STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495367	A. BUILDING _____ B. WING _____	04/29/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHAMPTON CONVALESCENT AND REHABILITATION CENTER	1028 TOPPING LANE HAMPTON, VA 23666

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 04/27/21 through 04/29/21. Corrections are required for compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities. No Emergency Preparedness complaints were investigated during the survey.	E 000		
E 036 SS=F	EP Training and Testing CFR(s): 483.73(d) §403.748(d), §416.54(d), §418.113(d), §441.184(d), §460.84(d), §482.15(d), §483.73(d), §483.475(d), §484.102(d), §485.68(d), §485.625(d), §485.727(d), §485.920(d), §486.360(d), §491.12(d), §494.62(d). *[For RNCHIs at §403.748, ASCs at §416.54, Hospice at §418.113, PRTFs at §441.184, PACE at §460.84, Hospitals at §482.15, HHAs at §484.102, CORFs at §485.68, CAHs at §486.625, "Organizations" under 485.727, CMHCs at §485.920, OPOs at §486.360, and RHC/FHQs at §491.12:] (d) Training and testing. The [facility] must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years. *[For LTC facilities at §483.73(d):] (d) Training and testing. The LTC facility must develop and maintain an emergency preparedness training and testing program that is based on the	E 036		6/10/21

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

Electronically Signed | 05/28/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495367	A. BUILDING _____ B. WING _____	04/29/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHAMPTON CONVALESCENT AND REHABILITATION CENTER	1028 TOPPING LANE HAMPTON, VA 23666

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 036	Continued From page 1 emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually. *[For ICF/IIDs at §483.475(d):] Training and testing. The ICF/IID must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years. The ICF/IID must meet the requirements for evacuation drills and training at §483.470(i). *[For ESRD Facilities at §494.62(d):] Training, testing, and orientation. The dialysis facility must develop and maintain an emergency preparedness training, testing and patient orientation program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training, testing and orientation program must be evaluated and updated at every 2 years. This REQUIREMENT is not met as evidenced by: Based on facility document review and staff interviews the facility staff failed to annually review and update emergency preparedness	E 036	This plan of correction is respectfully submitted as evidence of alleged compliance. The submission is not an	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495367	A. BUILDING _____ B. WING _____	04/29/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHAMPTON CONVALESCENT AND REHABILITATION CENTER	1028 TOPPING LANE HAMPTON, VA 23666

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 036	Continued From page 2 training and testing after an annual full-scale community or facility based emergency preparedness exercise. The findings included: On 4/27/21 the facility Emergency Preparedness Plan was reviewed. The Administrator was asked for the annual full-scale community based exercise or the facility based exercise that was last completed. The Administrator provided documentation to support that a facility table top exercise and analysis was completed on 3/5/2020 titled Epidemic Infectious Disease Outbreak. On 4/27/21 at 7:13 P.M. during an email correspondence the Administrator was asked the following, "How and when is emergency preparedness training material updated prior to the staff training? Also when does the staff emergency preparedness training occur yearly?" The Administrator replied, "The training material is reviewed and updated annually and reviewed by the Quality Assurance and Review Committee or as needed for any new updates or changes. Training occurs once approved by the committee and throughout the year." On 4/28/21 at 12:20 P.M. a phone interview was conducted with the Administrator regarding the facility table top exercise that was completed on 3/5/2020 and if there had been an emergency preparedness exercise since then. The Administrator stated."No not yet, but we have one planned to do next month." The Administrator was also asked if the last exercise was done on 3/5/20 when should the annual one have been completed by and what happens after you complete a facility emergency preparedness	E 036	admission that the deficiencies existed or that we are in agreement with them. It is an affirmation that corrections to the areas F5505 have been made and the facility is in compliance with participation requirements. The date of completion serves as my allegation of compliance. 1.) On April 30, 2021, the facility completed a facility-based table top exercise on an active shooter scenario and completed an after action report. 2.) The annual completion of this emergency preparedness exercise, helps maintain the safety of all residents by ensuring staff members know how to handle emergency situations. 3.) The Administrator/designee will in-service staff on emergency preparedness, to include the annual facility table top exercise that occurred on April 30, 2021 4) The Administrator /designee will implement the emergency preparedness program checklist to ensure all the training and exercises have been conducted per guidance. This will include an annual review of the emergency preparedness program. The Administrator/designee will review the audit results for any patterns or trends and report any findings to our Quality Assurance Performance Improvement	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495367	A. BUILDING _____ B. WING _____	04/29/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHAMPTON CONVALESCENT AND REHABILITATION CENTER	1028 TOPPING LANE HAMPTON, VA 23666

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 036	Continued From page 3 exercise. The Administrator stated, "It should have been completed by March 5, 2021 and I would do the analysis and update the training program." The facility policy titled "Emergency Management Plan" last reviewed 9/19/20 was reviewed and is documented in part, as follows: Policy and Organizational Statements: This plan will be reviewed and updated on an annual basis, and the Administrator will be assigned this responsibility. Should there be significant revisions to the plan, all staff will be trained regarding the revisions. An "Annual Review and Analysis" will take place. The facility response to each exercise will be documented to capture lessons learned, opportunities for plan and procedure improvements, and to evaluate staff knowledge and response. Prior to exit no further information was shared.	E 036	Committee 5.) June 10, 2021	
E 039 SS=F	EP Testing Requirements CFR(s): 483.73(d)(2) §416.54(d)(2), §418.113(d)(2), §441.184(d)(2), §460.84(d)(2), §482.15(d)(2), §483.73(d)(2), §483.475(d)(2), §484.102(d)(2), §485.68(d)(2), §485.625(d)(2), §485.727(d)(2), §485.920(d)(2), §491.12(d)(2), §494.62(d)(2). *[For ASCs at §416.54, CORFs at §485.68, OPO, "Organizations" under §485.727, CMHCs at §485.920, RHCs/FQHCs at §491.12, and ESRD Facilities at §494.62]:	E 039		6/10/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495367	A. BUILDING _____ B. WING _____	04/29/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHAMPTON CONVALESCENT AND REHABILITATION CENTER	1028 TOPPING LANE HAMPTON, VA 23666

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 039	Continued From page 4	E 039		

(2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following:

(i) Participate in a full-scale exercise that is community-based every 2 years; or
(A) When a community-based exercise is not accessible, conduct a facility-based functional exercise every 2 years; or
(B) If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required community-based or individual, facility-based functional exercise following the onset of the actual event.
(ii) Conduct an additional exercise at least every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following:
(A) A second full-scale exercise that is community-based or individual, facility-based functional exercise; or
(B) A mock disaster drill; or
(C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.
(iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed.

*[For Hospices at 418.113(d):]

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495367	A. BUILDING _____ B. WING _____	04/29/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHAMPTON CONVALESCENT AND REHABILITATION CENTER	1028 TOPPING LANE HAMPTON, VA 23666

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 039	Continued From page 5 (2) Testing for hospices that provide care in the patient's home. The hospice must conduct exercises to test the emergency plan at least annually. The hospice must do the following: (i) Participate in a full-scale exercise that is community based every 2 years; or (A) When a community based exercise is not accessible, conduct an individual facility based functional exercise every 2 years; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospital is exempt from engaging in its next required full scale community-based exercise or individual facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (3) Testing for hospices that provide inpatient care directly. The hospice must conduct exercises to test the emergency plan twice per year. The hospice must do the following: (i) Participate in an annual full-scale exercise that is community-based; or	E 039		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495367	A. BUILDING _____ B. WING _____	04/29/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHAMPTON CONVALESCENT AND REHABILITATION CENTER	1028 TOPPING LANE HAMPTON, VA 23666

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 039	Continued From page 6 (A) When a community-based exercise is not accessible, conduct an annual individual facility-based functional exercise; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospice is exempt from engaging in its next required full-scale community based or facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop led by a facilitator that includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the hospice's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the hospice's emergency plan, as needed. *[For PRFTs at §441.184(d), Hospitals at §482.15(d), CAHs at §485.625(d):] (2) Testing. The [PRTF, Hospital, CAH] must conduct exercises to test the emergency plan twice per year. The [PRTF, Hospital, CAH] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or	E 039		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495367	A. BUILDING _____ B. WING _____	04/29/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHAMPTON CONVALESCENT AND REHABILITATION CENTER	1028 TOPPING LANE HAMPTON, VA 23666

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 039	Continued From page 7 (B) If the [PRTF, Hospital, CAH] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an [additional] annual exercise or and that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the [facility's] emergency plan, as needed. *[For PACE at §460.84(d):] (2) Testing. The PACE organization must conduct exercises to test the emergency plan at least annually. The PACE organization must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the PACE experiences an actual natural or man-made emergency that requires activation of	E 039		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495367	A. BUILDING _____ B. WING _____	04/29/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHAMPTON CONVALESCENT AND REHABILITATION CENTER	1028 TOPPING LANE HAMPTON, VA 23666

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 039	Continued From page 8	E 039		

the emergency plan, the PACE is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event.

(ii) Conduct an additional exercise every 2 years opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted that may include, but is not limited to the following:
(A) A second full-scale exercise that is community-based or individual, a facility based functional exercise; or
(B) A mock disaster drill; or
(C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.
(iii) Analyze the PACE's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the PACE's emergency plan, as needed.

*[For LTC Facilities at §483.73(d):]
(2) The [LTC facility] must conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The [LTC facility, ICF/IID] must do the following:
(i) Participate in an annual full-scale exercise that is community-based; or
(A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise.
(B) If the [LTC facility] facility experiences an actual natural or man-made emergency that

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495367	A. BUILDING _____ B. WING _____	04/29/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHAMPTON CONVALESCENT AND REHABILITATION CENTER	1028 TOPPING LANE HAMPTON, VA 23666

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 039	Continued From page 9 requires activation of the emergency plan, the LTC facility is exempt from engaging its next required a full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [LTC facility] facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [LTC facility] facility's emergency plan, as needed. *[For ICF/IIDs at §483.475(d)]: (2) Testing. The ICF/IID must conduct exercises to test the emergency plan at least twice per year. The ICF/IID must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or. (B) If the ICF/IID experiences an actual natural or man-made emergency that requires activation of the emergency plan, the ICF/IID is exempt from engaging in its next required full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event.	E 039		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495367	A. BUILDING _____ B. WING _____	04/29/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHAMPTON CONVALESCENT AND REHABILITATION CENTER	1028 TOPPING LANE HAMPTON, VA 23666

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 039	Continued From page 10	E 039		

(ii) Conduct an additional annual exercise that may include, but is not limited to the following:
(A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or
(B) A mock disaster drill; or
(C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.
(iii) Analyze the ICF/IID's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IID's emergency plan, as needed.

*[For HHAs at §484.102]
(d)(2) Testing. The HHA must conduct exercises to test the emergency plan at least annually. The HHA must do the following:
(i) Participate in a full-scale exercise that is community-based; or

(A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise every 2 years; or.

(B) If the HHA experiences an actual natural or man-made emergency that requires activation of the emergency plan, the HHA is exempt from engaging in its next required full-scale community-based or individual, facility based functional exercise following the onset of the emergency event.
(ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495367	A. BUILDING _____ B. WING _____	04/29/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHAMPTON CONVALESCENT AND REHABILITATION CENTER	1028 TOPPING LANE HAMPTON, VA 23666

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 039	Continued From page 11	E 039		

limited to the following:

(A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or

(B) A mock disaster drill; or

(C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.

(iii) Analyze the HHA's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the HHA's emergency plan, as needed.

*[For OPOs at §486.360]

(d)(2) Testing. The OPO must conduct exercises to test the emergency plan. The OPO must do the following:

(i) Conduct a paper-based, tabletop exercise or workshop at least annually. A tabletop exercise is led by a facilitator and includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. If the OPO experiences an actual natural or man-made emergency that requires activation of the emergency plan, the OPO is exempt from engaging in its next required testing exercise following the onset of the emergency event.

(ii) Analyze the OPO's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495367	A. BUILDING _____ B. WING _____	04/29/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHAMPTON CONVALESCENT AND REHABILITATION CENTER	1028 TOPPING LANE HAMPTON, VA 23666

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 039	Continued From page 12 *[RNCHIs at §403.748]: (d)(2) Testing. The RNHCI must conduct exercises to test the emergency plan. The RNHCI must do the following: (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (ii) Analyze the RNHCI's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the RNHCI's emergency plan, as needed. This REQUIREMENT is not met as evidenced by: Based on facility document review and staff interviews the facility staff failed to ensure a full-scale community or facility based emergency preparedness exercise was completed and analyzed annually. The findings included: On 4/27/21 the facility Emergency Preparedness Plan was reviewed. The Administrator was asked for the annual full-scale community based exercise or the facility based exercise that was last completed. The Administrator provided documentation to support that a facility table top exercise was completed on 3/5/2020 titled Epidemic Infectious Disease Outbreak. On 4/28/21 at 12:20 P.M. a phone interview was conducted with the Administrator regarding the facility table top exercise that was completed on 3/5/2020 and if there had been an emergency preparedness exercise since then. The	E 039	The date of completion serves as my allegation of compliance. 1.) On April 30, 2021, the facility completed a facility-based table top exercise on an active shooter scenario and completed an after-action report. 2.) The annual completion of this emergency preparedness exercise, helps maintain the safety of all residents by ensuring staff members know how to handle emergency situations. 3.) The Administrator/designee will in-service staff on emergency preparedness, to include the annual facility table top exercise that occurred on April 30, 2021. 4) The Administrator /designee will	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495367	A. BUILDING _____ B. WING _____	04/29/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHAMPTON CONVALESCENT AND REHABILITATION CENTER	1028 TOPPING LANE HAMPTON, VA 23666

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 039	Continued From page 13 Administrator stated."No not yet, but we have one planned to do next month. The previous administrator left in the middle of March and I started on April 12th. The interim administrator between the previous administrator and myself was our Vice President of Operations." The Administrator was also asked if the last exercise was done on 3/5/20 when should the annual one have been completed by and what happens after you complete a facility emergency preparedness exercise. The Administrator stated, "It should have been completed by March 5, 2021 and I would do the analysis and update the training program." On 4/28/21 at 1:12 P.M. a phone interview was conducted with the Vice President of Operations. The Vice President of Operations was asked if he had completed a emergency preparedness exercise while he was the facility's interim administrator in march of this year, The Vice President of Operations stated, "No, I did not. I'm also new to the company. I started on March 1st and I was only the interim administrator for about a month. We do have a emergency preparedness exercise setup for May 6th." The facility policy titled "Emergency Management Plan" last reviewed 9/19/20 was reviewed and is documented in part, as follows: Policy and Organizational Statements: This plan will be reviewed and updated on an annual basis, and the Administrator will be assigned this responsibility. Should there be significant revisions to the plan, all staff will be trained regarding the revisions. An "Annual Review and Analysis" will take place.	E 039	implement the emergency preparedness program checklist to ensure all the training and exercises have been conducted per regulatory guidance. This will include an annual review of the emergency preparedness program. The Administrator/designee will review the audit results for any patterns or trends and report any findings to our Quality Assurance Performance Improvement Committee 5.) June 10, 2021	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495367	A. BUILDING _____ B. WING _____	04/29/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHAMPTON CONVALESCENT AND REHABILITATION CENTER	1028 TOPPING LANE HAMPTON, VA 23666

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 039	Continued From page 14 Annual Testing: The facility will conduct annual testing of the Emergency Preparedness through exercises as follows: The facility will conduct two separate exercises on an annual basis. One of these exercises will be a community based full scale exercise (when available) and the second may be a tabletop of similar exercise. The facility response to each exercise will be documented to capture lessons learned, opportunities for plan and procedure improvements, and to evaluate staff knowledge and response. Prior to exit no further information was shared.	E 039		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 4/27/21 through 4/29/21. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. No complaints were investigated during the survey. The census in this 70 certified bed facility was 62 at the time of the survey. The survey sample consisted of 28 current Resident reviews and closed record reviews	F 000		
F 574 SS=D	Required Notices and Contact Information CFR(s): 483.10(g)(4)(i)-(vi) §483.10(g)(4) The resident has the right to receive notices orally (meaning spoken) and in writing (including Braille) in a format and a	F 574		6/10/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495367	A. BUILDING _____ B. WING _____	04/29/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHAMPTON CONVALESCENT AND REHABILITATION CENTER	1028 TOPPING LANE HAMPTON, VA 23666

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 574	Continued From page 15	F 574		

language he or she understands, including:
(i) Required notices as specified in this section. The facility must furnish to each resident a written description of legal rights which includes -
(A) A description of the manner of protecting personal funds, under paragraph (f)(10) of this section;
(B) A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment of resources under section 1924(c) of the Social Security Act.
(C) A list of names, addresses (mailing and email), and telephone numbers of all pertinent State regulatory and informational agencies, resident advocacy groups such as the State Survey Agency, the State licensure office, the State Long-Term Care Ombudsman program, the protection and advocacy agency, adult protective services where state law provides for jurisdiction in long-term care facilities, the local contact agency for information about returning to the community and the Medicaid Fraud Control Unit; and
(D) A statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, non-compliance with the advance directives requirements and requests for information regarding returning to the community.
(ii) Information and contact information for State and local advocacy organizations including but not limited to the State Survey Agency, the State Long-Term Care Ombudsman program (established under section 712 of the Older

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495367	A. BUILDING _____ B. WING _____	04/29/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHAMPTON CONVALESCENT AND REHABILITATION CENTER	1028 TOPPING LANE HAMPTON, VA 23666

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 574	Continued From page 16 Americans Act of 1965, as amended 2016 (42 U.S.C. 3001 et seq) and the protection and advocacy system (as designated by the state, and as established under the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (42 U.S.C. 15001 et seq.) (iii) Information regarding Medicare and Medicaid eligibility and coverage; (iv) Contact information for the Aging and Disability Resource Center (established under Section 202(a)(20)(B)(iii) of the Older Americans Act); or other No Wrong Door Program; (v) Contact information for the Medicaid Fraud Control Unit; and (vi) Information and contact information for filing grievances or complaints concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, non-compliance with the advance directives requirements and requests for information regarding returning to the community. This REQUIREMENT is not met as evidenced by: Based on staff interview and resident interviews the facility staff failed to ensure residents were informed of their rights and given information on how to formally complain to the State Agency and informational agencies about the care they are receiving and ensure residents were educated on where the Ombudsman contact information was posted. The findings included: On 04/28/2021 at approximately 11:00 a.m., a Resident Group Meeting was held with 5 cognitively intact residents present. When asked	F 574	The date of completion serves as my allegation of compliance. 1. Resident rights, grievance process and information for local and state ombudsman were reviewed with the 5 residents who participated in the Resident Group Meeting on 4/28/21. 2. Grievance process and resident rights to be reviewed with all residents.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495367	A. BUILDING _____ B. WING _____	04/29/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHAMPTON CONVALESCENT AND REHABILITATION CENTER	1028 TOPPING LANE HAMPTON, VA 23666

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 574	Continued From page 17 if they knew where the Ombudsman contact information was posted in the facility, the residents responded, "No, what is a Ombudsman?" When asked if they were informed of their rights, and given information on how to formally complain to the State Agency if they have a concern about the care they are receiving, the residents stated, "No." On 04/28/2021 at approximately 12:00 p.m., an interview was conducted with Director of Activities. When asked was contact information for the Ombudsman and location of where it is posted reviewed with the residents, Director of Activities stated, "No, I haven't done that. I will do that at the next Resident Council Meeting." When asked have the residents been informed of their rights and given information on how to formally complain to the State Agency if they have a concern about the care they are receiving, Director of Activities stated, "No." Director of Activities stated, "I did give out Resident Rights to the residents last month." When asked do residents get a copy of Resident Rights on admission, Director of Activities stated, "No." The Director of Activities stated, "I will type up and pass out to all residents how to contact the State Agency, how to make a complaint to the State Agency and who the Grievance Official is in the facility. I am going to ask (Ombudsman Name) to come in and talk with the residents and explain her role." On 04/29/2021 a copy of the facility policy on Resident Rights was requested and received. The Administrator and Director of Nursing was made aware of the finding at the pre-exit meeting on 04/29/2021 at approximately 6:00 p.m. No	F 574	3. Director of Counseling and Support Services/ designee will educate administration, social work and activities on importance of informing residents of their rights and give information on how to formally complain to the State Agency and information agencies about the care they are receiving and ensure resident are educated on where Ombudsman contact information is posted. Will educate on importance of reviewing rights and grievance process during each facility resident council meeting. 4. Assistant Administrator/designee will conduct an audit consisting of 20% of new admissions to ensure residents were provided with information on their rights, how to formally complain to the state and where Ombudsman contact information is located. 5. June 10, 2021	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495367	A. BUILDING _____ B. WING _____	04/29/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHAMPTON CONVALESCENT AND REHABILITATION CENTER	1028 TOPPING LANE HAMPTON, VA 23666

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 574	Continued From page 18	F 574		

further information was provided about the finding.

Policy: Virginia Health Services Resident Rights Policy
Reviewed/Revised 9/3/03

F156 Notice of rights. Prior to or upon admission and during the resident's stay, the facility will inform the resident orally and in writing of his/her rights and all rules and regulations governing resident conduct and responsibilities during his/her stay in the facility. This shall be done in a language the resident can understand. The resident's authorized representative or a family member may interpret this information to a resident before he/she signs a receipt acknowledgement that the information has been received. All resident's rights under state law shall be included in this notice.

A signed receipt for this information, and any amendments to it, will be filed in the resident's records.

Resident rights will be reviewed with residents during resident council, with residents individually, or with resident's responsible party annually.

F156 Posting of names, addresses and telephone numbers. The names, addresses and telephone numbers of the State survey and certification agency, the State licensure office, the State Ombudsman program, the protection and advocacy network and the Medicaid fraud control unit are posted prominently in the facility. This posting includes a statement that the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495367	A. BUILDING _____ B. WING _____	04/29/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHAMPTON CONVALESCENT AND REHABILITATION CENTER	1028 TOPPING LANE HAMPTON, VA 23666

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 574	Continued From page 19 resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect or misappropriation of resident property in the facility.	F 574		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the	F 578		6/10/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495367	A. BUILDING _____ B. WING _____	04/29/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHAMPTON CONVALESCENT AND REHABILITATION CENTER	1028 TOPPING LANE HAMPTON, VA 23666

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 578	Continued From page 20 individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff interviews and facility documentation review, the facility staff failed to ensure 1 of 28 residents (Resident #53) in the survey sample was given the opportunity to formulate an Advance Directive. The findings included: Resident #53 was originally admitted to the nursing facility on 12/16/20. Diagnosis for Resident #53 included but not limited to Heart Failure. Resident #53's Minimum Data Set (MDS-an assessment protocol) a quarterly assessment with an Assessment Reference Date of 04/16/21 coded a 15 out of a possible score of 15 on the Brief Interview for Mental Status (BIMS), indicating no impaired cognitive skills for daily decision-making. Review of Resident #53's Physician Order Sheet (POS) for April 2021 revealed the following order with a start date of 01/22/21: Do Not Resuscitate (DNR.) The review of Resident #53's clinical record did not show evidence of an Advance Directive. On 04/29/21 at approximately 9:38 a.m., a phone interview was conducted with the Social Worker	F 578	The date of completion serves as my allegation of compliance. 1. Staff spoke with resident #53 on 4/29/21 to confirm directive, POST form completed to ensure clear documentation of resident wishes. 2. Social Worker/ designee completed facility wide audit to ensure advanced care planning has been reviewed with each resident and/or representative and documented in the medical record. 3. Provide education on how to promote appropriate conversation and provide education to residents and representatives. Initiate check list as a reminder to address advanced care planning and complete Advanced Care Planning form for each new admit, with comprehensive MDS and with any change in condition. Update nursing admission assessment to include code status review.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495367	A. BUILDING _____ B. WING _____	04/29/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHAMPTON CONVALESCENT AND REHABILITATION CENTER	1028 TOPPING LANE HAMPTON, VA 23666

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 578	Continued From page 21 (SW) and Corporate support. When asked, if Resident #53 had an Advance Directive, the SW replied, "Not on paper." Corporate said when Resident #53 transitioned from the hospital, to this facility, to another facility and back here, Resident #53's Advance Directive got lost in the mix. Corporate stated, "We did not follow our own process, we should have ensured education was provided, discussing risk vs. benefits for having an Advance Directive." Corporate said an Advance Directive should have been reviewed and discussed within 2-3 days after his first admission. When asked if Resident #53 was given the opportunity to formulate an Advance Directive, they replied, "No." The facility provided the following document for Resident #53: Advance Care Planning with an assessment date of 04/27/21, that read in part: Residents and/or their responsible health care decision makers should be provided the opportunity to discuss advance care planning with appropriate staff members and medical providers within the first few days of admission to the facility, at times of change in condition, and periodically for routine updating of care plans. The facility's Administration team was informed of the finding during a debriefing on 04/29/21 at approximately 6:00 p.m. The facility staff did not present any further information about the findings. The facility's policy titled Advance Directives with a review/revised date (04/28/21) included but not limited to: Policy: Advance Directives will be discussed with resident and/or family member upon admission or as soon as clinically appropriate so the resident's wished, with respect to life prolonging treatments,	F 578	4. The Administrator/Designee will conduct a weekly review of clinical record for all new admits for 6 weeks to ensure completion of the advance directive assessment form. Any issue noted will be corrected immediately and trends will be reported to our Quality Assurance and Performance Improvement Committee at least quarterly 5. June 10, 2021	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495367	A. BUILDING _____ B. WING _____	04/29/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHAMPTON CONVALESCENT AND REHABILITATION CENTER	1028 TOPPING LANE HAMPTON, VA 23666

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 578	Continued From page 22 can be documented in the medical record.	F 578		
F 585 SS=D	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance	F 585		6/10/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495367	A. BUILDING _____ B. WING _____	04/29/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHAMPTON CONVALESCENT AND REHABILITATION CENTER	1028 TOPPING LANE HAMPTON, VA 23666

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 585	Continued From page 23	F 585		

can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system;
(ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations;
(iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated;
(iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law;
(v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495367	A. BUILDING _____ B. WING _____	04/29/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHAMPTON CONVALESCENT AND REHABILITATION CENTER	1028 TOPPING LANE HAMPTON, VA 23666

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 585	Continued From page 24 regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on staff interview and resident interviews the facility staff failed to ensure residents were informed on how to file a grievance. The findings included: On 04/28/2021 at approximately 11:00 a.m., a Resident Group Meeting was held with 5 cognitively intact residents present. When asked if they had been told how to file a grievance, the residents stated, "No." An interview was conducted with the Director of Activities on 04/28/2021 at approximately 12:00 p.m. When asked have the residents been informed on how to file a grievance, the Director of Activities stated, "No, have not discussed that with them. Planning to ask the ADON (Assistant Director of Nursing) to go over grievance procedure." When asked should the residents	F 585	The date of completion serves as my allegation of compliance. 1. Resident rights, grievance process and information for local and state ombudsman were reviewed with the 5 residents who participated in the Resident Group Meeting on 4/28/21. 2. Grievance process and resident rights to be reviewed with all residents. 3. Director of Counseling and Support Services/ designee will educate administration, social work and activities on importance of informing residents of their rights and give information on how to	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495367	A. BUILDING _____ B. WING _____	04/29/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHAMPTON CONVALESCENT AND REHABILITATION CENTER	1028 TOPPING LANE HAMPTON, VA 23666

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 585	Continued From page 25 have been informed on how to file a grievance, Director of Activities stated, "Yes Ma'am." On 04/29/2021 a copy of the facility policy on Resident Rights was requested and received. The Administrator and Director of Nursing was made aware of the finding at the pre-exit meeting on 04/29/2021 at approximately 6:00 p.m. No further information was provided about the finding. Policy: Virginia Health Services Resident Rights Policy F156 Notice of rights. Prior to or upon admission and during the resident's stay, the facility will inform the resident orally and in writing of his/her rights and all rules and regulations governing resident conduct and responsibilities during his/her stay in the facility. This shall be done in a language the resident can understand. The resident's authorized representative or a family member may interpret this information to a resident before he/she signs a receipt acknowledgement that the information has been received. All resident's rights under state law shall be included in this notice. A signed receipt for this information, and any amendments to it, will be filed in the resident's records. Resident rights will be reviewed with residents during resident council, with residents individually, or with resident's responsible party annually.	F 585	formally complain to the State Agency and information agencies about the care they are receiving and ensure resident are educated on where Ombudsman contact information is posted. Will educate on importance of reviewing rights and grievance process during each facility resident council meeting. 4. Assistant Administrator/ designee will conduct an audit consisting of 20% of new admissions to ensure residents were provided with information on their rights, how to formally complain to the state and where Ombudsman contact information is located. 5. June 10, 2021	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495367	A. BUILDING _____ B. WING _____	04/29/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHAMPTON CONVALESCENT AND REHABILITATION CENTER	1028 TOPPING LANE HAMPTON, VA 23666

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 585	Continued From page 26 F165 Grievances. Residents may voice grievances without discrimination or reprisal from the facility. F166 A prompt investigation and resolution will be made for all grievances residents may have. Grievances include those related to treatment furnished, treatment that has not been furnished and behavior of other residents. Grievances may be oral or written.	F 585		
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when-	F 623		6/10/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495367	A. BUILDING _____ B. WING _____	04/29/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHAMPTON CONVALESCENT AND REHABILITATION CENTER	1028 TOPPING LANE HAMPTON, VA 23666

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 623	Continued From page 27	F 623		

(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;
(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;
(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;
(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30 days.

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:
(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged;
(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;
(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495367	A. BUILDING _____ B. WING _____	04/29/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHAMPTON CONVALESCENT AND REHABILITATION CENTER	1028 TOPPING LANE HAMPTON, VA 23666

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 623	Continued From page 28 C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility staff failed to send a notice of discharge to the Ombudsman for 1 resident (Resident #55) in the survey sample of 28 residents. The findings included: Resident #55 was admitted to the facility on 02/02/21 with diagnoses which included sepsis,	F 623	The date of completion serves as my allegation of compliance. 1.) On 4/27/2021, the Ombudsman was notified of R55's transfer to the hospital on 02/05/2021. 2.) On 4/27/2021, the Ombudsman was notified on all transfer & discharges from	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495367	A. BUILDING _____ B. WING _____	04/29/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHAMPTON CONVALESCENT AND REHABILITATION CENTER	1028 TOPPING LANE HAMPTON, VA 23666

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 623	Continued From page 29 hypothyroidism, vascular dementia without behavioral disturbance, hypertension, chronic atrial fibrillation, congestive heart failure, COVID-19 and chronic kidney disease. The facility staff failed to send a notice of discharge to the ombudsman. A Nursing Note dated 02/05/21 indicated: Resident #55 was experiencing low Oxygen Saturations. A review of the nursing notes indicated Resident #55 was transferred to the Emergency Room on 02/05/21 because resident was hypoxia with oxygen saturation at 89 percent on 3 liters of oxygen. During an interview on 4/29/21 at 5:44 PM with the administrator she stated, The Ombudsman was not sent a notice of discharge to the hospital for Resident #55. The facility staff failed to send a notice of discharge to the hospital for one resident. No additional information was provided prior to exit of survey.	F 623	1/1/2021 to 3/31/2021 to ensure they were sent all the information in this time period. Transfer and Discharge information for April 2021 was sent to the Ombudsman on 5/3/2021. 3.) Administration and Social Services was reeducated on the regulation involving the notice of reporting transfer and discharges to the Long Term Care Ombudsman. Inservice included but was not limited to reviewing report to ensure all residents were included that transferred and or discharged and the process of notifying the Ombusdman office. 4.) Assistant Administrator/Designee will review 100% of the resident transfers & discharges monthly for 3 months to verify the Ombudsman was notified. The Assistant Administrator/designee will review the audit results for any patterns or trends and report any findings to our Quality Assurance Performance Improvement Committee. 5.) June 10, 2021	
F 657 SS=E	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician.	F 657		6/10/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495367	A. BUILDING _____ B. WING _____	04/29/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHAMPTON CONVALESCENT AND REHABILITATION CENTER	1028 TOPPING LANE HAMPTON, VA 23666

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 30 (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, clinical record review and facility document review, it was determined that facility staff failed to revise the care plan for 3 of 28 residents in the survey sample to reflect that Resident #26 was receiving hospice services; Resident #12's Foley catheter had been discontinued; and Resident #4, acquired left heel pressure ulcer The findings included: 1. The facility staff failed to revise the comprehensive care plan for to reflect hospice services for Resident #26. Resident #26 was admitted to the facility on 6/12/18 with diagnoses that included but were not limited to muscle weakness, Alzheimer's disease,	F 657	The dates of completion serve as my allegation of compliance 1. The care plans for resident #26 and #43 were updated to reflect current plan of care. Resident #12 expired on 5/14/21. 2. The care plans of current residents receiving hospice services have been reviewed and updated to ensure the comprehensive care plan reflects services provided. The care plan of any resident who has had or currently has an indwelling catheter present in the past 30 days has been updated to reflect the current status and the care plan of residents with pressure areas have been	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495367	A. BUILDING _____ B. WING _____	04/29/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHAMPTON CONVALESCENT AND REHABILITATION CENTER	1028 TOPPING LANE HAMPTON, VA 23666

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 31 unspecified dementia with behavioral disturbance, and history of malignant melanoma of the skin. Resident #26's most recent MDS (minimum data set) assessment was a significant change assessment with an ARD (assessment reference date) of 3/5/21. Resident #26 was coded as being severely impaired in the ability to make daily decisions on the Staff Interview for Mental Status Exam. Resident #26 was coded in Section O (Special Treatments and Programs) as receiving hospice services. Review of Resident #26's clinical record revealed that she was admitted to hospice services on 3/1/21. The following social services note was documented: "Resident effective with hospice services through (Name of Hospice Provider) as of 3/1/21." Review of Resident #26's clinical record revealed a "Plan of Care Order" dated 3/2/21 from the Hospice provider. Further review of Resident #26's clinical record revealed that Resident #26 was on comfort measures prior to being placed on Hospice services. Her order for comfort measures started on 6/28/18. Review of Resident #26's comprehensive care plan dated 6/28/18 through present showed a comfort measures care plan that documented in part, the following: "(Name of Resident #26) and/or family has requested certain treatments be withheld related to residents current medical condition. No IVs, No Hospitalizations, No Tube Feeding, No Lab Work, No Weights...(Name of Resident #26) will not receive those measures decided upon in accordance with the resident	F 657	reviewed and updated as needed to ensure the care plan reflects the resident current interventions . New/Changed orders requiring a change to the resident plan of care will be reviewed and care plans updated accordingly on an ongoing basis by the Director of Nursing/Designee. 3. The Director of Nursing /designee will reeducate the MDS team on the Care Plan revision process. The in-service will include but is not limited to a review of the Baseline and Comprehensive Care Plan Policy. Education will focus on the importance of ensuring care plans are updated with hospice services, orders changes that impact the plan of care such as the removal of an indwelling urinary catheter and interventions for the prevention and treatment of pressure areas 4. The Director of Nursing /designee will review 20% of residents with an order change weekly for six weeks. The review will ensure the care plan has been updated and revised to capture the change in the resident's personalized plan of care. The Director of Nursing/designee will identify any patterns or trends and report to the Quality Assurance and Performance Improvement Committee at least quarterly. 5.) June 10, 2021	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495367	A. BUILDING _____ B. WING _____	04/29/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHAMPTON CONVALESCENT AND REHABILITATION CENTER	1028 TOPPING LANE HAMPTON, VA 23666

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 32	F 657		

and/or family request...Educate resident & (and) family about Hospice if desired."

There was no evidence that Resident #26's comprehensive care plan had been revised to reflect her new order for Hospice Services.

On 4/29/21 at 3:15 p.m., an interview was conducted with Registered Nurse #1, the MDS nurse. When asked if a resident was receiving hospice services if that should be reflected on the comprehensive care plan, RN #1 stated that Hospice Services would be added to the care plan. When asked the timeframe for revising the care plan to reflect Hospice Services; RN #1 stated that she would first complete a significant change MDS assessment and then create a Hospice care plan within 14 days. When asked what interventions would be included on a Hospice care plan, RN #1 stated that the care plan would specify care and services the facility would provide versus what the Hospice provider would do. RN #1 stated that the Hospice provider also provided a care plan of the care and services they provide. When asked if the Resident's comprehensive care plan should still be revised to reflect hospice services even if the Hospice provider sends their own care plan, RN #1 stated, "Yes."

On 4/29/21 at 3:26 p.m., RN #1 confirmed that Resident #26's comprehensive care plan was not revised to reflect that she was utilizing Hospice Services. RN #1 stated that she was going to update Resident #26's care plan.

On 4/29/21 at 5:52 p.m., the facility Administrator and the DON (Director of Nursing) were made aware of the above concerns.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495367	A. BUILDING _____ B. WING _____	04/29/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHAMPTON CONVALESCENT AND REHABILITATION CENTER	1028 TOPPING LANE HAMPTON, VA 23666

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 33	F 657		

2. The facility staff failed to revise the comprehensive care plan for Resident #12 to include the removal of a Foley catheter.

Resident #12 was admitted to the facility on 02/09/21. Diagnosis for Resident #12 included but not limited to retention of urine.

Resident #12's Minimum Data Set (MDS) an admission assessment with an Assessment Reference Date (ARD) of 02/15/21 coded the resident with a 15 out of a possible score of 15 on the Brief Interview for Mental Status (BIMS), indicating no cognitive impairment.

In addition, the MDS coded Resident #12 total dependence of two with transfer, total dependence of one with bathing, extensive assistance of one with bed mobility, dressing, toilet use and personal hygiene for Activities of Daily Living care. The resident was coded for Indwelling catheter under section (H) Bowel and Bladder.

Resident #12's comprehensive care plan created on 02/22/21 documented Resident #12 at risk for infection related to indwelling catheter. The goal: will remain free of urinary tract infection during period of catheterization. Some of the interventions to manage goals include but not limited to: clean around catheter with soap and water/provide catheter care, keep tubing below level of the bladder and free of kinks or twists, record output per shift and change drainage bag pre policy/order. The care plan was not revised to include the removal a Foley catheter.

During the initial tour on 04/27/21 at

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495367	A. BUILDING _____ B. WING _____	04/29/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHAMPTON CONVALESCENT AND REHABILITATION CENTER	1028 TOPPING LANE HAMPTON, VA 23666

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 34	F 657		

approximately 12:25 p.m., Resident #12 was observed without a Foley catheter in place.

Review of physician order dated 03/17/21 including the following: Remove Foley catheter, voiding trial.

During the review of Resident #12's clinical note dated 03/17/21 read in part: catheter removed without difficulty. After the review of Resident #12's clinical notes from 03/17/21 until 04/29/21 did not reveal Resident #12 had an indwelling Foley catheter in place.

A phone interview was conducted with the Director of Nursing (DON) on 04/29/21 at approximately 10:52 a.m. The DON reviewed the care plan and clinical record for Resident #12. After reviewing the clinical record the DON stated, "Resident #12's Foley was removed on 03/17/21; the care plan does not reflect the removal of the Foley catheter." When asked who was responsible for updating/revising Resident #12's care plan, she replied, "It's a team effort; the MDS Coordinator, Assistant Director of Nursing (ADON) and Myself are responsible for revising Resident #12's care plan." The DON said Resident #12's care plan should not include an indwelling Foley since it was removed on 03/17/21.

The facility's Administration team was informed of the finding during a debriefing on 04/29/21 at approximately 6:00 p.m. The facility staff did not present any further information about the findings.

The facility's policy titled: Person-centered Baseline and Comprehensive care Plan - last reviewed: 05/17/18.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495367	A. BUILDING _____ B. WING _____	04/29/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHAMPTON CONVALESCENT AND REHABILITATION CENTER	1028 TOPPING LANE HAMPTON, VA 23666

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 35	F 657		

Procedures read in part: The care plan is reviewed and updated as needed.

Definition:
A Foley catheter is a thin, sterile tube inserted into the bladder to drain urine. Reference www.NIH.gov (National Institutes of Health).

3. The facility staff failed to revise Resident #43's comprehensive care plan for pressure ulcers.

Resident #43's most recent Minimum Data Set assessment was an admission dated 3/29/21 and coded the resident with a score of 12 out of a total score of 15 which indicated she was moderately impaired in the cognitive skills for daily decision making. Resident #43 was coded always incontinent of bowel and bladder. Resident #43 was assessed to require extensive assistance of 2 for transfers, extensive assistance of 1 for dressing, toilet use, and totally dependent on one staff for bathing. The wheelchair was Resident #43's primary mode of mobility. Resident #43 was assessed with lower extremity impairment in range of motion on one side. Resident #43 was coded at risk for pressure ulcers based on the formal assessment, Braden scale and had a stage 1 or greater over a bony prominence. Resident #43 was coded for unhealed pressure ulcers; one stage 1, 2 stage 2's (admitted) and 2 unstageable pressure ulcers (admitted). Resident #43 was assessed for pressure reducing devices, pressure ulcer care, surgical wound care and application of ointments and medications other than feet.

The care plan dated 3/31/21 identified there was a stage 1, stage 2 pressure ulcer (PU), but the care plan did not identify the location of the stage

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495367	A. BUILDING _____ B. WING _____	04/29/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHAMPTON CONVALESCENT AND REHABILITATION CENTER	1028 TOPPING LANE HAMPTON, VA 23666

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 36	F 657		

1 or stage 2 PU's. The care plan did not address the unstageable PU's. A preventative pressure ulcer care planning was dated 3/31/21, after Resident #43 acquired a left heel fluid filled blister on 3/30/21.

According to the wound documentation forms dated 3/24/21, Resident #43 was admitted with the following pressure ulcers, documentation by the wound care nurse, Registered Nurse (RN) #2:
-Left lateral medial foot with *eschar, .
-Left medial knee with eschar, 4.5 cm x 3.5 cm.
-Stage 2 to sacrum (3.5 cm x 1.0 cm x 0.1) and left buttock (3.5 cm x 1.5 cm x 0.1 cm). None of these areas were identified on the care plan.

On 3/30/21 RN #2 documented on the wound documentation form that Resident #43 acquired a left heel fluid filled blister, 3.2 cm x 3.5 cm, to offload and skin prep. On 4/6/21 the wound measures 4.5 cm by 5.0 cm. On 4/14/21 the area is not resolved and requires re-evaluation. The pressure ulcer opens to be assessed as 100% eschar. The documentation indicated that prior to the fluid filled blister, Prevalon boots were in place and pillows to offload as tolerated. It was noted that the resident self-repositions in bed by pushing up and placing pressure on bilateral heels. None of this personalized information was identified on the care plan. The preventative care plan was developed on 3/31/21 after this left heel blister was identified.

On 4/29/21 at 2:40 p.m. and interview was conducted with the Director of Nursing (DON). She reviewed Resident #43's care plan, but could not explain the lack or personalization or revisions related to the resident's admitted or acquired pressure ulcer.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495367	A. BUILDING _____ B. WING _____	04/29/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHAMPTON CONVALESCENT AND REHABILITATION CENTER	1028 TOPPING LANE HAMPTON, VA 23666

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 37 On 4/29/21 at 6:00 p.m., a debriefing was conducted with the Administrator, Assistant Administrator, DON, Infection Control Preventionist and Corporate, CFO. All of the aforementioned issues were reviewed, and again it could not be explained why the care plan was not personalized to reflect the resident's admitted pressure ulcers and acquired pressure ulcer or that the pressure ulcer preventative plan of care was dated 3/31/21 after Resident #43 acquired the left heel pressure ulcer on 3/30/21. No further information was provided prior to survey exit.	F 657		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on family and resident interview, clinical record review, and facility document review, it was determined that facility staff failed to provide ADL (Activities of Daily Living) services to maintain personal hygiene for 2 of 28 sampled residents, Resident #24 and #35. The findings included: 1. The facility staff failed to ensure Resident #24 was offered and received a scheduled twice-weekly shower to maintain good personal hygiene. Resident #24 was admitted to the facility on 12/3/20 with diagnoses that included but were not	F 677	The dates of completion serve as my allegation of compliance 1. Resident # 35 received a shower on 4/30/21 and resident # 24 was offered a shower and stated she prefers to have bed baths. The resident's care plan was updated with her preference. 2. The shower records for all residents have been reviewed for the past week to ensure the medical records reflect residents were offered showers twice weekly. Any variances identified will be corrected. Residents who refuse showers or have preferences regarding their	6/10/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495367	A. BUILDING _____ B. WING _____	04/29/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHAMPTON CONVALESCENT AND REHABILITATION CENTER	1028 TOPPING LANE HAMPTON, VA 23666

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 677	Continued From page 38 limited to muscle weakness, type two diabetes mellitus, vascular dementia without behavioral disturbance and hemiplegia of the left nondominant side. Resident #24's most recent MDS (Minimum Data Set) assessment was a significant change assessment with an ARD (Assessment Reference Date) of 3/2/21. Resident #24 was coded as being severely impaired in cognitive function scoring 03 out of possible 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #24 was coded as being totally dependent on one staff member with personal hygiene and bathing. On 4/28/21 at 10:15 a.m., in an interview with a family member, a concern was expressed that the resident may not be getting her hair washed due to not receiving showers. This family member also stated that Resident #24 had refused showers on a few occasions. Review of Resident #24's current care plan revealed the following for ADLs: "ADL- has reacher (sic) her maximum functional potential and is at risk for decline.. Effective: 12/15/20 to Present...Have personal hygiene needs met in accordance with resident preference and need...Encourage Resident to take at least two showers/tub a week." Further review of Resident #24's care plan revealed another ADL care plan that documented the following: "(Name of Resident #24) has the potential for health and safety concerns related to ADL needs and mobility status...Effective: 12/15/20 to Present...Assist (Name of Resident #24) with bathing as needed." Review of the shower schedule revealed that	F 677	shower will be accommodated to the extent possible and preferences will be care planned. Nursing staff will be responsible for documenting showers or refusals and alternate received at least twice weekly. 3. The Director of Nursing /designee will in-services the CNA's on the importance of ensuring residents are offered a shower at least twice weekly including accurate documentation that showers are provided/refused. The charge nurse/designee will review the daily ADL documentation at the end of each shift for 2 weeks to ensure the records accurately reflect showers provided/refused. 4. The Director of Nursing /designee will review 20% of resident's shower logs weekly for six weeks. The review will ensure ongoing compliance with offering/providing showers twice weekly and accurate documentation. The Director of Nursing/Designee will identify any patterns or trends and report to the Quality Assurance and Performance Improvement Committee at least quarterly. 5.) June 10, 2021	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495367	A. BUILDING _____ B. WING _____	04/29/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHAMPTON CONVALESCENT AND REHABILITATION CENTER	1028 TOPPING LANE HAMPTON, VA 23666

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 677	Continued From page 39	F 677		

Resident #24 was to receive showers on Wednesday and Saturday 2:30- 11:00 p.m.

Review of Resident #24's bathing and shower log dated 12/2020 through 4/2020 revealed that Resident #24 refused showers on 3/3/21 and on 4/12/21. It was documented that a bed bath was given in place of a shower during those time.

Further review of Resident #24's bathing/shower log failed to evidence that Resident #24 ever received a shower from 12/3/20 until 4/27/21.

Further review of Resident #24's care plan and clinical record failed to evidence that Resident #24 frequently refused showers.

On 4/29/21 at 2:05 p.m. an interview was conducted with Resident #24. Resident #24 stated that she normally receives a bed bath. Resident #24 stated that she does not get offered a shower. When asked if she would like to receive her showers, Resident #24 stated that she would only like her showers so her hair can be washed. Resident #24 stated that when she is given bed baths, her hair is not washed. When asked how long it has been since her hair was washed, Resident #24 stated; "It's been months." At the time of this interview and during the course of survey, Resident #24 had been wearing her wig over her hair.

On 4/29/21 at 2:15 p.m., an interview was conducted with CNA (Certified Nursing Assistant) #1, a CNA who frequently worked with Resident #24. When asked if Resident #24 refuses showers, CNA #1 stated that Resident #24 refuses occasionally but not all the time. CNA #1 could not recall Resident #24's shower days.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495367	A. BUILDING _____ B. WING _____	04/29/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHAMPTON CONVALESCENT AND REHABILITATION CENTER	1028 TOPPING LANE HAMPTON, VA 23666

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 677	Continued From page 40	F 677		

When asked if it should be documented on the clinical record if a resident refuses showers, CNA #1 stated that it should. CNA #1 stated that their was an option to document "Refused" and "Received" etc. When asked if a resident's hair was washed if a bed bath was given, CNA #1 stated that hair was normally washed in the shower. When asked the last time she personally gave Resident #24 a shower, CNA #1 stated that it has been awhile since she had personally washed the resident in the shower or had washed her hair. CNA #1 stated that she normally worked 6:30 to 2:30 p.m. shift. (Day shift). When asked how would we determine that Resident #24 received a shower if it was not documented on her shower log, CNA #1 stated that she was not sure how to know.

On 4/29/21 at 03:06 p.m., an interview was conducted with LPN (Licensed Practical Nurse) #1, Resident #24's nurse. When asked who was responsible for giving showers, LPN #1 stated the nursing aides were responsible for giving showers. When asked when Resident #24 was supposed to receive a shower, LPN #1 stated that she wasn't familiar with shower schedules; that the nursing aides would know that information. When asked if nursing aides should be documenting if showers are refused, LPN #1 stated "They should be." LPN #1 stated that if a resident refuses a shower, the nursing aides should be alerting the nurse so the nurse can encourage the resident to take a shower. LPN #1 stated some ways to encourage a resident would be saying things like, "Hey, lets try this new body wash" or "Lets go wash your hair." When asked if a resident refuses showers on multiple occasions if that would be documented on the care plan, LPN # 1 stated, "Yes. The care plan

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495367	A. BUILDING _____ B. WING _____	04/29/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHAMPTON CONVALESCENT AND REHABILITATION CENTER	1028 TOPPING LANE HAMPTON, VA 23666

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 677	Continued From page 41	F 677		

should be revised." When asked if Resident #24 refuses showers frequently, LPN #1 stated that the nursing aides had not told her that. When asked if nursing aides should be documenting when a resident receives a shower, LPN #1 stated, "They should be." When asked if hair can be washed while the resident is laying in the bed, LPN #1 stated, "We used to have shower caps that can be warmed up in the microwave that will sit on the resident's head or we use dry shampoo." When asked how we would know if Resident #24 received a shower if there was no evidence on the shower logs, LPN #1 stated that she wasn't sure.

On 4/29/21 at 5:52 p.m., the facility Administrator and the DON (Director of Nursing) were made aware of the above concerns.

2. The facility staff failed to ensure Resident #35 was offered and received a scheduled twice-weekly shower to maintain good personal hygiene.

Resident #35 was originally admitted to the facility 11/23/05. Diagnosis for Resident #35 included but not limited to muscle weakness and contracture to the left upper arm. Resident #35's Minimum Data Set (MDS-an assessment protocol) a quarterly assessment with an Assessment Reference Date of 03/10/21 coded a 03 out of a possible score of 15 on the Brief Interview for Mental Status (BIMS), indicating severe impaired cognitive skills for daily decision-making.

In addition, the MDS coded Resident #35 total dependence of one with bathing, extensive

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495367	A. BUILDING _____ B. WING _____	04/29/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHAMPTON CONVALESCENT AND REHABILITATION CENTER	1028 TOPPING LANE HAMPTON, VA 23666

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 677	Continued From page 42	F 677		

assistance of one with bed mobility, dressing, toilet use and personal hygiene for Activities of Daily Living (ADL) care.

Resident #35's comprehensive care plan with a created date of 05/16/16 document Resident #35 refuses her showers when offered at times. The goal: will not experience preventative complications, or decline in condition related to refusal of care as ordered/care planned through next review. Some of the intervention included but not limited to: Resident prefers showers first thing in the morning; staff to attempt to accommodate resident preference in coordinating preferred time and staff to report refusals to charge nurse. The care plan also included to document resident's refusal for care in the medical record and notify the physician of persistent refusal of treatments, medications, and care.

On 4/27/21 at approximately 11:30 a.m., Resident #35 was in her room in her wheelchair. A strong urine odor was detected upon entering the room. After exploring around the bed, it was determined the odor emanated around the resident. The resident was also hollering out, but not able to understand the content. When asked the Certified Nursing Assistant (CNA) #2 if she smelled urine around the resident, she responded that the resident did not like to be changed, but did not smell anything.

On 4/28/21 at 1:00 p.m., the resident was sitting in her wheelchair in the hallway. The same urine odor was detected from the resident.

Resident #35 showers are scheduled to be given twice weekly every Tuesday and Friday (6:30-3p

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495367	A. BUILDING _____ B. WING _____	04/29/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHAMPTON CONVALESCENT AND REHABILITATION CENTER	1028 TOPPING LANE HAMPTON, VA 23666

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 677	Continued From page 43	F 677		

shift.) Review of Resident 35's Data Collection Worksheet for bathing revealed the following: Showers were not given on the following shower days: March 2021 (03/30/21) and April 2021 (04/09, 04/13, 04/16 and 04/27/21.)

A phone interview was conducted with the Director of Nursing (DON) on 04/29/21 at approximately 10:52 a.m. The DON said showers are to be given twice a week and bed baths on their non-showers days. She said if the resident refuse their shower or bed bath, the Certified Nursing Assistant (CNA) is to report the refusal to the nurse; the nurse will speak with the resident and if the resident still refuses, the nurse will document their refusal in the clinical record. When asked if the CNA's should also documented Resident #35's refusal of showers or baths, she replied, "Yes."

During a phone interview with the DON on 04/29/21, a request was made to do a phone interview with CNA #2, CNA #3, and CNA #4, who were assigned to Resident #35 on the missed shower days in March and April 2021. The DON she will have the CNA's contact me away via phone; the staff never called."

During the clinial record review from 02/05/21 - 04/23/21 revealed two refusal of care (03/06/21 and 04/23/21.)
A phone interview with the DON on 04/29/21, a request was made to do a phone interview with CNA#2, CNA #3, and CNA #4. They were assigned to Resident #35 on her missed shower days in March and April 2021. The DON said she give the 3 CNA's my contact number and have them call you right away; staff never called."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495367	A. BUILDING _____ B. WING _____	04/29/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHAMPTON CONVALESCENT AND REHABILITATION CENTER	1028 TOPPING LANE HAMPTON, VA 23666

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 677	Continued From page 44 The facility's Administration team was informed of the finding during a debriefing on 04/29/21 at approximately 6:00 p.m. The DON was informed the CNA nursing staff never called, she replied, "I apologize, I was under the impression they had contacted you." The facility's Administration team was informed of the finding during a debriefing on 04/29/21 at approximately 6:00 p.m. The facility staff did not present any further information about the findings. The facility's policy titled Tub or Shower Bath (Revision date: 03/23/15.) Policy: Residents should receive a tub or shower bath at least twice weekly. Purpose read in part: To provide cleanliness and comfort to the resident and to prevent odors.	F 677		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observations, clinical record reviews,	F 686	The dates of completion serve as my	6/10/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495367	A. BUILDING _____ B. WING _____	04/29/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHAMPTON CONVALESCENT AND REHABILITATION CENTER	1028 TOPPING LANE HAMPTON, VA 23666

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 45 staff and resident interview, the facility staff failed to ensure care was provided to prevent and treat pressure ulcers for 1 of 28 residents (Resident #43) in the survey sample. The findings included: 1. For Resident #43, the facility failed to prevent the development of a facility acquired left heel pressure ulcer, as well as provide consistent offloading to the left medial knee pressure ulcer to ensure continued healing and comfort. Resident #43 was admitted to the nursing facility on 3/24/21 with diagnoses that included closed fractured right femur and pressure ulcers. Resident #43's most recent Minimum Data Set assessment was an admission dated 3/29/21 and coded the resident with a score of 12 out of a total score of 15 which indicated she was moderately impaired in the cognitive skills for daily decision making. Resident #43 was coded always incontinent of bowel and bladder. Resident #43 was assessed to require extensive assistance of 2 for transfers, extensive assistance of 1 for dressing, toilet use, and totally dependent on one staff for bathing. The wheelchair was Resident #43's primary mode of mobility. Resident #43 was assessed with lower extremity impairment in range of motion on one side. Resident #43 was coded at risk for pressure ulcers based on the formal assessment, Braden scale dated 3/24/21 (very limited limited in extremity and body position without assistance, bedfast and friction and shearing as a problem) and had a stage 1 or greater over a bony prominence. Resident #43 was coded for unhealed pressure ulcers; one stage 1, 2 stage	F 686	allegation of compliance. 1. Resident #43 has all appropriate pressure relieving devices in place to include a dedicated pillow between knees and heel float boots to be worn while in bed. Staff were immediately reeducated on the importance of ensuring these devices are in place for offloading and pressure reduction. 2. The Assistant Director of Nursing/designee will review current residents with pressure areas and residents who have been identified as high risk for developing pressure areas, to ensure all appropriate prevention interventions are in place and reflected in the care plan accurately. The Assistant Director of Nursing/designee will educate staff on the personalized interventions in place for each resident. 3. RN's, LPN's and CNA's will be in-serviced by the Nursing Education and Training coordinator/designee on Pressure Area Prevention. The inservice will include but is not limited to a review of the Pressure Area Prevention Policy. Special focus will be given to positioning devices for offloading pressure to include use of pillows, heel float boots and pressure relief support surfaces. The Assistant Director of Nursing will communicate updates to the pressure relieving interventions to the nursing staff.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495367	A. BUILDING _____ B. WING _____	04/29/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHAMPTON CONVALESCENT AND REHABILITATION CENTER	1028 TOPPING LANE HAMPTON, VA 23666

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 46 2's (admitted) and 2 unstageable pressure ulcers (admitted). Resident #43 was assessed for pressure reducing devices, pressure ulcer care, surgical wound care and application of ointments and medications other than feet. The care plan dated 3/31/21 identified there was a stage 1, stage 2 pressure ulcer (PU), but the care plan did not identify the location of the stage 1 or stage 2 PU's. The care plan did not address the unstageable PU's. A preventative pressure ulcer care planning was dated 3/31/21, after the resident acquired a left heel fluid filled blister on 3/30/21. The care plan dated 3/31/21, identified that the resident had the potential for and has altered skin integrity and was at risk for pressure ulcers. The goal set was that Resident #43 would not experience impaired skin integrity and or area of impaired skin integrity would demonstrate wound healing. Some of the approaches to accomplish this goal included use positioning/preventable devices as tolerated by the resident, turn and reposition, and encourage Resident #43 to reposition as able. Use pillows, pads, or wedges to reduce pressure on heels and pressure points. Perform complete skin assessment and record. Specialized mattress: low air loss implemented on 4/16/21. According to the wound documentation forms dated 3/24/21, Resident #43 was admitted with the following pressure ulcers, documentation by the wound care nurse, Registered Nurse (RN) #2: -Left lateral medial foot with *eschar, . -Left medial knee with eschar, 4.5 cm x 3.5 cm. -Stage 2 to sacrum (3.5 cm x 1.0 cm x 0.1) and left buttock (3.5 cm x 1.5 cm x 0.1 cm). None of	F 686	The nurses will be in-serviced by the Assistant Director of Nursing/designee on where to find the pressure relieving interventions on the care plan, and the importance of communicating those interventions to the C.N.A.'s. 4. The Assistant Director of Nursing/Designee will observe 100% of residents on a weekly basis for six weeks to ensure pressure area prevention measures are in place. The Assistant Director of Nursing will review 20% of pressure area prevention and treatment care plans to ensure they accurately reflect the resident's current plan of care. The Director of Nursing will report any trends or patterns to the Quality Assurance and Performance Improvement Committee at least quarterly. 5.) June 10, 2021	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495367	A. BUILDING _____ B. WING _____	04/29/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHAMPTON CONVALESCENT AND REHABILITATION CENTER	1028 TOPPING LANE HAMPTON, VA 23666

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 47	F 686		

these areas were identified on the care plan.

On 3/30/21 RN #2 documented on the wound documentation form that Resident #43 acquired a left heel fluid filled blister, 3.2 cm x 3.5 cm, to offload and skin prep. On 4/6/21 the wound measures 4.5 cm by 5.0 cm. On 4/14/21 the area is not resolved and requires re-evaluation. The pressure ulcer opens to be assessed as 100% eschar. The documentation indicated that prior to the fluid filled blister, Prevalon boots were in place and pillows to offload as tolerated. It was noted that the resident self-repositions in bed by pushing up and placing pressure on bilateral heels. None of this personalized information was identified on the care plan. The preventative care plan was developed on 3/31/21 after this left heel blister was identified. There was no pressure ulcer noted to the right heel. Low air loss mattress applied on 4/15/21.

The wound care physician reviewed all of the aforementioned admitted pressure ulcers with wound care recommendations, as well as the facility acquired pressure ulcer (left heel) that is assessed on her visit 4/14/21 as unstageable with 100% thick devitalized necrotic tissue, The wound care physician debrided the area, treatment with Santyl (topical debrider). Recommendations to float heels in bed, off load the wound, reposition per facility protocol. The wound care physician also recommend the left medial knee unstageable pressure ulcer be offloaded, reposition per facility protocol.

The following observations were made of Resident #43.

On 4/27/21 at 11:00 a.m., Resident #43 was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495367	A. BUILDING _____ B. WING _____	04/29/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHAMPTON CONVALESCENT AND REHABILITATION CENTER	1028 TOPPING LANE HAMPTON, VA 23666

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 48	F 686		

observed in bed on her air loss mattress, positioned on her right side. There was a pillow at her back and bilateral Prevalon boots in place. There was no pillow positioned between her legs to offload pressure to the left medial knee. On 4/27/21 at 3:00 p.m., the resident was positioned on her right side with pillow at her back, the Prevalon boots were in place to bilateral heels, but no pillow between her legs.

On 4/28/21 at 10:00 a.m., 1:30 p.m., there was no pillow positioned between the resident's legs to offload the left lateral knee while resident was in bed.

On 4/28/21 at 2:25 p.m., the wound care physician, accompanied by the wound care nurse performed complete assessments, treatments and dressing dressing changes for all pressure ulcers. It was determined that the resident could not lift her left heel off the mattress as she tried and stated, "See, I am not able to lift that heel. It is my bad side." The wound care nurse verified the resident's left leg was the weak side. The resident demonstrated she was able to move the right heel without difficulty, and no redness or skin integrity issues. The resident could not demonstrate she was able to push with both heels to pull herself up in bed as the care plan indicated she was able to perform. There was no pillow between the resident's legs to offload the left medial pressure ulcer. After the treatments were completed, the wound care nurse left the resident's room to retrieve a pillow, returned and positioned the pillow between the resident's legs to protect and ensure offloading of pressure and continued healing. The wound care nurse stated she expected the staff to maintain a pillow between the resident's legs to ensure pressure

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495367	A. BUILDING _____ B. WING _____	04/29/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHAMPTON CONVALESCENT AND REHABILITATION CENTER	1028 TOPPING LANE HAMPTON, VA 23666

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 49	F 686		

relief of bone to bone pressure from her knees which was how the pressure ulcer originally developed due the resident's inability to independently reposition that left leg.

On 4/29/21 at 11:05 a.m., the wound care nurse stated she was making sure the pillow was maintained between Resident #43's legs and staff education was started that would be ongoing. She also stated although she did not document Prevalon boots were in place from the resident's admission that was what she meant when she documented to float heels. She stated Prevalon boots were a nursing order and did not require a physician's order, nor were they entered on the Treatment Administration Record (TAR) for nurses to sign off per shift to ensure they were signed off in place. She stated even if floating heels with pillows were consistently in place, the resident should not have acquired the right heel blister that opened to be a eschar/necrotic area. She could not explain how the resident was able to acquired the left heel pressure ulcer, if Prevalon boots were in place from admission, as she indicated.

On 4/29/21 at 2:40 p.m. and interview was conducted with the Director of Nursing (DON). She stated that if pillows are appropriately in place, offloading is effective for residents that are compliant and unable to reposition themselves. It was determined that Resident #43 was compliant, unable to reposition herself and she expected that pillows and or Prevalon boots were in place for ongoing pressure relief. She stated Prevalon boots ensure pressure relief to heels even with resident movement and she thought they were in place from the resident's admission. She confirmed they were a nursing order, and not

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495367	A. BUILDING _____ B. WING _____	04/29/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHAMPTON CONVALESCENT AND REHABILITATION CENTER	1028 TOPPING LANE HAMPTON, VA 23666

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 50 signed off on the TAR for the accountability purposes to ensure they were in place every shift. On 4/29/21 at 6:00 p.m., a debriefing was conducted with the Administrator, Assistant Administrator, DON, Infection Control Preventionist and Corporate, CFO. All of the aforementioned issues were reviewed, no further information was provided prior to survey exit.	F 686		
F 689 SS=E	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, clinical record review, staff and resident interviews, the facility staff failed to ensure interventions were in place and operational for 3 out of 28 residents (Resident #41, #355 and #24) to prevent falls. The facility staff failed to ensure Resident #41's and #355's bed/chair alarms were properly positioned and functional. The facility staff failed to ensure Resident #24's call light was within reach and functional; and that her bed was in the lowest position per fall plan of care. The findings included: 1. The facility staff failed to ensure Resident #41's chair alarm was properly positioned and	F 689	The dates of completion serve as my allegation of compliance. 1. Residents #41 and #355 have been re-evaluated for the need of bed/chair alarms and physician orders and plan of care updated accordingly. Resident #24 was confirmed to have the call bell functioning and within reach, and bed in the lowest position. Nursing staff caring for Residents # 41 and 355 have been reeducated on the importance of verifying the placement and functioning of chair and sensor alarms prior to documentation. Nursing staff caring for resident #24 have been reeducated on the	6/10/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495367	A. BUILDING _____ B. WING _____	04/29/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHAMPTON CONVALESCENT AND REHABILITATION CENTER	1028 TOPPING LANE HAMPTON, VA 23666

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 51	F 689		

functional to alert staff that the resident has changed position, increasing the risk for falling.

Resident #41 was admitted to the nursing home on 5/28/19 with diagnoses that included history of falls with history of displaced right femur fracture, dementia, muscle weakness and high blood pressure.

The most recent Minimum Data Set (MDS) assessment was a significant change in status assessment dated 3/25/21 and coded the resident with a 14 out of a possible score of 15 which indicated the resident was cognitively intact with the skills needed for daily decision making. The resident was assessed to require extensive assistance from one staff for toilet use and bathing. She was coded to require extensive assistance of 2 for transfers. The resident was not steady during surface to surface transfer from bed and chair or wheelchair. The wheelchair was the primary mode of transportation. The resident was assessed to have 2 or more falls since admission and one with injury. She was assessed to have had recent surgery requiring active skilled care. The resident was coded always incontinent of bowel and bladder.

The care plan dated 6/7/19 to present identified Resident #41 had a history of falls since admission, prior admission and had repeated falls, 31 falls were listed on the care plan, 3/19/21 resulted in a fracture to the distal radius. The goal set by the staff was that the resident would maintain current level of mobility with no increase in the incidence of falls/injuries. Interventions to accomplish this goal included apply sensor mat to bed and chair.

importance of ensuring the call bell is within reach and the bed is in the lowest position according to the plan of care.

2. All resident's with current orders for alarms have been re-evaluated for bed/chair alarms, and their orders and plan of care updated accordingly. Any nurse assigned to a resident with a chair alarm will be responsible for verifying placement of the alarm prior to documenting on the treatment administration record. Residents who have had a fall in the past 30 days have been observed to ensure all care planned interventions to include bed in lowest position and call bell within reach are in place.

3. The Assistant Director of Nursing /designee has in-serviced the nursing staff on proper placement and functioning of sensor mat alarms, including daily checks with appropriate documentation.
The Education and Training Coordinator/designee will in-service the nursing staff on the Fall Prevention Program ("Professor Morse"), to include interventions that should be in place for residents on the program (those at high risk for falling). Interventions include bed in lowest position, call bell within reach, fall mat, scoop mattress, etc.

4. The Assistant Director of Nursing/ Designee will observe all residents with bed/chair alarms weekly for six weeks to ensure proper placement and functioning. The Assistant Director of Nursing will

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495367	A. BUILDING _____ B. WING _____	04/29/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHAMPTON CONVALESCENT AND REHABILITATION CENTER	1028 TOPPING LANE HAMPTON, VA 23666

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 52 The resident had physician orders dated 6/10/19 for a sensor mat to bed/chair to alert staff if resident attempts to transfer without assistance. Check placement and function every shift. The following observations of Resident #41 related to the chair alarm positioning and functionality: On 4/28/21 at 9:30 a.m., Resident #41 was in her room sitting in a wheelchair. There was a cast on the resident's right arm and wrist. The cord to the chair alarm was visibly hanging behind the resident, along the back of her wheelchair. There was no alarm box connected to the end, nor was the box attached anywhere on the wheelchair. The resident sat on the Pummel cushion and the sensor pad had been placed directly on the seat of the wheelchair under the Pummel cushion. Certified Nursing Assistant (C.N.A.) #1 was observed circulating around the resident, removed the breakfast meal tray. Licensed Practical Nurse (LPN) #5 was also observed administering medications to the resident without noticing there was no alarm box connected to the end of the cord. On 4/28/21 at 12:35 p.m., the resident was served her lunch meal. The chair alarm remained detached and no visible alarm box. On 4/28/21 at approximately 4:00 p.m., the resident was observed in bed. The sensor pad was under the resident's draw sheet, but no alarm box visible. On 4/29/21 at approximately 8:30 a.m. through 12:17 a.m., Resident #41 was again observed sitting in her wheelchair without the chair alarm	F 689	observe all residents on the Fall Prevention Program weekly for six weeks to ensure call bells are within reach and functioning, and their bed is in the lowest position. If any variances are identified, they will be investigated and/or corrected and responsible staff re-educated. The Director of Nursing/Designee will identify any patterns or trends and report them to the Quality Assurance and Performance Improvement Committee at least quarterly. 5.) June 10, 2021	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495367	A. BUILDING _____ B. WING _____	04/29/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHAMPTON CONVALESCENT AND REHABILITATION CENTER	1028 TOPPING LANE HAMPTON, VA 23666

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 53	F 689		

connected. The sensor pad was positioned under the pummel cushion as previously observed on 4/28/21.

On 4/29/21 at 12:20 p.m., CNA #1 stated she came on at 6:30 a.m. and there was no alarm box, only the sensor pad. She stated the resident always has the sensor pad with alarm, but could not explain where the alarm box was located. After a search of the resident's room, closet and drawers, the alarm box was not located.

On 4/29/21 at 12:30 p.m., Resident #41's assigned LPN #1 was asked if there was a place on the Treatment Administration Record (TAR) to sign off placement and functionality of the chair alarm. She stated. " I have already checked the resident's sensor pad alarm box and everything is in place and working fine." She showed this surveyor that she signed off on the TAR at 8:49 a.m. for placement and function of the alarm. The LPN was informed the alarm box had been missing and the sensor pad was positioned under the pummel cushion which may hamper the ability to activate the alarm. The LPN went into the resident's room and looked around for the alarm and stated she was so busy and she needed to evaluate how she signed off on the TAR in the future.

On 4/29/31 at 12:40 p.m. the Assistant Director of Nursing (ADON) stated she would find an alarm to attach to the cord/sensor pad. Upon return to the resident's room, LPN #2 had found an alarm that she stated was in the stock room, checked the batteries and attached the alarm. She stated any nurse at any time can unlock the stock room and replace the alarm. It was then asked if the sensor pad was properly placed in order to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495367	A. BUILDING _____ B. WING _____	04/29/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHAMPTON CONVALESCENT AND REHABILITATION CENTER	1028 TOPPING LANE HAMPTON, VA 23666

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 54	F 689		

activate the chair alarm, to which she responded, she did not know, but after the resident finished her lunch meal, they would lift the resident up off the wheelchair cushion to determine if the alarm sounded.

On 4/29/21 at 1:10 p.m., LPN #2 (charge nurse) and a CNA hooked the resident to the mechanical lift and lifted the resident off the pummel cushion. The alarm did not activate. LPN #2 and the CNA repositioned the sensor pad on top of the pummel cushion, sat the resident back down and lifted her again, at which time the alarm sounded with a very loud shrill.

On 4/29/21 at 2:40 p.m., the DON was informed of the aforementioned observations. She stated training would take place immediately for proper placement of sensor pads, functioning of the alarm, as well as ensuring that nurses accurately signed off for the device.

On 4/29/21 at 6:00 p.m., a debriefing was conducted with the Administrator, Assistant Administrator, DON, Infection Control Preventionist and Corporate CFO. The Administrator stated staff education would take place regarding the alarms, placement and check off for them. The DON stated staff should not sign off on what they have not done and that would be an essential part of the training.

2. The facility staff failed to ensure Resident #355 chair alarm was properly positioned and functional to alert staff that the resident has changed position, increasing the risk for falling.

Resident #355 was admitted to the nursing facility on 11/30/20 with diagnoses that included

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495367	A. BUILDING _____ B. WING _____	04/29/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHAMPTON CONVALESCENT AND REHABILITATION CENTER	1028 TOPPING LANE HAMPTON, VA 23666

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 55	F 689		

COVID-19, high blood pressure, atrial fibrillation and generalized weakness.

The most recent Minimum Data Set (MDS) assessment was a quarterly and coded the resident on the Brief Interview for Mental Status (BIMS) with a 3 out of a possible score of 15 which indicated the resident was severely impaired in the cognitive skills for daily decision making. Resident #355 was not coded to have behavioral or mood problems. The resident was required extensive assistance from one staff for bed mobility, dressing personal hygiene. The resident was coded totally dependent on two staff for transfer and bathing. There was no impairment in upper and lower extremities. The wheelchair was the resident's main mode of transportation. Resident #355 was assessed always incontinent of bowel and bladder. The resident was coded on the assessment with having no falls.

The care plan dated 12/11/20 to present identified the resident as having falls and remained at high risk for falls. The goals set by the staff for the resident was that the resident would not sustain injuries from a fall. Among the many approaches to accomplish this fall was the need for a personal or sensor mat alarm.

The following observations of Resident #355 related to the chair alarm positioning and functionality:

On 4/29/21 at 1:45 p.m., Resident #355 was observed in her room sitting in her wheelchair. She had an alarm box attached to the back of her wheelchair and the sensor pad was observed under her chair cushion by Certified Nursing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495367	A. BUILDING _____ B. WING _____	04/29/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHAMPTON CONVALESCENT AND REHABILITATION CENTER	1028 TOPPING LANE HAMPTON, VA 23666

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 56	F 689		

Assistant (CNA) #1. Licensed Practical Nurse (LPN) #3 assisted the resident to stand, at which time the alarm did not sound. The LPN stated she did not know why the CNA placed the sensor pad under the wheelchair cushion because it would not activate to alert staff of the resident's movement which was the purpose of the chair alarm. LPN #3 repositioned the sensor pad on top of the cushion, at which time the alarm sounded with a loud piercing shrill. The assigned LPN (#1), had signed off for the 7/3 shift on the functionality of the alarm, as well as the proper placement of the sensor pad.

On 4/29/21 at 2:40 p.m., the DON was informed of the aforementioned observations. She stated training would take place immediately for proper placement of sensor pads, functioning of the alarm, as well as ensuring that nurses accurately signed off for the device.

On 4/29/21 at 6:00 p.m., a debriefing was conducted with the Administrator, Assistant Administrator, DON, Infection Control Preventionist and Corporate CFO. The Administrator stated staff education would take place regarding the alarms, placement and check off for them. The DON stated staff should not sign off on what they have not done and that would be an essential part of the training.

The facility's policy and procedure titled Fall Management dated 3/20/19 indicated that it was the facility's goal to promote resident safety, assess each resident for fall risk, design an individualized person-centered plan for care and implement planned interventions to minimize falls and/or injury. The policy indicated that position change alarms were designed devices intended

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495367	A. BUILDING _____ B. WING _____	04/29/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHAMPTON CONVALESCENT AND REHABILITATION CENTER	1028 TOPPING LANE HAMPTON, VA 23666

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 57	F 689		

to monitor the resident's movement. The device emits an audible signal when the resident moved in a certain way. Types of position change alarms included chair and bed sensor pads.

3. The facility staff failed to ensure Resident #24's call light was within reach and functional; and that her bed was in the lowest position per fall plan of care.

Resident #24 was admitted to the facility on 12/3/20 with diagnoses that included but were not limited to muscle weakness, type two diabetes mellitus, vascular dementia without behavioral disturbance and hemiplegia of the left nondominant side. Resident #24's most recent MDS (Minimum Data Set) assessment was a significant change assessment with an ARD (Assessment Reference Date) of 3/2/21. Resident #24 was coded as being severely impaired in cognitive function scoring 03 out of possible 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #24 was coded as being totally dependent on two staff members with transfers.

Review of Resident #24's clinical record revealed her most recent fall was on 2/22/21 that resulted in a left fractured shoulder. The following was documented: "Resident was lowered to the floor after writer witnessed resident hanging onto the dresser with the right arm leaning forward...Interventions: Bed in lowest position, call bell within reach, Non-skid footwear, engage in activities."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495367	A. BUILDING _____ B. WING _____	04/29/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHAMPTON CONVALESCENT AND REHABILITATION CENTER	1028 TOPPING LANE HAMPTON, VA 23666

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 58	F 689		

Review of Resident #24's fall care plan dated 12/15/20 through present documented the following interventions: "Keep nurse call light within reach...Keep personal items within easy reach; bed to be in lowest positron with wheels locked."

On 4/29/21 at 10:00 a.m., an observation was made of Resident #24. Resident #24 was laying in bed with her call light within reach. Resident #24's bed did not appear to lowered all the way to the lowest position.

On 4/29/21 at 12:15 p.m., an observation was made of Resident #24. Resident #24 was laying awake in bed. Resident #24's call bell was detached from the wall and found to be on the floor. When asked the resident if she was able to use her call bell, Resident #24 stated that uses the call bell and that she wasn't sure what had happened to it.

On 4/29/21 at 12:56 p.m., an unidentified nursing aide had brought in Resident #24's lunch. This nursing aide put Resident #24's over bed table over her bed and set up her lunch tray. The CNA left the room at 12:57 p.m. without ensuring Resident #24's call light was within reach.

On 4/29/21 at 1:45 p.m., Resident #24 was sitting up in bed with now her over bed table over her bed, finishing up lunch. Resident #24's call bell was still detached from the wall and found to be on the floor.

On 4/29/21 at 1:50 p.m., an interview was conducted with Resident #24's assigned nursing aide; CNA (Certified Nursing Assistant) #1. When asked how she knows what each resident needs

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495367	A. BUILDING _____ B. WING _____	04/29/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHAMPTON CONVALESCENT AND REHABILITATION CENTER	1028 TOPPING LANE HAMPTON, VA 23666

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 59	F 689		

as far as preventing falls, CNA #1 stated that she will get a verbal report from the nurses. When asked what Resident #24 needed in place to prevent falls, CNA #1 stated the only thing she thought Resident #24 needed was to ensure her call light was within reach. CNA #1 was asked to follow this writer into Resident #24's room. CNA #1 confirmed that Resident #24's call bell was detached from the wall and on the floor. When asked Resident #24 needed her bed in the lowest position, CNA #1 stated that she thought the resident just couldn't have her bed too high. When asked if CNAs had access to the care plan, CNA #1 stated that they did not. When asked if Resident #24's bed was in the lowest position; CNA #1 took the bed controller and was able to lower the bed even further.

On 4/29/21 at 3:06 p.m., an interview was conducted with LPN (Licensed Practical Nurse) #1, Resident #24's nurse. When asked what fall preventative measures should be in place for Resident #24; LPN #1 stated that her call bell should always be in reach and functioning. When asked if Resident #24 was able to use to call bell, LPN #1 stated that she was. When asked if Resident #24's bed had to be in the lowest position, LPN #1 stated that she wasn't sure if her bed had to be in the lowest position. When asked if nurses had access to the care plan, LPN #1 stated that they did. When asked if nursing aides had access to the care plan, LPN #1 stated that she was not sure. LPN #1 stated that nurses usually verbally communicated Resident needs to the nursing aides.

On 4/29/21 at 5:52 p.m., the facility Administrator and the DON (Director of Nursing) were made aware of the above concerns.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495367	A. BUILDING _____ B. WING _____	04/29/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHAMPTON CONVALESCENT AND REHABILITATION CENTER	1028 TOPPING LANE HAMPTON, VA 23666

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 60 Facility policy titled, "Fall Management" documents in part, the following information: "The facility strives to promote resident safety and protect resident rights and dignity...the facility assesses each resident for his or risk for falls, designs an individualized person centered care plan for care, and implements interventions to minimize falls and/or injury...Fall mitigation strategies...Maintaining bed in low position, providing call system that is within reach reach and secured..."	F 689		
F 758 SS=E	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically	F 758		6/10/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495367	A. BUILDING _____ B. WING _____	04/29/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHAMPTON CONVALESCENT AND REHABILITATION CENTER	1028 TOPPING LANE HAMPTON, VA 23666

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 758	Continued From page 61 contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on clinical record reviews, staff interviews and facility documentation, the facility staff failed to do a Gradual Dose Reduction (GDR) for 1 of 28 residents (Resident #35) in the survey sample who were receiving a PRN (as needed) psychotropic medication. The findings included: 1. The facility staff failed to ensure a PRN (as needed) psychotropic medication (Ativan) was limited to 14 days for Resident #35. The physician did not do an evaluation of Resident #35 to extend the psychotropic medication pass	F 758	The date of completion serves as my allegation of compliance. 1. Resident #35 was seen by the provider on 4/28/21. The provider has documented the rationale for continued use of the prn Ativan at this time as the resident continues to have episodic behavioral outbursts that are unrelieved with non-pharmacological interventions and requires medication administration periodically. The medication will be discontinued in six months and reevaluated for continued need.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495367	A. BUILDING _____ B. WING _____	04/29/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHAMPTON CONVALESCENT AND REHABILITATION CENTER	1028 TOPPING LANE HAMPTON, VA 23666

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 758	Continued From page 62 14 days without documenting the rational and duration in the resident's medical record. Resident #35 was originally admitted to the facility on 11/23/05. Diagnosis for Resident #35 included but not limited to Dementia with behavioral disturbances, Anxiety and Major Depressive Disorder. Resident #35's Minimum Data Set (MDS-an assessment protocol) a quarterly assessment with an Assessment Reference Date of 03/10/21 coded Resident #35 a 03 out of a possible score of 15 on the Brief Interview for Mental Status (BIMS), indicating severe impaired cognitive skills for daily decision-making. In addition, the MDS with an ARD of 03/10/21, under section "E" (Behaviors), coded Resident #35 for not exhibiting physical and verbal behaviors directed towards others 1-3 days each week. The resident was also coded for not having behaviors symptoms not directed toward others. Under section (E0800), for rejection of care was coded for not having behavior occurred 1-3 days each week. Resident #35's person-centered comprehensive care plan with a revision date 05/10/16 documented Resident #35 at risk for side effects related to use psychoactive medication. The goal: will achieve desired effect from ordered medications and will experience no negative effects. Some of the interventions to manage goals include but not limited to: offer non-pharmalogical interventions prior to increasing medications or giving PRN medications, assess for other causes for mood or behavior disturbances prior to use of PRN medications and consulting Pharmacist Medication Regimen Review (MMR) at least	F 758	2. The Director of Nursing/Designee will complete a 100% audit of residents on psychotropic medications to ensure there is documentation for the clinical rationale and 14 day stop date of PRN psychotropic medications. If it is determined the provider believes it is appropriate for the PRN order to be extended beyond 14 days, the medical record will be updated, if needed, to ensure the rationale and duration of the order is documented. 3. The Medical Director/Designee will educate the providers on the required clinical rationale and 14-day limitation of psychotropic medications. The in-service will include but is not limited to a review of the regulatory guidance for prescribing all psychotropic medications, duration of orders and requirements for documentation rationale for extending orders beyond 14 days for psychotropic medications. The Director of Nursing/Designee will in-service nursing staff regarding PRN psychotropic medications and importance of physician documentation of rationale and a stop date for prn orders. 4. The Director of Nursing/Designee will review all new orders for PRN psychotropic medications for six weeks to ensure clinical rationale and a 14 day stop date is present. If the stop date is longer than 14 days, the audit will ensure documentation is present to reflect the rationale for extended use. Any concerns	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495367	A. BUILDING _____ B. WING _____	04/29/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHAMPTON CONVALESCENT AND REHABILITATION CENTER	1028 TOPPING LANE HAMPTON, VA 23666

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 758	Continued From page 63 monthly. The physician Order Sheet (POS) for April 2021 included the following order: Ativan 0.5 mg tablet by mouth as needed every 6 hours starting on 08/19/20 for Major Depressive Disorder. 1. Review of January 2021 Treatment Administration Record (TAR) revealed, PRN Ativan was administered on the following days: 01/05, 01/06, 01/08, 01/09, 01/26, 01/27 and 01/29/21. 2. Review of March 2021 Treatment Administration Record (TAR) revealed, PRN Ativan was administered on the following days: 03/03, 03/06, 03/26, 03/28 and 03/30/21. 3. Review of April 2021 Treatment Administration Record (TAR) revealed, PRN Ativan was administered on the following days: 04/01, 04/08, 04/18, 04/20 and 04/28/21. On 04/29/21 at approximately 10:57 a.m., a phone interviewed was conducted with the Director of Nursing (DON.) The DON reviewed Resident #35's Ativan order then stated, "The PRN Ativan order should have been written for 14 days then reevaluated by the physician." After the physician had reassess Resident #35 for the use of the PRN Ativan, a new order should have been written to resume the as needed Ativan with a physician progress note explaining the reason for the continuation of the Ativan. The facility's Administration team was informed of the finding during a debriefing on 04/29/21 at approximately 6:00 p.m. The facility staff did not present any further information about the findings.	F 758	will be forwarded to the provider for appropriate follow-up. The Director of Nursing/designee will review the audit results for any patterns or trends and report any findings to our Quality Assurance Performance Improvement Committee on at least a quarterly basis.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495367	A. BUILDING _____ B. WING _____	04/29/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHAMPTON CONVALESCENT AND REHABILITATION CENTER	1028 TOPPING LANE HAMPTON, VA 23666

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 758	Continued From page 64 A policy for the use of PRN psychotropic medication was requested on 04/29/21 at approximately 5:04 p.m., but not received.	F 758		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and facility document review, it was determined that the facility staff failed to store narcotics in a double lock compartment; AND failed to ensure one	F 761	The date of completion serves as my allegation of compliance. 1. The CathFlo Activase was removed	6/10/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495367	A. BUILDING _____ B. WING _____	04/29/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHAMPTON CONVALESCENT AND REHABILITATION CENTER	1028 TOPPING LANE HAMPTON, VA 23666

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 761	Continued From page 65 medication room (The Bethel Unit) was free from expired medication. The findings included: On 4/29/21 at 9:23 a.m., observation of the Bethel Unit medication room was conducted. An unopened 30 ml (milliliter) bottle of Ativan (1) was found in the door of the medication refrigerator behind only one lock to get into the refrigerator. The bottle of Ativan was not stored in a black locked box with the other bottles of Ativan. On 4/29/21 at 9:24 a.m., an interview was conducted with LPN (Licensed Practical Nurse) #2. LPN #2 stated that the Ativan was being stored in the door of the refrigerator because the resident (that the Ativan belonged to) had recently passed. When asked if the Ativan should still be stored in the locked black box or behind a double lock; LPN #2 stated that it should. Upon further review of the medication room; an unopened house stock bottle of CathFlo Activase (2) was observed in the medication refrigerator. The expiration date on this bottle documented: "July 2019." When asked LPN #2 if all medications in the refrigerator were available to be used, LPN #2 that they were. When asked if the bottle of Cath Flo should have been removed, LPN #2 looked at the expiration date and stated "Yes, Ma'am." On 4/29/21 at 5:52 p.m., the facility Administrator and the DON (Director of Nursing) were made aware of the above concerns. Facility policy titled, "Storage and Expiration Dating of Medications, Biologicals, Syringes, and	F 761	and discarded from refrigerator due to being expired, narcotic Ativan was placed in double lock container in refrigerator. 2. All medication refrigerators have been inspected to ensure any expired medications have been removed and all narcotics are behind double lock system. 3. The Director of Nursing/designee will in-service RNs and LPNs on the Storage and Expiration Dating of Medications, Biologicals, Syringes, and Needles. The in-service will include a review on checking medications for manufacturer expiration dates and/or use by dates and storage of controlled substances behind a double lock. 4. The Director of Nursing/designee will inspect the medication refrigerators weekly for six weeks to ensure there are no expired medications are present and all controlled substances are behind double lock system. The Director of Nursing will report findings to the Quality Assurance and Assessment committee at least quarterly. 5.) June 10, 2021	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495367	A. BUILDING _____ B. WING _____	04/29/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHAMPTON CONVALESCENT AND REHABILITATION CENTER	1028 TOPPING LANE HAMPTON, VA 23666

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 761	Continued From page 66	F 761		

Needles" documents in part, the following: "...Facility should store Scheduled II-V Controlled Substances and other medications deemed by facility to be at risk for abuse or diversion in a separate compartment within the locked medication carts and should have a different key or access device...Facility should ensure that all controlled substances are stored in a manner that maintains their integrity and security...Facility should ensure that medications and biologicals that:(1) have an expired date on the label; (2) have been retained longer than recommended by manufacturer or supplier guidelines; or (3) have been contaminated or deteriorated, are stored separate from other medications until destroyed or returned to the supplier."

(1) Ativan-"A scheduled IV controlled substance indicated for the management of anxiety disorders or for the short-term relief of the symptoms of anxiety or anxiety associated with depressive symptoms." This information was obtained from The National Institutes of Health. https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=89057c93-8155-4040-acec-64e877bd2b4c.

(2) Cathflo Activase- "is indicated for the restoration of function to central venous access devices as assessed by the ability to withdraw blood." This information was obtained from The National Institutes of Health. https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=91ecdef2-95ff-42dd-a31c-c8a09cab3ad9.