                              | PROVIDER OR SUPPLIER   |   |  | STREET ADDRESS, CITY, STATE, ZIP CODE   | 07.   | /29/2021                          | - |
| GLENBU                       | RNIE REHAB & NURSING   |   |  | 1901 LIBBIE AVE<br>RICHMOND, VA 23226   |   |                                   |   |
| (X4) ID<br>PREFIX<br>TAG     | (EACH DEFICIENCY   | NTEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG  | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)  | È<br>FE   | (X5)<br>COMPLETION<br>DATE        |   |
| ii § d b c c d § p: ui di in | Chapman, page 120. Free from Unnec Psyc CFR(s): 483.45(c)(3)(e §483.45(e) Psychotrop §483.45(c)(3) A psycho affects brain activities a processes and behavio but are not limited to, d categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic  Based on a comprehens resident, the facility mus §483.45(e)(1) Residents sychotropic drugs are i unless the medication is specific condition as diag in the clinical record; (483.45(e)(2) Residents lrugs receive gradual do ehavioral interventions, ontraindicated, in an eff rugs; (483.45(e)(3) Residents sychotropic drugs pursu nless that medication is agnosed specific condit the clinical record; and | both edition, Rothenberg and hotropic Meds/PRN Use e)(1)-(5) ic Drugs. botropic drug is any drug that associated with mental or. These drugs include, rugs in the following  sive assessment of a set ensure that s who have not used not given these drugs ancessary to treat a gnosed and documented  who use psychotropic observed and unless clinically ort to discontinue these do not receive that a gnosed and approximately ort to a proper to treat a gnosed and the set of t | in the second se | Psychotropic Meds/PRN Use  1. Resident #62 still resides in faciliand is being monitored for behaviorand side effects for the use of Psychotropic Medications. Resident #114 has been discharged from the facility.  2. All residents have the potential to affected by this alleged deficient practice. Nursing management will audit the behavior and side effect monitoring in PCC for documentat Audit the prn psychotropic medicate for stop date, documentation of nor pharmacological interventions implemented prior to administering prn psychotropic medication.  3. DON or designee will educate all nursing staff on Residents receiving Psychotropic Medications must have top date. Must have documentation PCC for monitoring of behaviors and ide effects and use of compharmacological interventions pro administering a prn psychotropic medication with documentation. | ors  nt  o be  lion.  tion  -  the  g prn  re  n in  dd |                                   |   |
| 3                            | (-)(-)   | s ioi possilottopio di aga  |  |   |   |                                   |   |

|                          | T OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  |                     | LE CONSTRUCTION  | (X3) DAT  | E SURVEY<br>IPLETED        |
|--------------------------|--|---|---------------------|--|---|----------------------------|
|                          |  | 495391  | B. WING             |  |   | C                          |
|                          | PROVIDER OR SUPPLIER  JRNIE REHAB & NURSING  | CENTER  |                     | STREET ADDRESS, CITY, STATE, ZIP CODE 1901 LIBBIE AVE RICHMOND, VA 23226   | 07  | //29/2021                  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY   | ATEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROPRI<br>DEFICIENCY)   | BE  | (X5)<br>COMPLETION<br>DATE |
|                          | are limited to 14 days. §483.45(e)(5), if the air prescribing practitione appropriate for the PR beyond 14 days, he or rationale in the resider indicate the duration for \$483.45(e)(5) PRN ordered are limited to 14 renewed unless the attraction practitioner the appropriateness of This REQUIREMENT in the facility staff failed to free of unnecessary psy two of 49 residents in the Residents #62 and #11.  1. The facility staff failed for targeted behaviors a of Seroquel (1).  2. The facility staff failed non-pharmacological introducing administration of the as a anti-anxiety medication, reason for the administration. | Except as provided in tending physician or r believes that it is N order to be extended she should document their natis medical record and or the PRN order.  Hers for anti-psychotic days and cannot be ending physician or evaluates the resident for that medication.  Is not met as evidenced  W, facility document review ew, it was determined that the ensure residents were exchotropic medications for the survey sample,  It to monitor Resident #62 and side effects for the use  If to offer erventions prior to the needed (PRN) Ativan an failed to document the eation of Ativan failed to have a stop date anti-anxiety medication practitioner failed to for the use of an |                     | 4.DON or designee will audit Re that admit or have new orders for psychotropic medications have st date, behavior and side effect monitoring and non-pharmacolog interventions utilized prior to administering a prn psychotropic medication weekly times 4 weeks monthly times 2. Any identified i will be immediately corrected. Re will be reported to Quality Assuracommittee for analysis and revision months.  Date of compliance will August 22021. | e prn<br>cop<br>gical<br>s and<br>ssues<br>esults<br>ance<br>on x 3 |                            |

|   | STATEMENT                | OF DEFICIENCIES   | (X4) PBOMPED (ALIER LEE LEE  | 7                    |  | OWR I | NO. 0938-0391              |
|---|--------------------------|---|--|----------------------|--|-------|----------------------------|
|   | AND PLAN C               | OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  | (X2) MUL<br>A. BUILD | TIPLE CONSTRUCTION   |       | TE SURVEY<br>MPLETED       |
|   |                          |   | 495391   | B, WING              |  |       | C<br>7/29/2021             |
|   |                          | PROVIDER OR SUPPLIER  RNIE REHAB & NURSING  | CENTER   |                      | STREET ADDRESS, CITY, STATE, ZIP CODE 1901 LIBBIE AVE RICHMOND, VA 23226 |       | 112312021                  |
| _ | (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY  | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)  | ID<br>PREFI<br>TAG   | PROVIDER'S PLAN OF CORRECT   | D BF  | (X5)<br>COMPLETION<br>DATE |
|   | F ir ttree si            | 1. Resident #62 was an 1/20/17. Resident #62' were not limited to obs disorder, major depress pain. Resident #62's signification assessment reference or resident as being cognicoded Resident #62 as antipsychotic medication days.  Review of Resident #62 as antipsychotic medication days.  Review of Resident #62 a physician's order date mg (milligrams) by mour psychosis.  Review of Resident #62 administration records) for 7/26/21 revealed the door resident received Seroque Resident #62's comprehend 2/2/17 failed to docume garding antipsychotic resident was monitored for five effects for the use of the resident was monitored for 1/28/21 at 12:27 p.m. anducted with LPN (licer PN #4 stated Resident #62 to obsorder. LPN #4 stated resident polynomials with the stated resident. | dmitted to the facility on so diagnoses included but essive compulsive sive disorder and low back gnificant change in status essment with an date of 3/15/21, coded the tively intact. Section No having received in six out of the last seven seven sev | F7                   | 758  |       |                            |

|   | AND PLAN  | T OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  |                     | PLE CONSTRUCTION  | (X3) DAT | O. 0938-0391<br>E SURVEY<br>MPLETED | L |
|---|---|--|--|---------------------|---|----------|-------------------------------------|---|
|   |   |  | 495391   | B. WING             |   |          | С                                   |   |
| r | NAME OF   | PROVIDER OR SUPPLIER   |  |                     | CTREET ADDRESS OF COLUMN  | 07       | 7/29/2021                           |   |
| _ | GLENBU  | URNIE REHAB & NURSING  |  |                     | STREET ADDRESS, CITY, STATE, ZIP CODE 1901 LIBBIE AVE RICHMOND, VA 23226  |          |                                     |   |
|   | (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIENCY   | ITEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD I<br>CROSS-REFERENCED TO THE APPROPRI,<br>DEFICIENCY) | 3E       | (X5)<br>COMPLETION<br>DATE          |   |
|   | (<br>(<br>(<br>(<br>(<br>(<br>(<br>(<br>(<br>(<br>(<br>(<br>(<br>(<br>(<br>(<br>(<br>(<br>( | documented on the M/Resident #62's July 20 behavior and side effect documented but was n would fix this.  On 7/28/21 at 4:52 p.m staff member) #1, the n services and ASM #2, the made aware of the about the facility policy titled, Use" documented, "16. document and report to information regarding the interventions, including a 17. Nursing staff shall mof the following side effects who further information were reference:  (1) "Quetiapine (Seroque | AR. LPN #4 reviewed 21 MAR and stated 21 MAR and stated 21 monitoring should be 31 of monitoring should be 32 of monitoring should be 33 of monitoring should be 34 of monitoring should be 35 of monitoring were 36 of monitoring were 37 of monitoring were 38 of monitoring were 39 of monitoring were 39 of monitoring were 30 of monitoring were 30 of monitoring were 30 of monitoring were 31 of monitoring were 32 of monitoring were 33 of monitoring were 34 of monitoring were 35 of monitoring were 36 of monitoring were 36 of monitoring were 36 of monitoring were 36 of monitoring were 36 of monitoring were 36 of monitoring were 36 of monitoring were 36 of monitoring were 36 of monitoring were 36 of monitoring were 36 of monitoring were 36 of monitoring were 36 of monitoring were 36 of monitoring were 36 of monitoring were 36 of monitoring were 36 of monitoring were 36 of monitoring were 37 of monitoring were 38 of monitoring were 38 of monitoring were 39 of monitoring were 39 of monitoring were 30 of moni | F 75                |   |          |                                     |   |

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

| AND | TATEMENT OF DEFICIENCIES<br>IND PLAN OF CORRECTION                |  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:                       | (X2) MUL<br>A. BUILD | LTIPLE CONSTRUCTION DING   |                               | (X3) DATE SURVEY<br>COMPLETED |                            |
|-----|---|--|---|----------------------|--|-------------------------------|-------------------------------|----------------------------|
|     |   | 495391 OF PROVIDER OR SUPPLIER   |   | B. WING              |  |                               | 07                            | C<br>/29/2021              |
| GL  | .ENBU   | RNIE REHAB & NURSING   |   |                      | STREET ADDRESS, CITY, STATE, ZIP CO<br>1901 LIBBIE AVE<br>RICHMOND, VA 23226 | ODE                           | U 07                          | 729/2021                   |
| P   | X4) ID<br>REFIX<br>TAG  | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID<br>PREFI,<br>TAG  |  | ON SHOULD BE<br>HE APPROPRIAT | Ē                             | (X5)<br>COMPLETION<br>DATE |
| 1   | F 758   | tablets are also used a medications to treat de information was obtain   | long with other<br>pression." This  | F7                   | 758  |                               |                               |                            |
|     | i<br>( )<br>( )<br>( )  | 2. Resident # 114 was admitted to the facility on 5/27/2021 with a recent readmission on 7/9/2021, with diagnoses that included but were not limited to: end stage renal disease requiring hemodialysis (a procedure used in toxic conditions and renal [kidney] failure, in which wastes and impurities are removed from the blood by a special machine) (1), chronic obstructive pulmonary disease (COPD - general term for chronic, nonreversible lung disease that is usually a combination of emphysema and chronic bronchitis) (2) high blood pressure and anxiety disorder (state of mild to severe apprehension, often without specific cause, resulting in body changes such as quickened heartbeat and sweat) (3). |   |                      |  |                               |                               |                            |
|     | a<br>a<br>R<br>(I<br>th<br>d<br>c<br>f<br>f<br>o<br>N<br>re<br>du | The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 7/15/2021, Resident # 114 as scoring a "12" on the BIMS (brief interview for mental status) score, indicating the resident was moderately impaired to make daily cognitive decisions. The resident was coded as limited assistance of one staff member for most of her activities of daily living. In Section N - Medications, the resident was coded as receiving two days of an antianxiety medication during the look back period.  The physician order dated 6/14/2021, documented, "Ativan tablet (used to treat anxiety)   |   |                      |  |                               |                               |                            |

| 1 | STATEMENT | ENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIED/CLIA  |   |  |         |                                       |                               | O. 0938-03         | 91       |
|---|-----------|--|---|--|---------|---------------------------------------|-------------------------------|--------------------|----------|
|   |           | OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   | (X2) MULTIPLE CONSTRUCTION A. BUILDING |         |                                       | (X3) DATE SURVEY<br>COMPLETED |                    |          |
| ŀ | NAME OF   |  | 495391  | B. WING                                | B. WING |                                       | C<br>07/29/2021               |                    |          |
| ı | NAME OF   | PROVIDER OR SUPPLIER   |   |  | 5       | STREET ADDRESS, CITY, STATE, ZIP CODE |                               |                    | _        |
| ı | 01.51151  |  |   |  |         | 1901 LIBBIE AVE                       |                               |                    |          |
| l | GLENBL    | JRNIE REHAB & NURSING  | CENTER  |  |         |                                       |                               |                    |          |
| ŀ |           | 1  |   |  | F       | RICHMOND, VA 23226                    |                               |                    | - 1      |
| l | (X4) ID   | SUMMARY STA  | TEMENT OF DEFICIENCIES  | ID                                     |         | PROVIDER'S PLAN OF CORRECTION         |                               | T                  | $\dashv$ |
| l | PREFIX    | (EACH DEFICIENCY   | MUST BE PRECEDED BY FULL  | PREF                                   | IX      | (EACH CORRECTIVE ACTION SHOULD B      | E                             | (X5)<br>COMPLETION | ,        |
| ı | TAG       | REGULATURY OR LS   | SC IDENTIFYING INFORMATION)   | TAG                                    |         | CROSS-REFERENCED TO THE APPROPRIA     | TE                            | DATE               | `        |
| L |           |  |   |  |         | DEFICIENCY)                           |                               | 1                  | - 1      |
| ľ |           |  |   |  | _       |                                       |                               | -                  | -        |
|   | F 758     | Continued From page  | 190   |  | 750     |                                       |                               |                    | - 1      |
|   |           | (4) 0.5 mg (milligrams) (Lorazepam) Give .25 mg  |   | F                                      | 758     |                                       |                               | I                  | - 1      |
|   |           |  |   | 1                                      |         |                                       |                               |                    | - 1      |
|   |           | by mouth every 8 hours   | s as needed for anxiety."   | 1                                      |         |                                       |                               |                    | - 1      |
|   |           | J.   |   |  |         |                                       |                               |                    |          |
|   |           | Review of Resident #1  |   |  | - 1     |                                       |                               |                    |          |
|   |           | (medication administration record) documented the above physician order for as needed Ativan. Further review of the MAR revealed |   |  |         |                                       |                               |                    |          |
|   |           |  |   |  |         |                                       |                               |                    |          |
|   |           |  |   |  | - 1     |                                       |                               |                    | - 1      |
|   | )         | documentation the Ativa  | ocumentation the Ativan was administered on<br>ne following dates and times:<br>/16/2021 at 11:16 a.m., 6/16/2021 at 8:09 p.m., |  | - 1     |                                       |                               |                    | -1       |
|   |           | the following dates and  |   |  | - 8     |                                       | - 1                           |                    |          |
|   |           | 6/16/2021 at 11:16 a m   |   |  |         |                                       | - 1                           |                    | - 1      |
|   |           | 6/19/2021 at 11:16 a.m., 6/16/2021 at 8:09 p.m.,   |   |  | - 1     |                                       |                               |                    |          |
|   |           | 6/19/2021 at 10:22 p.m., 6/23/2021 at 12:48 p.m., 6/25/2021 at 3:37 a.m., 6/25/2021 at 10:51 a.m.,                               |   |  |         |                                       | 1                             |                    |          |
|   |           | 6/27/2021 at 3.37 a.m.,  | 0/25/2021 at 10:51 a.m.,  |  | - 1     |                                       |                               |                    |          |
|   |           |  | and 6/30/2021 at 11:40  |  | - 1     |                                       |                               |                    | 1        |
|   |           | a.m.   |   |  |         |                                       |                               |                    |          |
|   | 1         | Review of Resident #11   | 4's nurses' notes for June  |  |         |                                       |                               |                    |          |
|   |           | 2021, revealed there wa  | 4 s harses hotes for June   |  | - 1     |                                       | 1                             |                    | 1        |
|   |           | evidence of why the ma   | disation (toward )  |  |         |                                       |                               |                    |          |
|   |           | evidence of why the me   | dication (targeted  |  | - 10    |                                       | - 1                           |                    | 1        |
|   | - 1       | beliavior) was given or w  | vhat non-pharmacological  |  |         |                                       | 1                             |                    |          |
|   | 1         | interventions were atten   | npted/ provided prior to  |  | - 1     |                                       |                               |                    |          |
|   |           | the administration of the  | Ativan on the following   |  | - 1     |                                       | 1                             |                    |          |
|   |           | dates and times:   | 1   |  | - 1     |                                       |                               |                    |          |
|   | 1         | 6/16/2021 at 11:16 a.m.,   | 6/16/2021 at 8:09 p.m.,   |  | - 31 -  |                                       | 1                             |                    | d)       |
|   | 1         | 6/19/2021 at 10:22 a.m.,   | 6/23/2021 at 12:48 p.m.   |  |         |                                       |                               |                    | 1        |
|   | - la      | 6/25/2021 at 3:37 a.m., 6  | 3/27/2021 at 10:48 a.m.   |  |         |                                       |                               |                    |          |
|   | H.        | and on 6/30/2021 at 11:4   | 10 a.m.   |  | - 1     |                                       | 1                             |                    | 1        |
|   |           |  |   |  |         |                                       |                               |                    |          |
|   |           |  |   |  |         |                                       |                               |                    | 1        |
|   | J -       | The July 2021 MAR docu   | Imented the above   |  |         |                                       |                               |                    | 1        |
|   | 1,        | ohysician order for as nee   | dod Afiyan Furth-   |  |         |                                       |                               |                    | 1        |
|   | 1.5       | eview of the MAD   | led decreased it  |  |         |                                       |                               |                    | 1        |
|   |           | review of the MAR reveal   | eu documentation the  |  |         |                                       |                               |                    | 1        |
|   | '         | Ativan was administered  | on the following dates  |  |         |                                       |                               |                    | 1        |
|   |           | and times:   | f   |  |         |                                       |                               |                    |          |
|   | 7         | 7/1/2021 at 2:01 p.m., 7/2   | 2/2021 at 10:46 p.m.,   |  |         |                                       | 4                             |                    |          |
|   | 7         | 7/4/2021 at 12:06 a.m., 7/   | /10/2021 at 4:14 a.m.,  |  |         |                                       |                               |                    |          |
|   | 7         | 7/11/2021 at 6:57 p.m., 7/   | /15/2021 at 7:29 p.m  |  | 1       |                                       |                               |                    |          |
|   | 7         | 7/16/2021 at 10:10 a.m., 7   | 7/18/2021 at 11:16 a m  |  |         |                                       |                               |                    |          |
|   | 7         | 7/18/2021 at 10:48 p.m., 7   | 7/20/2021 at 11:02 a m  |  |         |                                       |                               |                    |          |
|   | 7         | 7/21/2021 at 7:08 a.m., 7/   | 21/2021 at 6:42 a m   |  | 1       |                                       |                               |                    |          |
|   |           | r ac r a.m., 11  | = 112021 at U.72 p.111.,  |  | 11      |                                       | - 1                           |                    | 1        |

| STATEME<br>AND PLAN      | NT OF DEFICIENCIES<br>N OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | (X2) MULTIPLE C     | ONSTRUCTION  | (X3) DA | TE SURVEY<br>MPLETED       | 91 |
|--------------------------|--|--|---------------------|--|---------|----------------------------|----|
| l                        |  | 495391   | B. WING             |  |         | С                          |    |
|                          | F PROVIDER OR SUPPLIER  BURNIE REHAB & NURSING   | CENTER   | STR 190             | EET ADDRESS, CITY, STATE, ZIP CODE  1 LIBBIE AVE  HMOND, VA 23226                                      | 0       | 7/29/2021                  |    |
| (X4) ID<br>PREFIX<br>TAG | (   (EACH DEFICIENCY   | ATEMENT OF DEFICIENCIES<br>MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPROFICIENCY) | ) BE    | (X5)<br>COMPLETION<br>DATE | N  |
|                          | 7/22/2021 at 11:56 a.m. 7:08 a.m.  Review of Resident #1 2021, revealed there we evidence of why the methavior) was given or interventions were attest administration of the dates and times: 7/1/20 at 10:46 p.m., 7/4/2021 at 4:14 a.m., 7/11/2021 7:29 p.m., 7/16/2021 at 11:16 a.m. 7/18/2021 at 11:02 a.m., 7/21/2021 at 7/23/2021 at 7:08 a.m.  The comprehensive car documented in part, "For effects related to use of | 14's nurses' notes for July /as no documented edication (targeted what non-pharmacological mpted/ provided prior to e Ativan on the following 121 at 2:01 p.m., 7/2/2021 at 12:06 a.m., 7/10/2021 at 12:06 a.m., 7/15/2021 at 10:10 a.m., 7/18/2021 at 10:10 a.m., 7/18/2021 at 10:48 p.m., 7/20/2021 at 11:56 a.m., and on e plan dated, 6/25/2021, rous: At risk for adverse anti-depression of the care plan failed to ated to the use of an ote, dated, 6/15/2021, n: Anxiety and insomnia m 0.25 mg q (every) 8 h anxiety. Spoke with ote dated, 6/17/2021, n: Anxiety and insomnia his morning, but she is a am does seem to be tor for over-sedation. | F 758               |  |         |                            |    |

| STATEMENT  | T OF DEFICIENCIES  | (V4) PROMETER (C. 175)   |                          |   | OMB N | O. 0938 <b>-</b> 0391      | 1 |
|--|--|--|--------------------------|---|-------|----------------------------|---|
| AND PLAN   | OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  | (X2) MULTI<br>A. BUILDIN | PLE CONSTRUCTION  G   |       | E SURVEY<br>MPLETED        |   |
| NAME OF  |  | 495391   | B. WING                  | B. WING   |       | C<br>7/ <b>29/2021</b>     |   |
|  | PROVIDER OR SUPPLIER  IRNIE REHAB & NURSING  | CENTER   |                          | STREET ADDRESS, CITY, STATE, ZIP CODE 1901 LIBBIE AVE RICHMOND, VA 23226                                      |       |                            |   |
| (X4) ID<br>PREFIX<br>TAG                         | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG      | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) |       | (X5)<br>COMPLETION<br>DATE |   |
| r<br>a<br>F<br>ii<br>p<br>L<br>tr<br>s<br>V<br>a | The nurse practitioner documented in part, "P - continue lorazepam 0  The nurse practitioner documented in part, "P - continue lorazepam 0  An interview was condupractical nurse) #3, the 7/28/2021 at 3:16 p.m. was reviewed with LPN why a nurse would adm Resident #114, LPN #3 anxious. First, you asse why they are anxious, wanxiousness? Offer to shelp them relax, calm th non-pharmacologicals." information would be do stated, "It should be do note or eMAR (electroniadministration record)."  An interview was conduct/28/2021 at 3:23 p.m. T | note, dated 6/24/2021, lan: Anxiety and insomnia 1.25 mg q8h PRN anxiety."  note, dated 7/12/2021, lan: Anxiety and insomnia 1.25 mg q8h PRN anxiety."  Letted with LPN (licensed unit manager, on The above order for Ativan #3. When asked when or inister the medication to stated, "If the resident is set the resident. Find out what is causing the ee if anything else would em down, like When asked where this cumented, LPN #3 numented in the nurses' comedication  cited with LPN #6, on the above order was when asked when or why in the medication to stated, "I'd give it for a sked about the diministering the Ativan, do an assessment. You conversation, offering a will request the Ativan." It is supposed to be | F 75                     | 8   |       |                            |   |

| AND PLAN                 | T OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  | (X2) MULTIP         | LE CONSTRUCTION  | (X3) DATE | O. 0936-0391<br>E SURVEY<br>IPLETED |
|--------------------------|--|--|---------------------|--|-----------|-------------------------------------|
|                          |  | 495391   | B. WING             |  | 1         | C                                   |
|                          | PROVIDER OR SUPPLIER<br>JRNIE REHAB & NURSING  | CENTER   |                     | STREET ADDRESS, CITY, STATE, ZIP CODE 1901 LIBBIE AVE RICHMOND, VA 23226                                     |           | 7/29/2021                           |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY   | ATEMENT OF DEFICIENCIES<br>MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) |           | (X5)<br>COMPLETION<br>DATE          |
|                          | An interview was condu (administrative staff m practitioner, on 7/29/20 asked the about proces anti-anxiety medication we are not supposed to a primary care setting (as needed) anti-anxiety patients." When asked receiving the Ativan, Ashaving shortness of breath. I hher, she reported she we nerves. We did a trial of medication. The use of of the hospital since we that we can't order a Prepeople that have panic of the scheduled. For her (Repisodic anxiety causing | ember) #3, the nurse 221 at 10:01 a.m. When 25 for administering 25 as, ASM #3 stated, "I know 26 have them. I came from 27 and we prescribed PRN 28 ty medications for elderly 29 why Resident #114 was 29 as stated, "She was 29 ath, high blood pressure, 20 and was calling 911 for her 20 at a conversation with 20 as having trouble with her 21 af the anti-anxiety 22 at the anti-anxiety 23 at the anti-anxiety 24 at the fact 28 at the anti-anxiety 26 at the anti-anxiety 27 at the anti-anxiety 28 at the anti-anxiety 29 at the anti-anxiety 20 at the anti-anxiety 21 at the fact 28 at the anti-anxiety 29 at the anti-anxiety 20 at the anti-anxiety 20 at the anti-anxiety 21 at the fact 29 at the fact 20 at the fact 20 at the fact 21 at the fact 22 at the fact 23 at the fact 24 at the fact 25 at the fact 26 at the fact 27 at the fact 28 at the fact 29 at the fact 29 at the fact 20 at the fact 20 at the fact 20 at the fact 20 at the fact 21 at the fact 21 at the fact 22 at the fact 23 at the fact 24 at the fact 25 at the fact 26 at the fact 27 at the fact 28 at the fact 28 at the fact 28 at the fact 29 at the fact 29 at the fact 20 at the fact 20 at the fact 20 at the fact 20 at the fact 20 at the fact 21 at the fact 22 at the fact 23 at the fact 24 at the fact 25 at the fact 26 at the fact 26 at the fact 27 at the fact 28 at the fact 28 at the fact 28 at the fact 28 at the fact 29 at the fact 20 at the fact 20 at the fact 20 at the fact 20 at the fact 20 at the fact 21 at the fact 21 at the fact 22 at the fact 23 at the fact 24 at the fact 25 at the fact 26 at the fact 26 at the fact 27 at the fact 28 at the fact 28 at the fact 29 at the fact 20 at the fact 20 at the fact 20 at the fact 20 at the fact 20 at the fact 21 at the fact 21 at the fact 21 at the fact 22 at the fact 24 at the fact 24 at the fact 25 at the fact 26 at the fact 26 at the fact 26 at the fact 27 at the fact 28 at the fact 28 at the fact 28 at the fact 28 at the fact 28 at the fact 28 at the fact 28 at the fact 28 at the fact 28 at the fact 28 at the fa | F 758               |  |           |                                     |

|   |   | OF DEFICIENCIES<br>F CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   |                     | PLE CONSTRUCTION   | (X3) DATE SURVEY<br>COMPLETED |                            |  |
|---|---|--|---|---------------------|--|-------------------------------|----------------------------|--|
| I |   |  |   |                     |  | 1                             | С                          |  |
| ŀ |   |  | 495391  | B. WING             |  | 0                             | 7/29/2021                  |  |
|   |   | PROVIDER OR SUPPLIER  RNIE REHAB & NURSING   | CENTER  |                     | STREET ADDRESS, CITY, STATE, ZIP CODE 1901 LIBBIE AVE RICHMOND, VA 23226                                     |                               |                            |  |
|   | (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIENCY   | ATEMENT OF DEFICIENCIES<br>MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) |                               | (X5)<br>COMPLETION<br>DATE |  |
|   | f e v v a a A v v A v A v v A v A v V A v A v | and responses to such medication orders will appropriate care proce interpretation and imple related to medications elements of the care prodequately detailed associated associ | e consistent with an prognosis, values, wishes a treatments. 3. All be supported by seses and practicesPolicy ementation: 2. All decisions shall include appropriate rocess, such as: sessment, review of consideration for the clinical and abnormal diagnostic of prescribing for the ent's wishes, values, goals, s. 4. Periodically and e present that represent a ion-related complications, in will review the continued indications, ation and possible adverse Physician will identify ations should be tapered, and to another medication, sident is being given in cessive periods of time, pring, or in the absence of the ector of clinical services, above findings on the edition, Rothenberg and the edition, Rothenberg and the edition, Rothenberg and the edition, Rothenberg and the edition, Rothenberg and the edition, Rothenberg and the edition, Rothenberg and the edition, Rothenberg and the edition is the edition, Rothenberg and the edition is the edition, Rothenberg and the edition is the edition in the edition, Rothenberg and the edition is the edition in the edition, Rothenberg and the edition is the edition in the edition in the edition in the edition, Rothenberg and the edition is the edition in | F 75                | В  |                               |                            |  |

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

|                          | T OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   |                     | LE CONSTRUCTION  | (X3) DATE SURVEY<br>COMPLETED   |
|--------------------------|--|---|---------------------|--|---------------------------------|
|                          |  | 495391  | B, WING             |  | C<br>07/29/2021                 |
|                          | PROVIDER OR SUPPLIER  JRNIE REHAB & NURSING  | CENTER  |                     | STREET ADDRESS, CITY, STATE, ZIP CODE 1901 LIBBIE AVE RICHMOND, VA 23226   | 01/20/2021                      |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY   | ATEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)   | E (X5) COMPLETION TE DATE       |
| i                        | Non-Medical Reader, 3<br>Chapman, page 124.<br>(3) Barron's Dictionary<br>Non-Medical Reader, 5<br>Chapman, page 43.<br>(4) This information was<br>following website:<br>https://medlineplus.gov<br>tml<br>Nutritive Value/Appear,<br>CFR(s): 483.60(d)(1)(2<br>§483.60(d) Food and d<br>Each resident receives | of Medical Terms for the oth edition, Rothenberg and as obtained from the oldruginfo/meds/a682053.h  Palatable/Prefer Temp  Tink and the facility provides- pared by methods that and appearance; I drink that is palatable, and appetizing Is not met as evidenced resident interview, staff focument review, it was lity staff failed to serve dilavor that was ment. | F 804               | F804: Nutritive Value/Appear, Palatable/Prefer Temp  1. Any Resident voicing concerns rest to food temperature or palatability offered alternative meal.  2. All residents have the potential to affected by this alleged deficient practice. Dietary Manager will audit food temperatures on current meal served.  3. Administrator or designee will educate Dietary staff on maintaining temperatures for foods and ensuring food is palatable.  4. Dietray Manager or designee will educate meals for presentation, palatability, and appropriate food emperatures weekly times 4 weeks monthly x 2 months. Any identified assues will be immediately corrected essues will be reported to Quality Assurance committee for analysis are evision x 3 months.  Date of compliance will August 2-1021. | are o be dit  ag g then l d. nd |

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION |                               | OF DEFICIENCIES<br>OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   | (X2) MULT           | TIPLE CONSTRUCTION   | (X3) DA | NO. 0938-03<br>TE SURVEY<br>MPLETED | <u>191</u> |
|---|-------------------------------|---|---|---------------------|--|---------|-------------------------------------|------------|
| 495391  |                               | B. WING   |   |                     | С  |         |                                     |            |
|   |                               | ROVIDER OR SUPPLIER RNIE REHAB & NURSING  | CENTER  |                     | STREET ADDRESS, CITY, STATE, ZIP CODE 1901 LIBBIE AVE RICHMOND, VA 23226 | 0       | 7/29/2021                           |            |
|   | (X4) ID<br>PREFIX<br>TAG      | (EACH DEFICIENCY  | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTIO   | BF      | (X5)<br>COMPLETIO<br>DATE           | N          |
|   | R te di C te C dr de C ine M: | On 7/28/21 at 11:40 All trayline was conducted obtained with a facility staff member. OSM #1/2 the dietary manager, ar for dietary services, we temperatures were as filled. Regular 170 deg degrees. Corn: Regular 190 degrees. Coleslaw: Regular 190 degrees. Coleslaw: Regular 37.6 Mashed potatoes: 175 con 7/28/21 at 12:31 PM and placed on the meal desidents were served, a was evaluated. The food obtained with a facility thind were as follows: | M, observation of the The temperatures were thermometer by a dietary (Other Staff Member) od OSM #16, a consultant re present. The follows:  grees; Pureed 153 rees. degrees; Pureed 161 degrees. degrees. degrees. degrees. degrees. a test tray was prepared cart to the unit. Once all it 12:51PM the test tray I temperatures were ermometer by OSM #16 es, a 72 degree drop in degrees, a 33 degree es, a 70 degree drop in egrees, a 71 degree ded 129 degrees, a 32 re. grees, a 13.4 degree egrees, a 40 degree | F8                  | 04   |         |                                     |            |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIE IDENTIFICATION NU |                            | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  | 1   | LE CONSTRUCTION     | (X3) DA1   | IO. 0938-03<br>TE SURVEY<br>MPLETED | 91                         |   |
|--|----------------------------|--|---|---------------------|--|-------------------------------------|----------------------------|---|
|  |                            |  | 495391  | B. WING             |  |                                     | C                          |   |
|  |                            | PROVIDER OR SUPPLIER RNIE REHAB & NURSING  | CENTER  |                     | STREET ADDRESS, CITY, STATE, ZIP CODE 1901 LIBBIE AVE RICHMOND, VA 23226                                     | 1 0                                 | 7/29/2021                  |   |
|  | (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | E                                   | (X5)<br>COMPLETION<br>DATE | N |
|  | t v p A S pp m CC D #: fir | food items. It was agree textured cabbage and renough for meal enjoys that the mashed potator undesirable off-taste are was different than norm not been seasoned. It was during meal preparation AM) the potatoes were and were not made with boxed powder or flake the addition, a piece of carredessert, that was at roo hot or cold food item) whom the dry side, and had colored pudding-like protraditional cream cheese On 7/28/21 at 1:45 PM, of OSM #15 (Senior Director were notified of the above OSM #16 agreed the food the flavorful. OSM #15 sand they will be doing expressed to the colored products for a better of the facility poservices Staff" document all all all all all all all all all al | riblet were not warm ment. It was also agreed were bland and had an ind texture about them that hal bland potatoes that had was noted that earlier in (approximately 11:30 observed being prepared in real potatoes, but was a type potato product. In not cake, which was im temperature (was not a las tasted and noted to be did a thin layer of a yellow iduct "icing" instead of the le frosting.  OSM #14, OSM #16, and lor of Culinary Services), we test tray concerns. Indicated that they should be discation and les. OSM #14 stated she her brands of mashed ter option.  Ilicy, "Food and Nutrition ted, " 4. Food will be served in a timely atures"  The Regional Director of the of Nursing and Medical taff Members (ASM) #1, were made aware of the | F 804               |  |                                     |                            |   |

| AND PLAN                 | T OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  |                     | PLE CONSTRUCTION<br>G   | (X3) DATE SURVEY<br>COMPLETED                   |  |
|--------------------------|--|--|---------------------|---|---|--|
|                          |  | 495391   | B. WING             |   | C   |  |
| GLENBU                   | PROVIDER OR SUPPLIER  JRNIE REHAB & NURSING  |  |                     | STREET ADDRESS, CITY, STATE, ZIP CODE 1901 LIBBIE AVE RICHMOND, VA 23226  | 07/29/2021                                      |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY   | ATEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROPRI<br>DEFICIENCY)  | BE COMPLETION                                   |  |
| t c r r                  | CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety The facility must - §483.60(i)(1) - Procure approved or considere state or local authoritie (i) This may include foo from local producers, s and local laws or regula (ii) This provision does facilities from using pro gardens, subject to com safe growing and food-I (iii) This provision does from consuming foods r §483.60(i)(2) - Store, pre serve food in accordance standards for food servic This REQUIREMENT is by: | e food from sources disatisfactory by federal, s. od items obtained directly subject to applicable State ations. In the probability of the probability of the procured by the facility of the procured by the facility. In the procured by the facility of the procured by the facility of the procured by the facility. In the professional content of the procured by the facility of the facility of the fa |                     | F812: Food Procurement, Store/Prepare/Serve-Sanitary 1. The box of fish fillets and thic orange juice were discarded on 7/27/2021. 2. All residents have the potential affected by this alleged deficient practice. Audit was conducted for food items to verify dated and sto appropriately. 3. Dietry Manager or designee will educate Dietary staff on food stor and date open food items. 4. Dieatry Manager or designee will audit food storage and open food dated weekly times 4 weeks then monthly x 2 months. Any identific issues will be immediately correct Results will be reported to Quality Assurance committee for analysis revision x 3 months. 5. Date of compliance will August 2021. | to be r open ored  l age ill items ed ed. r and |  |

|   | STATEMENT   |   | MEDIOAID GERVICES  | -                       |  | OMB N   | VO. 0938-03               | 391 |
|---|---|---|--|-------------------------|--|---------|---------------------------|-----|
|   |   | T OF DEFICIENCIES<br>OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | (X2) MULT<br>A. BUILDII | TIPLE CONSTRUCTION NG  | (X3) DA | TE SURVEY<br>MPLETED      |     |
|   | NAME OF   | PROVIDER OR SUPPLIER  | 495391   | B, WING                 | B, WING  |         | C<br>07/29/2021           |     |
|   |   | IRNIE REHAB & NURSING   | CENTER   |                         | STREET ADDRESS, CITY, STATE, ZIP CODE  1901 LIBBIE AVE   |         |                           |     |
| ŀ | 0/4) 15   | 1   |  |                         | RICHMOND, VA 23226   |         |                           |     |
|   | (X4) ID<br>PREFIX<br>TAG                          | (EACH DEFICIENCY  | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG     | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY) | BE      | (X5)<br>COMPLETIO<br>DATE | N   |
|   | 3<br>C<br>()<br>C<br>C<br>()<br>C<br>C<br>C<br>() | freezer an unsealed be observed. The fish filler to the environment in the bottle of thickened orar opened, half used, and opened date or placed opening.  On 7/27/21 at approxim (Other Staff Member) the that the fillets should have refrigerated. | ox of frozen fish fillets was its in the box were exposed he freezer. In the pantry, a nige juice had been was not dated with an in the refrigerator after  ately 11:45 AM, OSM #14 he dietary manager stated and the ve been sealed and the ve been dated and  If the day at approximately is provided with a list of urvey team. One for all yserving of food was he facility policies etary services failed to be proper storage of food.  In (B) and (C) of this protected from the FOOD:  In;  In;  In (B) and we he floor.  Ity.  It | F8                      |  |         |                           |     |
|   | 0   | xygen), botulism toxin m  | ay be formed.  |                         |  | 1       |                           | 1   |

|                          | NT OF DEFICIENCIES<br>N OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  | 1                   | PLE CONSTRUCTION<br>G   | (X3) DATE | SURVEY<br>PLETED           | _ |
|--------------------------|--|--|---------------------|---|-----------|----------------------------|---|
| 1                        |  | 495391   | B. WING _           |   | (         | С                          |   |
| NAME O                   | F PROVIDER OR SUPPLIER   | 495591   | B. WING             |   | 07/       | 29/2021                    |   |
| GLENB                    | URNIE REHAB & NURSING  |  |                     | STREET ADDRESS, CITY, STATE, ZIP CODE  1901 LIBBIE AVE  RICHMOND, VA 23226                                    |           |                            |   |
| (X4) ID<br>PREFIX<br>TAG | ( EACH DEFICIENCY  | ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)                                 | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | E<br>TE   | (X5)<br>COMPLETION<br>DATE |   |
| F 81                     | a samuel a rom pago  |  | F 81                | 2   |           |                            |   |
|                          | According to the Feder<br>Administration Food C<br>3-501.17 Ready-to-Eat<br>Control for Safety Food                  | ode, 2017:<br>, Time/Temperature<br>d, Date Marking:   |                     |   |           |                            |   |
|                          | refrigerated, READY-T TIME/TEMPERATURE FOOD prepared and P.  | CONTROL FOR SAFETY<br>ACKAGED by a FOOD  |                     |   |           | Y                          |   |
|                          | the time the original col  | shall be clearly marked, at<br>ntainer is opened in a<br>NT and if the FOOD is<br>ours, to indicate the date |                     |   |           |                            |   |
|                          | or day by which the FO<br>the PREMISES, sold, o<br>temperature and time or   | OD shall be consumed on r discarded, based on the ombinations specified in                                   |                     |   |           |                            |   |
|                          | (A) of this section and: (1) The day the original FOOD ESTABLISHME! Day 1; and                                       | container is opened in the<br>NT shall be counted as   |                     |   |           |                            |   |
|                          | (2) The day or date mar<br>ESTABLISHMENT may<br>manufacturer's use-by d  | not exceed a   |                     |   |           |                            |   |
|                          | determined the use-by of safety.  (C) A refrigerated, REAL   | late based on FOOD   |                     | ×   |           |                            |   |
|                          | TIME/TEMPERATURE C<br>FOOD ingredient or a po<br>READY-TO-EAT, TIME/   | ONTROL FOR SAFETY ortion of a refrigerated, TEMPERATURE  |                     |   |           |                            |   |
|                          | CONTROL FOR SAFET subsequently combined ingredients or portions of   | with additional f FOOD shall retain the  |                     |   |           |                            |   |
|                          | date marking of the earliefirst-prepared ingredient. (D) A date marking system (D) A date marking system (D) (D) (M) | m that meets the criteria  |                     |   |           |                            |   |
|                          | stated in (A) and (B) of th<br>(1) Using a method APPF<br>REGULATORY AUTHORI<br>READY-TO-EAT TIME/TE                 | ROVED by the TY for refrigerated,  |                     |   |           |                            |   |

| STATEME<br>AND PLA      | ENT OF DEFICIENCIES<br>IN OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  |                     | PLE CONSTRUCTION<br>G   | (X3) DATE SURVEY<br>COMPLETED |
|-------------------------|--|--|---------------------|---|-------------------------------|
|                         |  | 495391   | B. WING             |   | C<br>07/29/2021               |
| GLEN                    | DE PROVIDER OR SUPPLIER BURNIE REHAB & NURSING   |  |                     | STREET ADDRESS, CITY, STATE, ZIP CODE 1901 LIBBIE AVE RICHMOND, VA 23226  | 01123/2021                    |
| (X4) II<br>PREFI<br>TAG | X   (EACH DEFICIENCY   | ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)  | E (X5) COMPLETION TE DATE     |
| F 814<br>SS=C           | CONTROL FOR SAFE frequently rewrapped, roast, or for which date such as soft serve mix machine;  (2) Marking the date of procedure to discard the last date or day by which consumed on the premispecified under (A) of (3) Marking the date or is opened in a FOOD E procedure to discard the last date or day by which consumed on the premispecified under (B) of the (4) Using calendar date color-coded marks, or of methods, provided that disclosed to the REGULA upon request.  On 7/29/21 at 8:45 AM, Clinical Services, Director (Administrative #2, and #3 respectively) findings. No further inforthe end of the survey. | ETY FOOD that is such as lunchmeat or a marking is impractical, or milk in a dispensing and a person of the country of the FOOD on or before the country of the FOOD must be ises, sold, or discarded as this section; day the original container is STABLISHMENT, with a person of the FOOD on or before the country of the FOOD must be is section; or sold, or discarded as this section; or sold, or discarded as this section; or sold, or discarded as the section; or discarded as the section; or sold, or discarded as the section; or discarded as the section; or discarded as the section; or discarded as the section; or discarded as the section; or discarded as the section; or discarded as the section; or discarded as the section; or discarded as the section; or discarded as the section; or dis | F 814               | F814: Dispose Garbage and Refu<br>Property  1. The dumpster area was immediateleaned at time of finding.  2. All residents have the potential to affected by this alleged deficient practice. Audit conducted next day werify no debri on ground around dumpster. | ely<br>be                     |

|   | STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION |   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   |                     | PLE CONSTRUCTION  | (X3) DAT                                     | TE SURVEY MPLETED          | - |
|---|---|---|---|---------------------|---|--|----------------------------|---|
|   |   |   | 405204  | B. MILLO            |   |  | С                          |   |
| ŀ | NAME OF C   | POVIDED OR CURRUED  | 495391  | B. WING             | -   | 0  | 7/29/2021                  |   |
|   |   | PROVIDER OR SUPPLIER  RNIE REHAB & NURSING  | CENTER  |                     | STREET ADDRESS, CITY, STATE, ZIP CODE  1901 LIBBIE AVE  RICHMOND, VA 23226  |  |                            |   |
|   | (X4) ID<br>PREFIX<br>TAG                            | (EACH DEFICIENCY  | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)  | E<br>TE                                      | (X5)<br>COMPLETION<br>DATE |   |
|   | t till b  | bottle beverages. Multiple pieces of assort various food and medica A pile of string or yarn lile and blue colors. Significant amount of and dumpster. On 7/29/21 at 9:30 AM, acconducted with OSM #12 the dietary manager and Director of Culinary Service dumpster area at this tems should not be on the hat multiple departments but that ultimately, the director of the dump areview of the facility postarbage and Refuse Disportside dumpsters providervices will be kept close urrounding litter." | an inspection of the inducted. The following flattened and partially in a 6-pack of canned or ated plastic packaging for al supplies. The interview was trailing to and from the an interview was 4 (Other Staff Member) I OSM #15, the Senior vices. They were shown is time. They agreed the interview is the dumpster area etary department is ster area.  Ilicy, "Food-Related posal" documented, "7. ded by garbage pickuped and free of | F 81                | 3.Administrator or designee will educate staff on keeping the dump area clean, sanitary and the top of dumpster must remain closed to prodents and pest.  4.Administrator or designee will a the dumpster area to verify no debe grounds weekly times 4 weeks the monthly x 2 months. Any identified issues will be immediately correct Results will be reported to Quality Assurance committee for analysis revision x 3 months.  5.Date of compliance will August 2021. | revent<br>audit<br>ori on<br>en<br>ed<br>ed. |                            |   |
|   |   | TI TIZBIZI ALO.40 MIVI, [[  | e ASM #1, the Regional  |                     |   |  |                            |   |

| STATEMENT<br>AND PLAN C  | OF DEFICIENCIES OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   |                     | FIPLE CONSTRUCTION NG   |   | (X3) DATE SURVEY<br>COMPLETED |  |
|--------------------------|--|---|---------------------|---|---|-------------------------------|--|
|                          |  | 495391  | B, WING             | С   |   |                               |  |
| NAME OF F                | PROVIDER OR SUPPLIER   | 455051  |                     |   | 07/2  | 29/2021                       |  |
| GLENBU                   | RNIE REHAB & NURSING   |   |                     | STREET ADDRESS, CITY, STATE, ZIP CODE 1901 LIBBIE AVE RICHMOND, VA 23226  |   |                               |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY   | ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BI<br>CROSS-REFERENCED TO THE APPROPRIA'<br>DEFICIENCY)   |   | (X5)<br>COMPLETION<br>DATE    |  |
| SS=D  SS=D  (i)          | Director of Clinical Ser Member) was made at further information was survey.  Resident Records - Ide CFR(s): 483.20(f)(5), 4  §483.20(f)(5) Resident-(i) A facility may not relate resident-identifiable to accordance with a contagrees not to use or disexcept to the extent the to do so.  §483.70(i) Medical reco §483.70(i)(1) In accordate professional standards a must maintain medical rethat are-(i) Complete; (ii) Accurately document (iii) Readily accessible; a iv) Systematically organish (383.70(i)(2) The facility all information contained egardless of the form or ecords, except when relate (i) To the individual, or the presentative where per i) Required by Law; iii) For treatment, payme perations, as permitted with 45 CFR 164.506; | rvices (Administrative Staff ware of the findings. No a provided by the end of the entifiable Information (83.70(i)(1)-(5))  ridentifiable information.  rease information that is the public.  rease information that is an agent only in ract under which the agent eclose the information of facility itself is permitted.  rds.  rds.  rds.  race with accepted and practices, the facility ecords on each resident.  ed;  and hized  r must keep confidential in the resident's records, restorage method of the ease is-  reir resident mitted by applicable law;  ent, or health care by and in compliance | F 842               | F842: Resident Records – Identification  1. Resident #101 continues to reside facility and all duplicate orders has been discontinued and all orders at PEG tube. Resident #59 has been discharged from the facility.  2. All residents have the potential to affected by this alleged deficient practice. Nursing management will addit current residents with a peg to and a physician order for NPO to we medications are ordered via peg tule. An audit of current residents with dialysis sites to verify documentation assessing dialysis site.  3. DON or designee will educate all turses on the process for physician orders for peg tube with a NPO state ave medications ordered via peg tule. DON or designee will audit resident with peg tube and a NPO order to we medications have been ordered beg tube and audit resident with italysis sites having documentation assessing dialysis site weekly and at mes 4 weeks and monthly times. | le in ve re via  o be l ube verify be. on  us ube. ents erify via |                               |  |
| 1,0                      | ., . or public ricaltit activ  | rities, reporting of abuse,   | 1                   |   |   |                               |  |

| STATEMENT OF DEFICIENCIES (X1) PRO' IDEN |                          | T OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   |                     | LE CONSTRUCTION   | (X3) DATE SURVEY<br>COMPLETED |                            |
|--|--------------------------|--|---|---------------------|---|-------------------------------|----------------------------|
| L  |                          |  | 495391  | B. WING             |   | 0.5                           | C                          |
|  |                          | NAME OF PROVIDER OR SUPPLIER  GLENBURNIE REHAB & NURSING CENTER  |   |                     | STREET ADDRESS, CITY, STATE, ZIP CODE 1901 LIBBIE AVE RICHMOND, VA 23226  | 1 07                          | //29/2021                  |
|  | (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES<br>MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)  | ē<br>TE                       | (X5)<br>COMPLETION<br>DATE |
|  | k<br>a<br>t              | neglect, or domestic viactivities, judicial and a law enforcement purpopurposes, research purposes, fundamental examiners, fundamental purposes, fundamental pu | colence, health oversight administrative proceedings, bees, organ donation proses, or to coroners, areal directors, and to avert lith or safety as permitted with 45 CFR 164.512.  In y must safeguard medical nst loss, destruction, or ecords must be retained quired by State law; or after a resident reaches w.  In State law; or after a resident reaches w.  In I record must containto identify the resident; ent's assessments; plan of care and services eadmission screening uations and do by the State; and other licensed notes; and other diagnostic red under §483.50, not met as evidenced in clinical record review iew, it was determined naintain a complete and for two of 49 residents in | F 842               | identified issues will be immediated corrected. Results will be reported Quality Assurance committee for analysis and revision x 3 months. 5.Date of compliance will be Aug 2021. | l to                          |                            |

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

|   |  | TEMENT OF DEFICIENCIES PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  (X2) MULTIPLE CONSTRUCTION A. BUILDING  |   | (X3) DA             | NO. 0938-0391<br>TE SURVEY<br>MPLETED  |      |                            |
|---|--|--|---|---------------------|--|------|----------------------------|
| NAME OF PROVIDER OR SUPPLIER  GLENBURNIE REHAB & NURSING CENTER |  | B. WING_   |   | ,                   | C<br>07/29/2021  |      |                            |
|   |  |  | STREET ADDRESS, CITY, STATE, ZIP CODE 1901 LIBBIE AVE RICHMOND, VA 23226  |                     | 7/129/2021   |      |                            |
|   | (X4) ID<br>PREFIX<br>TAG                   | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY) | D BE | (X5)<br>COMPLETION<br>DATE |
|   | T aa aa c c tth inn res c c as dr fo ea Bo | #101.  The findings include:  1. The facility staff failed assessment of Resider [arteriovenous] shunt for shift, on seven shifts in shifts in July 2021.  Resident #59 was admutized to: diabetes mellitus (inability of the wastes and function in the lectrolyte balance) (2), the heart to pump enough the most recent MDS (not a hemost recent MDS) (not a hemost recent MDS) (not a hemost recent MDS) (not a hemost recent MDS) (not a hemost recent MDS) (not a hemost recent MDS) (not a hemost recent MDS) (not a hemost recent MDS) (not a hemost recent MDS) (not a hemost recent MDS) (not a hemost recent MDS) (not a hemost recent MDS) (not a hemost recent MDS) (not a hemost recent MDS) (not a hemost resident as some BIMS) (brief interview and the resident as recent most resident as recent most recent most resident was eview of the MDS Section of the MDS Section of the MDS Section of the MDS section of the most resident as recent most recent | d to document the nt #59's the AV or bruit and thrill every June 2021 and on eleven litted to the facility on hat included but were not lity of insulin to function ), ESRD [end stage renal kidneys to excrete the maintenance of heart failure (inability of gh blood to maintain nts) (3) and lot (abnormal condition in blockage of the blood is to a lack of oxygen) (4).  Ininimum data set) 5 day assessment, with rence date) of 6/14/21, oring a 15 out of 15 on for mental status) score, as cognitively intact. A lon G-functional status quiring extensive , limited assistance with pervision was required bed mobility, walking, view of MDS Section Hel the resident as always | F 8                 |  |      |                            |

| STATEMENT                | OF DEFICIENCIES  | (VA) BROWER OF THE  |  |  | OMB NO. 0938-0391  |                |
|--------------------------|--|---|--|--|--|----------------|
|                          | STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CL IDENTIFICATION NUMBER  495391  |   | (X2) MULTIPLE CONSTRUCTION A. BUILDING |  | (X3) DATE SURVEY<br>COMPLETED  |                |
|                          |  |   | B. WING                                |  | 07   | C<br>7/29/2021 |
| NAME OF P                | PROVIDER OR SUPPLIER   |   | T :                                    | STREET ADDRESS, CITY, STATE, ZIP CODE          |  |                |
| GLENBUI                  | RNIE REHAB & NURSING   | CENTER  |  | 1901 LIBBIE AVE<br>RICH <b>MOND</b> , VA 23226 |  |                |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY   | ATEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG                    |  | COMPLETED  C 07/29/2021  T ADDRESS, CITY, STATE, ZIP CODE  IBBIE AVE  MOND, VA 23226  PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE  COMPLETION DATE |                |
|                          | A review of the physici documented in part, "I vascular shunt-check if A review of the TAR (tr record) failed to show and thrill on seven of the seven and eleven of the seven the seven that the seven the se | an orders dated 6/10/21, Dialysis: site of arterial bruit and thrill every shift."  reatment administration documentation for the bruit the sixty shifts in June 2021 nty nine shifts in July 2021.  ucted on 7/28/21 at 3:05 practical nurse) #2. When | F 842                                  |  |  |                |
|                          | administration record) in "Legally it means it was mean it was not docum  On 7/27/21 at 11:11 AN standard of practice wat ASM (administrative standard)  | s not done, but it could<br>ented."<br>//, when asked what<br>s followed in the facility.   |  |  |  |                |
| t<br>t<br>t<br>E<br>iii  | to be documented in the reatments or services procumentation of procest noticed acrespecific defends of 7/28/21 at 5:30 PM, director of clinical services for foursing and ASM #4, in the reader.  | July 2017, which following information is resident medical record: performed. dures and treatments will tails."  ASM #1, the regional es, ASM #2, the director the Medical Director were  |  |  |  |                |
| N                        | nade aware of the conc   | ern.<br>as provided prior to exit.  |  |  |  |                |
| R                        | eferences:   | 1   | 1                                      |  |  |                |

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION |  | OF DEFICIENCIES<br>F CORRECTION  | I IDENTIFICATION NUMBER:  |                     | IPLE CONSTRUCTION<br>IG  | (X3) DATE SURVEY<br>COMPLETED |                            |
|---|--|--|---|---------------------|--|-------------------------------|----------------------------|
|   |  |  | 495391  | B. WING             |  |                               | С                          |
| ı   | NAME OF P  | ROVIDER OR SUPPLIER  |   |                     | STREET ADDRESS, CITY, STATE, ZIP CODE  | 1 0                           | 7/29/2021                  |
| GLENBURNIE REHAB & NURSING CENTER                   |  |  |   |                     | 1901 LIBBIE AVE<br>RICHMOND, VA 23226  |                               |                            |
|   | (X4) ID<br>PREFIX<br>TAG   | EIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL  |   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | E<br>JTE                      | (X5)<br>COMPLETION<br>DATE |
|   | Find In the control of the control o | (1) Barron's Dictionary Non-Medical Reader, 5 Chapman, page 160. (2) Barron's Dictionary Non-Medical Reader, 5 Chapman, page 498. (3) Barron's Dictionary Non-Medical Reader, 5 Chapman, page 259. (4) Barron's Dictionary Non-Medical Reader, 5 Chapman, page 259. (4) Barron's Dictionary Non-Medical Reader, 5 Chapman, page 111. 2.a. The facility staff fail inaccurate physician's of not entered into Resider and failed to ensure accordinistration of the medical failed to ensure accordinistration of the medical failed to ensure accordinistration of the medical failed to ensure accordinistration of the medical failed to ensure accordinistration of the medical failed to ensure accordinistration of the medical failed to ensure accordinistration of the medical failed to ensure accordinistration of the medical failed to ensure according to multiple and high blood pressure quarterly minimum data assessment reference desident's cognitive skills anaking as severely imparts and the properties of the prop | of Medical Terms for the ofth edition, Rothenberg and of Medical Terms for the th edition, Rothenberg and of Medical Terms for the th edition, Rothenberg and of Medical Terms for the th edition, Rothenberg and of Medical Terms for the th edition, Rothenberg and of Medical Terms for the the edition, Rothenberg and of Medical Terms for the the dition, Rothenberg and of Medical Terms for the the dition, Rothenberg and of Medical Terms for the the dition, Rothenberg and of Medical Terms for the dition, Rothenberg and of Medical Terms for the the dition, Rothenberg and of Medical Terms for the the dition, Rothenberg and record diagnoses included but only be sclerosis (2), seizures and diagnoses included but only seid and the dition of the | F 84                |  |                               | COMPLETED  C 07/29/2021    |

| STATEMENT<br>AND PLAN (  | OF DEFICIENCIES OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  | (X2) MULTIPL        | E CONSTRUCTION   | (X3) DAT | C. 0936-039<br>E SURVEY<br>MPLETED |
|--|--|--|---------------------|--|----------|------------------------------------|
|  |  | 495391   | B. WING             |  |          | С                                  |
|  | PROVIDER OR SUPPLIER   | CENTER   | 1                   | TREET ADDRESS, CITY, STATE, ZIP CODE<br>901 LIBBIE AVE<br>RICHMOND, VA 23226             | 07       | 7/29/2021                          |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIENCY   | ATEMENT OF DEFICIENCIES<br>' MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AP DEFICIENCY) | HOULD BE | (X5)<br>COMPLETION<br>DATE         |
| Constant of the constant of th | time a day for a rash.  Review of Resident #1 (medication administrated coumentation that 10 administered to the res 7/26/21 through 7/28/2 was administered to th 7/26/21 through 7/28/2 On 7/28/21 at 12:27 p.t. conducted with LPN (lie the nurse who signed of loratadine orders from LPN #4 stated Residen medications by mouth a via PEG tube. LPN #4 dated 7/25/21 was inact Resident #101's clinical stated she mistakenly do for the 7/25/21 loratadine through 7/28/21 becaustotal of 10 mg of loratad medication to Resident #101's clinical stated she mistakenly do for the 7/25/21 loratadine through 7/28/21 at 4:52 p.m. staff member) #1 (the reservices) and ASM #2 (the vere made aware of the reservices) and ASM #2 (the vere made aware of the resident's medical record medicated for a medication dinistering the medical record medication was adminosage; c. The route of a sident's medical record medication was adminosage; c. The route of a sident's medical record medication was adminosage; c. The route of a sident's medical record medication was adminosage; c. The route of a sident's medical record medication was adminosage; c. The route of a sident's medical record medication was adminosage; c. The route of a sident's medical record medication was adminosage; c. The route of a sident's medical record medication was adminosage; c. The route of a sident's medical record medication was adminosage; c. The route of a sident's medical record medication was administering the medical record medication was administering the medical record medication was administering the medical record medication was administering the medical record medication was administering the medical record medication was administering the medical record medication was administering the medical record medication was administering the medical record medication was administering the medical record medication was administering the medical record medication was administering the medical record medication was administering the medical record medication was administe | ation record) revealed mg of loratadine was sident via PEG tube from 1 and 10 mg of loratadine e resident by mouth from 1.  m., an interview was bensed practical nurse) #4, off administration of both 7/26/21 through 7/28/21. It #101 could not receive and received medications stated the loratadine order curately entered into record. LPN #4 further ocumented administration in e order from 7/26/21 e she only administered a ine and administrative gional director of clinical the director of nursing) above concern.  Administering d, "As required or n, the individual ation will record in the lat. a. The date and time nistered; b. The | F 842               |  |          |                                    |

|                          |  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  |  | LE CONSTRUCTION  |           | E SURVEY                   |
|--------------------------|--|--|--|--|-----------|----------------------------|
|                          |  | 495391   | B.WING   |  |           | С                          |
|                          | AME OF PROVIDER OR SUPPLIER  LENBURNIE REHAB & NURSING CENTER  (X4) ID  SUMMARY STATEMENT OF DEFICIENCIES  |  | STREET ADDRESS, CITY, STATE, ZIP CODE 1901 LIBBIE AVE RICHMOND, VA 23226 | 1 07   | 7/29/2021 |                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY   | MUST BE PRECEDED BY FULL   | ID<br>PREFIX<br>TAG  | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD )<br>CROSS-REFERENCED TO THE APPROPRI<br>DEFICIENCY) | BE        | (X5)<br>COMPLETION<br>DATE |
| F ( C c a 7 7 C C c      | References:  (1) Loratadine is used redness. This information website: https://medlineplus.gov.tml  (2) Multiple Sclerosis i disease that affects the This information was on https://vsearch.nlm.nih.meta?v%3Aproject=memedlineplus-bundle&ques.7.27485085.1627513122  2.b. The facility staff fai inaccurate physician's owas not entered in Resi and failed to ensure accadministration of the memothing by mouth. Furth#101's clinical record redated 7/25/21 for prednicy mouth one time a day Review of Resident #10 medication administration of the medication administra | to treat itching and tion was obtained from the   //druginfo/meds/a697038.h  s a nervous system  brain and spinal cord . btained from: .gov/vivisimo/cgi-bin/query- edlineplus&v%3Asources= ery=ms&_ga=2.16826909 122-1380714373.1627513  illed to ensure an  order for prednisone (1)  ident #101's clinical record  curate documentation for  edication.  O's clinical record  order dated 6/17/21 for  ner review of Resident  vealed a physician's order  isone 20 mg (milligrams)  y for a rash until 7/21/21.  1's July 2021 MAR  on record) revealed  thisone 20 mg was  to the resident from  . , an interview was  ensed practical nurse) #4, | F 842  |  |           |                            |

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 08/10/2021 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED STATEMENT OF DEFICIENCIES OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: (X3) DATE SURVEY A. BUILDING COMPLETED 495391 B. WING NAME OF PROVIDER OR SUPPLIER 07/29/2021 STREET ADDRESS, CITY, STATE, ZIP CODE GLENBURNIE REHAB & NURSING CENTER 1901 LIBBIE AVE RICHMOND, VA 23226 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) COMPLETION **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) Continued From page 210 F 842 prednisone by mouth from 7/26/21 through 7/28/21. LPN #4 stated Resident #101 could not receive medications by mouth and received medications via PEG tube (a feeding tube inserted into the stomach). LPN #4 stated the prednisone order dated 7/25/21 was inaccurately entered into Resident #101's clinical record because it should have documented administration via PEG tube instead of by mouth. LPN #4 further stated she mistakenly documented administration of the medication by mouth from 7/26/21 through 7/28/21 because she administered the medication via PEG tube. On 7/28/21 at 4:52 p.m., ASM (administrative staff member) #1 (the regional director of clinical services) and ASM #2 (the director of nursing) were made aware of the above concern. No further information was presented prior to exit. Reference: (1) "Prednisone is used alone or with other medications to treat the symptoms of low corticosteroid levels (lack of certain substances that are usually produced by the body and are needed for normal body functioning). Prednisone is also used to treat other conditions in patients with normal corticosteroid levels. These conditions include certain types of arthritis; severe allergic reactions; multiple sclerosis (a disease in which the nerves do not function properly)." This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a601102.ht ml