PRINTED: 06/22/2021 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION NG	(X3) DATE COMP	SURVEY
						0
		495133	B. WING		06/	10/2021
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
VALLEY F	REHABILITATION AND N	JRSING CENTER		940 EAST LEE HIGHWAY		
		0		CHILHOWIE, VA 24319		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	( (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	- 1	COMPLETION DATE
E 000			E	The filing of this Plan of Correction d constitute an admission that the alleg deficiencies did in fact exist. This placement of the correction is filed as evidence to compare the correction is filed as evidence to comp	ged an of	2
F 000	survey was conducte 06/10/2021. The facil compliance with 42 C Requirements for Lor	FR Part 483.73, g-Term Care Facilities.	5.0	the requirements of participation and continue to provide high quality residuentered care.		
F 000	An unannounced Me survey was conducte 06/10/21. Corrections	dicare/Medicaid standard d 06/08/21 through swere required for FR Part 483 Federal Long	FC			
	145 at the time of the sample consisted of 3 and 2 closed record r were investigated.	O certified bed facility was survey. The final survey to current resident reviews eviews. Three complaints				
F 607	CFR(s): 483.12(b)(1)-	(3)	F6	<sub>07</sub> Develop/Implement Abuse/Neglect Police	cies	
	§483.12(b)(1) Prohibit neglect, and exploitat misappropriation of results with the second state of the sec	cies and procedures that: and prevent abuse, ion of residents and sident property, sh policies and procedures h allegations, and training as required at is not met as evidenced		<ol> <li>Address how corrective action versidents found to have been affected by the deficient practice. Residents #72, #111, #108, #131, #28, #26, #140,#53, and #134 all remain within the facility and investigations have been complete for the incidents. Resident #115 has been discharged from the facility.</li> <li>Address how the facility will identify other residents having the potential to be affected by the same deficient practice: All residents have the potential to be affected.</li> </ol>	e: d as	
ABORATORY D	RECTOR'S OF PROVIDER/SL	IPPLIER REPRESENTATIVE'S SIGNATURE		TITLE	()	(6) DATE

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

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

Event ID: 097511

Facility ID: VA0251

If continuation sheet Page 1 of 77

PRINTED: 06/22/202 FORM APPROVEI OMB NO. 0938-039

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		CONSTRUCTION	(X3) DATE	SURVEY
		405422					С
	20/1252 02 0/125/155	495133	B. WING	_		06	10/2021
NAME OF PI	ROVIDER OR SUPPLIER			1	TREET ADDRESS, CITY, STATE, ZIP CODE		
VALLEY F	REHABILITATION AND NU	JRSING CENTER			40 EAST LEE HIGHWAY		
				_ c	CHILHOWIE, VA 24319		_
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL	ID		PROVIDER'S PLAN OF CORRECTION	_	(X5)
TAG		SC IDENTIFYING INFORMATION)	PREF TAG		(EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA		COMPLETIO DATE
					DEFICIENCY)		
E 000	Initial Comments		E		The filing of this Plan of Correction do constitute an admission that the alleg deficiencies did in fact exist. This pla	ed n of	
F 000	survey was conducted 06/10/2021. The facilic compliance with 42 C	ity was in substantial FR Part 483.73, g-Term Care Facilities.	F		correction is filed as evidence to com the requirements of participation and continue to provide high quality resid centered care.	. •	
	survey was conducted 06/10/21. Corrections	were required for FR Part 483 Federal Long					1
	145 at the time of the sample consisted of 3 and 2 closed record rewere investigated.	0 certified bed facility was survey. The final survey 0 current resident reviews eviews. Three complaints					
F 607 SS=E	CFR(s): 483.12(b)(1)-	(3)	F	607	Develop/Implement Abuse/Neglect Polic  1. Address how corrective action w		
	§483.12(b)(1) Prohibit neglect, and exploitat misappropriation of re §483.12(b)(2) Establisto investigate any suc §483.12(b)(3) Include paragraph §483.95, This REQUIREMENT by: Based on staff intervi	cies and procedures that:  and prevent abuse, ion of residents and sident property, sh policies and procedures			be accomplished for those residents found to have been affected by the deficient practice Residents #72, #111, #108, #131, #28, #26, #140,#53, and #134 all remain within the facility and investigations have been completed for the incidents. Resident #115 has been discharged from the facility.  2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: All residents have the potential to be affected.	d es	
ABORATORY D	RECTOR'S OR PROVIDER/SU	JPPLIER REPRESENTATIVE'S SIGNATURE			TITLE		(X6) DATE

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

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN		DNSTRUCTION		SURVEY PLETED
		495133	B. WING _			- 1	C / <b>10/2021</b>
	ROVIDER OR SUPPLIER	IURSING CENTER		940 [	EET ADDRESS, CITY, STATE, ZIP CODE EAST LEE HIGHWAY LHOWIE, VA 24319	00	71072021
(X4) ID PREFIX TAG	(EACH DEFICIENCE	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIED TO THE APPROPRIED CROSS-REFERENCE)	BE	(X5) COMPLETION DATE
F 607	the facility staff failed and procedures in reinvestigating incident Residents #72, #111 #53, #134, and #115 The findings included 1. For Resident #72 implement facility poreporting/investigating altercations  Resident #72's face included, but not limit disorder, dementia vanxiety, convulsions disease.  The most recent quaset) with an ARD (as 04/26/21 assigned the interview for mental states that the intact.  Resident #72's compreviewed and contain "Inappropriate behave verbal/physical agitate other residents relate traumatic brain injury is "to decrease/minimizer verbal/physical abuse."  Resident #72's clinic contained nurse's president #72's clinic contained #72's clinic contained nurse's president #72's clinic contained #	ation it was determined that d to implement facility policy egards to reporting and its for 10 of 30 Residents, ,#108,#131,#28,#26,#140, i. d:  the facility staff failed to olicy in regards to no resident may resident to resident sheet listed diagnoses which ited to major depressive with behavioral disturbance, and gastroesophageal reflux arterly MDS (minimum data issessment reference date) of the resident a BIMS (brief status) score of 14 out of 15. The resident is cognitively corehensive care plan was need a care plan for vior at times, history of tion/aggression towards and to Cognitive impairment, it. The goal for this care plan mize episodes of e.".  all record was reviewed and ogress notes, which read in	F 6		place or systemic changes material ensure that the deficient praction of recur: Facility staff will be expected in the regarding facility policy and process alleged abuse in a timely manner alleged abuse in a timely manner indicate how the facility plans monitor its performance to material the solutions are sustained of Nursing or designee will audit allegations to ensure facility policification of the sustained followed weekly times 4 weeks a monthly times 2. Audit findings were viewed monthly in the quality and performance improvement performance improvement performance interventions.	de to ice will ducated edures ating r. to ke sure d: Director alleged cy is being nd rill be ssurance rocess for eary	
	part 09/19/2020 15:3	24 CNA (certified nurse's					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION NG	(X3) DATE COMP	SURVEY
	495133	B. WING _			C 1 <b>0/2021</b>
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 00/	10/2021
VALLEY REHABILITATION AND NUR	SSING CENTER		940 EAST LEE HIGHWAY		
The state of the s	COMO CENTER		CHILHOWIE, VA 24319		
PRÉFIX (EACH DEFICIENCY N	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
because she was 'using turned the water off at the couldn't use it. Reminder roommate can use sink room as well", "09/20/20 nurse that this resident resident in to a chair. Reshouldn't be putting her "09/20/2020 15:26 this resident on the right side residents", "09/20/2020 (director of nursing) of resplained to resident the if she hits anyone else. "09/23/2020 18:20 Second this nurse that they obsolace her hand over anyone. She then hit the continue to observe.", "Residents were up at not and talking. This resident beside her in the head of the residents were sep notified", "4/7/2021 10:10 activity room, this reside resident and smacked in face to point you heard that was slapped was so with a drink in her hands removed from area. Whe other resident she state MD and RP (responsible "4/9/2021 16:43 the nur	ident slap her roommate g her sink'. this resident the cutoff so other resident ed this resident that and other areas of the 020 14:57 CNA reported to 'slammed' another teminded resident she rhands on other people", resident hit another de of the face. separated 0 15:34 Notified DON resident's behavior. That the police can be called Room change to 323 B", and floor staff called to tell served (Resident #72) other resident's face and other resident', (resident) found in room and roommate. Writer was and observed. Will 10/06/2020 11:04 urse's station watching TV and smacked the resident for no apparent reason. The smacked the resident for no apparent reason. The smacked the resident for no apparent reason. The smacked over to another the second slap, resident sitting in chair in corner is, no injury noted, resident en asked why she slapped and 'she was staring at me', the party) notified" and rese aides ([names that the resident pushed)	F 6	507		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTE			ATE SURVEY OMPLETED
		495133	B. WING				С
	ROVIDER OR SUPPLIER			940 EAST	DDRESS, CITY, STATE, ZIP CODE  FLEE HIGHWAY  WIE, VA 24319		06/10/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 607	omitted) stated 'He w not quit'. the two were issues at this time. We surveyor spoke with on 06/09/21 at appropriate appropria	ain any injury or fall (name as going to hit her if she did a separated, no further fill continue to monitor."  Ithe administrator and DON kimately 11:40 am. Surveyor ident to resident altercations a abuse, and DON stated in of abuse". The he facility follows their policy abuse. Surveyor asked if facility reported incidents for litercations and DON stated ury".  The facility policy entitled rogram" which read in part, and abuse prevention, the Protect our resident from uding, but not necessarily for the residents, rs, staff from other labers, legal representative, y other individual. 3. In the policies and procedures eventing abuse, neglect, or esidents. 6. Identify and cidents of abuse; 7. It any allegations of abuse required by federal yor also reviewed the facility and Reporting" policy, which g 1. All alleged violations	F	607			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO		(X3) DATE SURVEY COMPLETED
		495133	B. WING		C <b>06/10/2021</b>
	ROVIDER OR SUPPLIER REHABILITATION AND N	URSING CENTER	940	EET ADDRESS, CITY, STATE, ZIP CODE EAST LEE HIGHWAY LHOWIE, VA 24319	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE COMPLETION
F 607	responsible for surve the local/State Ombu Representative (Spon Protective Services (jurisdiction in long-terenforcement officials. Physician; and g. The An alleged violation of exploitation or mistre unknown source and property) will be reported than: a. Two (2) involves abuse OR hinjury; or b. Twenty-forviolation does not involve the famolicy for reporting/in resident to resident a with the administrative 06/10/21 at approximal No further information. THIS IS A COMPLAIN 2. For Resident #111 implement facility politics are which included, but lingulmonary disease, by disease, hypothyroidi	g/certification agency ying/licensing the facility; b. Idsman; c. The Resident's insor) of Record d. Adult where state law provides rm care); e. Law f. The resident's Attending e facility Medical Director. 2. In abuse, neglect, atment (including injuries of misappropriation of resident red immediately, but not hours if the alleged violation as resulted in serious bodily but (24) hours if the alleged olve abuse AND has not odily injury."  In cility not implementing their vestigating incidents of letercations was discussed to team during a meeting on ately 4:30 pm.  In was provided prior to exit.  INT DEFICIENCY	F 607		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			ONSTRUCTION	(X3) DATE COMF	SURVEY
		495133	B. WING			1	C
	ROVIDER OR SUPPLIER			STRE 940 E	ET ADDRESS, CITY, STATE, ZIP CODE EAST LEE HIGHWAY LHOWIE, VA 24319	06/	10/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 607	set) with an ARD (ass 05/13/21 assigned the interview for mental sin section C, cognitive resident is cognitively. Resident #111's compreviewed and contain for behavior symptoms disease/dementia, Big approach residents/of face, makes repetitive pudding/food and hug Resident #111's clinic contained nurse's propart "9/23/2020 18:20 phone call from 2nd fi saw another resident (Resident #111) mout (Resident #111) mout (Resident #111). Unit of nursing) notified, re will be monitored", "10 (resident) has been his completed head to too injuries noted at this ti been notified no new nurses station. Will co "4/7/2021 12:08 this moom, when another resident and smacked face to point you hear resident was sitting in in her hands when smother resident remove party) and md notified.	ressment reference date) of er resident a BIMS (brief status) score of 11 out of 15 er patterns. This indicates the rintact.  Prehensive care plan was red a care plan for "At risk is related to Alzheimer's polar; Resident will thers to hug and kiss in er statements demanding ps".  Fall record was reviewed and gress notes, which read in this nurse received a gress notes, which read in this nurse received a gress notes, and then hit manager and DON (director sidents were separated and D/4/2020 19:13 Rsd it by roommate. Writer has reassessment and no sime. Family and MD have orders. Rsd is safe sitting at patients and the activity resident walked over to this is ther twice to right side of the second slap. this chair in corner with a drink macked. no injury noted. It is responsible of the responsible of the resident responsible of the resident responsible of the resident responsible of the resident responsible of the responsible of the resident responsible of the res	F	607			

AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	495133	B. WING		C 06/10/2021	1
NAME OF PROVIDER OR SUPPLIER  VALLEY REHABILITATION AND	NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 940 EAST LEE HIGHWAY CHILHOWIE, VA 24319		
PREFIX (EACH DEFICIEN	STATEMENT OF DEFICIENCIES NOY MUST BE PRECEDED BY FULL PRESCRIPTION  RESCRIPTION  RESCRIPTION  STATEMENT OF DEFICIENCIES	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLE	ETION
were considered to they were "some for administrator stated on what is defined at the facility submitter resident to resident "only if there is an insurance and ministration will: abuse by anyone in limited to: facility state consultants, volunter agencies, family me friends, visitors, or a Develop and implement to aid our facility in mistreatment of our assess all possible Investigate and reposition read in part "Report involving abuse, nemistreatment, include source and misapping reported by the facility designee, to the follar. The State licensing responsible for surver the local/State Omb Representative (Sp. Protective Services jurisdiction in long-to	be abuse, and DON stated arm of abuse". The at the facility follows their policy as abuse. Surveyor asked if a facility reported incidents for altercations and DON stated injury".  The facility policy entitled Program" which read in part, then the facility policy entitled Program" which read in part, then the facility policy entitled Program" which read in part, then the facility policy entitled Program" which read in part, then the facility policy entitled Program" which read in part, then the facility and incidents of authorized program which residents, the facility and the facility in and Reporting abuse, neglect, or are residents. 6. Identify and incidents of abuse; 7. For any allegations of abuse is required by federal reyor also reviewed the facility in and Reporting" policy, which facility in and Reporting" policy, which ing 1. All alleged violations glect, exploitation, or ding injuries of an unknown repriation of property will be ality Administrator, or his/her owing persons or agencies: ing/certification agency eying/licensing the facility; b. and smart, c. The Resident's consor) of Record d. Adult (where state law provides	F 60	7		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	FIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED
		495133	B. WING _		C <b>06/10/2021</b>
	ROVIDER OR SUPPLIER REHABILITATION AND NO	JRSING CENTER		STREET ADDRESS, CITY, STATE, ZIP COI 940 EAST LEE HIGHWAY CHILHOWIE, VA 24319	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C  (EACH CORRECTIVE ACTIO  CROSS-REFERENCED TO TH  DEFICIENCY	ON SHOULD BE COMPLETION IE APPROPRIATE DATE
F 607	Physician; and g. The An alleged violation of exploitation or mistres unknown source and property) will be repolater than: a. Two (2) involves abuse OR had injury; or b. Twenty-for violation does not involved in serious boom the concern of the far policy for reporting/invesident to resident all with the administrative 06/10/21 at approximation.	e facility Medical Director. 2. If abuse, neglect, atment (including injuries of misappropriation of resident rted immediately, but not hours if the alleged violation as resulted in serious bodily bur (24) hours if the alleged live abuse AND has not dily injury."  cility not implementing their vestigating incidents of litercations was discussed the team during a meeting on ately 4:30 pm.	F 6	507	
	implement facility poliresident to resident all Resident #108's face which included, but not disease, psychosis, do obstructive pulmonary insomnia.  The most recent quart set) with an ARD (ass 05/12/21 assigned the interview for mental st section C, cognitive page 12/21 assigned the content of the content	the facility staff failed to cy in regards to reporting tercations.  sheet listed diagnoses of limited to Alzheimer's epressive disorder, chronic or disease, dementia, and terly MDS (minimum data essment reference date) of eresident a BIMS (brief fatus) score of 0 out of 15 in atterns. This indicates that by cognitively impaired.			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TIPLE CONSTRUCTION		TE SURVEY
		495133	B, WING _			C <b>06/10/2021</b>
	ROVIDER OR SUPPLIER	URSING CENTER		STREET ADDRESS, CITY, STATE, ZIP COD 940 EAST LEE HIGHWAY CHILHOWIE, VA 24319		10/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 607	reviewed and contain "Verbal/physical agita Change in routine, Co Communication disor	prehensive care plan was ned a care plan for ation/aggression related to ognitive impairment, der/visual impairment, oal for this care plan is "Will	F 6	07		
	contained nurse's propart "3/21/2021 20:34 another resident cam resident to 'shut up'. Their hands together a pulling each other barreceived two skin team became aggressive a several times in the b	cal record was reviewed and ogress notes, which read in a Resident in hall cursing, e out of his room and told. The residents then locked and began pushing and ck and forth, resident rs to left fingers. Resident and hit a staff member ack, resident then hit this le resident in the face."				
	on 06/09/21 at approx asked the DON if residence considered to be they were "some form administrator stated the on what is defined as the facility submitted for resident to resident al "only if there is an inju-	ne facility follows their policy abuse. Surveyor asked if facility reported incidents for tercations and DON stated ary".				
	"Abuse Prevention Pre "As part of the resider administration will: 1. abuse by anyone includimited to: facility staff consultants, volunteer	e facility policy entitled ogram" which read in part, nt abuse prevention, the Protect our resident from uding, but not necessarily , other residents, rs, staff from other bers, legal representative,				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDIN	PLE CONSTRUCTION  G		E SURVEY PLETED
		495133	B. WING		I .	C 5/10/2021
	ROVIDER OR SUPPLIER REHABILITATION AND N	URSING CENTER	_	STREET ADDRESS, CITY, STATE, ZIP CODE 940 EAST LEE HIGHWAY CHILHOWIE, VA 24319		71012021
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PL/ N OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 607	friends, visitors, or a Develop and implem to aid our facility in pormistreatment of our cassess all possible in Investigate and reporsition in timeframes as requirements". Survey "Abuse Investigation read in part "Reporting involving abuse, neg mistreatment, including source and misapproreported by the facility designee, to the folloga. The State licensing responsible for survey the local/State Ombut Representative (Spote Protective Services (jurisdiction in long-teen forcement officials Physician; and g. The An alleged violation of exploitation or mistre unknown source and property) will be reported than: a. Two (2) involves abuse OR hinjury; or b. Twenty-force in the factorial of the factori	ent policies and procedures reventing abuse, neglect, or residents. 6. Identify and acidents of abuse; 7. In any allegations of abuse required by federal eyor also reviewed the facility and Reporting" policy, which any 1. All alleged violations lect, exploitation, or any injuries of an unknown apriation of property will be by Administrator, or his/her wing persons or agencies: g/certification agency ying/licensing the facility; b. adsman; c. The Resident's ansor) of Record d. Adult where state law provides are care); e. Law of a facility Medical Director. 2. In a facility in a facili	F 60	07		

	CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRU	JCTION	(X3) DATE SURY COMPLETE	
		495133	B. WING _			C <b>06/10/2</b>	2021
	ROVIDER OR SUPPLIER	NURSING CENTER		940 EAST L	DRESS, CITY, STATE, ZIP CODE LEE HIGHWAY VIE, VA 24319	1 00.10.2	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE CO.	(X5) MPLETION DATE
F 607		on was provided prior to exit.	F 6	07			
		1 the facility staff failed to licy in regards to reporting a altercation.					
	which included, but behavioral disturban	e sheet listed diagnoses limited to dementia with ace, hypertension, ression, psychotic disorder,					
	set) with an ARD (as 05/23/21 assigned the interview for mental section C, cognitive	arterly MDS (minimum data seessment reference date) of the resident a BIMS (brief status score of 0 out of 15 in patterns. This indicates that ely cognitively impaired.					
	reviewed and contain "Verbal/physical agit	nprehensive care plan was ned a care plan for ation/aggression related to this care plan are "Will not					×
	contained a nurse's part "2/18/201 01:41 called this to residen hitting roommate with nurse. When this nurseident was in a ragswinging and hitting Resident threatened speaking of roomma	cal record was reviewed and progress note, which read in On rounds, other nurse t's room. Resident was seen h a knotted sock by other rese entered the room, ge, screaming loudly, this nurse and other nurse. to 'beat the shit out of her', te. Resident attempted back over to roommate and					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED	
		495133	B. WING _			C 06/10/2021	
	ROVIDER OR SUPPLIER REHABILITATION AND N	URSING CENTER		STREET ADDRESS, CITY, STATE, 940 EAST LEE HIGHWAY CHILHOWIE, VA 24319	ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE CROSS-REFERENCED	N OF CORRECTION ACTION SHOULD BE TO THE APPROPRIATI	(X5) COMPLETION DATE	
F 607	hit roommate. Other intervened and separa attempted multiple tir nurse and other nurse. Resident continued to nurse and other nurse sheet and swung and nurse was able to take redirect resident by ly shoulders. Resident orefused to lie down. Surveyor spoke with on 06/09/21 at appropasked the DON if resiwere considered to be they were "some form administrator stated to on what is defined as the facility submitted resident to resident a "only if there is an injute Surveyor reviewed the "Abuse Prevention Pre" "As part of the resident administration will: 1. abuse by anyone includinited to: facility staff consultants, voluntee agencies, family mem friends, visitors, or an Develop and implement of our reassess all possible incluvestigate and report within timeframes as	rated resident. Resident mes to shut the door on this e while separating residents. In this see that, scratch, and pinch this e. Resident tied a knot in her id hit this nurse with it. This is sheet and attempted to ving down and rubbing continued to be in a rage, Supervisor notified".  It he administrator and DON stimately 11:40 am. Surveyor dent to resident altercations e abuse, and DON stated in of abuse". The he facility follows their policy abuse. Surveyor asked if facility reported incidents for litercations and DON stated ary".  The facility policy entitled orgam" which read in part, introduced the protect our resident from uding, but not necessarily is, other residents, rs, staff from other ibers, legal representative, by other individual. 3. Introducion of abuse, neglect, or esidents. 6. Identify and cidents of abuse; 7. It any allegations of abuse	F 6	07			

	F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE  A. BUILDING	(X2) MULTIPLE CONSTRUCTION A. BUILDING		
		495133	B. WING			C <b>06/10/2021</b>
	REHABILITATION AND	NURSING CENTER	94	TREET ADDRESS, CITY, STATE, ZIP CODE 40 EAST LEE HIGHWAY HILHOWIE, VA 24319	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL IR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 607	read in part "Repor involving abuse, ne mistreatment, inclusource and misapp reported by the faci designee, to the foll The State licensing responsible for survithe local/State Omb Representative (Sp Protective Services jurisdiction in long-tenforcement official Physician; and g. The An alleged violation exploitation or mistre unknown source an property) will be replater than: a. Two (2 involves abuse OR injury; or b. Twenty-violation does not invresulted in serious but The concern of the female policy for reporting/ir resident to resident with the administration of 10/21 at approximation of the female policy for Resident #28 implement facility for Resident #28	n and Reporting" policy, which ting 1. All alleged violations glect, exploitation, or ding injuries of an unknown repriation of property will be lity Administrator, or his/her owing persons or agencies: a. //certification agency reying/licensing the facility; b. pudsman; c. The Resident's onsor) of Record d. Adult (where state law provides erm care); e. Law s; f. The resident's Attending the facility Medical Director. 2. of abuse, neglect, reatment (including injuries of d misappropriation of resident forted immediately, but not the control of the alleged violation has resulted in serious bodily and should be abuse AND has not bodily injury."  Facility not implementing their investigating incidents of altercations was discussed we team during a meeting on mately 4:30 pm.  On was provided prior to exit.  INT DEFICIENCY  The third in the state of the facility staff failed to oblicy regarding reporting and ent to resident altercation	F 607			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
		495133	B. WING			1	C /10/2021
	ROVIDER OR SUPPLIER	URSING CENTER		940	REET ADDRESS, CITY, STATE, ZIP CODE DEAST LEE HIGHWAY IILHOWIE, VA 24319		71072021
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 607	which included, but in Dementia with Behaviar Primary Hypertension Unspecified, Blindnes Other Eye, Muscle Williams Difficulty in Walking.  The most recent qualiset) with an ARD (ass 3/25/21 assigned the interview for mental sisection C, Cognitive II.  A review of Resident revealed the following A "SBAR (Situation, Review) Communicat 11:43 am states in panurses desk with wall and shoved resident inhitting right cheek on into the floor. Landed Assessed from head area noted on right choiced".  On 6/09/21 at 11:42 at the administrator and discuss the facility proaltercations. The DOI altercations can be a asked if the facility su incidents) for resident the DON stated "if the	osis list indicated diagnoses, not limited to Unspecified vioral Disturbance, Essential In, Anxiety Disorder is One Eye Low Vision Veakness Generalized, and sessment reference date) of resident a BIMS (brief tatus) score of 5 out of 15 in Patterns.  #28's clinical record goocumentation:  #2	F	607			
		ney try to follow their policy.					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MUL A. BUILD		(X3) DATE SURVEY COMPLETED		
		495133	B. WING				C
	ROVIDER OR SUPPLIER	JRSING CENTER		94	TREET ADDRESS, CITY, STATE, ZIP CODE 40 EAST LEE HIGHWAY CHILHOWIE, VA 24319	] 0	6/10/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	BE .	(X5) COMPLETION DATE
	The following day at with the DON who stareported to them and administrator but coulincident.  On 6/10/21 at 1:28 pm the DON concerning altercations. The DON altercations, residents is not an injury, there is surveyor requested an policy entitled "Abuse Reporting" which state Policy Statement All reports of resident exploitation, misapproproperty, mistreatmen source ("abuse") shall local, state and federa current regulations) are by facility managemer investigations will also Reporting 1. All alleged violation exploitation, or mistreatmen source are property will be reported Administrator, or his/he following persons or aga. The State licensing responsible for surveyib. The local/State Om	ent involving Resident #28  10:52 am, surveyor spoke ated the incident was they then reported it to the id not find an FRI for the in, surveyor team spoke with resident to resident it stated that following are assessed and if there is nothing to report.  Ind received the facility Investigation and it and/or injuries of unknown be promptly reported to all agencies (as defined by ind thoroughly investigated int. Findings of abuse be reported.  Is involving abuse, neglect, atment, including injuries of ind misappropriation of ind misappropriation of its designee, to the gencies:  //certification agency ing/licensing the facility:	F	607			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		495133				С	
NAME OF P	ROVIDER OR SUPPLIER	455133	B. WING	STREET ADDRESS, CITY, STATE, ZIP COD		06/10/2021	
VALLEY F	REHABILITATION AND I	NURSING CENTER		940 EAST LEE HIGHWAY CHILHOWIE, VA 24319	_		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG	,	SHOULD BE	(X5) COMPLETION DATE	
F 607	provides jurisdiction e. Law enforcement f. The resident's Att g. The facility Medic  2. An alleged violati exploitation or mistre unknown source and property) will be repelater than: a. Two (2) hours if t abuse OR has result b. Twenty-four (24) does not involve abuserious bodily injury.  On 6/10/21 at 4:45 p administrator, admin ADON (assistant dirediscussed the conce implementing facility of a resident to resid Resident #28.  No further informatio presented to the sun conference on 6/10/2  6. For Resident #26 failed to implement for reporting a resident to occurring on 6/03/21  Resident #26's diagn which included, but in Dementia without Be Diabetes Mellitus with	Services (where state law in long-term care); to officials; ending Physician; and cal Director.  Ion of abuse, neglect, eatment (including injuries of dimisappropriation of resident orted immediately, but not orted immediately, but not whe alleged violation involves and in serious bodily injury; or shours if the alleged violation se AND has not resulted in m, during a meeting with the istrator in training, DON, and sector of nursing), surveyor rn of the facility not policy regarding an incident ent altercation involving	F	607			

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495133	B. WING				C <b>10/2021</b>
	ROVIDER OR SUPPLIER	JRSING CENTER		94	TREET ADDRESS, CITY, STATE, ZIP CODE 40 EAST LEE HIGHWAY HILHOWIE, VA 24319		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	- 1	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 607	Weakness Generaliz Resident #26's most (minimum data set) wireference date) of 3/3 a BIMS (brief intervie 4 out of 15 in section Resident #134's diag diagnoses, which incurrence downward of 15 in section Unspecified Dementi Disturbance, Schizop Disorder Unspecified, Pectoris. Resident #134's most an ARD of 5/24/21 as score of 15 out of 15 Patterns. On 6/08/21 at 1:55 p surveyor observed Runder the left eye and the face from the left Surveyor asked the inbruising and the resident the door and there fallen. At 2:08 pm, so (temporary certified concerning the causi #1 stated it was report #134 "punched" this Surveyor spoke with (director of nursing) concerning the bruis and the DON stated	recent quarterly MDS ith an ARD (assessment 22/21 assigned the resident ith for mental status) score of C, Cognitive Patterns. Inosis list indicated Ituded, but not limited to ita with Behavioral Information Unspecified, Bipolar and Unstable Angina  It recent quarterly MDS with Issigned the resident a BIMS In section C, Cognitive  In during initial rounds, It is section	F	607			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MUL A. BUILD		(X3) DATE SURVEY COMPLETED			
						(	С
		495133	B. WING		The state of the s	06/	10/2021
	ROVIDER OR SUPPLIER	JRSING CENTER		940	EET ADDRESS, CITY, STATE, ZIP CODE EAST LEE HIGHWAY ILHOWIE, VA 24319		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	BE	(X5) COMPLETION DATE
F 607	Continued From page	e 17	F	607			=
	final FRI report to the the FRI dated 6/04/2 6/03/21 involving Respart, "Reported by stamentioned above had altercation. It was repwheeled (his/her) self and started going throbelongings. (Resident leave (his/her) 'stuff' asked (Resident #26) to this being (his/her) (Resident #134) was #26) from (his/her) per (Resident #134) state me and I hit (him/her) assessed, and staff coleft side of the forehe upon entering the fact assessed (Resident # discolored area to the staff was verbally insmonitor for signa [sp] distress".  The FRI report did not (adult protective services resident to resident at 11:45 am, surveyor saked if APS was notiresident altercation be #134, the DON stated injury. At 11:52 am, sadministrator who stated and it was a team decrease.	d a resident-to-resident ported that (Resident #26) into (Resident #134's) room ough (his/her) personal at #134) asked (him/her) to alone, (Resident #134) also to leave (his/her) room due room and not (his/hers). unable to redirect (Resident ersonal belongings. ed, '(he/she) started cussing by (Resident #26) was observed a red area on the ad. I, (name omitted), DON, sility the next morning #26) and I observed a eleft side of the forehead, tructed to continue to and symptoms of any et include the date that APS ices) was notified of the litercation. On 6/10/21 at poke with the DON and fied of the resident to etween Resident #26 and d no because there was no surveyor spoke with the ited APS was not notified					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION	TRUCTION (X3) DATE SURN COMPLETE		
		495133	B. WING_	·-	,	C <b>06/10/2021</b>	
	ROVIDER OR SUPPLIER	URSING CENTER	da.	STREET ADDRESS, CITY, STATE, ZIP CODI 940 EAST LEE HIGHWAY CHILHOWIE, VA 24319			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 607	exploitation, or mistra an unknown source property will be reported and universely and the state of a consistency of the source of the s	tes in part:  ons involving abuse, neglect, eatment, including injuries of and misappropriation of red by the facility ther designee, to the agencies:  ng/certification agency eying/licensing the facility; mbudsman; epresentative (Sponsor) of Services (where state law in long-term care); officials; ending Physician; and al Director.  om, during a meeting with the istrator in training, DON, and ector of nursing) surveyor rn of the facility not policy regarding reporting and to resident altercation 26 and Resident #134 to  n regarding this issue was vey team prior to the exit 21.  O, the facility staff failed to licy regarding reporting and altercations occurring on	F6	607			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTIONS		(X3) DATE SURVEY COMPLETED	
		495133	B. WING				C /10/2021
	ROVIDER OR SUPPLIER	JRSING CENTER		STREET ADDRESS 940 EAST LEE H CHILHOWIE, V		1 00	10.2021
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	(EA	PROVIDER'S PLAN OF CORRECTIC ICH CORRECTIVE ACTION SHOULD SS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 607	diagnoses, which inc Parkinson's Disease, Unspecified, Unspeci Behavioral Disturban Pulmonary Disease U The most recent qual set) with an ARD (ass 5/25/21 assigned the interview for mental s section C, Cognitive II A review of Resident revealed the following A nursing progress no (7:55 pm) states "Thi (male/female) resider and with hands joined other back and forth.	luded, but not limited to Alzheimer's Disease ified Dementia with ce, and Chronic Obstructive Unspecified.  Interly MDS (minimum data sessment reference date) of resident a BIMS (brief status) score of 3 out of 15 in Patterns.  #140's clinical record g documentation:  Interly MDS (minimum data sessment reference date) of resident a BIMS (brief status) score of 3 out of 15 in Patterns.  #140's clinical record g documentation:  Interly MDS (minimum data sessment reference date) of resident a BIMS (brief status) score of 3 out of 15 in Patterns.	F	607			
	Summary for Provided "resident entered and resident, denies pain immediately intervented and residents safety staff entered the room and residents room hitting immediately moved but the administrator and discuss the facility proaltercations. The DO altercations can be a	witnessed and stated 'As I other Resident was in this					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495133	B. WING			1	C / <b>10/2021</b>	
	ROVIDER OR SUPPLIER	NURSING CENTER		STREET ADDRE  940 EAST LEE  CHILHOWIE,			70/2021	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO ACH CORRECTIVE ACTION SHOULD OSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 607	incidents) for reside the DON stated "if the administrator stated aforementioned incident #140. On 6/09/21 aprovided the survey form, "Incident #827 form states in another (male/fematogether and with his shoved each other intervened and sept two small (.5 cm) skithe section "Reside documented "I told cussing".  On 6/10/21 at 1:28 pthe DON concerning altercations. The DO altercations, resider is not an injury, there is not an injury, there is surveyor requested policy entitled "Abus Reporting" which stime an unknown source property will be reported and instrator, or his following persons of a. The State licens responsible for surveyor the local/State Control of the policy state	Int to resident altercations and here's an injury". The I they try to follow their policy.  If the FRI reports for the idents involving Resident at 12:30 pm, the DON for with a risk management rows for Resident #140. Incident part, "This resident and le) resident locked hand [sp] ands joined, pushed and back and forth. Staff arated residents. Received kin tears to right fingers". In int Description", it is (him/her) to shut up and quit sare assessed and if there are is nothing to report.  If and received the facility is Investigation and lates in part:  I cons involving abuse, neglect, reatment, including injuries of and misappropriation of corted by the facility is/her designee, to the ragencies: ing/certification agency eying/licensing the facility;	F	607				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		495133	B. WING			C / <b>10/2021</b>	
	ROVIDER OR SUPPLIER	URSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 940 EAST LEE HIGHWAY CHILHOWIE, VA 24319		. 10.2021	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 607	Record; d. Adult Protective Sprovides jurisdiction e. Law enforcement f. The resident's Atte g. The facility Medic 2. An alleged violati exploitation or mistre unknown source and property) will be repelater than: a. Two (2) hours if t abuse OR has result b. Twenty-four (24) does not involve abuserious bodily injury.  On 6/10/21 at 4:45 p administrator, admin ADON (assistant dirediscussed the conce implementing the face reporting of two incide altercations involving.  No further information presented to the sur conference on 6/10/2 8. For Resident #53 implement facility po investigating a residuoccurring on 6/08/21  Resident #53's diagr which included, but in	Services (where state law in long-term care); officials; ending Physician; and all Director.  on of abuse, neglect, eatment (including injuries of dimisappropriation of resident borted immediately, but not the alleged violation involves and in serious bodily injury; or shours if the alleged violation see AND has not resulted in "  m, during a meeting with the istrator in training, DON, and sector of nursing) surveyor arm of the facility not bodility policy regarding the dents of resident to resident and great many control of the facility staff failed to dicy regarding reporting and sent to resident altercation onesis list indicated diagnoses, not limited to Chronic any Disease Unspecified,	F 60'				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	DNSTRUCTION	(X3) DATE SURVEY COMPLETED			
		495133	B. WING			l .	C / <b>10/2021</b>
	ROVIDER OR SUPPLIER	JRSING CENTER	,	940 I	EET ADDRESS, CITY, STATE, ZIP CODE EAST LEE HIGHWAY LHOWIE, VA 24319	1 00/	10/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	_	(X5) COMPLETION DATE
F 607	set) with an ARD (ass 4/13/21 assigned the interview for mental s section C, Cognitive On 6/08/21 at approx #2 observed Residen around the head and nursing assistant) #1 At 2:08 pm, this surve and asked if Residen other resident when to TCNA #1 stated yes, with the back of the of #1 also stated that the there" and saw it.  A nursing progress note (2:11 pm) states in particular day with resident atteresidents".  On 6/09/21 at 11:42 at the administrator and discuss the facility proaltercations. The DO altercations can be a asked if the facility suincidents) for resident the DON stated "if the administrator stated to Surveyor spoke with nursing) concerning the progress note dated for the section of the date of the section of the date of the section	rterly MDS (minimum data sessment reference date) of resident a BIMS (brief tatus) score of 5 out of 15 in Patterns.  simately 12:05 pm, surveyor at #53 hit at another resident TCNA (temporary certified separated the two residents. eyor spoke with TCNA #1 tr. #53 made contact with the hey hit at them earlier and the resident made contact other resident made contact other resident's head. TCNA the nurse was "sitting right att, "Behavior episodes this sempting to hit other  am, survey team met with DON (director of nursing) to be president to resident attercations and the ere's an injury". The hey try to follow their policy.	F	607			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED
		495133	B. WING		C 06/10/2021
	ROVIDER OR SUPPLIER	JRSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 940 EAST LEE HIGHWAY CHILHOWIE, VA 24319	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE COMPLETION HE APPROPRIATE DATE
F 607	needs to be done".  On 6/09/21 at 12:28 preserved with the survey to Resident #53 swatted from behind them and the face.  On 6/10/21 at 1:28 preserved from behind them and the face.  On 6/10/21 at 1:28 preserved from behind them and the face.  On 6/10/21 at 1:28 preserved from behind them and the face.  On 6/10/21 at 1:28 preserved from behind them and the face.  On 6/10/21 at 1:28 preserved from behind them and the face.  On 6/10/21 at 1:28 preserved from behind them and the face.  On 6/10/21 at 1:28 preserved from behind them and the face.  On 6/10/21 at 1:28 preserved from behind them and the face.  On 6/10/21 at 1:28 preserved from behind them and the face.  On 6/10/21 at 1:28 preserved from behind them and the face.  On 6/10/21 at 1:28 preserved from behind them and the face.  On 6/10/21 at 1:28 preserved from behind them and the face.  On 6/10/21 at 1:28 preserved from behind them and the face.  On 6/10/21 at 1:28 preserved from behind them and the face.  On 6/10/21 at 1:28 preserved from them and t	om, the DON and TCNA #1 eam and TCNA #1 stated if the other resident's hat off if it was not a slap across  m, surveyor team spoke with resident to resident N stated that following s are assessed and if there is nothing to report.  and received the facility e Investigation and tes in part:  It abuse, neglect, opriation of resident not and/or injuries of unknown II be promptly reported to all agencies (as defined by and thoroughly investigated ent. Findings of abuse of be reported.  In sinvolving abuse, neglect, eatment, including injuries of and misappropriation of ted by the facility her designee, to the agencies: g/certification agency ying/licensing the facility; mbudsman;	F 6	607	
	Record;	epresentative (Sponsor) of			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		STRUCTION	(X3) DATE SURVEY COMPLETED	
		495133	B. WING			06/	0/2021
	ROVIDER OR SUPPLIER			940 EA	FADDRESS, CITY, STATE, ZIP CODE ST LEE HIGHWAY IOWIE, VA 24319		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	- 1	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 607	d. Adult Protective Sprovides jurisdiction e. Law enforcement f. The resident's Atte g. The facility Medic 2. An alleged violati exploitation or mistre unknown source and property) will be repolater than: a. Two (2) hours if t abuse OR has result b. Twenty-four (24) does not involve abuserious bodily injury. On 6/10/21 at 4:45 p administrator, admin ADON (assistant dir discussed the conce implementing facility and investigating an resident altercation No further information presented to the sur conference on 6/10/ 9. For Resident #11 implement facility por resident to resident 4/05/21 and 5/26/21 Resident #115's dia diagnoses, which in Alzheimer's Disease Dementia with Beha	Services (where state law in long-term care); officials; ending Physician; and al Director.  on of abuse, neglect, eatment (including injuries of a misappropriation of resident orted immediately, but not the alleged violation involves sed in serious bodily injury; or hours if the alleged violation se AND has not resulted in "  om, during a meeting with the histrator in training, DON, and sector of nursing) surveyor ern of the facility not or policy regarding reporting a incident of a resident to involving Resident #53.  on regarding this issue was evey team prior to the exit (21.)  15, the facility staff failed to oblicy regarding reporting of altercations occurring on altercations occurring on longer the proposed in the control of the control of the facility staff failed to oblicy regarding reporting of altercations occurring on longer the proposed in the control of the control	F	607			

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495133	B. WING				C 10/2021
	OVIDER OR SUPPLIER			94	REET ADDRESS, CITY, STATE, ZIP CODE  0 EAST LEE HIGHWAY  HILHOWIE, VA 24319		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	ix	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	Ε	(X5) COMPLETION DATE
	Primary Hypertension The most recent quaset) with an ARD (as 5/16/21 assigned the interview for mental section C, Cognitive A review of Resident revealed the following dated 4/05/21 09:45 "resident entered this resident, discolored no injuries noted state ensured both reside A nursing progress resident resident, resident entered this resident room with resident room with both havic could voice any type stated I didn't do and didn't roll out of bed going in and out of and FNP (family nurspoke with RP regared RP in agreeance to another room as a green	pecified, and Essential n.  Interly MDS (minimum data sessment reference date) of e resident a BIMS (brief status) score of 0 out of 15 in Patterns.  ##115's clinical record g documentation:  e in Condition Evaluation" (9:45 am) states in part, s residents room and hit area to left eye, denies pain ff immediately intervened and	F	607			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			TIPLE CONSTRUCTION	1, ,	(X3) DATE SURVEY COMPLETED	
			71. 50.25			С
		495133	B. WING		0	6/10/2021
	ROVIDER OR SUPPLIER	URSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CC 940 EAST LEE HIGHWAY CHILHOWIE, VA 24319	DE	8
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 607	altercations. The DC altercations can be a asked if the facility si incidents) for resider the DON stated "if the administrator stated Surveyor requested incidents involving R 4/05/21 and 5/26/21 provided risk manag and 5/26/21 and stated On 6/10/21 at 1:28 p the DON concerning altercations. The DC asked in the DON concerning altercations.	ocess for resident to resident ON stated resident to resident of form of abuse. Surveyor ubmits FRIs (facility reported at to resident altercations and ere's an injury". The they try to follow their policy. the FRI reports for the esident #115 occurring on At 12:30 pm, the DON ement reports dated 4/05/21 ed FRIs were not done.  m, surveyor team spoke with resident to resident oN stated that following ts are assessed and if there	F	607		
- 13	policy entitled "Abus Reporting" which sta "Reporting 1. All alleged violatic exploitation, or mistro an unknown source property will be repo Administrator, or his following persons or a. The State licensis responsible for surve b. The local/State Cc. The Resident's Record; d. Adult Protective Sprovides jurisdiction e. Law enforcement	ons involving abuse, neglect, eatment, including injuries of and misappropriation of orted by the facility of the designee, to the agencies: ng/certification agency eying/licensing the facility; ormbudsman; epresentative (Sponsor) of Services (where state law in long-term care); tofficials; ending Physician; and				

	(3) DATE SURVEY COMPLETED C
	С
D WING	00/40/0004
495133 B. WING	06/10/2021
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	
940 EAST LEE HIGHWAY	
VALLEY REHABILITATION AND NURSING CENTER CHILHOWIE, VA 24319	
(X4) ID PROVIDER'S PLAN OF CORRECTION PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION)  SUMMARY STATEMENT OF DEFICIENCIES ID 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	
2. An alleged violation of abuse, neglect, exploitation or mistreatment (including injuries of unknown source and misappropriation of resident property) will be reported immediately, but not later than:  a. Two (2) hours if the alleged violation involves abuse OR has resulted in serious bodily injury; or b. Twenty-four (24) hours if the alleged violation does not involve abuse AND has not resulted in serious bodily injury."  On 6/10/21 at 4:45 pm, during a meeting with the administrator, administrator in training, DON, and ADON (assistant director of nursing) surveyor discussed the concern of the facility not implementing facility policy regarding reporting incidents of resident to resident altercations involving Resident #115 occurring on 4/05/21 and 5/26/21.  No further information regarding this issue was presented to the survey team prior to the exit conference on 6/10/21.  F 609  SS=E  F609  Reporting of Alleged Violations  CFR(s): 483.12(c)(1)(4)  1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: Residents #72, #111, #108, #131, #28, #26, #140,#53, and #134 all re-nain within the facility and reporting has been completed for the incidents. Resident #115 has been discharged from the facility.	•

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	495133	B. WING	<del></del>	C 06/10/2021	
NAME OF PROVIDER OR SUPPLIER  VALLEY REHABILITATION AND NU			STREET ADDRESS, CITY, STATE, ZIP CODE 940 EAST LEE HIGHWAY CHILHOWIE, VA 24319	06/10/2021	
PREFIX (EACH DEFICIENCY	ATEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL  .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	E COMPLETION	
the events that cause abuse and do not res the administrator of the officials (including to the adult protective service for jurisdiction in long accordance with State procedures.  §483.12(c)(4) Report investigations to the adesignated represent accordance with State Survey Agency, within incident, and if the all appropriate corrective This REQUIREMENT by:  Based on staff interver review, clinical record a complaint survey it facility staff failed to residents, Residents #26, #140, #53, #134  The findings included 1. For Resident #72 to report incidents of realtercations.  Resident #72's face sincluded, but not limit disorder, dementia wanxiety, convulsions disease.	or not later than 24 hours if the allegation do not involve ult in serious bodily injury, to ne facility and to other the State Survey Agency and ces where state law provides term care facilities) in e law through established  the results of all administrator or his or her rative and to other officials in e law, including to the State n 5 working days of the leged violation is verified e action must be taken.  T is not met as evidenced view, facility document d review and in the course of was determined that the report incidents for 10 of 30 s #72, #111, #108, #131, #28, d, and #115.  It: the facility staff failed to	F 609	2. Address how the facility will other residents having the pet to be affected by the same depractice: All residents have the potential to be affected.  3. Address what measures will into place or systemic changemade to ensure that the define practice will not recur: Facilit will be educated regarding facing and procedures regarding repositivestigating alleged abuse in amanner.  4. Indicate how the facility plane monitor its performance to near sure that the solutions are sustained: Director of Nursing designee will audit of alleged allegations to ensure facility per being followed weekly times 4 and monthly times 2. Audit fine be reviewed monthly in the quassurance and performance improvement process for tracking/trending and any neces additional interventions.  5. Include dates when the correction will be completed: Date Compliance: 8/5/21	be put pes cient y staff lity policy orting and a timely s to nake J or olicy is weeks dings will ality essary	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  A. BUILDING			(X3) DATE SURVEY COMPLETED				
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		495133	B. WING			06/	/10/2021
	ROVIDER OR SUPPLIER	URSING CENTER		STREET ADDRESS, CITY, STATE, ZIP C 940 EAST LEE HIGHWAY CHILHOWIE, VA 24319	ODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	FATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		ION SHOULD I	3E	(X5) COMPLETION DATE
F 609	set) with an ARD (as 04/26/21 assigned the interview for mental strains and indicates that the intact.  Resident #72's compreviewed and contain "Inappropriate behave verbal/physical agitate other residents relate traumatic brain injuring some decrease/minity verbal/physical abuse.  Resident #72's clinical contained nurse's propert "09/19/2020 15 aide) observed this because she was 'unturned the water off couldn't use it. Remonommate can use shouldn't use it. Remonommate can use shouldn't be putting "09/20/2020 15:26 to resident on the right residents", "09/20/20/20/20/20/20/20/20/20/20/20/20/20/	sessment reference date) of the resident a BIMS (brief status) score of 14 out of 15. The resident is cognitively to rehensive care plan was need a care plan for vior at times, history of ation/aggression towards ted to Cognitive impairment, by". The goal for this care plan mize episodes of se".  The goal for this care plan mize episodes of se".  The goal for this care plan mize episodes of ses.  The goal for t	F	609			
	With Curtain pulicul	nitting roommate. Writer was					

	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	IDENTIFICATION NUMBER			(X3) DATE SURVEY COMPLETED	
		A. BOILD				
	495133	B. WING			06/	10/2021
	URSING CENTER		940 E	AST LEE HIGHWAY		
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informed of what sta continue to observe. Residents were up a and talking. This res beside her in the hearther resident were so notified", 4/7/2021 1 activity room, this resresident and smacke face to point you hear was slapped was sit drink in her hands. It removed from area. other resident she sident may be mother resident (Instead of the sident did not sust omitted) relayed to another resident (Instead of the word from a state of the word of the word from a state of the word from the were sat this time. It is supposed to they were "some for administrator stated on what is defined at the facility submitted the facility submitted in the facility submitted and DON stated, "It documented and reeducation on that an education of the education of	ff had observed. Will ", "10/06/2020 11:04 t nurse's station watching TV ident smacked the resident ad for no apparent reason. eparated and unit manager 0:10 this nurse entered sident walked over to another ed her twice to right side of and the second slap. resident ting in chair in corner with a no injury noted. resident when asked why she slapped tated 'she was staring at me'. sible party) notified" and nurses aides ([names me that the resident pushed ame omitted]) three times. rain any injury or fall (name was going to hit her if she did re separated, no further Will continue to monitor."  In the administrator and DON oximately 11:40 am. Surveyor resident to resident altercations be abuse, and DON stated rem of abuse". The If the facility follows their policy as abuse. Surveyor asked if d facility reported incidents for altercations and DON stated highly". Surveyor asked the should have been reported to me. We will do and do what needs to be done".	F	609			
Surveyor reviewed	tne facility policy entitled		94.		1 22 .	
	ROVIDER OR SUPPLIER  EHABILITATION AND N  SUMMARY ST (EACH DEFICIENCE REGULATORY OR  Continued From pag informed of what sta continue to observe. Residents were up a and talking. This res beside her in the hea The resident were se notified", 4/7/2021 11 activity room, this res resident and smacke face to point you hea was slapped was sit drink in her hands. It removed from area. other resident she s MD and RP (respon "4/9/2021 16:43 the omitted]) relayed to another resident ([na resident did not sust omitted]) relayed to another resident ([na resident did not sust omitted]) relayed to another resident ([na resident did not sust omitted]) relayed to another resident ([na resident did not sust omitted]) relayed to another resident ([na resident did not sust omitted]) relayed to another resident ([na resident did not sust omitted]) relayed to another resident ([na resident did not sust omitted]) relayed to another resident ([na resident did not sust omitted]) relayed to another resident ([na resident did not sust omitted]) relayed to another resident ([na resident did not sust omitted]) relayed to another resident ([na resident did not sust omitted]) relayed to another resident ([na resident did not sust omitted]) relayed to another resident ([na resident did not sust omitted]) relayed to another resident ([na resident did not sust omitted]) relayed to another resident ([na resident did not sust omitted]) relayed to another resident ([na resident did not sust omitted]) relayed to another resident ([na resident did not sust omitted]) relayed to another resident ([na resident did not sust omitted]) relayed to another resident ([na resident did not sust omitted]) relayed to another resident ([na resident did not sust omitted]) relayed to another resident ([na resident did not sust omitted]) relayed to another resident ([na resident did not sust omitted]) relayed to another resident ([na resident did not sust omitted]) relayed to another resident ([na resident did not sust omitted]) relayed to another resident ([na re	F DEFICIENCIES CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  495133  ROVIDER OR SUPPLIER  EHABILITATION AND NURSING CENTER	F DEFICIENCIES CORRECTION  (X1) PROVIDER SUPPLIER LABILITATION AND NURSING CENTER  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 30 informed of what staff had observed. Will continue to observe.", "10/06/2020 11:04 Residents were up at nurse's station watching TV and talking. This resident smacked the resident beside her in the head for no apparent reason. The resident were separated and unit manager notified", 4/7/2021 10:10 this nurse entered activity room, this resident walked over to another resident and smacked her twice to right side of face to point you heard the second slap. resident was slapped was sitting in chair in corner with a drink in her hands. no injury noted. resident removed from area. when asked why she slapped other resident she stated 'she was staring at me'. MD and RP (responsible party) notified" and "4/9/2021 16:43 the nurses aides ([names omitted]) relayed to me that the resident pushed another resident ([name omitted]) three times. resident did not sustain any injury or fall (name omitted) stated 'He was going to hit her if she did not quit'. the two were separated, no further issues at this time. Will continue to monitor."  Surveyor spoke with the administrator and DON on 06/09/21 at approximately 11:40 am. Surveyor asked the DON if resident to resident altercations were considered to be abuse, and DON stated they were "some form of abuse". The administrator stated the facility reported incidents for resident to resident altercations and DON stated "only if there is an injury". Surveyor asked the DON if the incidents should have been reported and DON stated, "They should have been reported and DON stated, "They should have been documented and reported to me. We will do education on that and do what needs to be done".	TOUTION OF THE PROVIDER STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  CONTINUED FROM THE PROVIDER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  CONTINUED FROM THE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  F 609  Informed of what staff had observed. Will continue to observe.", "10/06/2020 11:04  Residents were up at nurse's station watching TV and talking. This resident smacked the resident beside her in the head for no apparent reason. The resident were separated and unit manager notified", 4/7/2021 10:10 this nurse entered activity room, this resident walked over to another resident and smacked her twice to right side of face to point you heard the second slap, resident was slapped was sitting in chair in corner with a drink in her hands. no injury noted. resident removed from area. 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We will do education on that and do what needs to be done".	F GERICENCIES CORRECTION  (X1) PROVIDERSUPPLIER A95133  (A95133  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION)  CONTINUE from page 30  informed of what staff had observed. Will continue to observe.", "10/06/2020 11:04 Residents were up at nurse's station watching TV and talking. This resident smacked the resident beside her in the head for no apparent reason. The resident were separated and unit manager notified", 47/72021 10:10 this nurse entered activity room, this resident walked over to another resident and smacked her twice to right side of face to point you heard the second slap, resident was slapped driber resident she stated 'she was staring at me'. MD and RP (responsible party) notified" and "49/2021 16:43 the nurses addes ([names omitted]) treas satient ([name omitted)) stated "He was going to hit her if she did not sustain any injury or fall(name omitted) stated "He was going to hit her if she did not quif.' the two were separated, no further issues at this time. Will continue to monitor."  Surveyor spoke with the administrator and DON on 08/09/21 at approximately 11:40 am. Surveyor asked the DON if resident to resident altercations were considered to be abuse, and DON stated they were "some form of abuse". The administrator stated the facility reported incidents for resident to resident altercations and DON stated they were "some form of abuse". The administrator stated the facility reported incidents for resident to resident should have been reported and DON stated, "They should have been documented and reported to me. We will do education on that and do what needs to be done".	ENTITION OF PROVIDERGENERS (DY.) PROVIDERGENCIAN (DENTIFICATION NUMBER:  495133  STREET ADDRESS, CITY, STATE, JP CODE 940 EAST LEE HIGHWAY CHILHOWIE, VA 24319  SUMMARY STATEMENT OF DEPICIENCIES GEACH DEPICIENCY WIST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 30 informed of what staff had observed. Will continue to observe.", "10/06/2020 11:04 Residents were up at nurse's station watching TV and talking. This resident smacked the resident beside her in the head for no apparent reason. The resident were separated and unit manager notified", 4/17/201 10:10 this nurse entered activity room, this resident wasked over to another resident and smacked her twice to right side of face to point you heard the second slap, resident was slapped was sitting in chair in corner with a drink in her hands, no injury noted. resident hor resident she stated 'she was staring at me'. 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	ENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: A. BUILDING			(X3) DATE SURVEY COMPLETED		
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		495133	B. WING			06/10/2021
NAME OF PI	ROVIDER OR SUPPLIER		1	STREET ADDRESS, CITY, STATE, Z	IP CODE	102
				940 EAST LEE HIGHWAY		
VALLEY R	EHABILITATION AND N	URSING CENTER		CHILHOWIE, VA 24319		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	X (EACH CORRECTIVE	TO THE APPROPRIA	
F 609	"As part of the reside administration will: 1 abuse by anyone inclimited to: facility state consultants, volunted agencies, family mer friends, visitors, or at Develop and implem to aid our facility in prinistreatment of our assess all possible in Investigate and repowithin timeframes as requirements". Surve "Abuse Investigation read in part "Reporti involving abuse, negmistreatment, includ source and misapported by the facility designee, to the folica. The State licensification or surve the local/State Ombin Representative (Sport Protective Services jurisdiction in long-teenforcement officials Physician; and g. The An alleged violation exploitation or mistre unknown source and property) will be replater than: a. Two (2 involves abuse OR injury; or b. Twenty-	rogram" which read in part, ent abuse prevention, the . Protect our resident from sluding, but not necessarily ff, other residents, ers, staff from other mbers, legal representative, my other individual. 3. ent policies and procedures reventing abuse, neglect, or residents. 6. Identify and incidents of abuse; 7. and an allegations of abuse is required by federal eyor also reviewed the facility and Reporting" policy, which ing 1. All alleged violations glect, exploitation, or ing injuries of an unknown oppriation of property will be ity Administrator, or his/her owing persons or agencies: ing/certification agency eying/licensing the facility; b. udsman; c. The Resident's onsor) of Record d. Adult (where state law provides erm care); e. Law is; f. The resident's Attending the facility Medical Director. 2.	F	609		
	resulted in serious b					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	PLE CONSTRUCTION  G	(X3	(X3) DATE SURVEY COMPLETED		
		495133	B. WING _			06/10/2021	
	ROVIDER OR SUPPLIER	NURSING CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE  940 EAST LEE HIGHWAY  CHILHOWIE, VA 24319				
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 609	Continued From pa	age 32	F 6	09			
	of resident to reside with the administration of 10/21 at approximate No further informated THIS IS A COMPLE.  2. For Resident #1 report an incident altercation.  Resident #111's fawhich included, but	tion was provided prior to exit.  AINT DEFICIENCY  11 the facility staff failed to of resident to resident  ace sheet listed diagnoses at limited to chronic obstructive				•	
	pulmonary disease disease, hypothyromatic disease, hypothyromatic disease, hypothyromatic disease, hypothyromatic disease, assigned interview for mention section C, cognition resident is cognition. Resident #111's coreviewed and confor behavior symptodisease/demention approach resident face, makes reperpudding/food and Resident #111's contained nurse's part "9/23/2020 1	e, bipolar disorder, Alzheimer's oidism, and schizophrenia.  quarterly MDS (minimum data (assessment reference date) of d the resident a BIMS (brief tal status) score of 11 out of 15 itive patterns. This indicates the vely intact.  comprehensive care plan was stained a care plan for "At risk toms related to Alzheimer's a, Bipolar; Resident will ts/others to hug and kiss in titive statements demanding					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED		
, , , , , , , , , , , , , , , , , , , ,	-	495133	B. WING	NG		l .	0 10/2021
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 940 EAST LEE HIGHWAY CHILHOWIE, VA 24319	<u> </u>	00/	10/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		SHOULD B		(X5) COMPLETION DATE
F 609	saw another resident (Resident #111). Uniof nursing) notified, rwill be monitored", "(resident) has been completed head to to injuries noted at this been notified no new nurses station. Will of "4/7/2021 12:08 this room, when another resident and smacker face to point you have resident was sitting in her hands when so other resident remove party) and mod notified. Surveyor spoke with on 06/09/21 at appreasked the DON if rewere considered to they were "some for administrator stated on what is defined at the facility submitted resident to resident "only if there is an in DON if the incidents and DON stated, "Todocumented and reeducation on that are surveyor reviewed "Abuse Prevention". "As part of the resident inistration will:	t place her hand over uth and nose, and then hit it manager and DON (director esidents were separated and 10/4/2020 19:13 Rsd hit by roommate. Writer has be assessment and no time. Family and MD have by orders. Rsd is safe sitting at continue to observe", and nurse entered the activity resident walked over to this ed her twice to right side of eard the second slap. this in chair in corner with a drink emacked. no injury noted. Eved from area. rp (responsible ed".  In the administrator and DON eximately 11:40 am. Surveyor sident to resident altercations be abuse, and DON stated	F	609			

Olivital and Carrolland		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDIN	PLE CONSTRUCTION  IG	COMPLETED	
		495133	B. WING _		06/10/20	21
	ROVIDER OR SUPPLIER	URSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 940 EAST LEE HIGHWAY CHILHOWIE, VA 24319		
(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 CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COME	(X5) PLETION DATE
F 609	friends, visitors, or an Develop and implem to aid our facility in p mistreatment of our assess all possible in Investigate and repowithin timeframes as requirements". Surve "Abuse Investigation read in part "Reporti involving abuse, negmistreatment, includ source and misapported by the facilidesignee, to the follow The State licensing/responsible for surve the local/State Omb Representative (Sport Protective Services jurisdiction in long-teenforcement officials Physician; and g. The An alleged violation exploitation or mistreatment unknown source and property) will be replater than: a. Two (2 involves abuse OR injury; or b. Twenty-violation does not in resulted in serious to the of resident to resident.	ers, staff from other inbers, legal representative, my other individual. 3. ent policies and procedures reventing abuse, neglect, or residents. 6. Identify and incidents of abuse; 7. In any allegations of abuse is required by federal eyor also reviewed the facility in and Reporting" policy, which ing 1. All alleged violations glect, exploitation, or ing injuries of an unknown oppriation of property will be ity Administrator, or his/her owing persons or agencies: a. certification agency eying/licensing the facility; b. udsman; c. The Resident's onsor) of Record d. Adult (where state law provides erm care); e. Law is; f. The resident's Attending the facility Medical Director. 2. of abuse, neglect, eatment (including injuries of d misappropriation of resident forted immediately, but not it) hours if the alleged violation has resulted in serious bodily affour (24) hours if the alleged violation has resulted in serious bodily injury."	F6	609		
	with the administrat	ive team during a meeting on				

STATEMENT OF DEFICIENCIES (2) AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED C	
		495133	B. WING			06	/10/2021	
	ROVIDER OR SUPPLIER	URSING CENTER		940 E	T ADDRESS, CITY, STATE, ZIP CODE AST LEE HIGHWAY HOWIE, VA 24319			
(X4) ID PREFIX TAG	(EACH DEFICIENC	FATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 609	06/10/21 at approxim	nately 4:30 pm. n was provided prior to exit.	F	609				
	3. For Resident #108 report an incident of altercations.	3 the facility staff failed to resident to resident						
	which included, but in disease, psychosis,	e sheet listed diagnoses not limited to Alzheimer's depressive disorder, chronic ary disease, dementia, and						
	set) with an ARD (as 05/12/21 assigned t interview for mental section C, cognitive	arterly MDS (minimum data ssessment reference date) of he resident a BIMS (brief status) score of 0 out of 15 in patterns. This indicates that rely cognitively impaired.						
1	reviewed and conta "Verbal/physical agi Change in routine, ( Communication disc	mprehensive care plan was ined a care plan for tation/aggression related to Cognitive impairment, order/visual impairment, Goal for this care plan is "Will ers"	A.C.					
	contained nurse's p part "3/21/2021 20: another resident ca resident to "shut up their hands togethe	nical record was reviewed and rogress notes, which read in 34 Resident in hall cursing, me out of his room and told ". The residents then locked r and began pushing and back and forth, resident						

AND DUAN OF CORRECTION IDENTIFICATION NUMBER		1 ' '	TIPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED			
		495133	B. WING_		0	C <b>6/10/2021</b>		
	ROVIDER OR SUPPLIER	URSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE  940 EAST LEE HIGHWAY  CHILHOWIE, VA 24319				
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION)	ID PREFII TAG		OULD BE	(X5) COMPLETION DATE		
F 609	several times in the tanurse and other females and other females. Surveyor spoke with on 06/09/21 at approasked the DON if reswere considered to they were "some for administrator stated on what is defined as the facility submitted resident to resident a "only if there is an in DON if the incidents and DON stated, "The documented and repeducation on that an Surveyor reviewed the "Abuse Prevention Passes and part of the reside administration will: 1 abuse by anyone inclimited to: facility state consultants, volunted agencies, family mention and our facility in part of aid our facility in passess all possible in Investigate and repowithin timeframes as requirements". Surventage investigation in the several part of the residence of	ars to left fingers. Resident and hit a staff member back, resident then hit this ale resident in the face."  The administrator and DON eximately 11:40 am. Surveyor sident to resident altercations be abuse, and DON stated in of abuse". The the facility follows their policy is abuse. Surveyor asked if facility reported incidents for altercations and DON stated jury". Surveyor asked the should have been reported hey should have been reported hey should have been reported to me. We will do do do what needs to be done".  The facility policy entitled program" which read in part, ent abuse prevention, the protect our resident from cluding, but not necessarily ff, other residents, ers, staff from other mbers, legal representative, my other individual. 3. Intent policies and procedures reventing abuse, neglect, or residents. 6. Identify and incidents of abuse; 7. Our any allegations of abuse is required by federal eyor also reviewed the facility and Reporting" policy, which	F	609				
	read in part "Report involving abuse, neg	ing 1. All alleged violations glect, exploitation, or	15					

IDENTIFICATION NI MADED:		1 ' '	CONSTRUCTION	COMPLETED		
		495133	B. WING		06/10/2021	
	ROVIDER OR SUPPLIER	NURSING CENTER	9	TREET ADDRESS, CITY, STATE, ZIP CODE 40 EAST LEE HIGHWAY CHILHOWIE, VA 24319		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION	
F 609	source and misappreported by the fact designee, to the form The State licensin responsible for suithe local/State Om Representative (S. Protective Service jurisdiction in long enforcement offici. Physician; and g. An alleged violatic exploitation or misunknown source a property) will be relater than: a. Two involves abuse Olinjury; or b. Twent violation does not resulted in serious. The concern of the of resident to resident to resident to resident to resident the administr 06/10/21 at approviation. No further information. Resident #131's fix which included, but the state of the sident form and the	adding injuries of an unknown propriation of property will be cility Administrator, or his/her llowing persons or agencies: a. g/certification agency reveying/licensing the facility; b. abudsman; c. The Resident's ponsor) of Record d. Adult is (where state law provides e-term care); e. Law als; f. The resident's Attending The facility Medical Director. 2. In of abuse, neglect, attreatment (including injuries of and misappropriation of resident exported immediately, but not (2) hours if the alleged violation is has resulted in serious bodily y-four (24) hours if the alleged involve abuse AND has not is bodily injury."	F 609			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULT A. BUILDI		(X3) DATE SURVEY COMPLETED		
			1	_		(	
		495133	B. WING			06/	10/2021
NAME OF PR	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
VALLEY B	EHABILITATION AND N	IDRING CENTER		9	40 EAST LEE HIGHWAY		
VALLET N	ENABILITATION AND IN	SKSING CENTER		C	CHILHOWIE, VA 24319		
(X4) ID		ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI		(EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPRI		COMPLETION DATE
TAG	REGODATORTOR	·	1,70		DEFICIENCY)		
F 609	Continued From page	e 38	F	609	-		
	hypothyroidism, depr	ession, psychotic disorder,					
	and anxiety.						
	The most recent aug	rterly MDS (minimum data					
		sessment reference date) of					
		e resident a BIMS (brief					
		status score of 0 out of 15 in					
		patterns. This indicates that					
	the resident is severe	ely cognitively impaired.					
	Resident #131's com	prehensive care plan was					
	reviewed and contain						
		ation/aggression related to					
	t .	this care plan are "Will not					
	harm self or others".						
	Resident #131's clini	cal record was reviewed and					
	contained a nurse's p	orogress note, which read in			<u>-</u>		
	'	On rounds, other nurse					
	ł	t's room. Resident was seen					
22	_	h a knotted sock by other rse entered the room,					
	resident was in a rag						
		this nurse and other nurse.					
		to 'beat the shit out of her',					
		te. Resident attempted					
		back over to roommate and nurse and this nurse					
		rated resident. Resident					
	l '	mes to shut the door on this					
_		e while separating residents.					
		to hit, scratch, and pinch this					
	1	se. Resident tied a knot in her					
1		d hit this nurse with it. This ke sheet and attempted to					
	l .	ying down and rubbing					
	1 -	continued to be in a rage,					
	refused to lie down.	-					

IDENTIFICATION AND FOR				NSTRUCTION	COMPLETED		
		495133	B. WING			1	/10/2021
	ROVIDER OR SUPPLIER	URSING CENTER	<b>-</b>	940 E	ET ADDRESS, CITY, STATE, ZIP CODE  AST LEE HIGHWAY  .HOWIE, VA 24319	,1 33	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 609	Surveyor spoke with on 06/09/21 at approasked the DON if rewere considered to be they were "some for administrator stated on what is defined a the facility submitted resident to resident a "only if there is an in DON if the incidents and DON stated, "The documented and regeducation on that an Surveyor reviewed t "Abuse Prevention F"As part of the reside administration will: 1 abuse by anyone inclimited to: facility state consultants, volunte agencies, family mentioned friends, visitors, or and Develop and implement to aid our facility in prince aid our facility in prince aid our facility in prince and in part "Report involving abuse, negmistreatment, include source and misapproported by the facility the facility of the facility of the facility of the facility abuse investigation read in part "Report involving abuse, negmistreatment, include source and misapproported by the facility the facility of	the administrator and DON eximately 11:40 am. Surveyor sident to resident altercations be abuse, and DON stated m of abuse". The the facility follows their policy is abuse. Surveyor asked if facility reported incidents for altercations and DON stated jury". Surveyor asked the should have been reported be should have been reported to me. We will do do do what needs to be done".  The facility policy entitled the facility is a facility policy entitled the facility is and facility and facility and facility is and Reporting" policy, which is required by federal entitled the facility is and Reporting policy, which is glect, exploitation, or ing injuries of an unknown oppriation of property will be the facility and policy and facility of an unknown oppriation of property will be the facility and policy persons or agencies: a.	F	609			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1, ,		NSTRUCTION	COMPLETED	
		495133	B. WING				/10/2021
	ROVIDER OR SUPPLIER	NURSING CENTER		940 E	ET ADDRESS, CITY, STATE, ZIP CODE  AST LEE HIGHWAY  .HOWIE, VA 24319		
(X4) ID PREFIX TAG	(EACH DEFICIEN	SUMMARY STATEMENT OF DEFICIENCIES ID  (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG					(X5) COMPLETION DATE
F 609	the local/State Oml Representative (Sp. Protective Services jurisdiction in long-enforcement officia Physician; and g. T. An alleged violation exploitation or mist unknown source ar property) will be relater than: a. Two (involves abuse OR injury; or b. Twenty violation does not in resulted in serious  The concern of the of resident to resident to resident to resid with the administra 06/10/21 at approx  No further informat  THIS IS A COMPL.  5. For Resident #2 report a resident to on 3/15/21.  Resident #28's diameter with Ber Primary Hypertens Unspecified, Blindin Other Eye, Muscle Difficulty in Walkin	veying/licensing the facility; b. budsman; c. The Resident's consor) of Record d. Adult is (where state law provides term care); e. Law ls; f. The resident's Attending the facility Medical Director. 2. In of abuse, neglect, reatment (including injuries of and misappropriation of resident ported immediately, but not 2) hours if the alleged violation has resulted in serious bodily efour (24) hours if the alleged avolve abuse AND has not bodily injury."  It facility not reporting incidents ent altercations was discussed ative team during a meeting on imately 4:30 pm.  It ion was provided prior to exit.  AINT DEFICIENCY  8, the facility staff failed to resident altercation occurring  gnosis list indicated diagnoses, at not limited to Unspecified navioral Disturbance, Essential sion, Anxiety Disorder mess One Eye Low Vision weakness Generalized, and	F	609			

OLIVILIN	OT CITIBLE DIOP TITLE OF	TEDIO/ NE CENTROLO						
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			1 ' '		ONSTRUCTION		(X3) DATE SURVEY COMPLETED	
						l		
		495133	B. WING				06/	10/2021
	ROVIDER OR SUPPLIER	URSING CENTER		940	REET ADDRESS, CITY, STATE, ZIP CODE DEAST LEE HIGHWAY IILHOWIE, VA 24319			
(X4) ID PREFIX TAG	(EACH DEFICIENC	FATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE		(X5) COMPLETION DATE
F 609	set) with an ARD (as 3/25/21 assigned the interview for mental section C, Cognitive A review of Resident revealed the followin A "SBAR (Situation, Review) Communica 11:43 am states in p nurses desk with wa and shoved resident hitting right cheek or into the floor. Lande Assessed from head	sessment reference date) of e resident a BIMS (brief status) score of 5 out of 15 in Patterns. #28's clinical record	F	609				
	the administrator and discuss the facility produced altercations. The DO altercations can be a asked if the facility sincidents) for residenthe DON stated "if the administrator stated Surveyor requested aforementioned incident occurring on 3/15/2.  The following day as with the DON who sereported to them an administrator but conincident.	t 10:52 am, surveyor spoke stated the incident was d they then reported it to the ould not find an FRI for the						
	On 6/10/21 at 1:28	pm, surveyor team spoke with						

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495133	B. WING			06/1	) 10/2021
	ROVIDER OR SUPPLIER	*		STREET ADDRESS, CITY, STATE, ZIP COL 940 EAST LEE HIGHWAY CHILHOWIE, VA 24319	DE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	A DATE OF THE PARTY OF THE PART	N SHOULD B E APPROPRIA	E	(X5) COMPLETION DATE
F 609	altercations, resident is not an injury, there is not an injury which start is an unknown source property will be reported Administrator, or his following persons or a. The State licensity responsible for survey b. The local/State Cc. The Resident's Record; d. Adult Protective is provides jurisdiction e. Law enforcement. The resident's Att g. The facility Medical is a likely of the property) will be replater than:  a. Two (2) hours if abuse OR has result b. Twenty-four (24) does not involve abuse rious bodily injury.  On 6/10/21 at 4:45	resident to resident N stated that following Is are assessed and if there Is is nothing to report.  In and received the facility Is elivestigation and Ites in part:  In sinvolving abuse, neglect, Ite atment, including injuries of Ite and misappropriation of Ite dby the facility In designee, to the Ite agencies: Ing/certification agency Ite agencies Ing/certification agency Ite agency	F	609			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	TIPLE CON	COMPLETED			
		495133	B. WING				10/2021
	ROVIDER OR SUPPLIER	URSING CENTER		940 E	ET ADDRESS, CITY, STATE, ZIP CODE AST LEE HIGHWAY .HOWIE, VA 24319		*2
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 609	discussed the concernant incident of a resident without presented to the sunconference on 6/10/2 6. For Resident #26 failed to report a resident #26's diagratic which included, but a Dementia without Be Diabetes Mellitus with Deficiency Anemia L. Weakness Generalist Resident #26's most (minimum data set) was reference date) of 3 a BIMS (brief intervied out of 15 in section Resident #134's diadiagnoses, which in Unspecified Dementia Disturbance, Schizo Disorder Unspecified Pectoris.  Resident #134's most diadiagnoses which in Unspecified Dementiaturbance, Schizo Disorder Unspecified Pectoris.  Resident #134's most diadiagnoses which in Unspecified Dementiaturbance, Schizo Disorder Unspecified Pectoris.	ector of nursing), surveyor on of the facility not reporting lent to resident altercation 28.  In regarding this issue was vey team prior to the exit 21.  and #134, the facility staff ident to resident altercation to Adult Protective Services.  Inosis list indicated diagnoses, not limited to Unspecified chavioral Disturbance, Type 2 thout Complications, Iron Unspecified, and Muscle 2ed.  It recent quarterly MDS vith an ARD (assessment /22/21 assigned the resident ew for mental status) score of a C, Cognitive Patterns.  In gnosis list indicated cluded, but not limited to tia with Behavioral phrenia Unspecified, Bipolar , and Unstable Angina  The street quarterly MDS with assigned the resident a BIMS in section C, Cognitive	F	609			
	On 6/08/21 at 1:55	om during initial rounds,					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING				(X3) DATE SURVEY COMPLETED	
		495133	B. WING		100		C 06/10/2021	
	ROVIDER OR SUPPLIER	. , , , , , , , , , , , , , , , , , , ,		940 EAST L	DRESS, CITY, STATE, ZIP CODE LEE HIGHWAY VIE, VA 24319			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD B	E	(X5) COMPLETION DATE
F 609	under the left eye an the face from the left Surveyor asked the in bruising and the resion the door and ther fallen. At 2:08 pm, si (temporary certified concerning the caus #1 stated it was reported with the surveyor spoke with (director of nursing) concerning the bruis and the DON stated incident) was completed incident) was completed final report now.  At 12:30 pm, the DO final FRI report to the FRI dated 6/04/26/03/21 involving Repart, "Reported by sementioned above has altercation. It was rewheeled (his/her) seand started going the belongings. (Reside leave (his/her) 'stuff asked (Resident #20 to this being (his/her) (Resident #134) was #26) from (his/her) (Resident #134) started and I hit (him/heassessed, and staff left side of the forements.)	desident #26 with redness desident #26 with redness desident to the left side of eye down to the cheek area. The sident what caused the dent stated they hit their face a stated they must have curveyor spoke with TCNA charming assistant) #1 desident to them that Resident	F	609				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	(X2) MULTIPLE CONSTRUCTION  A. BUILDING				
		495133	B. WING		C 06/10/2021		
	ROVIDER OR SUPPLIER	NURSING CENTER	g	TREET ADDRESS, CITY, STATE, ZIP CODE 140 EAST LEE HIGHWAY CHILHOWIE, VA 24319			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION		
F 609	discolored area to the staff was verbally in monitor for signa [states distress].  The FRI report did report did report to resident to resident 11:45 am, surveyor asked if APS was not resident altercation #134, the DON staff	ge 45 a #26) and I observed a ne left side of the forehead, estructed to continue to p] and symptoms of any not include the date that APS rvices) was notified of the altercation. On 6/10/21 at spoke with the DON and otified of the resident to between Resident #26 and led no because there was no a surveyor spoke with the	F 609				
	administrator who sand it was a team of sand it was a like the sand it was	tated APS was not notified lecision.  If and received the facility se Investigation and tates in part:  Itions involving abuse, neglect, treatment, including injuries of e and misappropriation of torted by the facility s/her designee, to the or agencies:  Ising/certification agency veying/licensing the facility;  Ombudsman;  Representative (Sponsor) of  Services (where state law in long-term care);  Int officials;  Ittending Physician; and					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1	LE CONSTRUCTION	(X3)	(X3) DATE SURVEY COMPLETED C		
		495133	B. WING		i	06/10/2021	
	OVIDER OR SUPPLIER	URSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 940 EAST LEE HIGHWAY CHILHOWIE, VA 24319			
(X4) ID PREFIX TAG	(EACH DEFICIENC	FATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 609	unknown source and property) will be reported to the serious bodily injury.  On 6/10/21 at 4:45 p administrator, admin ADON (assistant directions) and incident of a reside involving Resident # APS.  No further information presented to the surconference on 6/10/27. For Resident #14 report resident to resident to resident and 4/05.  Resident # 140's diadiagnoses, which in Parkinson's Disease Unspecified, Un	eatment (including injuries of misappropriation of resident orted immediately, but not the alleged violation involves ed in serious bodily injury; or hours if the alleged violation se AND has not resulted in "  m, during a meeting with the istrator in training, DON, and ector of nursing) surveyor or of the facility not reporting dent to resident altercation 26 and Resident #134 to an regarding this issue was every team prior to the exit 21.  O, the facility staff failed to exident altercations occurring with a country of the facility staff failed to exident altercations occurring with a country of the facility staff failed to exide the country of the facility staff failed to exide the country of the facility staff failed to exide the country of the facility staff failed to exide the country of the facility staff failed to exide the country of the facility staff failed to exide the country of the facility staff failed to exide the country of the facility staff failed to exide the country of the facility staff failed to exide the country of the facility staff failed to exide the country of the facility staff failed to exide the country of the failed to ex	F 60				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			COMPLETED	
		495133 B. WING					0 10/2021
	ROVIDER OR SUPPLIER	URSING CENTER		940	REET ADDRESS, CITY, STATE, ZIP CODE EAST LEE HIGHWAY IILHOWIE, VA 24319		e:
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOULI		BE	(X5) COMPLETION DATE
F 609	revealed the followin  A nursing progress in (7:55 pm) states "Th (male/female) reside and with hands joine other back and forth separated residents. skin tears to right fin:  A 4/05/21 09:45 (9:4 Summary for Provide "resident entered an resident, denies pair immediately interver residents safety staff entered the room an residents room hittin immediately moved  On 6/09/21 at 11:42 the administrator and discuss the facility paltercations. The Doaltercations can be asked if the facility sincidents) for reside the DON stated "if the administrator stated Surveyor requested aforementioned inci #140. On 6/09/21 a provided the survey form, "Incident #827 #827 form states in another (male/female)	#140's clinical record g documentation: ote dated 3/21/21 19:55 is resident and another nt locked hand [sp] together d, pushed and shoved each . Staff intervened and Received two small (.5 cm)	F	609			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION  3	=	COMPLETED		
		495133	B. WING			C <b>06/10/2021</b>		
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 940 EAST LEE HIGHWAY CHILHOWIE, VA 24319	DE			
(X4) ID PREFIX TAG	(EACH DEFICIENC	FATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE IE APPROPRIA		N	
F 609	two small (.5 cm) ski the section "Residen documented "I told (I cussing".  On 6/10/21 at 1:28 p the DON concerning altercations. The DO altercations, residen is not an injury, there is not an injury, there surveyor requested policy entitled "Abus Reporting" which sta "Reporting" which sta "Reporting 1. All alleged violatic exploitation, or mistre an unknown source property will be reported an unknown source property will be reported and inistrator, or his following persons or a. The State licensi responsible for survey b. The local/State Oc. The Resident's Record; d. Adult Protective provides jurisdiction e. Law enforcement. The resident's Att. The facility Medical exploitation or mistred unknown source and source in the section of the section o	ack and forth. Staff rated residents. Received in tears to right fingers". In it Description", it is him/her) to shut up and quit  In, surveyor team spoke with it resident to resident it on stated that following its are assessed and if there is is nothing to report.  In and received the facility is Investigation and interesting abuse, neglect, eatment, including injuries of and misappropriation of orted by the facility if her designee, to the in agencies: ing/certification agency exping/licensing the facility; including injuries of and misappropriation of orted by the facility if her designee, to the in agencies: ing/certification agency exping/licensing the facility; including injuries of and misappropriation of orted by the facility if officials; it officials;	F 60	09				

STATEMENT (	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		NSTRUCTION	J	(X3) DATE SURVEY COMPLETED	
		495133	B. WING				06/	) 10/2021
	ROVIDER OR SUPPLIER	URSING CENTER		940 E	ET ADDRESS, CITY, STATE, ZIP COD AST LEE HIGHWAY LHOWIE, VA 24319	E		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD B APPROPRIA		(X5) COMPLETION DATE
F 609	a. Two (2) hours if the abuse OR has resulted. Twenty-four (24) I does not involve abuse serious bodily injury.  On 6/10/21 at 4:45 pure administrator, admi	ne alleged violation involves ed in serious bodily injury; or nours if the alleged violation se AND has not resulted in " m, during a meeting with the istrator in training, DON, and ector of nursing) surveyor rn of the facility not reporting dent to resident altercations 140. In regarding this issue was vey team prior to the exit 21. In the facility staff failed to esident altercation occurring Inosis list indicated diagnoses, not limited to Chronic ary Disease Unspecified, isorder Recurrent inal Stenosis Site  arterly MDS (minimum data assessment reference date) of the resident a BIMS (brief status) score of 5 out of 15 in	F	609				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NI IMPED:		TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		495133	B. WING			C 06/10/20	21
	ROVIDER OR SUPPLIER  EHABILITATION AND N	URSING CENTER		STREET ADDRESS, 940 EAST LEE HIG CHILHOWIE, VA			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION)	ID PREF TAG	X (EACH	ROVIDER'S PLAN OF CORRECTION H CORRECTIVE ACTION SHOULD S-REFERENCED TO THE APPROPRI DEFICIENCY)	BE COMP	X5) PLETION PATE
F 609	other resident when TCNA #1 stated yes with the back of the of #1 also stated that there" and saw it.  A nursing progress in (2:11 pm) states in p day with resident attresidents".  On 6/09/21 at 11:42 the administrator and discuss the facility p altercations. The Do altercations can be asked if the facility s incidents) for reside the DON stated "if the administrator stated Surveyor spoke with nursing) concerning progress note dated "it should have been me. We will do educe needs to be done".  On 6/09/21 at 12:28 met with the survey Resident #53 swatte from behind them at the face.  On 6/10/21 at 1:28 the DON concerning altercations. The Don in the pool is the pool in t	the #53 made contact with the they hit at them earlier and the resident made contact other resident's head. TCNA he nurse was "sitting right oted dated 6/08/21 14:11 art, "Behavior episodes this empting to hit other  am, survey team met with d DON (director of nursing) to rocess for resident to resident DN stated resident to resident a form of abuse. Surveyor submits FRIs (facility reported into resident altercations and here's an injury". The they try to follow their policy. In the DON (director of the above incident and 16/08/21 14:11, DON stated in documented and reported to cation on that and do what the policy when the policy is the policy of the above incident and 16/08/21 14:11, DON stated in documented and reported to cation on that and do what the policy is the policy of the policy of the above incident and the policy of the above incident and the policy of the above incident and the policy of the policy	F	609			
	altercations. The De altercations, reside						

STATEMENT O	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION  A. BUILDING				E SURVEY PLETED
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	ROVIDER OR SUPPLIER		B. WING	STF 940	REET ADDRESS, CITY, STATE, ZIP CODE  DEAST LEE HIGHWAY  IILHOWIE, VA 24319	1 08	6/10/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION)	ID PREF TAC		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPROPROPROPROPROPROPROPROPROPROPROPRO	BE	(X5) COMPLETION DATE
F 609	Continued From pag	e 51	F	609		-	
	policy entitled "Abus Reporting" which state "Reporting 1. All alleged violation exploitation, or mistran unknown source property will be reported and unknown source property will be reported and unknown source property will be reported at the state licensis responsible for survey bear the local/State Control of the local/State Control of the Resident's Record; described and the state of the	ons involving abuse, neglect, eatment, including injuries of and misappropriation of orted by the facility of agencies: Ing/certification agency eying/licensing the facility; or mbudsman; epresentative (Sponsor) of Services (where state law in long-term care); to officials; ending Physician; and cal Director.  Ion of abuse, neglect, eatment (including injuries of d misappropriation of resident orted immediately, but not the alleged violation use AND has not resulted in serious bodily injury; or hours if the alleged violation use AND has not resulted in					
	administrator, admin ADON (assistant din discussed the conc	om, during a meeting with the nistrator in training, DON, and rector of nursing) surveyor ern of the facility not reporting ident to resident altercation \$\frac{45}{253}\$.					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			A. BOI	LDING _			С
		495133	B. WIN	IG		00	6/10/2021
	ROVIDER OR SUPPLIER	URSING CENTER		94	TREET ADDRESS, CITY, STATE, ZIP CODE 40 EAST LEE HIGHWAY CHILHOWIE, VA 24319	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PR	ID EFIX AG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 609	Continued From pag	e 52		F 609			
		on regarding this issue was vey team prior to the exit 21.					II.
		5, the facility staff failed to sident altercations occurring /21.			- a		
-	Alzheimer's Disease Dementia with Beha Obsessive-Compuls	cluded, but not limited to Unspecified, Unspecified vioral Disturbance, ive Disorder Unspecified, specified, and Essential					
12	set) with an ARD (as 5/16/21 assigned th	arterly MDS (minimum data ssessment reference date) of e resident a BIMS (brief status) score of 0 out of 15 in Patterns.					-
	A review of Residen revealed the following	nt #115's clinical recording documentation:					
	dated 4/05/21 09:45 "resident entered th resident, discolored	ge in Condition Evaluation" 5 (9:45 am) states in part, is residents room and hit area to left eye, denies pair aff immediately intervened ar ents safety".					
	(2:00 pm) states "rediscolored raised at center. resident nor residents roommate	note dated 5/26/21 14:00 esident noted to have a rea with scratched area in the nambulatory, bedbound. The has been witnessed standibed, cursing (him/her), hittin	ng g				
FORM CMS-25	67(02-99) Previous Versions O	bsolete Event	ID:097511	F	acility ID: VA0251 If c	ontinuation sh	eet Page 53 of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	IPLE CONSTRUCTION  NG	COMPLETED		
	495133 B. WING  E OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE			l .	0/2021		
	ROVIDER OR SUPPLIER	JRSING CENTER		STREET ADDRESS, CITY, 940 EAST LEE HIGHWA CHILHOWIE, VA 243	ΛY		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	(EACH COR	ER'S PLAN OF CORRECTION RECTIVE ACTION SHOULD B ERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 609	manner. upon interviroom with both havin could voice any type stated I didn't do any didn't roll out of bed. going in and out of roand FNP (family nurs spoke with RP regar RP in agreeance to another room as a proposition of the administrator and discuss the facility proposition of the polymer in the polym	with residents in this g a BIMS score of 0, neither of incident. roommate thing, resident stated no I no other resident observed from rp (responsible party) se practitioner) notified. ding move to another room, move resident up the hall to recaution/prevention".  am, survey team met with a DON (director of nursing) to rocess for resident to resident to resident to resident a form of abuse. Surveyor submits FRIs (facility reported into to resident altercations and here's an injury". The they try to follow their policy. The try try to follow their policy. The try try to follow their policy. The they try to follow their policy. The try try to follow their policy. The try try to follow their policy. The try try try to follow their policy. The try try try to follow their policy. The try try to follow their policy. The try try try to follow their policy. The try try try to follow their policy. The try	F	609			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		I DESTRICTO ATION STREET,			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495133 B. WING					
		495133	B. WING			06/	10/2021
NAME OF PR	OVIDER OR SUPPLIER			\$	STREET ADDRESS, CITY, STATE, ZIP CODE		
		WIDOWG GENTER		6	940 EAST LEE HIGHWAY		
VALLEY R	EHABILITATION AND N	IURSING CENTER		(	CHILHOWIE, VA 24319		
(X4) ID PREFIX	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL	ID PREF	ΊX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E	3E	(X5) COMPLETION DATE
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)	TAG	ì	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	VIE	<u> </u>
						琶	
F 609	Continued From pag		+	609	<b>'</b>		
		and misappropriation of	i				
	property will be repo						
		her designee, to the					
	following persons or	•					
		ng/certification agency				ļ	
	-	eying/licensing the facility;					
	b. The local/State C						
	c. The Resident's R	Representative (Sponsor) of					
	Record;						
ļ	d. Adult Protective	Services (where state law					1
i	provides jurisdiction	in long-term care);					
	e. Law enforcemen	t officials;					
	f. The resident's Att	ending Physician; and					
	g. The facility Medic	- ·					
					0		
	2. An alleged violat	tion of abuse, neglect,					
	exploitation or mistr	eatment (including injuries of					
	unknown source an	d misappropriation of resident					
	property) will be rep	oorted immediately, but not					
	later than:						
	a. Two (2) hours if	the alleged violation involves					
	abuse OR has resul	Ited in serious bodily injury; or					
		hours if the alleged violation					
		use AND has not resulted in					
	serious bodily injury						
	i	,•					
	On 6/10/21 at 4:45	pm, during a meeting with the					
	ı	nistrator in training, DON, and	=				
25		rector of nursing) surveyor					
		ern of the facility not reporting					
		it to resident altercations	>-				
	1						
	_	#115 occurring on 4/05/21 and	1				
	5/26/21.						
	No foutback to form 1	on regarding this issue					
	l .	on regarding this issue was					
		rvey team prior to the exit					
	conference on 6/10						
F 610	Investigate/Prevent/	Correct Alleged Violation	F	<del>-</del> 61	0		
SS=E							<u></u>
FORM CMS-256	7(02-99) Previous Versions O	bsolete Event ID: 0975	311	F	Facility ID: VA0251 If contin	nuation shee	et Page 55 of 7

					ATE SURVEY OMPLETED	
		495133	B. WING		I	C / <b>10/2021</b>
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
VALLEY B	EHABILITATION AND N	IIIPSING CENTER		940 EAST LEE HIGHWAY		
VALLET N	ENABILITATION AND I			CHILHOWIE, VA 24319		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		LD BE	(X5) COMPLETION DATE
F 610	neglect, exploitation, must:  §483.12(c)(2) Have violations are thorous §483.12(c)(3) Preveneglect, exploitation investigation is in prospective states are thorous §483.12(c)(4) Report investigations to the designated represer accordance with States Survey Agency, with incident, and if the appropriate corrective This REQUIREMENT by:  Based on staff interfacility document recomplaint investigate facility staff failed to of abuse for 4 of 30 #131, #28 and #53.  The findings included 1. For Resident #72 investigate incidents altercations.  Resident #72's face included, but not limit disorder, demential	nse to allegations of abuse, or mistreatment, the facility evidence that all alleged aghly investigated.  Int further potential abuse, or mistreatment while the ogress.  In the results of all eadministrator or his or her intative and to other officials in ate law, including to the State hin 5 working days of the alleged violation is verified we action must be taken.  In it is not met as evidenced eview, view and in the course of a cion it was determined that the cinvestigate alleged incidents residents, Residents #72,  In the facility staff failed to so of resident to resident esheet listed diagnoses which nited to major depressive with behavioral disturbance,	F	1. Address how corrective will be accomplished for residents found to have affected by the deficient practice: , Residents #72, #28 and #53 remain in the and the investigation has be completed.  2. Address how the facility identify other residents the potential to be affect the same deficient practice residents have the potential affected.  3. Address what measures into place or systemic of made to ensure that the practice will not recur: Facility staff will be educated facility policy and procedure porting and investigating abuse in a timely manner.  4. Indicate how the facility monitor its performance sure that the solutions a sustained: Director of Nu designee will audit alleged to ensure facility policy is followed weekly times 4 we monthly times 2. Audit find reviewed monthly in the quassurance and performan improvement process for tracking/trending and any additional interventions.  5. Include dates when the action will be completed compliance: 8/5/21	#131, facility een  #131, facility een  will aving ed by ce: All al to be  will be put anges deficient ed regarding es regarding alleged  blans to to make re re sing or allegations being eeks and ings will be lality ee mecessary corrective	
	anxiety, convulsions	s and gastroesophageal reflux				

STATEMENT C	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		NSTRUCTION		DATE SURVEY COMPLETED
		495133	B. WING	144			C <b>06/10/2021</b>
	ROVIDER OR SUPPLIER EHABILITATION AND N	URSING CENTER	5	940 E	ET ADDRESS, CITY, STATE, ZIP CODE EAST LEE HIGHWAY LHOWIE, VA 24319		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 610	disease.  The most recent quaset) with an ARD (as 04/26/21 assigned the interview for mental and the interview for mental and the intact.  Resident #72's compreviewed and contai "Inappropriate behaverbal/physical agits other residents related traumatic brain injuries "to decrease/minity verbal/physical abuse.  Resident #72's clinical contained nurse's pipart "09/19/2020 15 aide) observed this because she was 'unturned the water off couldn't use it. Remproommate can use from as well", "09/2 nurse that this resident in to a chais shouldn't be putting "09/20/2020 15:26 to resident on the right residents", "09/20/2 (director of nursing) Explained to reside if she hits anyone e	arterly MDS (minimum data assessment reference date) of the resident a BIMS (brief status) score of 14 out of 15. The resident is cognitively corehensive care plan was need a care plan for vior at times, history of attion/aggression towards to Cognitive impairment, y". The goal for this care plan mize episodes of	F	610			
		observed (Resident #72) another resident's face and					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 '		DINSTRUCTION		(X3) DATE S	
		495133	B. WING				06/1	0/2021
	ROVIDER OR SUPPLIER  EHABILITATION AND N			940 E	EET ADDRESS, CITY, STATE, ZIP CODE EAST LEE HIGHWAY LHOWIE, VA 24319	<u> </u>		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	- 1	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD B		(X5) COMPLETION DATE
F 610	nose. She then hit the "4/9/2021 16:43 the comitted]) relayed to ranother resident ([naresident did not sustate omitted]) stated 'He wont quit'. the two were issues at this time. We surveyor spoke with on 06/09/21 at approasked the DON if resewere considered to be they were "some for administrator stated on what is defined at the facility investigat resident altercation, take it to risk manage these specific incide and the facility could to indicate that they  Surveyor reviewed to "Abuse Prevention F" As part of the reside administration will: 1 abuse by anyone inclimited to: facility state consultants, volunte agencies, family me friends, visitors, or and Develop and implement to aid our facility in printer to mistreatment of our assess all possible in linvestigate and report within timeframes as	e other resident", and nurses aides ([names me that the resident pushed ame omitted]) three times. ain any injury or fall (name vas going to hit her if she did re separated, no further vill continue to monitor."  The administrator and DON eximately 11:40 am. Surveyor sident to resident altercations be abuse, and DON stated m of abuse". The the facility follows their policy is abuse. Surveyor asked if ed the incident of resident to and the DON stated, "We ement". Surveyor asked if ints had been investigated, if not provide any information had.  The facility policy entitled Program" which read in part, ent abuse prevention, the Protect our resident from cluding, but not necessarily iff, other residents,	F	610				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495133	B. WING			1	C 10/2021
	ROVIDER OR SUPPLIER	URSING CENTER		940	REET ADDRESS, CITY, STATE, ZIP CODE EAST LEE HIGHWAY IILHOWIE, VA 24319		
(X4) ID PREFIX TAG	(EACH DEFICIENC	FATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 610	"Abuse Investigation read in part "All reponeglect, exploitation, property, mistreatme source ('abuse') shall local, state, and federurrent regulations) by facility manageme investigations will also the concern of the fresident to resident a with the administration of 10/21 at approximation. This is a COMPLA!  2. For Resident # 13 investigate incidents altercations.  Resident #131's fact which included, but behavioral disturbant hypothyroidism, depland anxiety.  The most recent quaset) with an ARD (at 05/23/21 assigned to interview for mental section C, cognitive the resident #131's corrected.	and Reporting" policy, which rts of resident abuse, misappropriation of resident and/or injuries of unknown and be promptly reported to eral agencies (as defined by and thoroughly investigated ent. Findings of abuse so be reported".  acility not investigating altercations was discussed by the team during a meeting on anately 4:30 pm.  INT DEFICIENCY  If the facility staff failed to so of resident to resident  be sheet listed diagnoses alimited to dementia with ance, hypertension, be session, psychotic disorder, arterly MDS (minimum data assessment reference date) of the resident a BIMS (brief status score of 0 out of 15 in patterns. This indicates that rely cognitively impaired.	F	610			
<u> </u>	reviewed and conta	ineu a care pian loi				A	

	F DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE (	CONSTRUCTION	(X3) DATE SURVEY		
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING		COMPLETED		
		495133	B. WING			06/	10/2021	
NAME OF PE	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE			
VALLEY R	EHABILITATION AND N	URSING CENTER			0 EAST LEE HIGHWAY			
				CI	HILHOWIE, VA 24319			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	3E	(X5) COMPLETION DATE	
F 610	"Verbal/physical agitadementia". Goals for	e 59 ation/aggression related to this care plan are "Will not	F	610				
	Resident #131's clinic contained a nurse's part "2/18/201 01:41 called this to residen hitting roommate with nurse. When this nurseident was in a ragswinging and hitting Resident threatened speaking of roommate multiple times to go hit roommate. Other intervened and sepa attempted multiple tinurse and other nurse Resident continued nurse and other nurse sheet and swung an nurse was able to ta redirect resident by shoulders. Resident refused to lie down.  Surveyor spoke with on 06/09/21 at approasked the DON if reswere considered to they were "some for administrator stated"	cal record was reviewed and progress note, which read in On rounds, other nurse it's room. Resident was seen in a knotted sock by other rese entered the room, ge, screaming loudly, this nurse and other nurse. To 'beat the shit out of her', ite. Resident attempted back over to roommate and nurse and this nurse arated resident. Resident mes to shut the door on this is while separating residents. To hit, scratch, and pinch this is e. Resident tied a knot in her id hit this nurse with it. This is ke sheet and attempted to lying down and rubbing continued to be in a rage, Supervisor notified.						
	the facility investigatersident altercation, take it to risk manage this specific incident	ted the incident of resident to and the DON stated, "We gement". Surveyor asked if t had been investigated, and provide any information to		3				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDII		COMPLETED				
		495133	B. WING_		,	06/10/2021		
	ROVIDER OR SUPPLIER	IURSING CENTER		940 E	ET ADDRESS, CITY, STATE, ZIP CODE AST LEE HIGHWAY HOWIE, VA 24319			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFII TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	) BE	(X5) COMPLETION DATE	
F 610	indicate that is had.  Surveyor reviewed to "Abuse Prevention for "As part of the residual administration will: abuse by anyone in limited to: facility state consultants, volunted agencies, family me friends, visitors, or a Develop and implement to aid our facility in mistreatment of our assess all possible Investigate and reposition in part "All reposition read in part "All reposition read in part "All reposition property, mistreatm source ('abuse') shallocal, state, and fed current regulations) by facility managem investigations will at the concern of the resident to resident with the administration of 10/21 at approximation of the resident to resident to resident to resident with the administration of 10/21 at approximation.  This is a complete.	the facility policy entitled Program" which read in part, ent abuse prevention, the I. Protect our resident from cluding, but not necessarily aff, other residents, ers, staff from other mbers, legal representative, any other individual. 3. nent policies and procedures preventing abuse, neglect, or residents. 6. Identify and incidents of abuse; 7. For any allegations of abuse is required by federal reyor also reviewed the facility in and Reporting" policy, which forts of resident abuse, in, misappropriation of resident ent and/or injuries of unknown all be promptly reported to deral agencies (as defined by and thoroughly investigated ment. Findings of abuse lso be reported".  facility not investigating a altercation was discussed give team during a meeting on imately 4:30 pm.	F	510				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	(X2) MULTIPLE CONSTRUCTION  A. BUILDING				
		495133	B. WING			C <b>06/10/2021</b>	
	ROVIDER OR SUPPLIER	URSING CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 940 EAST LEE HIGHWAY CHILHOWIE, VA 24319				
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	(EACH CORRECTIVE ACTION	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE ROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
F 610	which included, but r Dementia with Behav Primary Hypertensio Unspecified, Blindne Other Eye, Muscle V Difficulty in Walking.  The most recent qua set) with an ARD (as 3/25/21 assigned the interview for mental s section C, Cognitive  A review of Resident revealed the followin  A "SBAR (Situation, Review) Communica 11:43 am states in p nurses desk with wa and shoved resident hitting right cheek or into the floor. Lande Assessed from head area noted on right of voiced".  On 6/09/21 at 11:42 the administrator and discuss the facility p altercations. The Do altercations can be a asked if the facility s incidents) for reside	nosis list indicated diagnoses, not limited to Unspecified vioral Disturbance, Essential in, Anxiety Disorder is One Eye Low Vision Weakness Generalized, and writerly MDS (minimum data sessment reference date) of eresident a BIMS (brief status) score of 5 out of 15 in Patterns.  #28's clinical recording documentation:  Background, Appearance, ation Form" dated 3/15/21 at lart, "Resident standing at liker, another resident came in the back. Resident fell, in nurses desk as went downed on (his/her) buttocks. It to toe with red slightly raised cheek. No other complaints  am, survey team met with d DON (director of nursing) to rocess for resident to resident a form of abuse. Surveyor submits FRIs (facility reported int to resident altercations and	F 610				
	Review) Communica 11:43 am states in p nurses desk with wa and shoved resident hitting right cheek or into the floor. Lande Assessed from head area noted on right ovoiced".  On 6/09/21 at 11:42 the administrator and discuss the facility p altercations. The Do altercations can be a sked if the facility s incidents) for reside the DON stated "if the	ation Form" dated 3/15/21 at lart, "Resident standing at alker, another resident came to in the back. Resident fell, an nurses desk as went downed on (his/her) buttocks. It to toe with red slightly raised cheek. No other complaints am, survey team met with d DON (director of nursing) to rocess for resident to resident ON stated resident to resident a form of abuse. Surveyor submits FRIs (facility reported					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			A. BUILD			COMPLETED			
		495133	B. WING				06/10/2021		
NAME OF PROVID		NURSING CENTER	=	STREET ADDRESS, CITY, STATE, ZIP CODE 940 EAST LEE HIGHWAY CHILHOWIE, VA 24319					
(X4) ID PREFIX TAG	REFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREF TAG	- 1	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATI	<b>I</b>	(X5) MPLETION DATE	
Sur afo occording to the with rep adrinction inverse properties of the sexperse souloc current by inverse souloc current by inverse properties of the sexperse souloc current by inverse souloc current by inverse properties of the sexperse souloc current by inverse properties of the sexperse souloc current by inverse souloc current by inve	rementioned incurring on 3/15/2 e following day a n the DON who orted to them ar ninistrator but or dent. Surveyor estigation of the vided prior to th rveyor requested icy entitled "Abu porting" which s icy Statement reports of reside porting which s icy Statement reports of reside reports of reside porting which s icy Statement reports of the vided prior to the resident s icy Statement reports of reside porting which s icy Statement reports of reside porting which s icy Statement reports of the vided prior to the vided prior to the resident s icy Statement reports of the vided prior to the vided prior to the report of the vided prior to th vided prior to the vided prior to the vided prior to the vided p	at the FRI report for the ident involving Resident #28 id.  at 10:52 am, surveyor spoke stated the incident was and they then reported it to the build not find an FRI for the then requested the facility incident, however, none was a survey exit.  If and received the facility incident, however, none was a survey exit.  If and received the facility is and thoroughly reported to deral agencies (as defined by and thoroughly investigated ment. Findings of abuse also be reported. Strator:  suspected incident of resident int, neglect or injury of reported, the Administrator will ation to an appropriate	F	610					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					COMPLETED		
	495133	B. WING _			06/10/2021		
ROVIDER OR SUPPLIER  EHABILITATION AND	NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP COI 940 EAST LEE HIGHWAY CHILHOWIE, VA 24319	DE			
SUMMARY STATEMENT OF DEFICIENCIES  EFIX  (EACH DEFICIENCY MUST BE PRECEDED BY FULL  AG  REGULATORY OR LSC IDENTIFYING INFORMATION)		(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX		N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE		
appropriate); f. Interview the ras needed to deter level of cognitive functing. Interview staff have had contact uperiod of the alleged incident. Interview other accused employed j. Review all ever incident. 5. Upon conclusion investigator will reconstructed investigator on an and provide the condinistrator.  On 6/10/21 at 4:45 administrator, admini	esident's Attending Physician mine the resident's current tion and medical condition; members (on all shifts) who with the resident during the ant; esident's roommate, family tors; residents to whom the provides care or services; and ants leading up to the alleged on of the investigation, the cord the results of the proved documentation forms ampleted documentation to the proved documentation to the director of nursing) surveyor cern of the facility not cident of a resident to resident and Resident #28 occurring on tion regarding this issue was survey team prior to the exit 0/21.	F	510				
which included, bu	at not limited to Chronic						
	CORRECTION  ROVIDER OR SUPPLIER  EHABILITATION AND  SUMMARY (EACH DEFICIEI REGULATORY CONTINUED FROM PARTY (EACH DEFICIE REGULATORY CONTINED FROM PARTY (EACH DEFICIE REGULATORY CONTINUED FROM PARTY (EAC	CORRECTION  A95133  ROVIDER OR SUPPLIER  EHABILITATION AND NURSING CENTER  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 63 appropriate); f. Interview the resident's Attending Physician as needed to determine the resident's current level of	CORRECTION  A BUILDIT 495133  B. WING	CONTIDER OR SUPPLIER  ### EHABILITATION AND NURSING CENTER  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  CONTIDER OR page 63 appropriate); f. Interview the resident's Attending Physician as needed to determine the resident's current level of cognitive function and medical condition; g. Interview staff members (on all shifts) who have had contact with the resident during the period of the alleged incident; h. Interview other residents to whom the accused employee provides care or services; and j. Review all events leading up to the alleged incident.  5. Upon conclusion of the investigation, the investigation on approved documentation forms and provide the completed documentation to the Administrator.  On 6/10/21 at 4:45 pm, during a meeting with the administrator, administrator in training, DON, and ADON (assistant director of nursing) surveyor discussed the concern of the facility not investigating an incident of a resident to resident altercation involving Resident #28 occurring on 3/15/21.  No further information regarding this issue was presented to the survey team prior to the exit conference on 6/10/21.  4. For Resident #53, the facility staff failed to investigate a resident to resident altercation occurring on 6/08/21.  Resident #53's diagnosis list indicated diagnoses,	A BUILDING  495133  B. WING  SUMMARY STATEMENT OF DEFICIENCIES  RECOULT FOR ILLE HIGHWAY  CHILHOWIE, VA 24319  SUMMARY STATEMENT OF DEFICIENCIES  REQUIATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 63 appropriate); f. Interview the resident's Attending Physician as needed to determine the resident during the period of the alleged incident; h. Interview the resident's roommate, family members, and Visitors; i. Interview other resident's to whom the accused employee provides care or services; and j. Review all events leading up to the alleged incident.  S. Upon conclusion of the investigation, the investigation on approved documentation to the Administrator.  On 6/10/21 at 4:45 pm, during a meeting with the administrator, administrator in training, DON, and ADON (assistant director of nursing) surveyor discussed the concern of the facility not investigating an incident of a resident to resident investigating an incident of a resident to resident investigating an incident of a resident to resident intercation involving Resident #28 occurring on 3/15/21.  No further information regarding this issue was presented to the survey team prior to the exit conference on 6/10/21.  4. For Resident #53, the facility staff failed to investigating an incident of a resident to resident investigate a resident to resident altercation occurring on 6/08/21.  Resident #53's diagnosis list indicated diagnoses,		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CON AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING				COMPLETED			
		495133	B. WING				, 10/2021
	ROVIDER OR SUPPLIER	JRSING CENTER		940 E	EET ADDRESS, CITY, STATE, ZIP CODE EAST LEE HIGHWAY LHOWIE, VA 24319		
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREF TAG	- 1	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	BE	(X5) COMPLETION DATE
F 610	Obstructive Pulmona Major Depressive Dis Unspecified, and Spi Unspecified.  The most recent quaset) with an ARD (as 4/13/21 assigned the interview for mental section C, Cognitive  On 6/08/21 at approx #2 observed Resider around the head and nursing assistant) #1 At 2:08 pm, this survand asked if Resider other resident when TCNA #1 stated yes with the back of the #1 also stated that the there" and saw it.  A nursing progress in (2:11 pm) states in p day with resident attresidents".  On 6/09/21 at 11:42 the administrator and discuss the facility p altercations. The Do altercations can be a asked if the facility sincidents) for reside the DON stated "if the administrator stated Surveyor spoke with set."	ry Disease Unspecified, sorder Recurrent nal Stenosis Site  rterly MDS (minimum data sessment reference date) of e resident a BIMS (brief status) score of 5 out of 15 in Patterns.  kimately 12:05 pm, surveyor nt #53 hit at another resident I TCNA (temporary certified separated the two residents. reyor spoke with TCNA #1 nt #53 made contact with the they hit at them earlier and the resident made contact other resident's head. TCNA ne nurse was "sitting right oted dated 6/08/21 14:11 art, "Behavior episodes this	F	610			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING	(X2) MULTIPLE CONSTRUCTION  A. BUILDING				
	495133	B. WING		00	C 6/10/2021		
NAME OF PROVIDER OR SUPPLIER  VALLEY REHABILITATION AND NUI	RSING CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE  940 EAST LEE HIGHWAY  CHILHOWIE, VA 24319					
PREFIX (EACH DEFICIENCY	REFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		PROVIDER'S PLF.N OF CORRECT (EACH CORRECTIVE ACTION SHOUND CROSS-REFERENCED TO THE APPRIDEFICIENCY)	JLD BE	(X5) COMPLETION DATE		
"it should have been dime. We will do educate needs to be done".  On 6/09/21 at 12:28 pile met with the survey teresident #53 swatted from behind them and the face.  Surveyor requested an policy entitled "Abuse Reporting" which state Policy Statement All reports of resident exploitation, misapproproperty, mistreatment source ("abuse") shall local, state and federa current regulations) and by facility management investigations will also Role of the Administrational to the Administrational for the Administrational for the Administrational for the Administrational formula for the Investigation individual.  Role of the Investigation individual contast a minimum:  a. Review the compute the residual formula for the Investigation as a minimum:  a. Review the residual formula for the Investigation as a minimum:  a. Review the compute for the Investigation as a minimum:  a. Review the compute for the Investigation as a minimum:  a. Review the compute for the Investigation as a minimum:  a. Review the compute for the Investigation as a minimum:  a. Review the compute for the Investigation as a minimum:  a. Review the compute for the Investigation as a minimum:  a. Review the compute for the Investigation as a minimum:  a. Review the compute for the Investigation as a minimum:  a. Interview the personal as a minimum as a	locumented and reported to tion on that and do what the many the DON and TCNA #1 and and TCNA #1 and TCNA #1 stated the other resident's hat off it was not a slap across and received the facility Investigation and the inpart:  abuse, neglect, oppriation of resident and/or injuries of unknown the promptly reported to all agencies (as defined by and thoroughly investigated int. Findings of abuse to be reported.  ator: spected incident of resident neglect or injury of ported, the Administrator will on to an appropriate or: ducting the investigation will, betted documentation forms; ent's medical record to ding up to the incident; son(s) reporting the incident; nesses to the incident;	F 610					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			ONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495133	B. WING			1	0 <b>10/2021</b>
	ROVIDER OR SUPPLIER			STR 940	EET ADDRESS, CITY, STATE, ZIP CODE EAST LEE HIGHWAY ILHOWIE, VA 24319		10/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAC		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(X5) COMPLETION DATE
F 610	f. Interview the res as needed to determ level of cognitive functio g. Interview staff m have had contact wit period of the alleged incident; h. Interview the res members, and visito i. Interview other reaccused employee p j. Review all events incident.  5. Upon conclusion of investigator will recoinvestigation on app	ident's Attending Physician ine the resident's current in and medical condition; embers (on all shifts) who in the resident during the ident's roommate, family residents to whom the rovides care or services; and is leading up to the alleged of the investigation, the	F	610			
F 684 SS=D	administrator, admin ADON (assistant direction discussed the concessive altercation involving)  No further information presented to the surconference on 6/10/Quality of Care CFR(s): 483.25  § 483.25 Quality of Quality of care is a fapplies to all treatment facility residents. Bar	dent of a resident to resident Resident #53. In regarding this issue was vey team prior to the exit 21.	F	<del>-</del> 684			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MUL		COMP	(X3) DATE SURVEY COMPLETED C		
		495133	B. WING		10		10/2021
NAME OF PE	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
		UDOING CENTER		94	940 EAST LEE HIGHWAY		
VALLEY R	EHABILITATION AND N	DRSING CENTER		С	CHILHOWIE, VA 24319		_
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	) BE	(X5) COMPLETION DATE
E 694	O ti d France man	- 67	_		Quality of Care  1. Address how corrective a	ction will	
F 684	accordance with prof practice, the comprel care plan, and the re This REQUIREMEN' by: Based on observation review of documents facility staff failed en- was provided for a si sampled residents (Find the findings included The facility staff failed received care/treatments to the medical provided	e treatment and care in fessional standards of hensive person-centered sidents' choices.  T is not met as evidenced ons, interviews, and the sure treatment and/or care kin tear for one (1) of 30 Resident #47).  d:  d to ensure Resident #47 lent for a skin tear according der's orders.	F	684	be accomplished for thos residents found to have be affected by the deficient process and orders for skin tear treat documentation completed with measurements are in place.  2. Address how the facility was other residents having the tobe affected by the same practice: All residents have to be affected.  3. Address what measures with the description of description/measurements, treatments reridered.	een ractice: ractice: ractice: ractice: ractice: ractice: ractice: ractice: racticy tment, rith rill identify repotential racticent repotential rill be put racticent	
	(ARD) of 4/8/21, was 4/9/21. Resident #47 being able to make susually being able to Resident #47's brief (BIMS) summary so out of 15. Resident requiring assistance dressing, toilet use, Resident #47's diaglimited to: anemia, hidementia, and lung on 6/9/21 at 09:50 a observed to have a their left lower leg. Tand was not initialed 6/9/21 at 10:13 a.m.	assessment reference date is signed as completed on it was assessed as usually self understood and as understand others. Interview for mental status ore was documented as 13 tata with bed mobility, transfers, and personal hygiene. In oses included, but were not ligh blood pressure, diabetes,			4. Indicate how the facility promitor its performance is sure that the solutions are sustained: Director of Nurse designee will randomly aud with any skin alterations we 4 weeks and monthly times completion documentation description of skin alteration measurements, orders for treatment, and treatment or ordered with dressing to be initialed by nurse upon cha Audit findings will be review in the quality assurance an performance improvement tracking/trending and any radditional interventions.  5. Include dates when the caction will be completed: completion: 8/5/21	o make  ing or  it Residents ekly times 2 for of complete empleted as dated and age. red monthly d process for ecessary  orrective	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			IPLE CONSTRU NG		(X3) DATE SURVEY COMPLETED			
		495133	B. WING_				C <b>06/10/2021</b>	
	ROVIDER OR SUPPLIER	JRSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 940 EAST LEE HIGHWAY CHILHOWIE, VA 24319				
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFII TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)			(X5) COMPLETION DATE
F 684	(registered nurse) #2 was neither dated no On 6/9/21 at 10:18 a. and wound to left, ou by NP (nurse practitic 10:28, NP #22 report wound was approxim unsure if the wound or reapproximated. The found in a note docur at 10:29 a.m.: "Din wound are as follows does not appear app appears stable." The found in a note docur at 11:16 a.m.: "Wour occurred from a traus report, patient picks a (their) diagnosis of de mental status. Appear skin/skin tear with no noted. Wound is state On 6/9/21 at 10:20 a present) was asked a aforementioned wou found a note dated 4 care but did not see related to wound can  Resident #47's docur note dated 4/7/21 at indicated the residen 4/7/21 while self tran This documentation	On 6/9/21 at 10:18 a.m., RN 1 confirmed the dressing r initialed.  m., Resident #47's dressing ter, lower leg was assessed oner) #22. On 6/9/21 at ed it did not appear as if the ated but indicated they were was able to be following information was mented by NP #22 on 6/9/21 mensions of left lower leg at 4x3x0.1 cm. Skin flap roximated today but wound following information was mented by NP #22 on 6/9/21 and appears to have possibly ma of the skin. Per staff at (their) skin often due to ementia/(their) altered ars to be a slight abrasion of a skin flap approximated one."  m., RN #23 (with RN #24 about documentation of the ind. RN #23 reported they /7/21 of the initial wound additional documentation e of this area.	F	584				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDI			COMPLETED		
		495133	B. WING				06/10/2021
	ROVIDER OR SUPPLIER  EHABILITATION AND	NURSING CENTER	_	940 E			
(X4) ID PREFIX TAG	REFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFI TAG		PROVIDER'S PLAN OF CORRE- (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 684	"dressing was reinf Resident #47's clin following medical p 4:44 p.m.: "May co as signed upon ad specified by physic  The following "stan document titled "Nt ORDERS": "Woun tear)[sic] Cle reapproximate skir steri-strips. Apply cover with dry dres rounds weekly." (F	stated Resident #47's orced (due to) bleeding."  ical record included the rovider order dated 8/16/19 at ontinue to use standing orders mission, unless otherwise	F	684			
	providing a descrip #47 received on 4/ provided to the surentered by NP #22 wound on 6/9/21). to address if the sl reapproximated at care. No document the skin tear had heneded at the time The following infor document titled "S Minor Breaks, Car September 2013): surrounding skin for tissue healing provided to the surrounding skin for tissue healing the surrounding	sessing the size of and stion of the skin tear Resident 7/21 was neither found by nor veyor (prior to documentation after being asked about the No documentation was found tin tear had been the time of the initial wound station was found to address if ad steri-strips applied or of the initial wound care.  mation was found in a facility kin Tears - Abrasions and e of' (with a revised date of " Assess the wound and or edema, redness, drainage, gress and wound stage dressing and secure with tape					

	NT OF DEFICIENCIES N OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION  A. BUILDING		COMPLETED		
		495133	B. WING _		C 06/10/2021
	ROVIDER OR SUPPLIER	JRSING CENTER	,	STREET ADDRESS, CITY, STATE, ZIP COE 940 EAST LEE HIGHWAY CHILHOWIE, VA 24319	DE
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	ON SHOULD BE COMPLETION DATE
F 684	or bordered dressing and initials to top of or the following information document titled "Dreservised date of September is a physician's (Note: This may be go	per order Label with date	F6	684	
F 842 SS=D	discussed during a s 6/9/21 at 5:19 p.m. T Director of Nursing () were present during issues related to Res was discussed: (a) measurements and/o (b) the absence of disteri-strips were nee to document dressin Resident Records - I CFR(s): 483.20(f)(5) §483.20(f)(5) Reside (i) A facility may not resident-identifiable (ii) The facility may resident-identifiable accordance with a cagrees not to use or except to the extent to do so.	or description of the skin tear, ocumentation addressing if ded or not, and (c) the failure g changes. dentifiable Information, 483.70(i)(1)-(5) Int-identifiable information. release information that is to the public. lelease information that is to an agent only in contract under which the agent disclose the information the facility itself is permitted	F	Resident Records - Identifia  1. Address how corrective accomplished for those to have been affected practice: Residents #90 in the facility. Facility not physician and residents parties regarding income documentation.  2. Address how the facility other residents having be affected by the same practice: All residents to be affected.	ve action will be se residents found by the deficient 2 and #142 remain otified attending s' responsible aplete

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
		495133	B. WING				C 1 <b>10/2021</b>	
	(EACH DEFICIENC		ID PREF TAG	94 CI	REET ADDRESS, CITY, STATE, ZIP CODE  10 EAST LEE HIGHWAY  HILHOWIE, VA 24319  PROVIDER'S PLAN OF CORRECTIC  (EACH CORRECTIVE ACTION SHOULD  CROSS-REFERENCED TO THE APPROPI	ON BE	(X5) COMPLETION DATE	
F 842	that are- (i) Complete; (ii) Accurately docum (iii) Readily accessib (iv) Systematically of §483.70(i)(2) The far all information contained regardless of the form records, except where (i) To the individual, representative where (ii) Required by Law (iii) For treatment, properations, as permit with 45 CFR 164.50 (iv) For public health reglect, or domestic activities, judicial are law enforcement purposes, research medical examiners, a serious threat to be a serious threat threa	nented; ole; and rganized cility must keep confidential tined in the resident's records, and or storage method of the en release istory their resident e permitted by applicable law; or; ayment, or health care itted by and in compliance los; activities, reporting of abuse, coviolence, health oversight adaministrative proceedings, purposes, or to coroners, funeral directors, and to avert health or safety as permitted the with 45 CFR 164.512.  Incility must safeguard medical against loss, destruction, or safety as retained the required by State law; or the date of discharge when ment in State law; or ears after a resident reaches	F	842	3. Address what measures will be place or systemic changes may ensure that the deficient pract not recur: Education with licens regarding completion of EMAR as progress note if indicated on EMAR as progress note if indicated on EMAR as progress note if indicated on EMAR as monitor its performance to may that the solutions are sustained Director of Nursing or designeer randomly audit EMARs of reside times 4 weeks and monthly time findings will be reviewed monthly quality assurance and performance improvement process for tracking and any necessary additional interventions.  5. Include dates when the correct action will be completed: Date compliance: 8/5/21	ice will ed nurses and AR. to ike sure ed: will ent weekly s 2. Audit y in the nce g/trending		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		LE CONSTRUCTION	COMPLETED
		495133	B. WING		C 06/10/2021
	ROVIDER OR SUPPLIER	NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 940 EAST LEE HIGHWAY CHILHOWIE, VA 24319	
(X4) ID PREFIX TAG	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE COMPLETION
F 842	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 72 (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review the facility document review the facility staff failed to ensure a complete and accurate clinical record for 2 of 30 residents, Residents #142 and #92.  The findings included:  1. For Resident #142 the facility staff failed to initial eMAR's (electronic medication administration record).  Resident #142's face sheet listed diagnoses which included, but not limited to dementia, depression, anxiety, insomnia, encephalopathy and constipation.  The most recent quarterly MDS (minimum data set) with an ARD (assessment reference date) of 05/27/21 assigned the resident a BIMS (brief interview for mental status) score of 9 out of 15 is section C, cognitive patterns.  Resident #142's clinical record was reviewed and contained a physician's order summary (POS) for		F 84		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL <sup>a</sup> A. BUILDI		(X3) DATE SURVEY COMPLETED			
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		495133	B. WING			06/10/2021		
NAME OF PROVIDER OR SUPPLIER				ST	REET ADDRESS, CITY, STATE, ZIP CODE			
				94	0 EAST LEE HIGHWAY			
VALLEY R	REHABILITATION AND N	URSING CENTER		CI	HILHOWIE, VA 24319			
	CUMMADVC	FATEMENT OF DEFICIENCIES	QI		PROVIDER'S PLAN OF CORRECTION		(X5)	
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	BE	COMPLETION DATE	
F 842	Continued From pag	e 73	l F	842				
	, ,	iprazole) Give 1 tablet by						
	mouth one time a da							
	1	ces", "Linzess Capsule 290						
	1	Give 1 capsule by mouth 1						
	, , ,	ritable bowel syndrome)",			6			
:	,	n urine for stone every shift						
	for Kidney stones inc	crease fluids strain urine for						
	stones", "Intrusive wa							
		unit in other residents rooms		i				
	, ,	any additional detail as						
		note)", "Pain score every						
		pain", "S/E (side effects)						
		RESSANTS-Observation and tential side effects: Nausea,						
		nd weight gain, Fatigue and						
		a, Dry mouth, Blurred vision,		ļ				
		ess, Agitation, Irritability,						
	Anxiety every shift re		F.					
	RECURRENT DEPF	RESSIVE DISORDERS						
	(Provide any addition	nal detail in progress notes)"						
	and "S/E							
		CHOTICS-Observation and						
		otential side effects: Blurred						
		rowsiness, Muscle spasms						
		ain, Tardive dyskinesia every		-				
	note)".	dditional detail in progress						
	note) .				3			
	Resident #142's eM	AR's for the month of May						
		contained entries as above.						
	The entry for Abilify	was coded as "9" on						
		21, and 05/08-09/21. The						
	entry for Linzess wa							
		06/21 and 05/11/21. Chart						
		nt to "other/see nurses notes".			**			
		se's notes were reviewed and			19			
		ed notes. The other entries						
	and 05/30/21, day s	n 05/15-16/21, evening shift hift.						

AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDII			COMPLETED		
		495133	B. WING_	B. WING			C <b>06/10/2021</b>
NAME OF PROVIDER OR SUPPLIER  VALLEY REHABILITATION AND NURSING CENTER			,	STR 940 CH	-		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI) TAG	(	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APPI DEFICIENCY)	DULD BE	(X5) COMPLETION DATE
F 842	Surveyor asked DON note for the coding of stated that there show a note there is no was medication was giver that blanks on the eM The concern of the inthe eMAR's was discrete (administrator, DON, ADON (assista 06/10/21 at approxim). No further information 2. For Resident #92 the ensure eMAR's (elect administration record Resident #92's faced.	the DON (director of at approximately 1:30 pm. if there should have been a region on the eMAR and DON ald have been, because with your to determine if the nor not. DON also stated IAR are "uncalled for".  Incomplete documentation of assed with the administrative administrator in training, and director of nursing) on ately 4:30 pm.  In was provided prior to exit.  The facility staff failed to tronic medication  In were complete.	F	342		2	
-	convulsions, anemia, and chronic pain.  The most recent sign (minimum data set) wireference date) of 05 a BIMS (brief intervie 0 out of 15 in section indicates the residen Resident #92's clinic physician's order sur	y disease, psychosis, dementia, hypertension, ificant change MDS th an ARD (assessment /06/21 assigned the resident w for mental status) score of C, cognitive patterns. This t is not cognitively intact.					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF A. BUILDING	PLE CONSTRUCTION  G	COMPLE	COMPLETED	
		495133	B. WING		06/10	0/2021	
NAME OF PROVIDER OR SUPPLIER  VALLEY REHABILITATION AND NURSING CENTER			Α (	STREET ADDRESS, CITY, STATE, ZIP CODE 940 EAST LEE HIGHWAY CHILHOWIE, VA 24319			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 842	D (dinner) trays -star "Fall mat every shift of FRACTURE OF RIGENTCOUNTER FOR WITH ROUTINE HEAD EVERY Shift related to OF RIGHT FEMUR, ENTCOUNTER FOR WITH ROUTINE HEAD Shiftevery shift for attempting to hit staff (Provide any addition progress note)", "Rais shift related to UNSFRIGHT FEMUR, SUBFOR CLOSED FRACE HEALING", "S/E (sict Tracking-ANTIPSYCE) documentation of povision, Dry mouth, Dor tremors, Weight granift (Provide details)  Resident #92's eMA 2021 were reviewed above. The entry for initialed on 05/06/21 and 05/24/21 at 5 pm initialed on 05/15/21, day shift.  Surveyor spoke with nursing) on 06/10/21 regarding the eMAR stated that blanks or	vention-w (with)/ L (lunch) & t date- 05/08/2021 1200", related to UNSPECIFIED HT FEMUR, SUBSEQUENT CLOSED FRACTURE ALING", "Monitor for pain UNSPECIFIED FRACTURE SUBSEQUENT CLOSED FRACTURE ALING", "Pain Score every pain", "Physically abusive: f while providing every shift had detail as needed in itsed edge mattress every PECIFIED FRACTURE OF BSEQUENT ENTCOUNTER CTURE WITH ROUTINE DE effects) "HOTICS-Observation and tential side effects: Blurred rowsiness, Muscle spasms ain, Tardive dyskinesia every	F 84	42			
	for".  The concern of the in	ncomplete documentation of					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED C	
		495133	B. WING	B. WING			10/2021
NAME OF PROVIDER OR SUPPLIER  VALLEY REHABILITATION AND NURSING CENTER				940 EAST LE	RESS, CITY, STATE, ZIP CODE EE HIGHWAY E, VA 24319	•	s
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PROVIDER'S PLAN OF CORREC' PREFIX (EACH CORRECTIVE ACTION SHOUL TAG CROSS-REFERENCED TO THE APPRO DEFICIENCY)		BE	(X5) COMPLETION DATE
F 842	the eMAR's was disc team (administrator, DON, ADON (assista 06/10/21 at approxim	ussed with the administrative administrator in training, ant director of nursing) on	F	842			
8							