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	495291	A. BUILDING _____ B. WING _____	C 07/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETH SHOLOM HOME OF VIRGINIA	1600 JOHN ROLFE PARKWAY RICHMOND, VA 23233

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 07/20/21 through 07/22/21. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities.	E 000		
F 000	INITIAL COMMENTS An unannounced {Medicare/Medicaid} standard survey was conducted 07/20/21 through 07/22/21. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. One complaint (VA00051018 Substantiated without a related deficiency) was investigated during the survey. The census in this 101 certified bed facility was 91 at the time of the survey. The survey sample consisted of 33 resident reviews.	F 000		
F 565 SS=D	Resident/Family Group and Response CFR(s): 483.10(f)(5)(i)-(iv)(6)(7) §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation. (iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings.	F 565		9/3/21

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

Electronically Signed | 08/13/2021

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F 565	Continued From page 1 (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group. §483.10(f)(6) The resident has a right to participate in family groups. §483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, group interview and staff interview, the facility staff failed to act promptly to resolve grievances discussed in the group interviews. For 6 of 6 residents in the Resident Council group, the facility staff failed to resolve the issues/concerns discussed in Resident Council. The Findings included: Review of the Resident Council meeting minutes from March 2021 through July 2021, revealed documentation of the same concerns during several of the months. There was no documentation of the facility administration's response to the concerns expressed during the meetings.	F 565	F-565 □ Resident and Family Group and Response Criterion #1 □ Correction □ The DON or designee met with resident's # 78, #13, #19, #34, #64, and # 67 to reassure that the nursing staff had been re-educated on the importance of introducing themselves at the beginning of the shift. Criterion #2 □Other Potential Residents -- All residents may have potentially been impacted. The nursing staff will be educated on customer service, including the importance of introducing themselves to the residents are the beginning of the shift. A Resident's Council meeting was held on August 24 and the residents were	

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F 565	Continued From page 2 4/28/2021 Meeting agenda- New Business included statement "Nursing: DON (Director of Nursing) and Administrator will remind nursing to introduce them self (sic) at the beginning of each shift." 5/19/2021- Meeting Minutes-Old Business "Aides still not introducing themselves when they come on shift (residents would like to know who their aides are for the morning and night." Under New Business, the statement was included "When residents need something, they are having to go and find the staff. Staff are not checking on them as they feel they should. " 6/14/2021- Meeting Agenda- Old Business included "Aids-Let you know who they are." Under Discussion of New Business was written "Aids-poor attitudes, make beds/open blinds, responding to call bells, check on residents. Not enough aids on every shift" Under Action items -an X was written beside the space for "issues to raise within facility (Such as with Administrator or Quality Assurance Committee)." 7/17/2021- Meeting Agenda-Council Old Business- "Aids-not making beds or wrong way/still not introducing themselves, not enough. Under Discussion of New Business was written "Aids-trying to get more/addressing continuing issues from old business Under Action items -an X was written beside the space for "issues to raise within facility (Such as with Administrator or Quality Assurance Committee)." On 7/21/2021 at 2:30 PM, a Group interview was conducted with six residents (Residents # 13, # 19, # 34, # 64, # 67 and # 78) who attended the meeting. One resident (Resident # 13) first	F 565	informed that they should know who their caregivers are for a designated shift and that the facility would be monitoring staff compliance with identifying themselves to the residents at the beginning of the shift and on the grievance report process with notification to the resident or residents filing the grievance and the minutes from the last resident council will be reviewed at the next resident council. Criterion #3 □ System Changes - The nursing staff (RN's, LPN's and CNA's) will be educated by the DON or Unit Manager on customer service, introducing themselves to their assigned residents at the beginning of the shift. The nursing aides will make rounds on assigned residents at the beginning of each shift and will introduce themselves to the residents to whom they are assigned. The facility will include this measure in the agency orientation manual, so that agency staff are also required to make introductions and include it in the customer service portion of orientation for Beth Sholom staff. The Life Enrichment staff and social worker will be educated by the VP of QA on the grievance report process and documentation in the resident council minutes with follow up notification to the resident or the residents that filed the grievance report of the findings and resolution. The resident council minutes from the prior month meeting will be reviewed in the next resident council to identified if grievance continues to be resolved or if revision of plan is required.	

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F 565	Continued From page 3 spoke up and stated she wished the nursing assistants would introduce themselves to the residents at the beginning of their shifts. Resident # 13 stated it would help to know which Certified nursing assistant was working with them so they would know who would give them care that day and provide showers. All of the other residents agreed that there was an issue with the CNAs not introducing themselves. Resident # 13 stated it was :a problem almost every day" that she did not know who was working with her that day. Residents # 67, # 34 and # 19 stated they continued to experience this problem even though they had talked about it several times to the Administration staff. The other residents nodded in agreement. 5 Residents in the group stated they do not get feedback after the Resident Council meetings. They stated they express their concerns and wait to hear back but do not hear any results. One stated she did not feedback but did not know how to answer that question since she was still waiting to hear an answer. On 7/22/2021 at 2:35 PM, an interview was conducted with the Director of Nursing about the concerns expressed during the Group Interview on 7/21/2021. The Director of Nursing reviewed the minutes of the Resident Council from March - July 2021 with Surveyor. The Director of Nursing stated the nursing staff including Certified Nursing Assistants should introduce themselves to the residents with whom they are scheduled. The Director of Nursing stated the nursing staff should make rounds at the beginning of their shift on the residents with whom they were scheduled and should introduce themselves The Director of	F 565	Criterion #4 □ Monitoring □ Three random resident interviews will be conducted weekly x 6 weeks by the Administrator or designee to monitor nursing staff compliance with introduction to residents at the beginning of their assigned shift. Identified variances will be investigated and appropriate re-education / counseling will be performed with the staff. An audit of any grievance reports initiated in resident council meeting will be reviewed for follow up to the resident or residents with findings, resolution or need for revision of plan by the Social Worker x 3 months. The weekly observations will be reported to the VP of Quality Assurance for trending and a monthly summary will be provided to the facility QAPI Committee for additional oversight and recommendation.	

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F 565	Continued From page 4 Nursing stated the facility administration should follow up with the residents about their concerns expressed during the council meetings. The Director of Nursing stated the expectation was that all staff would know they should make rounds and she stated that the issue would be added to the staff education meetings ,new employee orientation and during regular staff meetings. The Director of Nursing stated the facility often used agency staff but the expectation was the same that staff would introduce themselves at the beginning of their shifts. The Director of Nursing stated she would follow up with the residents to let them know their concerns have been heard and of any steps taken to resolve them. During the end of day debriefing, the Administrator and Director of Nursing were informed of the findings. No further information was provided.	F 565		
F 577 SS=D	Right to Survey Results/Advocate Agency Info CFR(s): 483.10(g)(10)(11) §483.10(g)(10) The resident has the right to- (i) Examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility; and (ii) Receive information from agencies acting as client advocates, and be afforded the opportunity to contact these agencies. §483.10(g)(11) The facility must-- (i) Post in a place readily accessible to residents, and family members and legal representatives of	F 577		9/3/21

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F 577	Continued From page 5	F 577		

residents, the results of the most recent survey of the facility.
(ii) Have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding years, and any plan of correction in effect with respect to the facility, available for any individual to review upon request; and
(iii) Post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public.
(iv) The facility shall not make available identifying information about complainants or residents.
This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview and group interview, the facility staff failed to ensure the results of the most recent surveys of the facility were readily accessible to residents and family representatives.

For 6 of 6 attendees of the group interview, the facility staff failed to ensure the residents knew where to find the survey results form the previous surveys.

The Findings included:

The following written statement was submitted by Surveyor E regarding observations and an interview with the receptionist.

"On 7/21/21 at 10:40 AM, I (Surveyor E) went to the front lobby and reception area and didn ' t see any notice indicating where survey results were posted. I then went to the nursing station at unit 1 and looked around as well as looked on the bulletin board. I still didn ' t see any notice regarding the posting of survey results. I asked

F-577 Survey Results / Advocate Agency Information

Criterion #1 □ Correction -- Residents #13, 19, 34, 64, 67 and 78 have been educated on the new location of the survey result book.

Criterion #2 □Other Potential Residents - All residents may have potentially been affected. At Resident Council meeting will be held on August 24, 2021 and the residents will be informed of the location of the survey result book located in the front lobby in top drawer of the credenza with signage posted on top of the credenza with the last 3 years of survey results and location of the book.

Criterion #3 □ System Changes - The survey book has been moved to a location away from the receptionist desk and there is a visible sign posted identifying its location in the top drawer of the credenza

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F 577	Continued From page 6 _____ (name redacted), the ADON (Assistant Director of Nursing) where they were kept and she said 'at the front desk.' I returned to the receptionist and behind her, against the wall on the counter was a sign that read "last 3 years survey results" and had an arrow pointing down to the drawer. I asked for the book and review of it did reveal 3 years of survey results contained within. On 7/21/21 at 10:46 AM, an interview was conducted with the receptionist. She indicated visitors don ' t come behind the desk that is considered her office area. She said people have to ask for the book of survey results and she will hand it to them. She also confirmed the receptionist area is staffed 24 hours a day." On 7/21/2021 at 2:30 PM, a Group interview was conducted with six residents (Residents # 13, # 19, # 34, # 64, # 67 and # 78) who attended the meeting. When the group was asked about the location of the previous survey results, all attendees stated they did not know exactly where to find the results. During the end of day debriefing on 7/22/2021. the administrator and Director of Nursing were informed of the findings. The Administrator stated the results were available in an area behind the receptionist. The Administrator stated the Receptionist's area was were the results were located inside a drawer under a sign pointing to the area. The Administrator was informed of the difficulty that the surveyor encountered in finding the results. The Administrator was informed of the fact that individuals who want to examine survey results have to ask to see them. The	F 577	in the front lobby. The book is now easily accessible to residents and visitors without having to ask for staff assistance to see the survey results. The Life Enrichment staff will review the location of the survey book with the residents during the next Resident Council meeting and document in the resident council minutes. The other residents and families will be notified of the survey book and location via our website. Criterion #4 □ Monitoring □ Three (3) resident interviews will be conducted weekly x 4 weeks by the Administrator or her designee to ensure that residents are aware of the location of the survey results book. In addition, the Administrator or designee will observe the book in its assigned location two (2) times weekly for six weeks to ensure that the book remains in place, accessible to residents and visitors without having to ask for assistance. The Life Enrichment staff will review the location of the survey book with the residents during the next three Resident Council meetings and document in the resident council minutes x 3 months. Any identified variances will be corrected. Findings from the weekly observations will be given to the VP of Quality Assurance for trending and a summary report will be provided to the QAPI Committee for additional oversight and recommendation.	

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F 577	Continued From page 7 Administrator stated the receptionist would give the book with the results to anyone who requested to see them. No further information was provided.	F 577		
F 582 SS=D	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other	F 582		9/3/21

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F 582	Continued From page 8 items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility documentation review and clinical record review, the facility staff failed to complete a SNF ABN (Skilled Nursing Facility Advance Beneficiary Notice) for 1 Residents (Resident #66) in a survey sample of 33 Residents. For Resident #66, the facility staff failed to provide a SNF ABN notice prior to skilled care services, paid by Medicare, ended. Resident #66 was not afforded the opportunity to continue skilled care services and have Medicare make a determination about coverage of such services, as known as a demand bill. The Findings included:	F 582	F582 □ Medicare Liability Notice Criterion #1 □ Correction □ Resident #66's daughter was contacted and notified that she did not receive a SNF ABN along with her Notice of Medicare Non-Coverage when her Medicare coverage ended on 5/4/11 and her payment source changed to Medicaid. A copy of the notice has been provided to the daughter. Criterion #2 -Other Potential Residents -Other residents discharged from Medicare Part A services and who remained in the nursing facility may have potentially been impacted. The facility will	

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F 582	Continued From page 9 Resident #66, was admitted to the facility on 2/17/21, with a readmission date of 3/5/21. Resident #66's diagnoses included but were not limited to: status post fall and hip fracture with repair. Resident #66's most recent MDS (minimum data set) (an assessment tool) with an ARD (assessment reference date) of 5/18/21 was coded as a quarterly assessment. Resident #66 was coded as cognitive skills for daily decision making being severely impaired. The resident was also coded as requiring extensive assistance of two staff members for activities of daily living (ADL's). Resident #66 was discharged from a Medicare covered Part A stay on 5/4/21, she remained in the facility. Facility record review of Medicare discharge notices on 7/21/21, revealed the facility issued a NOMNC (notice of Medicare non-coverage) and noted Resident #66's Responsible Representative was given the information via telephone on 4/30/21. When the staff provided a copy of the NOMNC for review, there had been a post-it note placed on the form which read, "No ABN [Advance Beneficiary Notice] needed. Transitioned to MCD [Medicaid]". On 07/21/21 at 03:42 PM, an interview was conducted with Employee X, the Social Worker. Employee G confirmed that she is the person responsible for issuing NOMNC and ABN forms. Employee G stated that an "ABN is the letter that explains once SNF [skilled nursing facility] services stop Medicare may not cover their stay	F 582	review the notices provided to these residents since June 1, 2021 for compliance. Criterion #3 □-System Changes - The VP of QA will educate the Social Worker representative, BOM, Rehab Director, the Social Worker upon hire on the NOMNC and ABN process that the facility social worker is responsible for ensuring that residents completing their Medicare Part A stays and who elect to remain the in the nursing facility will receive timely NOMNC and ABN notices. The facility has a new social worker effective August 19th, and she will be provided a copy of this plan of correction and educated on completion of the NOMNC and SNF ABN notices as part of her scheduled orientation. Until that time, every resident whose Medicare-covered stay is ending will receive both the NOMNC and SNF ABN from our billing representative, who will submit copies to the VP of Quality Assurance for review. Criterion #4 □ Monitoring -Prior to a resident's discharge from Part A Medicare services, the Administrator or her designee will audit the completion of the Medicare Liability Notices [NOMNC and ABN] for residents being discharged from Medicare Part A stays for six weeks, to ensure that the residents have been given the appropriate notices and that these were given timely. Any identified variances will be immediately corrected and reported to the facility QAPI Committee for further recommendation.	

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F 582	Continued From page 10	F 582		

here and why. It explains the costs for them to remain here if Medicare doesn't cover it". When asked who receives an ABN, Employee G stated, "Anyone that is planning to remain in-house and they say whether they want to continue SNF services, or stay and pay privately". Employee G was asked if Resident #66 was issued an ABN and she said, "No. She transitioned to where Medicaid was going to be covering and she didn't need any skilled services. The family wasn't responsible for the payment of anything and Medicaid was paying the room and board, so an ABN wasn't needed". Employee G was asked if Resident #66 had a patient liability [a financial obligation to pay towards her cost of care using her monthly income, then Medicaid pays the remainder of the costs]. Employee G stated, "That I don't know".

On 7/21/21 at approximately 4:00 PM, Surveyor E and Employee G went to the Administrator's office. The Administrator stated the purpose of ABN's and NOMNC's is "to let the Resident know that their skilled stay is ending". The facility Administrator was unable to speak to when the 2 notices are provided and unable to speak to why Resident #66 was not issued an ABN.

CMS identifies when the ABN is required to be issued in their document titled "Form Instructions Skilled Nursing Facility Advanced Beneficiary Notice of Non-coverage (SNFABN)" read, "Medicare requires SNFs to issue the SNFABN to Original Medicare, also called fee-for-service (FFS), beneficiaries prior to providing care that Medicare usually covers, but may not pay for in this instance because the care is:
not medically reasonable and necessary; or
Considered custodial."

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 582	Continued From page 11 "The SNFABN provides information to the beneficiary so that s/he can decide whether or not to get the care that may not be paid for by Medicare and assume financial responsibility. SNFs must use the SNFABN when applicable for SNF Prospective Payment System services (Medicare Part A). SNFs will continue to use the ABN Form CMS-R-131 when applicable for Medicare Part B items and services". Accessed online at: https://www.cms.gov/search/cms?keys=ABN The Administrator was informed on 7/21/21 at approximately 4:10 PM, of the failure of facility staff to provide Resident #66 with a SNF ABN notice prior to skilled care services ending, which would have allowed Resident #66 or his representative, to make a decision about continuation of services and have Medicare make the coverage determination. No further information was provided.	F 582		
F 600 SS=E	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must-	F 600		9/3/21

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	495291	A. BUILDING _____ B. WING _____	C 07/22/2021

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F 600	Continued From page 12 §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on observations, resident interview, staff interview, clinical record review, facility documentation review, and in the course of a complaint investigation, the facility staff failed to prevent abuse involving 4 Residents (Resident #30, #17, #2, #71) in a sample size of 33 Residents. The Findings included: 1. For Resident #30, the facility staff failed to protect her from 3 episodes of Resident-to-Resident altercations by another female Resident (Resident #2) on 07/20/2021. For Resident #17, the facility staff failed to prevent another female Resident (Resident #2) from rummaging through her closet and taking her purple top and floral sweater on 07/20/2021. Resident #30, a 95- year old female, was admitted to the facility on 11/02/2020. Diagnoses included but were not limited to dementia and major depressive disorder. Resident #30's most recent Minimum Data Set with an Assessment Reference Date of 04/21/2021 was coded as a quarterly assessment. The Brief Interview for Mental Status was coded as "9" out of possible "15" indicative of moderate cognitive impairment. Bed mobility and transfers were coded as requiring limited assistance from staff. Dressing was coded as requiring extensive assistance from staff. Mobility devices were coded as walker and	F 600	F600 □ Free from Abuse and/or Neglect Criterion #1 - Correction - The Facility Report of Incident (FRI) was completed and submitted on 7/20/21 regarding the altercations between Residents #30, and Resident #2; a comprehensive investigation was completed, and final report was completed and submitted to all required entities on July 27, 2021. The facility responded in returning resident #17's clothes to her. Resident #2's care plan has been reviewed and updated to reflect the behavioral incident with additional interventions that staff will utilize in preventing aggressive behaviors towards others and decreasing the rummaging behaviors that provoke others. Resident #71 has not experienced any further observations of abuse by agency staff. The agency CNAs involved in the incident were immediately removed and are no longer eligible for work at this nursing facility. Mandatory reporting to OLC, APS and the Board of Nursing was completed prior to the survey and at the time of the incident and the resident was seen by a geriatric psychologist in follow up. Criterion #2 -Other Potential Residents - All residents that demonstrate aggressive behaviors or behaviors effecting others	

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	495291	A. BUILDING _____ B. WING _____	C 07/22/2021

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F 600	Continued From page 13 wheelchair. Resident #17, an 89-year old female, was admitted to the facility on 03/22/2013. Diagnoses included but were not limited to Alzheimer's disease and major depressive disorder. Resident #17's most recent Minimum Data Set with an Assessment Reference Date of 04/09/2021 was coded as a quarterly assessment. Cognitive Skills for Daily Decision-Making were coded as severely impaired. Functional status for bed mobility, transfers, and dressing were coded as requiring extensive assistance from staff. Resident #2, a 77-year old female, was admitted to the facility on 08/06/2020. Diagnoses included but were not limited to unspecified dementia with behavioral disturbance. Resident #2's most recent Minimum Data Set with an Assessment Reference Date of 03/08/2021 was coded as a quarterly assessment. Cognitive Skills for Daily Decision-Making were coded as severely impaired. Behavioral symptoms were coded as "0" meaning behaviors not exhibited during the 7-day lookback period. On 07/20/2021 at approximately 12:10 P.M., this surveyor entered Unit 4, the locked unit. At 12:13 P.M., this surveyor observed Certified Nursing Assistant A (CNA A) and another staff member attempt to redirect Resident #2 as she was yelling out to them. Resident #2 then hit CNA A on the left side of her head as she stood next to her. Resident #2 then sat down in a chair near the nurse's station. At approximately 12:15 P.M., this	F 600	are at risk to other residents or at risk for harm. Criterion #3 -System Changes - The Administrator, DON, and the UMs will receive training from a geriatric psychologist and VP of QA on September 2 to learn about conducting risk assessments for aggressive behaviors in residents with dementia. The team will use this training in developing and implementing individualized care plans for residents who are at risk for these behaviors. The RN's and LPN's will be educated by the DON and/or the Unit Manager on the process for completing the risk assessment for behaviors. The nursing staff (RN's, LPN's and CNA's) will receive additional training from the DON or Unit Managers on abuse and neglect and their responsibility for timely reporting of any observed actions of abuse or neglect. The nursing staff (RN's, LPN's and CNA's)assigned to the secure unit will be provided education on how to monitor, re-direct residents and to minimize resident altercations by the DON or Unit Manager. The contract agencies for interim staffing are being contacted by Director of Human Resources to inform the agencies that all criminal background checks must be obtained for CNAs from the Virginia State Police (as opposed to other databases that they may be using) and that verification of the VSP criminal background checks must be made available to the nursing facility upon demand.	

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F 600	Continued From page 14 surveyor asked CNA A about the incident. CNA A stated that when [Resident #2] is [resistant], staff will redirect her and "give her something to play with." CNA A also stated that [Resident #2] "likes to clean" so staff try to "find things she can help us with." On 07/20/2021 at 12:20 P.M., Resident #2 was observed in Resident #17's room rummaging through the closet. Resident #17 was in her room seated in her wheelchair by her bed. Resident #2 then took a purple-colored top that was hanging on the door handle of Resident #17's room and proceeded to walk down the hall. Resident #2 then entered the room of Resident #30. Resident #30 was seated in her wheelchair and facing the hall just inside the threshold of her room entrance. Resident #2 walked past Resident #30, then turned and faced Resident #30 and shouted, "Get out of here! Get out of here!" Resident #30 stated, "Why are you yelling at me?" Licensed Practical Nurse A (LPN A) was there to redirect Resident #2 out of Resident #30's room. Resident #2 then walked back to Resident #17's room to the closet touching the clothes on hangers. A staff member stood in the doorway of Resident #17's room and tried to redirect Resident #2 to go to the dining room for lunch. Resident #2 stated, "No! Get out of here!" Resident #2 then took a floral sweater off of the hanger and walked back down the hall toward Resident #30's room with Resident #17's purple top and floral sweater. As Resident #2 entered Resident #30's room, LPN A and another staff member were heading toward Resident #30's room. Resident #2 started yelling unintelligibly. Resident #30 stated, "I have no idea what she wants from me!" Resident #2 then left Resident #30's room and stood outside her room door holding the purple	F 600	Contract agencies have been contacted by the Director of Human Resources to inform the agencies that criminal record checks must be obtained from the Virginia State Police Criminal Records Exchange and that the agency must provide validation of such to the nursing facility upon request. This requirement is being added to all current and future agency contracts. Criterion #4 □ Monitoring - The Administrator or designee will review any reported incidents of abuse or neglect x 3 months to ensure that the incidents were reported timely, that a comprehensive investigation is completed, and that actions have been implemented to reduce the potential for recurrence. Findings of variance will be investigated and corrected according to the situation. The Human Resource staff will audit x 3 months any new contract agencies have been contacted and informed that criminal record checks must be obtained from the Virginia State Police Criminal Records Exchange and that the agency must provide validation of such to the nursing facility upon request. This requirement is being added to all current and future agency contracts. A summary of the allegations and actions taken will be reported to the QAPI Committee for additional trending and action.	

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F 600	Continued From page 15	F 600		

top and floral sweater. LPN A positioned herself between Resident #2 and Resident #30 while trying to redirect Resident #2. Resident #2 then walked to the nurse's station area and sat in a chair nearby.

On 07/20/2021 at 12:32 P.M., an interview with Registered Nurse A (RN A) was conducted. RN A was standing near the med card by the nurse's station. When asked about Resident #2's behaviors, RN A stated that Resident #2 had underlying mood behaviors. RN A also stated that [Resident #2] is usually easily redirected and "we let her cool off." When asked if she has been involved in Resident-to-Resident Altercations, RN A stated, "No. We don't see her yelling at other Residents." When asked about the process when a Resident-to-Resident Altercation occurs, RN A stated that they separate the Residents, try to figure out what happened, have activities come to offer snack, fluids, and games. RN A then stated they would document the altercation as well.

On 07/20/2021 at 12:37 P.M., this surveyor noted Resident #2 was no longer sitting in the chair by the nurse's station. This surveyor went to Resident #30's room. The door was closed. This surveyor knocked on the door and heard Resident #30 state, "Come in." From the hall, this surveyor observed Resident #30 in her wheelchair by a table just hanging up the phone and stated, "I was just trying to call my son." Resident #30 then self-propelled her wheelchair near the entrance of her room. Her bathroom door was open slightly and situated to her left. When asked how she was feeling about what happened with [Resident #2], Resident #30 pointed to her bathroom and stated, "She's washing something in my apartment! I don't know

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	495291	A. BUILDING _____ B. WING _____	C 07/22/2021

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F 600	Continued From page 16	F 600		

what the hell she wants!" At that time, Resident #2 exited Resident #30's bathroom holding a roll of toilet paper and several paper towels in her left hand. Resident #2 spoke loudly in unintelligible speech. Resident #2 then grabbed Resident #30's right wheelchair handle and forcefully pushed Resident #30's wheelchair forward. The left side of Resident #30's wheelchair hit the door jamb of her room entrance. Resident #30 stated, "Let go of my chair!" Resident #2 then walked past Resident #30, exited her room, and walked down the hall with the roll of toilet paper and paper towels. When Resident #30 was asked if she was okay and how was she feeling about this, Resident #30 stated, "I feel sorry for her." When asked if this happens frequently, Resident #30 stated, "This has been happening a lot; especially today." There was no staff observed in the hall during this time.

At 12:49 P.M., Resident #2 was observed seated by the nurse's station eating lunch.

At 12:56 P.M., an interview with LPN A, the unit manager, was conducted. When asked about her perspective of the Resident-to-Resident altercation between [Resident #30 and Resident #2], LPN A stated that it sounded like [Resident #2] was telling [Resident #30] to get out of her own room. LPN A also stated that she was trying to redirect [Resident #2]. When asked if this occurs frequently, LPN A stated "No." LPN A also stated that "we try to redirect" and "normally that works." LPN A added that [Resident #2] was "confused and upset about something." When asked about the process when a Resident-to-Resident Altercation occurs, LPN A stated that the staff is expected to "make sure the one is safe and redirect the other." LPN A also

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	495291	A. BUILDING _____ B. WING _____	C 07/22/2021

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F 600	Continued From page 17	F 600		

stated that staff should "reassure her [Resident #30]" and "make sure she [Resident #2] doesn't go back and do it again." LPN A also indicated the process included getting "everyone to monitor her" and "keep an eye on her." LPN A was notified Resident #2 was observed by this surveyor in Resident #30's room for a third time and forcefully moving Resident #30's wheelchair into the door jamb. LPN A did not mention reporting Resident-to-Resident altercations to the administrator.

At 1:36 P.M., this surveyor notified the administrator of the above observations of Resident to Resident altercations involving Resident #2, Resident #30, and Resident #17. The administrator stated he would send a Facility-Reported Incident (FRI) to the state agency and begin an investigation.

On 07/20/2021 at 3:19 P.M., the facility staff provided a copy of the FRI that was submitted to the state agency related to the above observations.

On 07/20/2021, Resident #2's clinical record was reviewed. A nurse's noted dated 07/20/2021 at 3:19 P.M. documented, "Resident became agitated before lunch and went into another residents [sic] room then into her bathroom and washed her hands, came back out and resident in room [number] was sitting in her wheelchair and this resident shoved the wheelchair into the wall (resident in room [number] was unharmed) and left the room." A nurse's note dated 07/20/2021 at 3:19 P.M. documented, "[Name] NP [nurse practitioner] notified and RP [responsible party] [name] via voicemail."

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F 600	Continued From page 18	F 600		

Resident #2's care plan was reviewed. A focus dated 08/20/2020 documented, "[Resident #2] exhibits the following behaviors: she has poor safety awareness and she will bump into walls, objects etc. when walking at a fast pace. Observed to wipe down tables and desk areas. Wandering in and out of other resident rooms and turning lights on and off, pushing on exit doors. Combative with ADL care. Refusing skin care treatments. Verbally, and physically aggressive with staff. Behavior increases with staff attempts at redirection or when providing care. hx [history of] of Hit [sic] staff with her shoe, smack staff in the chest area, picking up objects in attempt to use as a weapon toward staff . Use of profanity toward staff. Physically combative toward others, taking items of others, not belonging to her. Using others drinks to clean tables. Turning the lights on of others, removing the covers off of others, Not easily re-directed at times. Flailing her arms and yelling, cries. "One intervention associated with this focus included but was not limited to the following: "When resident becomes physically abusive, keep distance between resident and others to ensure safety of resident and others (e.g., staff, other residents, visitors)."

On 07/20/2021, Resident #30's most recent progress notes were reviewed. A nurse's note dated 07/20/2021 at 3:21 P.M., documented, "Writer was notified that another resident entered this residents [sic] room and went into her bathroom and washed her hands then came out and told resident "get out of the way" and pushed resident's wheelchair into the wall with resident sitting in the chair - the chair hit the wall and the resident was unharmed. Writer went and spoke with resident about incident and she could not recall incident writer was describing. RP

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	495291	A. BUILDING _____ B. WING _____	C 07/22/2021

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F 600	Continued From page 19	F 600		

[responsible party] [name] notified - message left on voicemail. [name] NP [nurse practitioner] notified of above."

At the end of day meeting on 07/20/2021 at 4:53 P.M., the administrator was asked about the process when a Resident-to-Resident altercation occurs, the administrator indicated that a FRI would be filled out; they would launch an investigation, obtain witness statements, compile all the information, have a plan, submit a 5-day follow-up [to the state agency] and re-evaluate the plan.

On 07/20/2021, the facility staff provided a copy of their policy entitled, "Abuse Prevention, Investigation and Reporting." An excerpt in Section IV (C) documented, "Resident to Resident altercations are potentially situations of abuse." " ...the facility will respond immediately to protect the safety of others, investigate the incident and respond with measure [sic] to prevent recurrence. "

On 07/21/2021 at 3:30 P.M., the administrator and Director of Nursing were notified of concerns with the repeated Resident-to-Resident altercations observed on 07/20/2021. By the end of survey on 07/22/2021, the administrator stated there was no further documentation or information to submit.

2. For Resident #71, the facility staff failed to ensure freedom from abuse by a contracted agency CNA.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495291	A. BUILDING _____ B. WING _____	C 07/22/2021

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F 600	Continued From page 20	F 600		

Resident #71, a 90 year old woman admitted to the facility on 6/5/20 with diagnoses that included diabetes type II, dementia with behavioral disturbance, chronic kidney disease, and pancreatitis. Resident #71's most recent MDS (Minimum Data Set) assessment coded Resident #71 as having a BIMS (Brief Interview of Mental Status) score of 4 indicating severe cognitive impairment. She was coded as requiring extensive assistance with all aspects of ADL (Activities of Daily Living). The Resident required the use of a sit to stand lift for transfers and a wheel chair for mobility.

On 7/20/21 at approximately 12:30 PM during meal observations, Resident #71's family member requested to speak to surveyor A she stated she would like to come in the following day and bring her notes, a time was set for 7/21/21 at 9:30 AM.

On 7/21/21 an interview was conducted at 9:36 AM with Resident #71's family member. During interview the family member stated that she comes to the facility every day. She showed folders where she takes notes on what is happening at the facility while she is present. She expressed concern that Resident #71 had recently been hit by an agency staff member while she was being given a shower. She further stated the incident was witnessed by 2 other staff. The family member got a call at 9:45 PM on 6/29/21 from the Administrator telling her of an incident involving her mother. She stated that he told her three CNA's were working in the memory care unit 2 were Agency and one was a staff CNA. One of the agency CNA's (CNA G)

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	495291	A. BUILDING _____ B. WING _____	C 07/22/2021

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F 600	Continued From page 21	F 600		

assigned to Resident #71 didn't want to give her shower. CNA G asked the other 2 CNA's for assistance with the shower as this Resident was confused and upset. While giving her a shower the Resident pushed CNA G's hand out of the way. CNA G then hit the Resident in the head with the hand held shower wand and sprayed her in the face with the water.

[The facts of this story were corroborated by the FRI, Investigation and Witness Statements sent in to the OLC.]

The family member stated I was upset because "I was here at dinner time 5:30- ish and spoke to the 3 CNA's. They said they gave her a shower before dinner and everything was fine. Mom looked and smelled good. No one mentioned a word about the incident, and I didn't see any marks or bruises. So then at 9:45 PM [Administrator's name redacted] called and basically said it took the other 2 CNA's [that witnessed the incident] 3 hours to decide to report it" She said "The CNA that hit mom was a large intimidating woman the other two were younger they were intimidated by her."
"The facility told me they were firing the Agency CNA's and they asked me about the Beth Shalom employee, I told them I do want the Beth Sholom employee to work with mom because she knows her, yes she had a major lapse in judgement and should have reported it immediately, but in the end she did report it."
A Review of the FRI submitted with the witness statements revealed that the supervisor sent the agency CNA's home that night, they did a head to toe assessment and no injuries were found at that time.

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	495291	A. BUILDING _____ B. WING _____	C 07/22/2021

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F 600	Continued From page 22	F 600		

"06/30/2021 12:26 AM - Writer assessed [Resident 71 name redacted] for injury and pain post reported incident, Resident denied pain and discomfort r/t incident and has no visible injurie's [sic] or skin impairments r/t incident. Will continue to monitor."

On 7/21/20 at approximately 2:30 PM an interview was conducted with the DON who stated that she was made aware of the incident by Tommy. She stated that it was her expectation that any time abuse is suspected the staff are to call her or the Administrator. She stated she came to the facility immediately after the phone call informing her of what happened.

She stated that she suspended all three employees until the investigation was done. The agency CNA was terminated and banned from the building. They did a head to toe assessment to check for injuries and no bruises, red marks or open areas were found. Resident is unable to recall due to cognitive status. They submitted a FRI to the OLC on 6/29/21 at approximately 10:00 PM. The facility FRI was reviewed, and it included the initial FRI , the investigation witness statements and the subsequent statements that this employee was banned from working at the facility and the Ombudsman, APS, local police as well as the DPH were notified. All pieces of the FRI and Investigation were completed.

The FRI investigation folder also contained in service education about timely reporting of abuse.

During an interview with the Business office Manager on 7/22/21 at approximately 2:00 PM revealed the facility did not have the Agency Employee's VA State Police Criminal background

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495291	A. BUILDING _____ B. WING _____	C 07/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETH SHOLOM HOME OF VIRGINIA	1600 JOHN ROLFE PARKWAY RICHMOND, VA 23233

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 23 check at the facility. They attempted to obtain it from the Agency however they only received a criminal check from a private company. She had a valid CNA license but they had no record of VA State Police Check to see if she had any barrier crimes prior to working in the facility. On 7/22/21 during the end of day meeting the Administrator was made aware of the concerns and no further information was provided.	F 600		
F 607 SS=D	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(3) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by: Based on interview, clinical record review, and facility documentation review the facility staff failed to implement the abuse policy for 2 Residents (#71and #2) in a survey sample of 33 Residents. 1. For Resident #71 the facility staff failed to obtain prevent physical abuse of by a CNA contracted employee, and also failed to obtain the Virginia State Police criminal background check prior to allowing the staff to work with the	F 607	F607 □ Abuse/Neglect Policies Criterion #1 □ Correction □ Resident #71 has had no other observations of abuse or neglect. The agency CNA involved in the reported incident was immediately removed from the facility and is no longer eligible to return to the nursing facility. The facility aide who observed the reported incident was re-educated on abuse and the expectation of timely	9/3/21

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F 607	Continued From page 24 Resident. Resident #71, a 90 year old woman admitted to the facility on 6/5/20 with diagnoses including diabetes type II, dementia with behavioral disturbance, chronic kidney disease, and pancreatitis. Resident #71's most recent MDS (Minimum Data Set) assessment coded Resident #71 as having a BIMS (Brief Interview of Mental Status) score of 4 indicating severe cognitive impairment. She was coded as requiring extensive assistance with all aspects of ADL (Activities of Daily Living) care. The Resident required the use of a sit to stand lift for transfers and a wheel chair for mobility. On 7/21/21 an interview was conducted at 9:36 AM with Resident #71's family member. During interview the family member stated that she comes to the facility every day. She showed folders where she takes notes on what is happening at the facility while she is present. She expressed concern that Resident #71 recently been hit by an agency staff member while she was being given a shower. She further stated the incident was witnessed by 2 other staff. The family member she got a call at 9:45 PM on 6/29/21 from the Administrator telling her of an incident involving her mother. She stated that he told her three CNA's were working in the memory care unit 2 were Agency and one was a staff CNA. One of the agency CNA's (CNA G) assigned to Resident #71 didn't want to give her shower. CNA G asked the other 2 CNA's for assistance with the shower as this Resident was confused and upset. While giving her a shower the Resident pushed CNA G's hand out of the way. CNA G then hit the Resident in the head with the hand held shower wand and sprayed her	F 607	reporting of allegations and/or observations of abuse by the Administrator on June 29, 2021. There have been no further altercations between Resident #30 and Resident #2. Care plans for both Resident #30 and Resident #2 have been reviewed and have interventions to monitoring and re-direction to minimize altercations with other residents. Criterion #2 □Other Potential Residents -- Other residents residing on the memory unit may have potentially been impacted. Criterion #3 □ System Changes □ Nursing staff assigned to the secure unit will be provided reeducation regarding interventions to monitor, re-direct residents and to minimize resident altercations. Nursing staff will be re-trained on abuse prevention and expectations of timely reporting of allegations or observations of abuse and neglect by the Director of Nursing. Contract agencies have been contacted and informed that criminal record checks must be obtained from the Virginia State Police and that the agency must provide validation of such to the nursing facility upon request. Additionally, the interdisciplinary team will receive training from a geriatric psychologist on September 2 in conducting risk assessments for aggressive behaviors in residents with dementia. The team will use this training in developing and implementing individualized care plans for residents who	

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	495291	A. BUILDING _____ B. WING _____	C 07/22/2021

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F 607	Continued From page 25 in the face with the water. [The facts of this story were corroborated by the FRI Investigation and Witness Statements sent in to the OLC.] An interview was conducted with the Business office Manager on 7/22/21 at approximately 2:00 PM. She stated that the facility did not have (Agency) CNA G's VA State Police Criminal background check at the facility. She stated that she made several attempts to obtain it from the agency, however they only received a criminal check from a private company not the Virginia State Police Background Check. The CNA's license was valid in VA, but they had no record of VA State Police Check to see if she had any barrier crimes prior to working in the facility. The criminal background check was performed by private company and the background check on file contained the following statement, "criminal records obtained from a database search for employment screening purposes must be verified with a County Criminal Court Search to obtain current up to date case status. This report does not guarantee the accuracy or truthfulness of the information." A review of the facility Abuse and Neglect Policy read: "Abuse Policy" "C. Criminal record checks are requested on all new employees prior to assuming resident related duties. If agency or contract staff is use the vendor providing the contracted service will be required to obtain a criminal record checks for all staff assigned to the home and make the criminal record checks information available to the facility	F 607	are identified as at risk for these behaviors. Residents who demonstrate new or increased behaviors that may put them at risk for aggressive behaviors will be reviewed in the weekly Resident at Risk Meeting. Criterion #4 □ Monitoring -- The Administrator or designee will review all reported incidents of abuse or neglect to ensure that the incidents were reported timely and as mandated, a comprehensive investigation has been completed, and actions have been implemented to reduce recurrence. Findings of variance will be investigated and corrected according to the situation. A summary of the allegations and actions taken will be reported to the QAPI Committee for additional trending and action. On a monthly basis, the Human Resource Director or designee will request copies of criminal background checks from contract agencies, for at least one nurse or C.N.A. from each agency, in order to validate the agency□s compliance in obtaining sworn statements disclosure and background checks that are in compliance with the Code of Virginia. Criterion #5 □ Completion Date is September 3, 2021	

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	495291	A. BUILDING _____ B. WING _____	C 07/22/2021

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F 607	Continued From page 26	F 607		

in a timely manner upon request."

On 7/22/21 during the end of day meeting the Administrator was made aware of the concerns and no further information was provided.

2. For Resident #2, the facility staff failed to prevent a recurrence of Resident to Resident altercation with Resident #30 on 07/20/2021.

2. For Resident #2, the facility staff failed to prevent a Resident to Resident altercation and 2 recurrences with Resident #30 on 07/20/2021.

Resident #2, a 77-year old female, was admitted to the facility on 08/06/2020. Diagnoses included but were not limited to unspecified dementia with behavioral disturbance.

Resident #2's most recent Minimum Data Set with an Assessment Reference Date of 03/08/2021 was coded as a quarterly assessment. Cognitive Skills for Daily Decision-Making were coded as severely impaired. Behavioral symptoms were coded as "0" meaning behaviors not exhibited during the 7-day lookback period.

Resident #30, a 95- year old female, was admitted to the facility on 11/02/2020. Diagnoses included but were not limited to dementia and major depressive disorder.

Resident #30's most recent Minimum Data Set with an Assessment Reference Date of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495291	A. BUILDING _____ B. WING _____	C 07/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETH SHOLOM HOME OF VIRGINIA	1600 JOHN ROLFE PARKWAY RICHMOND, VA 23233

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 607	Continued From page 27	F 607		

04/21/2021 was coded as a quarterly assessment. The Brief Interview for Mental Status was coded as "9" out of possible "15" indicative of moderate cognitive impairment. Bed mobility and transfers were coded as requiring limited assistance from staff. Dressing was coded as requiring extensive assistance from staff. Mobility devices were coded as walker and wheelchair.

Resident #17, an 89-year old female, was admitted to the facility on 03/22/2013. Diagnoses included but were not limited to Alzheimer's disease and major depressive disorder.

Resident #17's most recent Minimum Data Set with an Assessment Reference Date of 04/09/2021 was coded as a quarterly assessment. Cognitive Skills for Daily Decision-Making were coded as severely impaired. Functional status for bed mobility, transfers, and dressing were coded as requiring extensive assistance from staff.

On 07/20/2021 at approximately 12:10 P.M., this surveyor entered Unit 4, the locked unit. At 12:13 P.M., this surveyor observed Certified Nursing Assistant A (CNA A) and another staff member attempt to redirect Resident #2 as she was yelling out to them. Resident #2 then hit CNA A on the left side of her head as she stood next to her. Resident #2 then sat down in a chair near the nurse's station. At approximately 12:15 P.M., this surveyor asked CNA A about the incident. CNA A stated that when [Resident #2] is [resistant], staff will redirect her and "give her something to play with." CNA A also stated that [Resident #2] "likes to clean" so staff try to "find things she can help us with."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495291	A. BUILDING _____ B. WING _____	C 07/22/2021

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F 607	Continued From page 28	F 607		

On 07/20/2021 at 12:20 P.M., Resident #2 was observed in Resident #17's room rummaging through the closet. Resident #17 was in her room seated in her wheelchair by her bed. Resident #2 then took a purple-colored top that was hanging on the door handle of Resident #17's room and proceeded to walk down the hall. Resident #2 then entered the room of Resident #30. Resident #30 was seated in her wheelchair and facing the hall just inside the threshold of her room entrance. Resident #2 walked past Resident #30, then turned and faced Resident #30 and shouted, "Get out of here! Get out of here!" Resident #30 stated, "Why are you yelling at me?" Licensed Practical Nurse A (LPN A) was there to redirect Resident #2 out of Resident #30's room. Resident #2 then walked back to Resident #17's room to the closet touching the clothes on hangers. A staff member stood in the doorway of Resident #17's room and tried to redirect Resident #2 to go to the dining room for lunch. Resident #2 stated, "No! Get out of here!" Resident #2 then took a floral sweater off of the hanger and walked back down the hall toward Resident #30's room with Resident #17's purple top and floral sweater. As Resident #2 entered Resident #30's room, LPN A and another staff member were heading toward Resident #30's room. Resident #2 started yelling unintelligibly. Resident #30 stated, "I have no idea what she wants from me!"
Resident #2 then left Resident #30's room and stood outside her room door holding the purple top and floral sweater. LPN A positioned herself between Resident #2 and Resident #30 while trying to redirect Resident #2. Resident #2 then walked to the nurse's station area and sat in a chair nearby.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495291	A. BUILDING _____ B. WING _____	C 07/22/2021

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F 607	Continued From page 29	F 607		

On 07/20/2021 at 12:32 P.M., an interview with Registered Nurse A (RN A) was conducted. RN A was standing near the med card by the nurse's station. When asked about Resident #2's behaviors, RN A stated that Resident #2 had underlying mood behaviors. RN A also stated that [Resident #2] is usually easily redirected and "we let her cool off." When asked if she has been involved in Resident-to-Resident Altercations, RN A stated, "No. We don't see her yelling at other Residents." When asked about the process when a Resident-to-Resident Altercation occurs, RN A stated that they separate the Residents, try to figure out what happened, have activities come to offer snack, fluids, and games. RN A then stated they would document the altercation as well.

On 07/20/2021 at 12:37 P.M., this surveyor noted Resident #2 was no longer sitting in the chair by the nurse's station. This surveyor went to Resident #30's room. The door was closed. This surveyor knocked on the door and heard Resident #30 state, "Come in." From the hall, this surveyor observed Resident #30 in her wheelchair by a table just hanging up the phone and stated, "I was just trying to call my son." Resident #30 then self-propelled her wheelchair near the entrance of her room. Her bathroom door was open slightly and situated to her left. When asked how she was feeling about what happened with [Resident #2], Resident #30 pointed to her bathroom and stated, "She's washing something in my apartment! I don't know what the hell she wants!" At that time, Resident #2 exited Resident #30's bathroom holding a roll of toilet paper and several paper towels in her left hand. Resident #2 spoke loudly in unintelligible speech. Resident #2 then grabbed Resident #30's right wheelchair handle and forcefully

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495291	A. BUILDING _____ B. WING _____	C 07/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 607	Continued From page 30	F 607		

pushed Resident #30's wheelchair forward. The left side of Resident #30's wheelchair hit the door jamb of her room entrance. Resident #30 stated, "Let go of my chair!" Resident #2 then walked past Resident #30, exited her room, and walked down the hall with the roll of toilet paper and paper towels. When Resident #30 was asked if she was okay and how was she feeling about this, Resident #30 stated, "I feel sorry for her." When asked if this happens frequently, Resident #30 stated, "This has been happening a lot; especially today." There was no staff observed in the hall during this time.

At 12:49 P.M., Resident #2 was observed seated by the nurse's station eating lunch.

At 12:56 P.M., an interview with LPN A, the unit manager, was conducted. When asked about her perspective of the Resident-to-Resident altercation between [Resident #30 and Resident #2], LPN A stated that it sounded like [Resident #2] was telling [Resident #30] to get out of her own room. LPN A also stated that she was trying to redirect [Resident #2]. When asked if this occurs frequently, LPN A stated "No." LPN A also stated that "we try to redirect" and "normally that works." LPN A added that [Resident #2] was "confused and upset about something." When asked about the process when a Resident-to-Resident Altercation occurs, LPN A stated that the staff is expected to "make sure the one is safe and redirect the other." LPN A also stated that staff should "reassure her [Resident #30]" and "make sure she [Resident #2] doesn't go back and do it again." LPN A also indicated the process included getting "everyone to monitor her" and "keep an eye on her." LPN A was notified Resident #2 was observed by this

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495291	A. BUILDING _____ B. WING _____	C 07/22/2021

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F 607	Continued From page 31	F 607		

surveyor in Resident #30's room for a third time and forcefully moving Resident #30's wheelchair into the door jamb. LPN A did not mention reporting Resident-to-Resident altercations to the administrator.

At 1:36 P.M., the administrator was notified of the above observations of Resident to Resident altercations involving Resident #2, Resident #30, and Resident #17. The administrator stated he would send a Facility-Reported Incident (FRI) to the state agency and begin an investigation.

On 07/20/2021 at 3:19 P.M., the facility staff provided a copy of the FRI that was submitted to the state agency related to the above observations.

On 07/20/2021, Resident #2's clinical record was reviewed. A nurse's noted dated 07/20/2021 at 3:19 P.M. documented, "Resident became agitated before lunch and went into another residents [sic] room then into her bathroom and washed her hands, came back out and resident in room [number] was sitting in her wheelchair and this resident shoved the wheelchair into the wall (resident in room [number] was unharmed) and left the room." A nurse's note dated 07/20/2021 at 3:19 P.M. documented, "[Name] NP [nurse practitioner] notified and RP [responsible party] [name] via voicemail." Interventions to prevent recurrence were not addressed in the note.

On 07/20/2021, Resident #30's most recent progress notes were reviewed. A nurse's note dated 07/20/2021 at 3:21 P.M., documented, "Writer was notified that another resident entered this residents [sic] room and went into her

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495291	A. BUILDING _____ B. WING _____	C 07/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 607	Continued From page 32	F 607		

bathroom and washed her hands then came out and told resident "get out of the way" and pushed resident's wheelchair into the wall with resident sitting in the chair - the chair hit the wall and the resident was unharmed. Writer went and spoke with resident about incident and she could not recall incident writer was describing. RP [responsible party] [name] notified - message left on voicemail. [name] NP [nurse practitioner] notified of above."

At the end of day meeting on 07/20/2021 at 4:53 P.M., the administrator was asked about the process when a Resident-to-Resident altercation occurs, the administrator indicated that a FRI would be filled out; they would launch an investigation, obtain witness statements, compile all the information, have a plan, submit a 5-day follow-up [to the state agency] and re-evaluate the plan.

On 07/20/2021, the facility staff provided a copy of their policy entitled, "Abuse Prevention, Investigation and Reporting." An excerpt in Section IV (C) documented, "Resident to Resident altercations are potentially situations of abuse." " ...the facility will respond immediately to protect the safety of others, investigate the incident and respond with measure [sic] to prevent recurrence. "

On 07/21/2021 at 3:30 P.M., the administrator and Director of Nursing were notified of concerns with the repeated Resident-to-Resident altercations observed on 07/20/2021. By the end of survey on 07/22/2021, the administrator stated there was no further documentation or information to submit.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495291	A. BUILDING _____ B. WING _____	C 07/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETH SHOLOM HOME OF VIRGINIA	1600 JOHN ROLFE PARKWAY RICHMOND, VA 23233

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 655	Continued From page 33	F 655		
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident.	F 655		9/3/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495291	A. BUILDING _____ B. WING _____	C 07/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 655	Continued From page 34 (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on interview, clinical record review and facility documentation and in the course of an investigation the facility staff failed to develop and implement a baseline care plan for 1 Resident (#340) in a survey sample of 33 Residents. The findings included For Resident #340 the facility staff failed to develop and implement a baseline care plan that includes the instructions needed to provide person centered care to the Resident. Resident #340 was admitted to the facility on 1/19/21. Diagnoses for Resident #340 included but were not limited to Rhabdomyolysis, acute respiratory failure, acute kidney failure, altered mental status, history of bladder cancer and BPH (Benign Prostatic Hypertrophy), history of UTI, and Atrial Fibrillation. Resident #340's Minimum Data Set (an assessment protocol) with an Assessment Reference Date of 1/26/21 coded Resident #340 with a BIMS (Brief Interview of Mental Status) score of 14 indicating no cognitive impairment. In addition, the Minimum Data Set coded Resident #340 as requiring extensive assistance for Activities of Daily Living care with the	F 655	F655 Comprehensive Care Plan Criterion #1 □ Correction □ Resident #340 was discharged from the facility on 2/1/2021. Criterion #2 -Other Potential Residents - New admissions may potentially be at risk. Residents admitted to the facility since the survey exit date will be reviewed to ensure that a baseline care plan has been developed timely and is reflective of resident needs. Criterion #3 - System Changes - The Licensed Nurses (RN's and LPN's) have been re-educated by the DON or Unit Manager on the process for developing and revising a baseline care plan. Upon admission, the licensed nurse who is reviewing the admission orders and performing the admission assessment of the resident will initiate a hard copy baseline care plan, based upon identification of the immediate needs of the resident. These initial care plans will be maintained in a binder on the unit, where the interdisciplinary team members can review or add interventions that are identified within the first two weeks of	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495291	A. BUILDING _____ B. WING _____	C 07/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 655	Continued From page 35 exception of eating he was independent with meals. The resident required a mechanical lift for transfers and used a wheelchair for mobility as he was non-ambulatory. On 7/21/21 at approximately 2:00 PM an interview was conducted with Employee D who was asked if there were any more documents related to the care plan other than the 3 pages she had submitted during the complaint investigation. She stated she did not believe so, and when asked about a baseline care plan or admission care plan she replied "We use the same form in the computer we just add to it, so it starts on admission and we just keep adding there is not a separate baseline and comprehensive." A review of the care plan submitted revealed that it was started on 1/20/21 and it read as follows; PROBLEM: Problem Start Date: 1/20/21 - CATEGORY - fall - Resident is at risk for falls due to weakness and history of falls GOAL: Short term target date 4/19/21 - Resident will be free of falls - APPROACH: Approach start date: 1/20/21 Implement exercise program that targets strength, gait and balance - Discipline - Nursing Approach Start date: 1/20/21 - Order comprehensive medication review by pharmacist, assess for polypharmacy and medication that will increase falls. - Discipline- Nursing PROBLEM:	F 655	admission. Following completion of the resident assessment instrument, the MDS/Care Plan Coordinator will remove the baseline care plan, review to ensure identified problems have been incorporated into the comprehensive care plan and provide the baseline care plan to medical records for uploading into the Resident Documents section of the individuals record. Criterion #4 -Monitoring -The DON or her designee will review new admissions weekly x 6 weeks to ensure that baseline care plans have been fully developed to reflect the newly admitted resident's needs. Variances will be investigated and corrected as appropriate to the situation and responsible staff will be re-educated and/or counseled. Findings from the reviews will be reported to the VP of Quality Assurance for trending and further recommendation. A summary of the weekly audits will be provided to the QAPI Committee for additional oversight.	

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F 655	Continued From page 36 Problem Start Date: - 1/20/21 - CATEGORY - Nutritional Status - Resident is at nutrition risk d/t obesity atherosclerotic heart disease, HTN, GERD, Respiratory failure. GOAL: Short term target date 4/19/21 - Resident will remain at stable weight + / - 2# by next review APPROACH: Approach Start Date: 1/20/21 - Monitor and record intake at meals Discipline - Nursing Approach Start Date: 1/20/21 - Monitor weight monthly and weekly as needed - Discipline - Nurse Practitioner, Nursing, Physician, RD Approach Start Date: 1/20/21 - Offer h.s. snack compliant with current diet Discipline - Nursing, dietary Approach Start Date: 1/20/21 - provide diet as ordered Discipline - Nursing dietary PROBLEM Problem Start Date: 1/25/21 - CATEGORY - Activities GOAL: Short term target date 4/25/21 - Life Enrichment staff will visit resident 1:1 at least once a week for social and emotion [sic] well-being, Due to COVID 19 restrictions group activities are not allowed, therefore, life enrichment staff will provide resident with independent activities as well during his stay. APPROACH: Approach Start Date: 1/25/21 - Life Enrichment staff will make sure resident has updated TV guide to be able to watch his favorite shows. Discipline - Activities	F 655		

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F 655	Continued From page 37 Approach Start Date: 1/25/21 - - Life Enrichment staff will make sure resident has books, magazines and newspapers to read to maintain cognition. Discipline - Activities Approach Start Date: 1/25/21 - - Life Enrichment staff will offer resident times to go outside when weather is nice to be able to get fresh air Discipline - Activities On 7/21/21 at approximately 11:00 AM an interview was conducted with LPN A, who was asked the purpose of a care plan. LPN A stated "A care plan is to show the staff the needs of the Resident and how to meet the needs. It should tell you how they transfer and how they eat, if they wear briefs or are incontinent, even stuff like thickened liquids and behaviors." When asked who updates the care plans she stated that the nurses could all update it. When asked how often it should be updated she said any time there is a change in the Resident's status or condition." In summary during the time of this admission 01/19/21 through the discharge on 2/1/21 only 3 care areas were addressed, Activities, fall, and Nutrition. On 7/22/21 during the end of day conference the Administrator was made aware of the concerns and no further information was provided.	F 655		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans	F 656		9/3/21

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F 656	Continued From page 38 §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this	F 656		

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F 656	Continued From page 39 section. This REQUIREMENT is not met as evidenced by: Based on observations, resident interview, staff interview, clinical record review, facility documentation review, and in the course of a complaint investigation, the facility staff failed to develop and implement the care plan for 2 residents (Resident #2 and Resident #71) in a sample size of 33 Residents. The Findings included: 1. For Resident #2, the facility staff failed to implement the care plan. Specifically, the facility staff failed to: a) Ensure adequate distance between resident and others to ensure safety of residents. This resulted in taking clothing from Resident #17 and 3 episodes of Resident-to-Resident altercations with Resident #30 on 07/20/2021. (b) Supervise wandering on units, resulting in Resident #2 walking with a fork, a stapler, and wandering into the unit manager's office on 07/21/2021. Resident #2, a 77-year old female, was admitted to the facility on 08/06/2020. Diagnoses included but were not limited to unspecified dementia with behavioral disturbance. Resident #2's most recent Minimum Data Set with an Assessment Reference Date of 03/08/2021 was coded as a quarterly assessment. Cognitive Skills for Daily Decision-Making were coded as severely impaired. Behavioral symptoms were coded as "0" meaning behaviors not exhibited during the 7-day lookback period.	F 656	F656 □ Develop / Implement Comprehensive Care Plan Criterion #1 -Correction - Resident #2 care plan has been reviewed and revised to include interventions to promote appropriate distancing with other residents and to minimize resident to resident altercations. Resident #2□s care plan has been reviewed and revised to include interventions for resident safety while wandering including resident access to items that may cause harm to the resident or to other residents. Resident #71□s care plan was reviewed and revised to reflect the resident's risk for falls and targeted behaviors to include resident centered interventions. The resident centered interventions to promote safety and to respond to resident behaviors have been communicated to the direct care team. Criterion #2 -Other Potential Residents - Other residents with behaviors have the risk to be impacted. Care plans for residents with behaviors will be reviewed to ensure that they specific resident concerns for safety and behaviors and that interventions are resident focused by the DON, Unit Manager or Social Worker. Criterion #3 -System Changes - An independent geriatric psychologist and the VP of QA will provide education to the	

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F 656	Continued From page 40 Resident #30, a 95- year old female, was admitted to the facility on 11/02/2020. Diagnoses included but were not limited to dementia and major depressive disorder. Resident #30's most recent Minimum Data Set with an Assessment Reference Date of 04/21/2021 was coded as a quarterly assessment. The Brief Interview for Mental Status was coded as "9" out of possible "15" indicative of moderate cognitive impairment. Bed mobility and transfers were coded as requiring limited assistance from staff. Dressing was coded as requiring extensive assistance from staff. Mobility devices were coded as walker and wheelchair. Resident #17, an 89-year old female, was admitted to the facility on 03/22/2013. Diagnoses included but were not limited to Alzheimer's disease and major depressive disorder. Resident #17's most recent Minimum Data Set with an Assessment Reference Date of 04/09/2021 was coded as a quarterly assessment. Cognitive Skills for Daily Decision-Making were coded as severely impaired. Functional status for bed mobility, transfers, and dressing were coded as requiring extensive assistance from staff. On 07/20/2021 at approximately 12:10 P.M., this surveyor entered Unit 4, the locked unit. At 12:13 P.M., this surveyor observed Certified Nursing Assistant A (CNA A) and another staff member attempt to redirect Resident #2 as she was yelling out to them. Resident #2 then hit CNA A on the left side of her head as she stood next to her.	F 656	interdisciplinary team (includes Social Worker, Administrator, DON and Unit Managers) on assessing resident risk for aggressive behaviors, to include investigating triggers for resident behavior and implementation of person-centered care plan interventions to promote safety and minimize behaviors that may cause harm to others. The Licensed Nurses (RN's and LPN's) will be educated by the DON or Unit Manager on documenting and implementing resident- centered plans of care to address targeted behaviors and to promote resident safety. Criterion #4 - Monitoring - The Administrator or her designee will review care plans of three residents with behaviors weekly x 6 weeks to ensure that the care plans are reflective of current resident behavior and safety needs and that resident centered interventions are being implemented. Variances will be investigated, and corrections made as appropriate. Findings from the weekly reviews will be provided to the DON for tracking. A summary of the weekly audits will be provided to the QAPI Committee for additional oversight and recommendation.	

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	495291	A. BUILDING _____ B. WING _____	C 07/22/2021

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F 656	Continued From page 41	F 656		

Resident #2 then sat down in a chair near the nurse's station. At approximately 12:15 P.M., this surveyor asked CNA A about the incident. CNA A stated that when [Resident #2] is [resistant], staff will redirect her and "give her something to play with." CNA A also stated that [Resident #2] "likes to clean" so staff try to "find things she can help us with."

On 07/20/2021 at 12:20 P.M., Resident #2 was observed in Resident #17's room rummaging through the closet. Resident #17 was in her room seated in her wheelchair by her bed. Resident #2 then took a purple-colored top that was hanging on the door handle of Resident #17's room and proceeded to walk down the hall. Resident #2 then entered the room of Resident #30. Resident #30 was seated in her wheelchair and facing the hall just inside the threshold of her room entrance. Resident #2 walked past Resident #30, then turned and faced Resident #30 and shouted, "Get out of here! Get out of here!" Resident #30 stated, "Why are you yelling at me?" Licensed Practical Nurse A (LPN A) was there to redirect Resident #2 out of Resident #30's room. Resident #2 then walked back to Resident #17's room to the closet touching the clothes on hangers. A staff member stood in the doorway of Resident #17's room and tried to redirect Resident #2 to go to the dining room for lunch. Resident #2 stated, "No! Get out of here!" Resident #2 then took a floral sweater off of the hanger and walked back down the hall toward Resident #30's room with Resident #17's purple top and floral sweater. As Resident #2 entered Resident #30's room, LPN A and another staff member were heading toward Resident #30's room. Resident #2 started yelling unintelligibly. Resident #30 stated, "I have no idea what she wants from me!"

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	495291	A. BUILDING _____ B. WING _____	C 07/22/2021

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F 656	Continued From page 42	F 656		

Resident #2 then left Resident #30's room and stood outside her room door holding the purple top and floral sweater. LPN A positioned herself between Resident #2 and Resident #30 while trying to redirect Resident #2. Resident #2 then walked to the nurse's station area and sat in a chair nearby.

On 07/20/2021 at 12:32 P.M., an interview with Registered Nurse A (RN A) was conducted. RN A was standing near the med card by the nurse's station. When asked about Resident #2's behaviors, RN A stated that Resident #2 had underlying mood behaviors. RN A also stated that [Resident #2] is usually easily redirected and "we let her cool off." When asked if she has been involved in Resident-to-Resident Altercations, RN A stated, "No. We don't see her yelling at other Residents." When asked about the process when a Resident-to-Resident Altercation occurs, RN A stated that they separate the Residents, try to figure out what happened, have activities come to offer snack, fluids, and games. RN A then stated they would document the altercation as well.

On 07/20/2021 at 12:37 P.M., this surveyor noted Resident #2 was no longer sitting in the chair by the nurse's station. This surveyor went to Resident #30's room. The door was closed. This surveyor knocked on the door and heard Resident #30 state, "Come in." From the hall, this surveyor observed Resident #30 in her wheelchair by a table just hanging up the phone and stated, "I was just trying to call my son." Resident #30 then self-propelled her wheelchair near the entrance of her room. Her bathroom door was open slightly and situated to her left. When asked how she was feeling about what happened with [Resident #2], Resident #30

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	495291	A. BUILDING _____ B. WING _____	C 07/22/2021

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F 656	Continued From page 43	F 656		

pointed to her bathroom and stated, "She's washing something in my apartment! I don't know what the hell she wants!" At that time, Resident #2 exited Resident #30's bathroom holding a roll of toilet paper and several paper towels in her left hand. Resident #2 spoke loudly in unintelligible speech. Resident #2 then grabbed Resident #30's right wheelchair handle and forcefully pushed Resident #30's wheelchair forward. The left side of Resident #30's wheelchair hit the door jamb of her room entrance. Resident #30 stated, "Let go of my chair!" Resident #2 then walked past Resident #30, exited her room, and walked down the hall with the roll of toilet paper and paper towels. When Resident #30 was asked if she was okay and how was she feeling about this, Resident #30 stated, "I feel sorry for her." When asked if this happens frequently, Resident #30 stated, "This has been happening a lot; especially today." There was no staff observed in the hall during this time.

At 12:49 P.M., Resident #2 was observed seated by the nurse's station eating lunch.

At 12:56 P.M., an interview with LPN A, the unit manager, was conducted. When asked about her perspective of the Resident-to-Resident altercation between [Resident #30 and Resident #2], LPN A stated that it sounded like [Resident #2] was telling [Resident #30] to get out of her own room. LPN A also stated that she was trying to redirect [Resident #2]. When asked if this occurs frequently, LPN A stated "No." LPN A also stated that "we try to redirect" and "normally that works." LPN A added that [Resident #2] was "confused and upset about something." When asked about the process when a Resident-to-Resident Altercation occurs, LPN A

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	495291	A. BUILDING _____ B. WING _____	C 07/22/2021

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F 656	Continued From page 44	F 656		

stated that the staff is expected to "make sure the one is safe and redirect the other." LPN A also stated that staff should "reassure her [Resident #30]" and "make sure she [Resident #2] doesn't go back and do it again." LPN A also indicated the process included getting "everyone to monitor her" and "keep an eye on her."

Resident #2's care plan was reviewed. A focus dated 08/20/2020 documented, "[Resident #2] exhibits the following behaviors: she has poor safety awareness and she will bump into walls, objects etc. when walking at a fast pace. Observed to wipe down tables and desk areas. Wandering in and out of other resident rooms and turning lights on and off, pushing on exit doors. Combative with ADL care. Refusing skin care treatments. Verbally, and physically aggressive with staff. Behavior increases with staff attempts at redirection or when providing care. hx [history of] of Hit [sic] staff with her shoe, smack staff in the chest area, picking up objects in attempt to use as a weapon toward staff . Use of profanity toward staff: "shove it up you ass, bitch", "Nigger". Physically combative toward others, taking items of others, not belonging to her. Using others drinks to clean tables. Turning the lights on of others, removing the covers off of others, Not easily re-directed at times. Flailing her arms and yelling, cries." One intervention associated with this focus included but was not limited to the following: "When resident becomes physically abusive, keep distance between resident and others to ensure safety of resident and others (e.g., staff, other residents, visitors)."

On 07/21/2021 at approximately 1:00 P.M., an interview with the Director of Nursing (DON) was conducted notified of finding and asked about the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495291	A. BUILDING _____ B. WING _____	C 07/22/2021

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F 656	Continued From page 45	F 656		

expectation of staff following a Resident-to-Resident altercation. The DON stated that staff should separate the Residents and redirect. The DON stated that staff should "get her mind [Resident #2] on something else." The DON also stated the expectation is to "call families and let them know" and to "document it." The DON also stated they could send an email to the pharmacist to "have a look at her medications."

On 07/21/2021 at 3:30 P.M., the administrator and DON were notified of concerns with the repeated Resident-to-Resident altercations observed on 07/20/2021. By the end of survey on 07/22/2021, the administrator stated there was no further documentation or information to submit.

1(b)

On 07/202/2021, Resident #2's care plan was reviewed. A focus dated 01/24/2021 documented, "[Resident #2] is at risk for: Skin Tears and Bruising related to: fragile skin and capillaries, hx [history] of multiple skin tears and bruises, reduced environmental safety awareness, wandering behaviors, hx of combative behaviors and during ADL [activities of daily living] care Dx [diagnosis]: Unspecified mood (affective) disorder, dementia with behavioral disturbance." One intervention associated with this focus included but was not limited to "Supervise wandering on units."

On 07/21/2021 at 8:10 A.M., Resident #2 was observed walking into the dining room on Unit 4 and standing next to a table situated by the glass wall on the right side of the room. Resident #2

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495291	A. BUILDING _____ B. WING _____	C 07/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETH SHOLOM HOME OF VIRGINIA	1600 JOHN ROLFE PARKWAY RICHMOND, VA 23233

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F 656	Continued From page 46	F 656		

was arranging silverware and napkins on the table. Resident #2 then picked up a fork, a spoon, and napkin and exited the dining room. Resident #2 was then observed entering the unit manager's office and closing the office door. Resident #2 was observed walking up to the desk, reaching out and touching the window beyond the desk, touching the desktop, then opening the office door, and exiting the office. Employee E was seated at the nurse's station which is just outside the unit manager's office. There were also 6 residents in chairs in close proximity to the nurse's station. Resident #2 walked to the desk behind Employee E. A staff member walked past the nurse's station toward the med cart beyond the unit manager's office. Neither staff member noticed Resident #2 had silverware in her hand. Resident #2 was observed cleaning the fork and spoon with the napkin while standing at the desk at the nurse's station behind Employee E. Employee E then left the area and walked down the hall. Resident #2 was observed with a stapler, opening and closing the anvil, and moving the spoon along the base of the stapler. At 8:14 A.M., Resident #2 was then observed picking up the stapler and the spoon (leaving the fork on the desk) and walking the length of the hallway and placed the stapler and the spoon on the windowsill at the end of the hall by room 427. Resident #2 was observed opening and closing the stapler by that window at the end of the hall. Resident #2 left the stapler on the windowsill and sat down on a bench at the end of the hall. At 8:18 A.M., the Director of Nursing (DON) was on Unit 4 and this surveyor notified the DON of observations. The DON retrieved the fork from the desk and the stapler from the windowsill.

On 07/21/2021 at approximately 1:00 P.M., the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495291	A. BUILDING _____ B. WING _____	C 07/22/2021

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F 656	Continued From page 47	F 656		

DON was interviewed. When asked about the expectation from staff concerning the observations of Resident #2 with a fork, the stapler, and entering the unit manager's office, the DON stated that the silverware should not have been set out on the tables in the dining room and the dining room doors should have been closed to keep [Resident #2 out of the dining room. The DON also stated that "we can't let her walk around with a fork." The DON also stated that [Resident #2] likes to clean and that staff will let her clean the desk [at the nurse's station]. At approximately 1:10 P.M., this surveyor and the DON entered the unit manager's office. There was a corkboard with thumb tacks on the left wall. The desk on the right side of the room had three side drawers. The top drawer had a lock and the DON stated that the unit manager, [Licensed Practical Nurse A (LPN A)] "usually locks these drawers." The DON then opened each of the drawers (they were unlocked). In the second drawer, the contents included but were not limited to 2 large pairs of scissors (one with orange handles and one with black handles). The DON removed them from the drawer and placed them on top of a cabinet in the office. At approximately 1:15 P.M., LPN A entered the office. When asked if the drawers were locked, she stated "no" and added that she didn't have a key to those drawers.

On 07/21/2021 at approximately 3:30 P.M., the administrator and DON were notified of concerns.

On 07/22/2021 at approximately 2:40 P.M., the DON was interviewed in the conference room with Surveyor A present. When asked about the intervention on the care plan "Supervise wanderings on units", the DON stated it was "not

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495291	A. BUILDING _____ B. WING _____	C 07/22/2021

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F 656	Continued From page 48	F 656		

a good intervention because you can't watch her every second."

On 07/22/2021, the facility staff provided a copy of their policy entitled, "Comprehensive Care Planning." Under the header "Procedure" in Section 9 (e) and (h), it was documented, "The comprehensive care plan will: (e) Reflect treatment goals, timetables, and objectives in measurable outcomes; (h) promote resident safety."

By the end of survey on 07/22/2021, the administrator stated there was no further documentation or information to submit.

2. For Resident #71 the facility staff failed to develop and implement a care plan that was patient centered and included measurable objectives to meet the needs of the Resident.

2. For Resident #71 the facility staff failed to develop and implement a care plan that was patient centered and included measurable objectives to meet the needs of the Resident.

Resident #71, a 90 year old woman admitted to the facility on 6/5/20 with diagnoses of but not limited to diabetes type II, dementia with behavioral disturbance, chronic kidney disease, and pancreatitis. Resident #71's most recent MDS (Minimum Data Set) assessment coded Resident #71 as having a BIMS (Brief Interview of Mental Status) score of 4 indicating severe cognitive impairment. She was coded as requiring extensive assistance with all aspects of ADL care. The Resident required the use of a sit

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495291	A. BUILDING _____ B. WING _____	C 07/22/2021

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F 656	Continued From page 49	F 656		

to stand lift for transfers and a wheel chair for mobility.

On 7/21/21 during the clinical record review it was noted that the Resident's care plan read:

Care plan read as follows:
"PROBLEM:"
"Problem Start Date - 6/5/2020 - Category: Falls
"[Resident name redacted] is at risk for falls r/t dementia with behavioral disturbance, metabolic encephalopathy, diminished safety awareness, impaired gait balance and mobility, use of assistive devices, side effects of cardiovascular and say psychotropic medication, history of falls sustaining fracture."

"Goal: long-term goal target 5/26/21"
"Resident will not experience a fall requiring hospital stay through the next review."

Approach:
"Approach start date 6/5/20 - Assist resident as needed with toileting incontinent care on a regular basis. Discipline - Nursing"

"Approach Start Date - 6/10/20 - Educate family and staff on needs for monitoring after window visits with family Discipline - nursing"

"Approach Start Date: 8/30/20 OT Re-eval W/C positioning. Discipline: Nursing and OT"
"Approach Start Date: 10/30/20 PT/OT referral -Discipline: Nursing"

"Approach Start Date: 11/5/20 - transfers with sit to stand lift-Discipline: Nursing"

"Approach Start Date: 4/20/21-Ensure completion

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495291	A. BUILDING _____ B. WING _____	C 07/22/2021

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F 656	Continued From page 50	F 656		

of routine rounds every shift, every day, every evening, and every night. Discipline nursing"

"Approach Start Date: 7/22/20 medication review completed to help patient sleep better at night. Discipline Nursing"
"Approach Start Date: 7/22/20 safety checks as indicated -Discipline: Nursing."

"Approach Start Date: 2/17/21 psych consult as needed discipline nursing"
"Approach Start Date: 2/17/21 PT to eval and treat as indicated discipline PT/OT"

"Approach Start Date: 7/5/20 frequent observations for safety checks -Discipline: Nursing"
"Approach Start Date: 7/22/20 bring resident to nurses station for closer monitoring.-Discipline: Nursing"

The following are excerpts from Resident #71's Care Plan for the "Problem Category Behavioral Symptoms":

PROBLEM: start date 6/8/20
CATEGORY: behavioral symptoms
[Resident name redacted] has behavior hx of resist care, get agitated with requests and combative and verbally abusive at times and hx of plays with her stool. Verbally abusive to staff, cursing, yelling, attempting to hit staff, wandering, entering room of other, banging on closet door, disrobing self of clothes and incontinent briefs. [Resident name redacted] is usually not a "morning person" Her behaviors can place her at increased risk of abuse as she can be combative and physically aggressive towards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495291	A. BUILDING _____ B. WING _____	C 07/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETH SHOLOM HOME OF VIRGINIA	1600 JOHN ROLFE PARKWAY RICHMOND, VA 23233

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F 656	Continued From page 51 staff. GOAL: Long term goal target date 5/26/21- Episodes of behaviors will decrease and resident's needs will be met thru next review. Approach Start Date: 6/8/20 Explain all procedures to resident before attempting. DO NO FORCE to participate in ADL's if behavior is escalating. Report to nurse and allow resident to calm down before re-attempting. PROBLEM: start date 6/30/21 CATEGORY: behavioral symptoms [Resident name redacted] is at risk for increased behaviors due to experiencing physical trauma. GOAL: long-term goal target gate 9/30/21 Resident will not experience increased behavior and all needs will be met through next review. APPROACH: Approach start date: 6/30/21 Assess for signs and symptoms of pain/discomfort and provide pain meds as ordered DISCIPLINE: nursing Approach start date 6/30/21 document residence behavior status on a regular basis. Discipline NURSING Approach start date 6/30/2021 explain all procedures to resident before attempting Discipline activities, nursing, OT/PT/RD and social services Approach start date: 6/30/21 offer support for family when needed and requested. DISCIPLINE administrator nurse practitioner nursing position and social services Approach start date: 6/30/21 provide support and encouragement when resident exhibits behaviors.	F 656		

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	495291	A. BUILDING _____ B. WING _____	C 07/22/2021

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F 656	Continued From page 52 DISCIPLINE activities, nursing, and social services Approach start date 6/30/21 psych consult as ordered Discipline NURSING Approach start date: 6/30/21 - Report increased behaviors or abnormalities to the MD discipline blank Approach start date 6/30/21 social service visits/consult as needed. The behavioral aspect of the care plan do not specify behaviors and or provide specific interventions to address each behavior that is targeted. This care plan "Problem" was only started after an incident of resident "experiencing physical trauma, however the Resident's chart reflects behavior disturbances beginning on admission. On 7/21/21 at approximately 11:00 AM an interview was conducted with LPN A, who was asked the purpose of a care plan. LPN A stated "A care plan is to show the staff the needs of the Resident and how to meet the needs. It should tell you how they transfer and how they eat, if they wear briefs or are incontinent, even stuff like thickened liquids and behaviors." When asked who updates the care plans she stated that the nurses could all update it. When asked how often it should be updated she said any time there is a change in the Resident's status or condition." On 7/22/21 at approximately 2:18 PM an interview was conducted with the DON who stated, that she was aware there were some	F 656		

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	495291	A. BUILDING _____ B. WING _____	C 07/22/2021

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F 656	Continued From page 53 issues with the care plans not being specific and resident centered with measurable objectives. She said "We are trying to make it a team approach so that we can fine tune the care plans." On 7/22/21 during the end of day meeting the Administrator was made aware of the concerns and no further information was provided	F 656		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, Resident interview, staff interview, facility documentation review and clinical record review, the facility failed to provide ADL assistance to maintain personal hygiene for 2 Residents (Resident #190, #71) in a survey sample of 33 Residents. For Resident #190, the facility staff failed to provide personal hygiene assistance for shaving; he was dependent on staff for assistance. The Findings included: Resident #190 was admitted to the facility on 7/7/2021, following hospitalization for a surgical wound infection. Resident #190 came to the facility requiring skilled services for therapy and IV (intravenous) antibiotic therapy treatment. Resident #190's diagnosis included but were not	F 677	F677 ADL Care for Dependent Residents Criterion #1 - Correction -Resident #190 was shaved on 7/22/21 and facial hair care is being provided per resident preference. Resident #71 has showers/bathes scheduled twice per week and the staff are documenting the resident's acceptance and type of assistance being provided during shower/bath. Criterion #2 -Other Potential Residents - All other residents could potentially be impacted. Audit of shower schedule on current residents are scheduled twice a week and residents with facial hair preference is care planned.	9/3/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495291	A. BUILDING _____ B. WING _____	C 07/22/2021

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F 677	Continued From page 54 limited to: MRSA(methicillin susceptible staphylococcus aureus) infection, cellulitis of left lower limb, difficulty walking, displaced intertrochanteric fracture of left femur, chronic atrial fibrillation, and hypertension. Resident #190 had not been in the facility long enough for an MDS (minimum data set) assessment to be completed. The clinical record revealed Resident #190 was alert, oriented and with some periods of confusion. He required assistance from facility staff with ADL's (activities of daily living). On 7/20/21 at 12:45 PM, observations were made of the Resident #190, he was observed with significant facial hair that was a full beard growth. On 7/20/21 at 3:10 PM, Resident #190 was interviewed and asked about the facial hair, when asked if he normally has a full beard, he said, "No. I haven't been shaved since I've been here and I can't do it". On 7/21/21, Resident #190 was observed with the facial hair again. He had not been shaven. On 7/22/21 at approximately 2:00 PM, an interview was conducted with CNA I. CNA I confirmed she was assigned to care for Resident #190 on 7/22/21. CNA I said, "I ask my male Residents in the morning if they want to be shaved. It took me 3 razors to get him shaved today". On 7/22/21 at approximately 2:30 PM, the Director of Nursing (DON) was asked about personal hygiene assistance for Resident #190.	F 677	Criterion #3 - System Changes - The CNA staff have been reeducated by the DON or Unit Manager on providing assistance with personal hygiene, including offering of showers/baths, and shaving of facial hair to residents. Bathing/shower schedules have been reviewed and assigned to ensure that each resident is offered two baths/showers weekly. Bathing/shower schedules have been reviewed and assigned to ensure that each resident is offered 2 baths/showers weekly. If a resident refuses a bath/shower, the team will inform the Charge nurse or unit manager and the refusal will be documented in the resident's medical record. The CNA staff have been re-educated by the DON or Unit Manager on accurate documentation within POC of the provision of personal hygiene and the type of assistance provided to the resident. The Licensed Nurses will be educated by the DON or Unit Manager on the processes for showers, CNAs responsibility to provide showers and report to Charge Nurse or Unit Manger refusals with documentation and the process for updating the care plan for resident preference of keeping facial hair. Criterion #4 - Monitoring -The Director of Nursing or designee will review five resident records weekly x 6 weeks to ensure that bath/showers are being provided 2x/week and documented appropriately within POC. The weekly reviews will include observation of the residents, including observation for facial hair care according to resident	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495291	A. BUILDING _____ B. WING _____	C 07/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETH SHOLOM HOME OF VIRGINIA	1600 JOHN ROLFE PARKWAY RICHMOND, VA 23233

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 677	Continued From page 55 The DON stated, "I know, I said something to them [the staff]. I told them to shave him". When asked when she made this request, she said, "On Tuesday, I went and talked with him after you had talked to him, and he told me he wanted to be shaved and bathed. It should have been done days ago". Review of the clinical record revealed that Resident #190 required staff assistance with personal hygiene per the ADL records. There was no indication within the record that the Resident refused to be shaved or desired to have a full beard. Review of the facility policy titled, "Resident Care and Services" read, "3. Residents are assigned to caregivers on each shift, who will be responsible to provide the necessary assistance to the resident in accomplishing ADLs for that shift, including: * Showering or Bathing (twice per week or as needed) * Dressing * Toileting * Transferring * Incontinence management * Eating *Ambulation or Mobility *Personal hygiene (such as shaving, oral care, brushing hair) *Medication Administration. 4. The provision of ADL assistance is documented in the resident's record." On 7/22/21 at approximately 2:30 PM, the DON was informed that facility staff had not provided Resident #190 with personal hygiene assistance with shaving since his admission on 7/7/21, until 7/22/21. No further information was provided. 2. For Resident #71 during the one month period from 6/5/20 through 7/5/20 failed to provide adequate bathing and or showering.	F 677	preference. Any variances will be investigated, and appropriate action taken to the situation. The weekly reviews will be reported to the DON for tracking/trending and additional action as needed. A summary of the weekly reviews will be reported to the facility QAPI Committee for additional oversight.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495291	A. BUILDING _____ B. WING _____	C 07/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETH SHOLOM HOME OF VIRGINIA	1600 JOHN ROLFE PARKWAY RICHMOND, VA 23233

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 677	Continued From page 56	F 677		

2. For Resident #71, during the one month period from 6/5/20 through 7/5/20, the facility staff failed to provide adequate bathing and or showering.

Resident #71, a 90 year old woman admitted to the facility on 6/5/20 with diagnoses of but not limited to diabetes type II, dementia with behavioral disturbance, chronic kidney disease, and pancreatitis. Resident #71's most recent MDS (Minimum Data Set) assessment coded Resident #71 as having a BIMS (Brief Interview of Mental Status) score of 4 indicating severe cognitive impairment. She was coded as requiring extensive assistance with all aspects of ADL care. The Resident required the use of a sit to stand lift for transfers and a wheel chair for mobility.

On 7/22/20 after hearing concerns from Resident #71's family about ADL care provided and showers being given, as well as resident's laundry "smelling of urine" a review of the ADL records was conducted. It was noted that in POC (Point of Care), the CNA documentation area of the chart, that Resident # 71 was only given 1 shower between 6/5/20 and 7/5/20. She was given only one complete bed bath in that same time frame. The documentation coded the Resident as receiving "Partial Bed Bath" on 33 occasions in that same 1 month period.

A review of the ADL policy revealed:
From day of admission 6/5/20 through 7/5/20 Resident #71 was only given a shower on 1 occasion according to the POC (Point of Care) system where the CNA's document the care

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495291	A. BUILDING _____ B. WING _____	C 07/22/2021

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 677	Continued From page 57	F 677		

provided to the Residents. The Resident was also only given a "Complete Bed Bath" on one occasion during this same time period.

On 7/21/21 at approximately 2:15 PM an interview with CNA B was conducted and she was asked how the CNA's documented care that was provided. CNA B stated that care was documented in POC. When asked how CNA's know the type of care to give and how much assistance is needed, she stated it's from the care plan.

On 7/22/21 at approximately 2:10 PM an interview was conducted with the DON who stated that the CNA's use POC to document when they provide any ADL care. The DON was told of family concern regarding ADL care especially on weekends and she replied "Weekend ADL's are tough due to staffing challenges." She was asked how often CNA's bathe or shower the Residents. She stated that each Resident was assigned 2 shower days a week. When asked if a Resident does not get a shower or refused a shower what should happen? She stated that the CNA should notify the Nurse and document the refusal, as well as, give a Complete Bed Bath instead. When asked if it was acceptable practice for a CNA to give only 1 Shower and 1"Complete Bed Bath" in a month, and give "Partial Bed Baths" 33 times in that same month, she stated that is was not acceptable. She stated the expectation is that the Resident should have 2 showers a week and be provided partial or complete bed bath between shower days.

It was also noted in the POC documentation that some staff were documenting the resident was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495291	A. BUILDING _____ B. WING _____	C 07/22/2021

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 677	Continued From page 58 totally dependent, some wrote independent, and some wrote set up only. When asked how the CNA's knew what type of care and assistance was required she stated that it was addressed in the care plan. When asked do the CNA's have access to the care plan she stated that they did On 7/22/21 during the end of day conference the Administrator was made aware of the concerns with ADL care and no further information was provided.	F 677		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and clinical record review, the facility staff failed to supervise one Resident (Resident #2) in a sample size of 33 Residents. Specifically, Resident #2 was observed walking with a fork, a stapler, and entering into the unit manager's office with access to items including but not limited to thumb tacks and scissors resulting in a potential accident hazard. The Findings included: Resident #2, a 77-year old female, was admitted to the facility on 08/06/2020. Diagnoses included	F 689	F689 □ Accident/Safety Criterion #1 - Correction - Resident #2 has not experienced any injury to self or others from wandering with items that may potentially cause harm. Resident #2's care plan has been revised to reflect resident centered interventions to promote safety to the resident and others. Criterion #2 -Other Potential Residents - Other residents residing on the secure unit who wander may have potentially been impacted. Resident care plans will	9/3/21

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	495291	A. BUILDING _____ B. WING _____	C 07/22/2021

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F 689	Continued From page 59 but were not limited to unspecified dementia with behavioral disturbance. Resident #2's most recent Minimum Data Set with an Assessment Reference Date of 03/08/2021 was coded as a quarterly assessment. Cognitive Skills for Daily Decision-Making were coded as severely impaired. Behavioral symptoms were coded as "0" meaning behaviors not exhibited during the 7-day lookback period. On 07/21/2021 at 8:10 A.M., Resident #2 was observed walking into the dining room on Unit 4 and standing next to a table situated by the glass wall on the right side of the room. Resident #2 was arranging silverware and napkins on the table. Resident #2 then picked up a fork, a spoon, and napkin and exited the dining room. Resident #2 was then observed entering the unit manager's office and closing the office door. Resident #2 was observed walking up to the desk, reaching out and touching the window beyond the desk, touching the desktop, then opening the office door, and exiting the office. Employee E was seated at the nurse's station which is just outside the unit manager's office. There were also 6 residents in chairs in close proximity to the nurse's station. Resident #2 walked to the desk behind Employee E. A staff member walked past the nurse's station toward the med cart beyond the unit manager's office. Neither staff member noticed Resident #2 had silverware in her hand. Resident #2 was observed cleaning the fork and spoon with the napkin while standing at the desk at the nurse's station behind Employee E. Employee E then left the area and walked down the hall. Resident #2 was observed with a stapler, opening and closing the anvil, and	F 689	be reviewed and revised to reflect resident behaviors that may pose risk for resident safety and will include resident centered interventions to promote safety. Criterion #3 - System Changes □The nursing staff (RN's, LPN's and CNA's) will be educated by the DON or Unit Manager on potentially hazardous items will be stored in a manner to minimize access by residents. Office doors will be kept locked when staff are not in attendance. Residents will be observed for wandering while carrying potentially hazardous items (such as a fork) and staff will re-direct the resident. Staff will be re-educated on the importance of observing and re-directing residents when potentially dangerous actions are observed. Criterion #4 - Monitoring-The Administrator or designee will make observations 3x/week x 6 weeks on the secure unit to ensure that resident safety precautions are being implemented; this will include observation of residents; that potentially dangerous objects are not accessible to residents and that staff offices are locked when not in attendance. Variances will be immediately corrected, and responsible staff re-educated and/or counseled. The findings from the weekly observations will be reported to the Administrator. A summary of the weekly audits will be provided to the QAPI Committee.	

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F 689	Continued From page 60	F 689		

moving the spoon along the base of the stapler. At 8:14 A.M., Resident #2 was then observed picking up the stapler and the spoon (leaving the fork on the desk) and walking the length of the hallway and placed the stapler and the spoon on the windowsill at the end of the hall by room 427. Resident #2 was observed opening and closing the stapler by that window at the end of the hall. Resident #2 left the stapler on the windowsill and sat down on a bench at the end of the hall. At 8:18 A.M., the Director of Nursing (DON) was on Unit 4 and this surveyor notified the DON of observations. The DON retrieved the fork from the desk and the stapler from the windowsill.

On 07/21/2021 at approximately 1:00 P.M., the DON was interviewed. When asked about the expectation from staff concerning the observations of Resident #2 with a fork, the stapler, and entering the unit manager's office, the DON stated that the silverware should not have been set out on the tables in the dining room and the dining room doors should have been closed to keep [Resident #2 out of the dining room. The DON also stated that "we can't let her walk around with a fork." The DON also stated that [Resident #2] likes to clean and that staff will let her clean the desk [at the nurse's station]. At approximately 1:10 P.M., this surveyor and the DON entered the unit manager's office. There was a corkboard with thumb tacks on the left wall. The desk on the right side of the room had three side drawers. The top drawer had a lock and the DON stated that the unit manager, [Licensed Practical Nurse A (LPN A)] "usually locks these drawers." The DON then opened each of the drawers (they were unlocked). In the second drawer, the contents included but were not limited to 2 large pairs of scissors (one with

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F 689	Continued From page 61 orange handles and one with black handles). The DON removed them from the drawer and placed them on top of a cabinet in the office. At approximately 1:15 P.M., LPN A entered the office. When asked if the drawers were locked, she stated "no" and added that she didn't have a key to those drawers. On 07/21/2021 at approximately 3:30 P.M., the administrator and DON were notified of concerns. By the end of survey on 07/22/2021, the administrator stated there was no further documentation or information to submit.	F 689		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic	F 758		9/3/21

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F 758	Continued From page 62 drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on interview, clinical record review and facility documentation, the facility staff failed to ensure residents are free from unnecessary psychotropic drugs for 1 Resident (#71) in a survey sample of 33 Residents. The Findings included: For Resident #71 the facility staff failed to attempt the required GDR's for the 3 psychotropic medications and failed to accurately document	F 758	F758 -Use of Psychotropic PRN Medication Use Criterion #1 -Correction - Resident #71's psychotropic medications have been reviewed by the facility's consulting pharmacist and the attending physician for appropriate diagnoses and potential drug reduction/elimination. Criterion #2 -Other Potential Residents -Residents with current orders for	

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F 758	Continued From page 63 appropriate diagnoses for the medications. Resident #71, a 90 year old woman admitted to the facility on 6/5/20 with diagnoses of but not limited to diabetes type II, dementia with behavioral disturbance, chronic kidney disease, and Pancreatitis. Resident #71's most recent MDS (Minimum Data Set) assessment coded Resident #71 as having a BIMS (Brief Interview of Mental Status) score of 4 indicating severe cognitive impairment. She was coded as requiring extensive assistance with all aspects of ADL care. The Resident required the use of a sit to stand lift for transfers and a wheel chair for mobility. On 7/21/20 a review of the clinical record revealed that Resident #71 had orders for the following psychotropic medications: Sertraline [generic Zoloft-Anti-depressant] - 50 mg [DX. Other specified depressive episodes] Once a day at 9:00 AM (start 6/5/20 D/C -6/10/20) Sertraline [generic Zoloft-Anti-depressant] - 50 mg [DX. Other specified depressive episodes] Once a day at 9:00 PM (start 6/10/20 D/C 6/30/20) Mirtazapine [Generic Remeron -Anti-Depressant] 7.5 mg once a day at bedtime 9:00 PM [DX: Adverse effect of appetite depressants] (Start 6/11/20 DC 6/30/20) Mirtazapine [Generic Remeron -Anti-Depressant] 7.5 mg give once a day at bedtime 9:00 PM [DX: Anorexia] (Start 6/30/20 DC 8/07/20)	F 758	psychotropic medications may potentially be at risk. A 100% audit of current residents will be conducted to ensure there is diagnosis supporting the need for the medication and that the resident has been reviewed for possible gradual dose reduction as appropriate. The prescribing provider will be notified of any action needed. Criterion #3 - System Changes - Education will be provided by the VP of QA to the consulting pharmacist, Medical Director and DON on the process for completion of monthly medication reviews and provide recommendations to the prescribing provider regarding appropriate diagnosis to support the psychotropic medications and recommendations regarding consideration for gradual dose reduction. These recommendations will be reported to the Director of Nursing and the Medical Director for additional oversight and response by the prescribing provider. The DON will educate the Unit Managers on the process for the monthly medication review and recommendations are completed and have documentation. Criterion #4 - Monitoring -The Director of Nursing or Unit Manager will monitor 4 residents per month x 3 months that the monthly medication regimen reviews with recommendations are clearly communicated to the attending physician and that there is provider response to the recommendations and completed. Findings of variances will be investigated, and appropriate action taken by the DON	

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F 758	Continued From page 64 Mirtazapine [Generic Remeron -Anti-Depressant] 7.5 mg give once a day at bedtime 9:00 PM [DX: Major depressive disorder, recurrent unspecified] (Start 8/7/20 DC 2/26/20) Mirtazapine [Generic Remeron -Anti-Depressant] 15 mg give once a day at bedtime 9:00 PM [DX: Major depressive disorder, recurrent unspecified] (Start 2/26/20 - open ended) Quetiapine [Generic Seroquel - Anti-psychotic] 25 mg Twice a day 9:00 AM, 5:00 PM [DX: unspecified mood disorder} (start date 6/30/20 DC 7/22/20) Seroquel [Generic- Quetiapine Anti-psychotic] Tablet 25 mg: amount 25 mg once a day at 6:00 AM [DX: unspecified mood disorder} (start date 7/22/20 DC 8/7/20) Seroquel [Generic- Quetiapine Anti-psychotic] Tablet 25 mg: amount 50 mg once a day at 5:00 PM [DX: unspecified mood disorder} (start date 7/22/20 DC 8/7/20) Seroquel [Generic- Quetiapine Anti-psychotic] Tablet 25 mg: amount 25 mg once a day at 6:00 AM [DX: unspecified mood disorder} (start date 8/7/20 - open ended) Seroquel [Generic- Quetiapine Anti-psychotic] Tablet 25 mg: amount 50 mg once a day at 5:00 PM [DX: unspecified mood disorder} (start date 7/22/20 - open ended) Lorazepam (ATIVAN - anti anxiety) 2 mg/ml (milligrams per milliliter) give 0.25 ml (0.5 mg) [Dx: anxiety disorder] every 12 hours PRN (start	F 758	and/or Medical Director. A summary of the recommendations including provider response will be reported to the QAPI Committee.	

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F 758	Continued From page 65 date 7/8/20 DC 7/22/20) Lorazepam (ATIVAN - anti anxiety) 0.5 mg Tablet; 0.25 mg amt.: [Dx: anxiety disorder] give twice a day 9:00 AM and 5:00 PM [start date 7/21/21 - DC 7/22/21) Lorazepam ((ATIVAN - anti anxiety)) 0.5 mg Tablet; 0.5 mg amt.: [Dx: anxiety disorder] give twice a day 9:00 AM and 9:00 PM [start date 7/21/20 - DC 7/22/20) Lorazepam ((ATIVAN - anti anxiety)) 0.5 mg Tablet; 0.5 mg amt: [Dx: anxiety disorder] give twice a day 9:00 AM and 9:00 PM [start date 8/7/20 - DC 9/22/20) Lorazepam ((ATIVAN - anti anxiety)) 0.5 mg Tablet; 0.5 mg [Dx: anxiety disorder] give twice a day 9:00 AM and 9:00 PM [start date 9/22/20- DC 10/30/20) Trazadone [Desyrel- Anti-Depressant] 50 mg at bedtime 9:00 PM [Dx; Primary Insomnia] (Start date 7/7/20 DC 8/7/20) Trazadone [Desyrel- Anti-Depressant] 50 mg at bedtime 9:00 PM [Dx; Primary Insomnia] (Start date 8/7/20 - open ended) On 7/22/21 a review of the pharmacy "Gradual Dose Reduction Tracking Report" for Resident #71 read as follows: Sertraline (Zoloft) Therapy start date 11/5/20 Last GDR Attempt [column left blank] -next GDR Eval. 5/5/21 "Mirtazapine (Remeron) therapy start date	F 758		

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F 758	Continued From page 66 6/12/20 - Last GDR Attempt - [column left blank] - next GDR Eval. 12/31/21" "Seroquel (Quetiapine) Therapy start date 6/30/20 - Last GDR Attempt [column left blank] Next GDR Eval 12/31/21" On 7/21/20 a review of the clinical record revealed that MDS diagnoses listed for Resident #71 included: MDS - Admission 6/12/20 -Section I -Active Diagnosis - Psychiatric/ Mood disorder coded the Resident as having "15800 Depression other than bi-polar." Quarterly MDS -11/14/20 - Section I -Active Diagnosis - Psychiatric/ Mood disorder coded the Resident as having "15800 Depression other" and "anxiety disorder" was also checked on this MDS. A review of the pharmacy recommendations revealed that on 7/2/20 the pharmacy report read: "[Resident #71 name redacted] was admitted with an anti-psychotic, Seroquel, for an inappropriate indication: Dementia with behavioral disturbance" "Seroquel Labeled indications: Bipolar depression, Bipolar disorder, mania, schizophrenia." "Recommendation:" "Please consider a GDR with the end goal of discontinuation while monitoring for re-emergence of target symptoms and or withdrawal. If this is not desired please update the medical record to include:	F 758		

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F 758	Continued From page 67 1. The specific diagnosis/indication requiring treatment that is used based upon an assessment of the resident's condition and therapeutic goals and 2. A list of the symptoms or target behaviors (e.g. hallucinations, scratching) including their impact on the resident (e.g. increases distress, presents a danger to the resident or others, interferes with his or her ability to eat)" The physician checked the box that read: " I accept the above with the following Mediation modifications: Indication- Mood Disorder." On 7/22/21 an interview was conducted with the DON who was asked about GDR for Psychotropic's and she stated that the physician signed for contraindication. When she examined the pharmacy consultation sheet she stated "I see he checked the box but did not put in the rationale for not attempting GDR with this Resident..." On 7/22/21 during the end of day meeting the Administrator was made aware of the concerns involving GDR and no further information was provided.	F 758		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.	F 761		9/3/21

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F 761	Continued From page 68 §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility documentation review, the facility staff failed to label and store medication according to accepted professional principles for one Resident (Resident #10) out of a sample size of 33 Residents. The Findings included: For Resident #10, his multi-dose bottle of lorazepam suspension was opened and undated in the med room #2 fridge. Resident #10, a 78-year old male, was admitted to the facility on 09/12/2018. Diagnoses included but were not limited to Parkinson's disease. On 07/21/2021 at 10:55 A.M., this surveyor and Licensed Practical Nurse B (LPN B) entered the med room on Unit 2. When asked about the acceptable temperature range for the fridge, LPN	F 761	F761 Label/Store Biologicals Criterion #1 - Correction Resident #10's bottle of Lorazepam was discarded on July 21,2021. Criterion #2 -Other Potential Residents - All residents with refrigerated medication may have potentially been impacted. Refrigerators on each nursing unit were reviewed by the DON or Unit Manager to ensure that refrigerator temperature logs were present and that medications stored in the refrigerator were appropriately labeled and had not expired. Medications that were stored outside of recommended temperatures and/or had not been appropriately labeled / dated when opened or that expired were discarded.	

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F 761	Continued From page 69 B stated it should be between 40-45 degrees and added "as long as it is not in the red zone." The temperature log for the small fridge could not be located. Upon opening the small med fridge, LPN B and this surveyor observed the temperature gauge inside the fridge to be 52 degrees Fahrenheit. LPN B stated that she would report it to maintenance and let the unit manager know. A sign on the wall next to the fridge documented the following: "If the refrigerator temps are not between 36 and 46 degrees: Adjust the temperature so that it ends up in that temperature range. Recheck the temperature to make sure it adjusted; and record the corrected temp if in range. We are losing thousands of $$$ in vaccines to out of range temps being recorded but not adjusted and re-recorded. 36 degrees to 46 degrees at all times." LPN B and this surveyor then observed the medications in the fridge. There was a locked, anchored box which contained an opened, undated bottle of lorazepam suspension labeled with Resident #10's name. When asked if the medication had been opened, LPN B stated, "Yes." When asked how that was determined, LPN B stated that unopened bottles have a seal across the top but this bottle for Resident #10 did not have a seal. When asked when it was opened, stated the bottle was not dated. When asked about the importance of dating the bottle, LPN B stated "so we'll know when it expires." When asked why that was important, LPN B stated that "it's dangerous" to give an expired medication to a Resident. At 11:08 A.M., this surveyor and LPN B saw LPN A, unit manager for Unit 4, outside the med room on Unit 2. LPN A was notified of observations in the med room. When asked about the expectation for dating medication, LPN A stated the bottle should be dated on the day it was	F 761	Criterion #3 - System Changes -The Licensed Nurses (RN's and LPN's) will be educated by the DON or Unit Manager on the process for refrigerator temperature logs for medication refrigerators will be maintained on each medication refrigerator. The 11-7 shift nurses will check the medication refrigerator and document it nightly and will observed that all opened medications have been appropriated labelled/dated. If temperatures are found outside of the recommended range, the refrigerator temperature will be adjusted and/or maintenance will be notified. If medications are observed to have been opened but not labeled/dated, an investigation will be completed, and the medication will either be appropriately labelled/dated or discarded if date opened is unknown. Criterion #4 --Monitoring - The DON or Unit Manager will conduct medication refrigerator audits 3x week on each unit x 6 weeks to ensure that the log sheets are being completed, that temperature ranges are within guidelines and that opened medications stored in the refrigerator have been appropriately labelled/dated and discarded if expired. Any findings in variances will be investigated and appropriate staff re-educated and/or counseled. The weekly audits will be provided to the Director of Quality Assurance for trending and a monthly summary report will be provided to the QAPI Committee.	

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	495291	A. BUILDING _____ B. WING _____	C 07/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 761	Continued From page 70	F 761		

opened. When asked about the fridge temperature log, LPN A went to the med room to look around. LPN A stated it is usually sitting on the top of the fridge and the 11-7 shift usually checks it. A copy of the manufacturer's information for Resident #10's lorazepam was requested as well as the narcotic sheet to determine when it was first opened.

On 07/21/2021 at approximately 1:20 P.M., LPN A offered an update. LPN A stated that Resident #10's lorazepam was first opened on 04/19/2021 according to the narcotic sheet. LPN A also stated "so it was disposed of." LPN A also stated that the small fridge temperature log was located in the protective sheet behind the other fridge's log. A copy of the temperature log was requested.

On 07/21/2021, the facility staff provided a copy of the small fridge temperature log, the manufacturer's information for Resident #10's lorazepam, and the narcotic sheet for Resident #10's lorazepam. The med room refrigerator temperature log document was entitled, "11-7 Shift Monthly Refrigerator/Freezer Checks." The sub-header was entitled, "Unit: #2." Under the column labeled "July 2021", there were 12 dates without temperatures recorded: 07/06/2021 - 07/09/2021; 07/11/2021; 07/13/2021-07/17/2021; and 07/19/2021-07/21/2021. At the bottom of the page, it was documented, "Note: the temperature of the Med Room refrigerator and freezer and the supplemental Refirgerator [sic] are to be read and recorded nightly by the 11-7 Nurse, for each unit. Please report all abnormal temperarures [sic] immediately to the Supervisor."
On 07/21/2021 the facility staff provided he manufacturer's information for Resident #10's lorazepam. Excerpts under the header,

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F 761	Continued From page 71 "Lorazepam Oral Concentrate" documented, "Store at cold temperature. Refrigerate at 2 to 8 degrees [Centigrade] (36-46 degrees F [Fahrenheit])." "Discard opened bottle after 90 days." On 07/21/2021 at 3:30 P.M., the administrator and Director of Nursing were notified of findings. By the end of survey on 07/22/2021, the administrator stated there was no further documentation or information to submit.	F 761		
F 807 SS=D	Drinks Avail to Meet Needs/Prefs/Hydration CFR(s): 483.60(d)(6) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(6) Drinks, including water and other liquids consistent with resident needs and preferences and sufficient to maintain resident hydration. This REQUIREMENT is not met as evidenced by: Based on observation, Resident interview, staff interview, facility documentation review and clinical record review, the facility failed to provide beverages consistent with Resident needs and preferences for 1 Resident (Resident #190) in a survey sample of 33 Residents. For Resident #190, the facility staff failed to provide liquids/beverages in a consistency as ordered by the physician and requested by the Resident. The Findings included: Resident #190 was admitted to the facility on	F 807	F 807 □ Drinks Available to Meet Needs/Hydration Criterion #1 - Correction - Resident #190 current dietary orders include aspiration precautions, upright for meals, no straws. His liquids are not thickened, by preference of the resident and his son. Staff have received communication regarding his preference and it is identified on his care plan. All thicken packets were removed from room. The resident is receiving liquids as ordered by the physician and his preference.	9/3/21

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F 807	Continued From page 72 7/7/2021, following hospitalization for a surgical wound infection. Resident #190 came to the facility requiring skilled services for therapy and IV (intravenous) antibiotic therapy treatment. Resident #190's diagnosis included but were not limited to: MRSA(methicillin susceptible staphylococcus aureus) infection, cellulitis of left lower limb, difficulty walking, displaced intertrochanteric fracture of left femur, chronic atrial fibrillation, and hypertension. Resident #190 had not been in the facility long enough for an MDS (minimum data set) assessment to be completed. The clinical record revealed Resident #190 was alert, oriented and with some periods of confusion. He required assistance from facility staff with ADL's (activities of daily living). On 7/20/21 at 12:45 PM, observations were made of a cup of liquid on the bedside table that was congealed. Additionally, a packet of thickener was noted on the bedside table. On 7/20/21 at 12:45 PM, during an interview with Resident #190, he reported "they keep giving me that stuff to drink and I would rather go home and die than drink that stuff! My son brought the papers over here showing them I'm not supposed to be on it, but they keep bringing it to me. I'm so thirsty". During this interview, staff brought in his meal tray which did have a cup of a thin consistency beverage. His meal tray ticket was observed and it read, "Diet: Regular, Texture: Regular, Fluid: Thin". Review of the clinical record revealed that Resident #190 had an active physician order for liquids of a thin consistency that was effective 7/14/21. The care plan revealed a nutritional	F 807	Criterion #2 -Other Potential Residents -All residents are at risk to be impacted. An audit was performed the DON and Unit Managers to verify residents were receiving and had liquids as per physician order. Criterion #3 - System Changes -The Nursing Staff (RN's, LPN's and CNA's) were educated by the DON or Unit Manager on the process for identifying liquid consistency per physician order for residents. The residents who receive thickened liquids will have a visual cue identifier placed in their room to inform staff of the thicken consistency. If a thicken liquid is noted in a resident room and not on a thicken liquid the staff will report to the Charge Nurse and the Nurse will investigate, remove or discard and correct the liquid consistency to the physician order. Criterion #4 - Monitoring - The ADON and Unit Manager will observe 3 residents on their units 3/week x 6 weeks to ensure that the residents have been provided the correct fluid consistency per physician order and that appropriate cue cards are present in their rooms if their liquids require thickening. Variances will be immediately corrected and appropriate staff re-educated/counseled. Findings from the weekly audits will be provided to the Director of Nursing for tracking/trending. A summary of the weekly audits will be reported to the QAPI Committee for additional recommendation	

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F 807	Continued From page 73	F 807		

status care plan that read, "Adjust diet, as needed, per SLP (Speech Language Pathologist)".

On 7/20/21 an interview was conducted with the Speech Therapist at the bedside of Resident #190. Resident #190 expressed his frustration to her over the facility staff continuing to provide thickened liquids. The speech therapist commented that "I don't know why you are still getting it, I changed that a week ago". When asked about the cup of thickened liquid at the bedside, she said it appeared someone had thickened something that it had sat so long it started to congeal. She threw the cup away as well as the packet of thickener, stating "it shouldn't be here".

On 7/22/21, a request was made of the facility staff to provide their policy with regards to following physician orders and dietary preferences. The requested policies were not received prior to survey exit.

On 7/22/21 at approximately 2:30 PM, the Director of Nursing (DON) was informed that facility staff continued to provide Resident #190 with thickened liquids which he did not have an order to receive and expressed dissatisfaction with.

No further information was provided.