PRINTED: 12/03/2021 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G		ATE SURVEY MPLETED
		495332	B. WING _			C 02/25/2021
	ROVIDER OR SUPPLIER E HEALTHY LIVING COM	MMUNITY-SMITHFIELD		STREET ADDRESS, CITY, STATE, ZIP CODE 101 JOHN ROLFE DRIVE SMITHFIELD, VA 23430		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
E 000	Initial Comments		E 0	00		
F 000	survey was conducte 02/25/21. The facility compliance with 42 C Requirement for Long emergency prepared investigated during the INITIAL COMMENTS. An unannounced Me conducted 02/23/21 the Corrections are requined CFR Part 483 Federal requirements. The Lift will follow. Two compliance during the survey: VA Twenty facility resided COVID-19 virus, 17 meters of the employee tested positive for the	was in substantial FR Part 483.73, g-Term Care Facilities. No ness complaints were ne survey. dicare standard survey was hrough 02/25/21. red for compliance with 42 nl Long Term Care ne Safety Code survey/report laint were investigated n00048948 and VA00049197. Ints tested positive for the necovered. At the time of the no current residents that ne virus. Eighteen facility tive for the COVID-19 virus, nd 1 remained quarantined	FO	00		
F 580 SS=D	Resident reviews and		F 5	80		4/9/21
ABORATORY	consult with the resid consistent with his or representative(s) who	ediately inform the resident; ent's physician; and notify, her authority, the resident en there is-		TITLE		(X6) DATE

03/19/2021 **Electronically Signed**

Facility ID: VA0200

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING			DATE SURVEY COMPLETED			
		495332	B. WING _			C 02/25/2021
	ROVIDER OR SUPPLIER E HEALTHY LIVING CO	DMMUNITY-SMITHFIELD		STREET ADDRESS, CITY, STATE, ZIP COD 101 JOHN ROLFE DRIVE SMITHFIELD, VA 23430		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CO ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE
F 580	Continued From page	ge 1	F 5	580		
	(A) An accident invoresults in injury and physician interventiin (B) A significant charmental, or psychosodeterioration in heal status in either life-tolinical complication (C) A need to alter to a need to discontinut reatment due to ad commence a new for (D) A decision to transident from the fas 483.15(c)(1)(ii). (iii) When making not (14)(i) of this section all pertinent informatic is available and prophysician. (iii) The facility must resident and the rest when there is-(A) A change in root as specified in §483. (B) A change in resistate law or regulat (e)(10) of this section (iv) The facility must update the address phone number of the representative(s). §483.10(g)(15) Admission to a communitation a composite §483.5) must disclose	blving the resident which has the potential for requiring on; ange in the resident's physical, ocial status (that is, a th, mental, or psychosocial hreatening conditions or as); reatment significantly (that is, as an existing form of verse consequences, or to form of treatment); or ansfer or discharge the cility as specified in station specified in \$483.15(c)(2) wided upon request to the at also promptly notify the sident representative, if any, and or roommate assignment as 10(e)(6); or dent rights under Federal or ions as specified in paragraph on. It record and periodically (mailing and email) and				

F 580 Continued From page 2 locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under \$483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on information gleamed during a complaint intreview, staff interviews, clinical record review, and review of facility documents, the facility s staff failed to notify the resident representative of a change in condition for 1 of 20 residents (Resident #21), in the survey sample. The findings included: Resident #21 was originally admitted to the facility 4/24/20, and was discharged 5/4/20, return not anticipated therefore; a closed record review was conducted. Resident #21's diagnoses included; a total right kneer replacement, diabetes and hyperlipidemia. The admission Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 4/30/21 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 15 out of a possible 15. This indicated Resident #21's cognitive abilities for daily decision making were intact. In section "G" (Physical functioning) the resident was coded as requiring extensive assistance of one person with thathing, tolleting and dressing, limited assistance of one person with transfers, walking in room and personal hygiene and independent after set-up with eating. F 580 SS=D Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(1(4)(f)(iv)(15) cross tag 12 VAC 5-371-220(B,D,H) Ontification of changes in condition on 22/24/2021. 1. Resident #21 no longer resides at the facility and was discharged on 5/15/2020. The nurse was educated 1:1 by the DON on ontification of changes in condition on 22/24/2021. 2. All TARs on current residents with pressure injuries Responsible Representative notification, change in condition nat verify notification, and condition and verify notification, change in condition and verify notification, change in condition and verify notification, change in condition and verify				(X3) DATE SURVEY COMPLETED		
RIVERSIDE HEALTHY LIVING COMMUNITY-SMITHFIELD SUMMARY STATEMENT OF DEFICIENCIES SMITHFIELD, V.2. 3430 SUMMARY STATEMENT OF DEFICIENCIES SMITHFIELD, V.2. 3430 SUMMARY STATEMENT OF DEFICIENCIES SMITHFIELD, V.2. 3430 SMITHFIELD, V.2.			495332	B. WING		
SUMMARY STATEMENT OF DEFICIENCIES SUMMARY STATEMENT OF DEFICIENCIES PREFIX SUMMARY STATEMENT OF DEFICIENCIES PREFIX PROPURED SPLAN OF CORRECTION SHOULD BE CROSS REFERENCED TO THE APPROPRIATE DATE OF THE PREFIX PROPURED SPLAN OF CORRECTION SHOULD BE CROSS REFERENCED TO THE APPROPRIATE DATE OF THE PREFIX PROPURED SPLAN OF CORRECTION SHOULD BE CROSS REFERENCED TO THE APPROPRIATE DATE OF THE PREFIX PROPURED SPLAN OF CORRECTION SHOULD BE CROSS REFERENCED TO THE APPROPRIATE DATE OF THE PREFIX PROPURED SPLAN OF CORRECTION SHOULD BE CROSS REFERENCED TO THE APPROPRIATE DATE OF THE PREFIX PROPURED SPLAN OF CORRECTION SHOULD BE CROSS REFERENCED TO THE APPROPRIATE DATE OF THE PREFIX PROPURED SPLAN OF CORRECTION SHOULD BE CROSS REFERENCED TO THE APPROPRIATE DATE OF THE PREFIX PROPURED SPLAN OF CORRECTION SHOULD BE CROSS REFERENCED TO THE APPROPRIATE DATE OF THE PREFIX PROPURED SPLAN OF CORRECTION SHOULD BE CROSS REFERENCED TO THE APPROPRIATE DATE OF THE PREFIX PROPURED SPLAN OF CORRECTION SHOULD BE CROSS REFERENCED TO THE APPROPRIATE DATE OF THE PREFIX PROPURED SPLAN OF CORRECTION SHOULD BE CROSS REFERENCED TO THE APPROPRIATE DATE OF THE PREFIX PROPURED SPLAN OF CORRECTION SHOULD BE CROSS REFERENCED TO THE APPROPRIATE DATE OF THE PREFIX PROPURED SPLAN OF CORRECTION SHOULD BE CROSS REFERENCED TO THE APPROPRIATE DATE OF THE PROPURED SPLAN OF CORRECTION SHOULD BE CROSS REFERENCED TO THE APPROPRIATE DATE OF THE PROPURED SPLAN OF CORRECTION SHOULD BE CROSS REFERENCED TO THE APPROPRIATE DATE OF THE PROPURED SPLAN OF CORRECTION SHOULD BE CROSS REFERENCED TO THE PREFIX PROPER OF THE PREFIX PROPURED SPLAN OF CORRECTION SHOULD BE CROSS REFERENCED TO THE PREFIX PROPURED SPLAN OF CORRECTION SHOULD BE CROSS REFERENCED TO THE PROPURED SPLAN OF CORRECTION OF THE PROPURED SPLAN OF CORRECTION SHOULD BE CROSS REFERENCED TO THE PREFIX PROPURED SPLAN OF CORRECTION SHOULD BE CROSS REFERENCED TO THE PROPURED SPLAN OF CORRECTION OF THE PROPURED SPLAN OF THE PROPURED SPLAN OF CORRECTION OF THE PROPURED SPLAN OF CORS	NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	02/25/2021
CMA-JID CMA-						
F 580 Continued From page 2 locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §48.3.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on information gleamed during a complaint investigation, a complainant interview, staff interviews, clinical record review, and review of facility documents, the facility's staff failed to notify the resident representative of a change in condition for 1 of 20 residents (Resident #21), in the survey sample. The findings included: Resident #21 was originally admitted to the facility 4/24/20, and was discharged 5/4/20, return not anticipated therefore; a closed record review was conducted. Resident #21's diagnoses included; a total right knee replacement, diabetes and hyperlipidemia. The admission Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 4/30/21 closed the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 15 out of a possible 15. This indicated Resident #21's cognitive abilities for daily decision making were intact. In section "G" (Physical functioning) the resident was coded as requiring extensive assistance of one person with thathing, tolieting and dressing, limited assistance of one person with transfers, walking in room and personal hygiene and independent after set-up with eating.	RIVERSID	E HEALTHY LIVING COM	MMUNITY-SMITHFIELD			
locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under \$433.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on information gleamed during a complaint investigation, a complainant interview, staff interviews, clinical record review, and review of facility documents, the facility's staff failed to notify the resident representative of a change in condition for 1 of 20 residents (Resident #21), in the survey sample. The findings included: The findings included: The findings included: The admission discharged 5/4/20, return not anticipated therefore; a closed record review was conducted. Resident #21's diagnoses included; a total right knee replacement, diabetes and hyperlipidemia. The admission Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 4/30/21 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 15 out of a possible 15. This indicated Resident #21's cognitive shillities for daily decision making were intact. In section "G" (Physical functioning) the resident was coded as requiring extensive assistance of one person with bathing, tolleting and dressing, limited assistance of one person with bathing, tolleting and dressing, limited assistance of one person with thathing, tolleting and dressing, limited assistance of one person with bathing, tolleting and dressing, limited assistance of one person with thathing, tolleting and dressing, limited assistance of one person with thathing, tolleting and dressing, limited assistance of one person with that the assistance of one person with that the assistance of one person with bathing, tolleting and dressing, limited assistance of one person with that the assistance of one person with the assistance of one person with the assistance of one	PRÉFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA	E COMPLETION
part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on information gleamed during a complaint investigation, a complainant interview, staff interviews, clinical record review, and review of facility documents, the facility's staff failed to notify the resident representative of a change in condition for 1 of 20 residents (Resident #21), in the survey sample. The findings included: The findings included: The findings included: The sident #21 was originally admitted to the facility 4/24/20, and was discharged 6/4/20, return not anticipated therefore; a closed record review was conducted. Resident #21's diagnoses included; a total right knee replacement, diabetes and hyperlipidemia. The admission Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 4/30/21 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 15 out of a possible 15. This indicated Resident #21's cognitive abilities for daily decision making were intact. In section "C" (Physical functioning) the resident was coded as requiring extensive assistance of one person with bathing, tolleting and dressing, limited assistance of one person with transfers, walking in room and personal hygiene and independent after set-up with eating.	F 580	Continued From page	÷ 2	F 580	0	
8 weeks to verify that changes in condition	F 580	locations that comprise part, and must specify room changes between under §483.15(c)(9). This REQUIREMENT by: Based on information complaint investigation staff interviews, clinic of facility documents, notify the resident reproduction for 1 of 20 method the survey sample. The findings included Resident #21 was orion 4/24/20, and was disconducted. Resident total right knee replace to hyperlipidemia. The admission Minimum assessment with an an (ARD) of 4/30/21 code completing the Brief I (BIMS) and scoring 1 indicated Resident #2 daily decision making (Physical functioning) requiring extensive as bed mobility, extensive with bathing, toileting assistance of one per in room and personal	see the composite distinct by the policies that apply to sen its different locations. It is not met as evidenced an gleamed during a son, a complainant interview, all record review, and review the facility's staff failed to presentative of a change in sesidents (Resident #21),	F 580	F580 SS=D Notify of Changes (Injury/Decline/Roor etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) cross tag 12 VAC 5-371-220(B,D,H) 1. Resident #21 no longer resides at facility and was discharged on 5/15/20 The nurse was educated 1:1 by the DC on notification of changes in condition 2/24/2021. 2. All TARs on current residents will reviewed by the DON/Designee since 2/25/2021 to ensure that residents with pressure injuries Responsible Representatives have been notified an notification has been documented. 3. The DON/Designee will review the 24HR report during morning huddle to identify new orders requiring Resident Representative notification, change in condition and verify notifications are communicated and documented to the Resident Representative. The Clinical Educator/Designee will provide educate to the nursing staff on compliance with Resident Representative notification by 4/9/2021. 4. The DON/Designee will conduct audits on 6 residents per week for 4	the 20. DN on on oe of the state of the stat
Daring the interview with the complainant on I have been communicated to the Nesident					- I	ition

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		495332	B. WING _			l	25/2021
NAME OF PI	ROVIDER OR SUPPLIER		1	ST	TREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	20/202 !
				10	01 JOHN ROLFE DRIVE		
RIVERSID	E HEALTHY LIVING COM	MMUNITY-SMITHFIELD			MITHFIELD, VA 23430		
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F 580	facility's staff never not had acquired a press. The complainant state the resident was very to sit on her behind we the facility therefore; so and that was when shareas to her behind. To open area were unconcomplainant stated share the facility to inquire complainant stated share was admitted with but the staff didn't see had been discharged. Review of Resident # she was admitted with buttock. The Braden and 5/8/20 indicated to for development of a notes stated the residuent continent of her bladd required assistance with mobility because of the revealed on 5/9/20 the area measuring 0.5 concentimeters to the right was obtained to treat read; cleanse the right saline and pat dry. A	the complainant stated the officed her that Resident #21 are ulcer while at the facility. The door the day of discharge uncomfortable and unable hen they arrived home from she assisted her to undress the first learned of the open. The complainant stated the vered and large. The the immediately telephoned of the open areas to the asked how to care for them the tocare since the resident. 21's clinical record revealed thout an open area to her scale completed on 4/24/20 the resident was a mild risk pressure ulcer. Nurses' the toileted and was mostly ler and bowels but she with transfers and bed the right knee limitations. ident #21's clinical record the estaff identified an open the entimeters by 0.5 and lower buttock. An order the open area. The order at buttock gently with normal	F	580	Representative and documented in the medical record. The results of the audi will be reported quarterly at the QAPI meeting by the DON/Designee for evaluation of compliance and ongoing monitoring for continuous improvement and analysis after the implementation. 5. All corrective actions will be completed by 4/9/2021.	its	
	Review of Resident # revealed the right but performed 5/10/20 an	tock dressing change was					

			(X3) DATE COMP	SURVEY LETED			
		495332	B. WING			1	25/2021
	ROVIDER OR SUPPLIER E HEALTHY LIVING CON	MMUNITY-SMITHFIELD		10	TREET ADDRESS, CITY, STATE, ZIP CODE 01 JOHN ROLFE DRIVE MITHFIELD, VA 23430	,	-
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F 580	Continued From page		F	580			
	the nurse who originated Resident #21's but initial order for care. hadn't been trained to or staging therefore; wound assessment wan in-depth assessment appropriate treatment. An interview was con Nursing on 2/25/21 at The Director of Nursing included to immediate wound, notify the propresentative, start to complete rCare documents and the area was healed. The stated the next busing leader/wound champ wasn't completed and determined. Neither was he of the open area or detime of Resident #21' representative was now of the open area or determined. On 2/25/21 at approximations were shared the Director of Nursing to stage the determined to the open area.	m. LPN #1 stated she was ally assessed the open area tock and she obtained the She further stated she of determine types of wounds a staff member trained in was responsible to complete ent and determine the most it. ducted with the Director of approximately 11:30 a.m. and stated LPN #1 duties ely assess and measure the wider and resident the ordered treatment, ments, a nurses note, write anotify nursing the on-coming shift until the elicity of the elicity was the Director of Nursing the elicity was the Director of Nursing					

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ' '		CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		495332	B. WING			1	C 25/2021
	ROVIDER OR SUPPLIER E HEALTHY LIVING COI	MMUNITY-SMITHFIELD	•	10 ⁻	REET ADDRESS, CITY, STATE, ZIP CODE 1 JOHN ROLFE DRIVE MITHFIELD, VA 23430		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 580	guides the nurse to e measures are met.	ntative of changes in he algorithm is utilized it nsure all necessary The Administrator stated she ern and had no additional	F	580			
F 582 SS=D	Medicaid/Medicare CCFR(s): 483.10(g)(17) \$483.10(g)(17) The facility and when the Medicaid of- (A) The items and senursing facility service for which the resident (B) Those other items facility offers and for charged, and the ameservices; and (ii) Inform each Medichanges are made to specified in §483.10(section. \$483.10(g)(18) The facility services, including ar covered under Medic facility's per diem rate (i) Where changes in and services covered	coverage/Liability Notice (7)(18)(i)-(v) acility must caid-eligible resident, in admission to the nursing resident becomes eligible for rvices that are included in es under the State plan and at may not be charged; and services that the which the resident may be count of charges for those caid-eligible resident when the items and services g)(17)(i)(A) and (B) of this acility must inform each the time of admission, and e resident's stay, of services y and of charges for those ny charges for services not lare/ Medicaid or by the	F	582			4/9/21

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED
		495332	B. WING _		C 02/25/2021
	ROVIDER OR SUPPLIER PE HEALTHY LIVING CO	MMUNITY-SMITHFIELD		STREET ADDRESS, CITY, STATE, ZIP CODE 101 JOHN ROLFE DRIVE SMITHFIELD, VA 23430	1 02/20/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' ((EACH CORRECTIVE ACTION SHOUNDER CORRECTIVE ACTION SHOUNDER CORRECTIVE ACTION SHOUNDER CORRECTIVE ACTION SHOUNDER CORRECTIVE ACTION OF CORRECTIVE ACTION OF CORRECTIVE ACTION OF CORRECTIVE ACT	JLD BE COMPLETION
F 582	notice to residents of reasonably possible. (ii) Where changes a items and services the facility must inform the 60 days prior to imple (iii) If a resident dies transferred and does facility must refund to representative, or estideposit or charges all per diem rate, for the resided or reserved of facility, regardless of discharge notice requivity. The facility must resident representative the resident within 30 date of discharge from (v) The terms of an abehalf of an individual facility must not confit these regulations. This REQUIREMENT by: Based on clinical regard facility document to ensure Medicare Eleacordance with app were issued to 2 of 3 Resident #13) out of The facility staff failed Beneficiary Notice (A	re made to charges for other nat the facility offers, the ne resident in writing at least rementation of the change. Or is hospitalized or is not return to the facility, the other resident, resident tate, as applicable, any ready paid, less the facility's days the resident actually or retained a bed in the any minimum stay or direments. The facility of any and all refunds due of days from the resident or over any and all refunds due of days from the resident's must facility. It is not met as evidenced for the facility staff failed deneficiary Notices in the facility staff failed deneficiary Notices in the survey sample. The the charges for other resident or the facility staff failed deneficiary Notices in the facility staff failed deneficiary Notices in the survey sample. The the charges for other resident and the charges for the survey sample. The the charges for other resident and the charges for the charges	F 5	F582 SS=D Medicaid/Medicare Coverage/Liab Notice CFR(s): 483.10(g)(17)(18)(i)-(v) cn 12 VAC 5-371-150 B1 (C, D, G, & 1. ABNs were provided to the tw residents identified as not having receiving ABNs on 2/24/2021. The Administrator provided 1:1 educati the Social Worker in the process o issuing ABN forms to resident/Res Representatives #2 and #13 on	oss tag F) o e on to f

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′			(3) DATE SURVEY COMPLETED
		495332	B. WING _			C 02/25/2021
NAME OF P	ROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CO	DDE	02/23/2021
				101 JOHN ROLFE DRIVE		
RIVERSID	E HEALTHY LIVING COI	MMUNITY-SMITHFIELD		SMITHFIELD, VA 23430		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE
F 582	1. Resident #2 was a facility on 11/16/20. I included but not limite Weakness. Resident (MDS) an OBRA Adm Assessment Referen 11/21/20 coded Reside possible score of 15 Mental Status (BIMS) impairment. Review of the SNF B Review provided by the noted that Resident #2 been issued the SNF Facility-Advanced Be resident had received Medicare Provider Noted the SNF ABN Resident #2 started a 11/17/20 and the last 11/27/20. Resident #4 Medicare Part A servinot exhausted. Resident a SNF ABN and an Nonly issued an NOMN An interview was con Worker (SW) on 02/2 p.m. He stated, "I'm rean't find a copy of the Resident #2." When	admitted to the nursing Diagnosis for Resident #2 ed to Generalized Muscle t #2's Minimum Data Set nission Assessment with an ce Date (ARD) date of dent #2 a 15 out of a on the Brief Interview for), indicated no cognitive eneficiary Notification the facility to surveyor, was the was not listed for having ABN (Skilled Nursing eneficiary Notice.). The dia NOMNC (Notice of on-Coverage), however; no I was provided. A Medicare Part A stay on covered day of this stay was the was discharged from dices when benefit days were dent #2 had only used 12 Part A services with 88 days the was discharged from dices when benefit days were dent #2 had only used 12 Part A services with 88 days the dioMNC. Resident #2 was NC. Inducted with the Social the days was discharged that approximately 2:45 that sure what happened; I	F 5	2/24/2021. 2. On 3/16/2021, the Social audited all Medicare A discharge issued as appropriate. All find appropriate. 3. The Administrator/Designeriew all upcoming level of and verify at the morning meweekday that the ABN has be Education was provided to the Worker by the Administrator 4. The Business Office/Demaudit 2 residents who have offrom SNF services with Medical days remaining for 4 weeks, resident per week for 8 week that the ABN was issued. The audits will be reported questionally and ongoing monitoring for and ongoing monitoring for a improvement and analysis a implementation. 5. All corrective actions with completed by 4/9/2021.	arges to BNs were Indings were Ignee will care change eeting each been provided the Social by 3/23/202' esignee will discharged licare A skille and then 1 ks to ensure the results of uarterly at the istrator/ ompliance continuous fter the	d. 1.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING		 	(X3) DATE SURVEY COMPLETED				
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(X4) ID PREFIX TAG	EFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFII TAG	(EACH	OVIDER'S PLAN OF CORRECTION H CORRECTIVE ACTION SHOULD I REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 582	2. Resident #13 was facility on 12/24/20. included but not limit Weakness. Resider (MDS) an OBRA Add Assessment Referer 12/30/20 coded Respossible score of 15 Mental Status (BIMS impairment. Review of the SNF ER Review provided by noted that Resident been issued the SNIF Facility-Advanced Bresident had receive Medicare Provider Nacopy of the SNF ABI Resident #13 started 12/26/20, and the lawas 01/25/20. Resident #13 started 12/26/20, and the lawas 01/25/20. Resident #13 was only issued a SNF ABN are maining. Resident i	Diagnosis for Resident #13 Led to Generalized Muscle Let #13's Minimum Data Set Imission Assessment with an Ince Date (ARD) date of Lident #13 a 14 out of a Lon the Brief Interview for Lident #13 was not listed for having Let ABN (Skilled Nursing Leneficiary Notice.) The Led a NOMNC (Notice of Lon-Coverage), however; no Lene Medicare Part A stay on Let covered day of this stay Lene #13 was discharged Lene #13 should have been Lend an NOMNC. Resident Lene ABN Letter." When asked, Lene ABN	F	582			

COMPLETED
02/25/2021
S, CITY, STATE, ZIP CODE E DRIVE /A 23430
ROVIDER'S PLAN OF CORRECTION CH CORRECTIVE ACTION SHOULD BE S-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X5) COMPLETION DATE
4/9/21
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED	
	495332	B. WING _		02/25/20	124	
NAME OF PROVIDER OR SUPPLIER RIVERSIDE HEALTHY LIVING			STREET ADDRESS, CITY, STATE, ZIP CO 101 JOHN ROLFE DRIVE SMITHFIELD, VA 23430	•) <u>Z 1</u>	
PREFIX (EACH DEFIC	RY STATEMENT OF DEFICIENCIES IENCY MUST BE PRECEDED BY FULL Y OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTIVE) CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) IPLETION DATE	
resident refuses to resident who becadmission to a faresident only allow or (F) The facility ce (ii) The facility maresident while the § 431.230 of this exercises his or has discharge notice 431.220(a)(3) of the discharge or transor safety of the refacility. The facility and the facility resident under an in paragraphs (c) section, the facility or discharge is downedical record and communicated to institution or proven (i) Documentation must include: (A) The basis for (i) of this section. (B) In the case of section, the special peeds, and the section in the section of the section in the section i	icaid, denies the claim and the to pay for his or her stay. For a omes eligible for Medicaid after cility, the facility may charge a wable charges under Medicaid; tasses to operate. ay not transfer or discharge the expeal is pending, pursuant to chapter, when a resident her right to appeal a transfer or from the facility pursuant to § this chapter, unless the failure to sfer would endanger the health exident or other individuals in the ty must document the danger hasfer or discharge would pose. Cumentation. transfers or discharges a hay of the circumstances specified (1)(i)(A) through (F) of this ty must ensure that the transfer ocumented in the resident's had appropriate information is the receiving health care ider. In in the resident's medical record the transfer per paragraph (c)(1) If paragraph (c)(1)(i)(A) of this iffic resident need(s) that cannot tempts to meet the resident ervice available at the receiving	F 6				

		TE SURVEY MPLETED					
	495332	B. WING _			C 2/25/2021		
ROVIDER OR SUPPLIER E HEALTHY LIVING CO	MMUNITY-SMITHFIELD		STREET ADDRESS, CITY, STATE, ZIP CODE 101 JOHN ROLFE DRIVE SMITHFIELD, VA 23430		2/20/2021		
SUMMARY STATEMENT OF DEFICIENCIES X (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		(EACH DEFICIENCY MUST BE PRECEDED BY FULL		(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX		SHOULD BE	(X5) COMPLETION DATE
(A) The resident's pl discharge is necess (A) or (B) of this sec (B) A physician whe necessary under pathis section. (iii) Information provemust include a minimal (A) Contact information responsible for the contact information (C) Advance Directive (D) All special instruction ongoing care, as ap (E) Comprehensive (F) All other necession copy of the resident consistent with §483 any other document a safe and effective This REQUIREMENT by: Based on clinical reand facility document failed to convey the comprehensive plant transfer/discharge for #23) in the survey significant of the receiving prove comprehensive care	nysician when transfer or ary under paragraph (c) (1) tion; and in transfer or discharge is ragraph (c)(1)(i)(C) or (D) of dided to the receiving provider num of the following: ion of the practitioner hare of the resident. The information including or propriate. In the information including a section of the practitioner propriate. In the information including a section of the practitions of propriate. In the information including a section of the practition of care plan goals; any information, including a section as applicable, and action, as applicable, to ensure transition of care. The information in the transfer summary of goals of the of care upon or 1 of 20 residents (Resident ample. The information include in the transfer that the facility staff conveyed diders the resident's plan goals at the time of	F	F622 SS=D Transfer and Discharge Requi CFR(s): 483.15(c)(1)(i)(ii)(2)(i tag 12 VAC 5-371-150 B1 (C, i 1. Resident #23 no longer re facility and was discharged on 2. All residents who were in as of 2/19/2021 had their plan summary sent to the hospital s acute care hospital has the rec information.	p-(iii) cross D, G, & F) esides at the 1/6/2021. the hospital of care so that the quired			
_			by the Clinical Educator/Desig	nee on the			
	CORRECTION ROVIDER OR SUPPLIER E HEALTHY LIVING CO SUMMARY S (EACH DEFICIEN REGULATORY OF REGULAT	ROVIDER OR SUPPLIER E HEALTHY LIVING COMMUNITY-SMITHFIELD SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 11 (A) The resident's physician when transfer or discharge is necessary under paragraph (c) (1) (A) or (B) of this section; and (B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff interviews and facility documentation review, the facility staff failed to convey the summary of goals of the comprehensive plan of care upon transfer/discharge for 1 of 20 residents (Resident #23) in the survey sample. The findings include: The facility staff failed to include in the transfer summary indication that the facility staff conveyed to the receiving providers the resident's comprehensive care plan goals at the time of discharge to the local hospital on 1/6/21 or as soon as possible to the actual time of transfer for	A BUILDIN 495332 ROVIDER OR SUPPLIER E HEALTHY LIVING COMMUNITY-SMITHFIELD SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 11 (A) The resident's physician when transfer or discharge is necessary under paragraph (c) (1) (A) or (B) of this section; and (B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. 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(B) A physician when transfer or discharge is necessary under paragraph (c) (1) ((C) or (D) of this section, and (D) All speal instructions or precautions for ongoing care, as appropriate, (E) Comprehensive care plan goals; (F) All other necessary information, including contact information (C) Advance Directive information (C) Advance Directive information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, ne ensure a safe and effective transition of care. This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff interviews and facility documentation review, the facility staff failed to convey the summary of goals of the comprehensive plan of care upon transfer/discharge for 1 of 20 residents (Resident #23) in the survey sample. 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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED	
		495332	B. WING _			C 02/25/2021	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE	ZIP CODE	02/25/2021	
				101 JOHN ROLFE DRIVE	, 2 3322		
RIVERSID	E HEALTHY LIVING COM	MMUNITY-SMITHFIELD		SMITHFIELD, VA 23430			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE CROSS-REFERENCE	AN OF CORRECTION 'E ACTION SHOULD BE D TO THE APPROPRIA CIENCY)	DATE	
F 622	on 12/15/20 with diag and bladder cancer. Resident #23's most (MDS) assessment w 12/21/20 and coded to Interview for Mental State of Nursing (MDS) assessment w 12/21/20 and coded to Interview for Mental State of Nurse was called to the staff members. Resid wheelchair in obvious transferred back to be mechanical lift) and 2 911 was called at app Paramedics arrived a CPR. The daughter at the situation. Parame pulse and the resident transferred to (name no documentation in staff conveyed to the resident's comprehentime of discharge or shospital. On 2/25/21 at 9:30 a. conducted with the Adof Nursing (DON). The goals and summary in the resident if possible email, but mostly faxe case, but it wasn't and	mitted to the nursing facility moses that included lung recent Minimum Data Set as an Annual dated he resident on the Brief Status (BIMS) with a score of core of 15 which indicated erely impaired in the skills for letted 1/6/21 indicated the ne room by other clinical ent was sitting in a st distress. He was ed via a Hoyer (brand name person CPR started while proximately 7:31 a.m. to 07:45 a.m. and took over and physician was notified of edics were able to get a set left the building to be of local hospital). There was the clinical record that facility receiving providers the asive care plan goals at the soon thereafter to the local	F	regulatory requirement provided to receiving institutions by 4/9/2024. A transfer/discharbeen developed and was needed by the DOI validate the plan of cabeen sent with the trathe receiving healthcathea DON/Designee will authe hospital for 8 weet plan of care summary hospital. The results reported quarterly at the DON/Designee for compliance and ongoin continuous improvemafter the implementation of the summary summary hospital authence and ongoin continuous improvemafter the implementation of the summary s	providers/healthca 1. The audit form has will be updated da N/Designee to re summary has ansferring resident re institution. It all discharges as to ensure that the was provided to the audits will be the QAPI meeting revaluation of any monitoring for ent and analysis on. The provider of the sum of the audits will be the control of the cont	to to the the be	

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3	(X3) DATE SURVEY COMPLETED			
		495332	B. WING			C
	ROVIDER OR SUPPLIER E HEALTHY LIVING CO	I		STREET ADDRESS, CITY, STATE, ZIP CODE 101 JOHN ROLFE DRIVE SMITHFIELD, VA 23430	ı	02/25/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG	PROVIDER'S PLAN OF CORF X (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 623 SS=D	a resident is transfer the nurse is prompter computer for the spe generates the transfer care plan summary whold notice, but there documents was sent that it was sent over after." The facility's policy tip Discharge/Transfer Findicated that the hose provided with all a notices at the time of possible for emergen including comprehen discharge summary. Notice Requirements CFR(s): 483.15(c)(3) §483.15(c)(3) Notice Before a facility transmesident, the facility most representative(s) of the reasons for the manguage and manner facility must send a corepresentative of the Long-Term Care Omicial (ii) Record the reason discharge in the residence and	the det to the ER or the hospital dethrough a check list in the coffic resident that in turn for summary that includes the with goals as well as the bed is no way to confirm the at the time of the transfer or to the ED or hospital soon. Ided Nursing Home realized at 12/11/19 repital of receiving facility will pplicable state and federal transfer or as soon as to discharges/transfers, sive care plan goals and. Before Transfer/Discharge refol(8) before transfer or discharge and retransfer or discharges a mustand the resident's fine transfer or discharge and retransfer or discharge a		523		4/9/21

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED		
		495332	B. WING _			C 02/25/2021	
	ROVIDER OR SUPPLIER	DMMUNITY-SMITHFIELD		STREET ADDRESS, CITY, STATE, ZIP CODE 101 JOHN ROLFE DRIVE SMITHFIELD, VA 23430		0212312021	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PREFIX (EACH CORRECTIVE ACTION SHOU		(X5) COMPLETION DATE	
F 623	(c)(8) of this section discharge required made by the facility resident is transferred (ii) Notice must be repetited to be endangered und this section; (B) The health of incide endangered, under this section; (C) The resident's health of allow a more immedunder paragraph (c); (D) An immediate the required by the resident has need to be endangered, under paragraph (c); (E) A resident has need to be endangered (c); (E) A resident has need to be endangered (c); (E) A resident has need to be endangered (c); (ii) The reason for the endangered or disched (iii) The location to be transferred or disched (iii) The seffective data (iii) The location to be transferred or disched (iii) A statement of the including the name, and telephone number to obtain an appeal completing the form the earing request;	g of the notice. ed in paragraphs (c)(4)(ii) and , the notice of transfer or under this section must be at least 30 days before the ed or discharged. hade as soon as practicable scharge when- dividuals in the facility would er paragraph (c)(1)(i)(C) of dividuals in the facility would er paragraph (c)(1)(i)(D) of ealth improves sufficiently to diate transfer or discharge, (1)(i)(B) of this section; ansfer or discharge is dent's urgent medical needs, (1)(i)(A) of this section; or ot resided in the facility for 30 ents of the notice. The written aragraph (c)(3) of this section owing: ansfer or discharge; e of transfer or discharge; which the resident is	F	523			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		495332	B. WING			1	C 25/2021
	ROVIDER OR SUPPLIER E HEALTHY LIVING COM	MMUNITY-SMITHFIELD		STREET ADDRESS, CITY, STATE, ZIP CODE 101 JOHN ROLFE DRIVE SMITHFIELD, VA 23430		1 021	Z3/Z0Z1
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECT PREFIX (EACH CORRECTIVE ACTION SHOUL TAG CROSS-REFERENCED TO THE APPRO DEFICIENCY)			(X5) COMPLETION DATE
F 623	Long-Term Care Omb (vi) For nursing facility and developmental disabilities, the mailing telephone number of the protection and addevelopmental disabilities. C of the Developmental disabilities of the Developmental disability of the Developmental disability of the Developmental disability. C of the Developmental disability of the Developmental disability of the Developmental disability. C of the Developmental disability of the Developmental disability of the Developmental disability. C of the Developmental disability of the Act codified at 42 U.S.C. (vii) For nursing facility disability of individual established under the for Mentally III Individual established under the for Mentally III Individual established under the formation in the effecting the transfer must update the recipas practicable once the becomes available. §483.15(c)(8) Notice In the case of facility the administrator of the written notification prito the State Survey A State Long-Term Carthe facility, and the rewell as the plan for the relocation of the residual the plan for the relocation of t	the Office of the State budsman; y residents with intellectual isabilities or related g and email address and the agency responsible for vocacy of individuals with lities established under Part tal Disabilities Assistance of 2000 (Pub. L. 106-402, 15001 et seq.); and ty residents with a mental esabilities, the mailing and dephone number of the por the protection and als with a mental disorder e Protection and Advocacy uals Act.	F	523 F	623		

PRINTED: 12/03/2021 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495332	B. WING _				25/2021
NAME OF PR	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 027	20/2021
				1	01 JOHN ROLFE DRIVE		
RIVERSID	E HEALTHY LIVING COI	MMUNITY-SMITHFIELD		S	MITHFIELD, VA 23430		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 623	Continued From page	e 16	F6	523			
	and facility document	t review the facility staff failed			SS=D		
	•	the State Long-Term Care			Notice Requirements Before		
		ng of applicable discharges			Transfer/Discharge		
	for 1 of 20 residents i				CFR(s): 483.15(c)(3)-(6)(8) cross tag	12	
	(Resident #23).				VAC 5-371-150 B1 (C, D, G, & F)		
	The findings included	d:			Resident #23 no longer resides at	the	
					facility and was discharged on 1/6/202	1.	
		d to notify the office of the			Since 2/25/2021, the ombudsman has		
	•	e Ombudsman of Resident			been notified of all facility initiated		
	#23's discharge to the	e hospital on 1/6/20.			discharges by the Admissions Coordinator.		
	Resident #23 was ad	mitted to the nursing facility			2. The Admissions		
		gnoses that included lung			Coordinator/Designee will complete an		
	and bladder cancer.	· ·			audit of all discharges since 2/25/2021		
					ensure all discharge notifications were		
	Resident #23's most	recent Minimum Data Set			issued to the ombudsman. Results of	the	
	(MDS) assessment w	vas an Annual dated			audit will be forwarded to the QAPI		
	12/21/20 and coded t	the resident on the Brief			Committee by the Admissions		
	Interview for Mental S	Status (BIMS) with a score of			Coordinator. Variances will be corrected	∍d	
	00 out of a possible s	score of 15 which indicated			with prompt notification to the state		
	the resident was seve	erely impaired in the skills for			ombudsman.		
	daily decision making] .			3. Administrator/Designee will educa	te	
					Clinical Staff and Interdisciplinary Tean	1	
		ted 1/6/21 indicated the			on the requirement to provide discharg	е	
		he room by other clinical			notification to the state long term care		
	staff members. Resid	_			ombudsman. As of 3/16/2021, IDT		
	wheelchair in obvious				reviews all facility initiated discharges		
		ed via a Hoyer (brand name			every weekday in morning huddle. Each		
	-	2 person CPR started while			facility initiated discharge notification is		
		proximately 7:31 a.m.			faxed and a copy and confirmation is k	ept	
		at 07:45 a.m. and took over			in the residents ☐ Business Office file.		
	•	and physician was notified of			4. For 4 weeks, the Admissions		
		edics were able to get a			Coordinator/Designee will conduct a	ĺ	
	•	nt left the building to be			weekly audit of 3 facility-initiated	ĺ	
	transferred to (name	of local hospital).			discharges, and then 2 weekly for 8	ĺ	
					weeks to ensure that the ombudsman		
	On 2/25/21 at 2:30 p.				was notified. The results of the audits		
	Coordinator presented the Transfer/Discharge				be reported quarterly at the QAPI meet	ing	

Facility ID: VA0200

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495332	B. WING			1	C 25/2021
	ROVIDER OR SUPPLIER E HEALTHY LIVING COI	MMUNITY-SMITHFIELD		10	TREET ADDRESS, CITY, STATE, ZIP CODE 11 JOHN ROLFE DRIVE MITHFIELD, VA 23430	1 027	23/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 623	Notice that indicated Ombudsman was not transfer to the hospits She stated, "I am su missed some and this least I informed them We normally send ou least a monthly notific This one should have January 2021." On 2/25/21 at 9:30 a. conducted with the Arof Nursing (DON). The Admission's Coordina maintain a list of transthe facility to be sent soon as they are transmonthly basis. The Arothy basis. The Arothy basis in the facility's policy tit Discharge/Transfer Prindicated that all applicated that all applicated to the Stat Notice of Bed Hold P CFR(s): 483.15(d)(1) Notice nursing facility transfer the resident goes on	the State Long-Term Care tified of Resident #23's all on 2/25/21 at 2:22 p.m. pposed to do this, but I is is one I missed, but I at after you asked me for it. It as soon as we can or at cation to the Ombudsman. It is been sent by the end of it. It is a soon as we can or at cation to the Ombudsman. It is been sent by the end of it. It is a soon as we can or at cation to the Ombudsman in the paternal stated that the laternal stated that the laternal stated is responsible to sefers and discharges from to the Ombudsman either as seferred, but at least on a ladministrator stated she were missed and ensure subudsman in timely. It is a laternal stated she were missed and ensure subudsman in timely. It is a laternal stated she were missed and federal ergent transfers or spital and to home as a applicable) will be e Ombudsman. Olicy Before/Upon Trnsfr		623	by the Admissions Coordinator/Designator evaluation of compliance and ongoi monitoring for continuous improvement and analysis after the implementation. 5. All corrective actions will be completed by 4/9/2021.	ng t	4/9/21

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		· ′	PLE CONSTRUCTION G	COMPLETED	
		495332	B. WING		C 02/25/2021
	ROVIDER OR SUPPLIER E HEALTHY LIVING CO	MMUNITY-SMITHFIELD		STREET ADDRESS, CITY, STATE, ZIP CODE 101 JOHN ROLFE DRIVE SMITHFIELD, VA 23430	02/23/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	O BE COMPLETION
F 625	specifies- (i) The duration of the any, during which the return and resume refacility; (ii) The reserve bed plan, under § 447.40 (iii) The nursing facility bed-hold periods, who paragraph (e)(1) of the resident to return; and (iv) The information sof this section. §483.15(d)(2) Bed-hold the time of transfer on hospitalization or the facility must provide the resident representating specifies the duration described in paragram. This REQUIREMENT by: The findings include The facility staff failed at the time of dischart 1/6/21 or as soon as transfer for Resident. Resident #23 was account and bladder cancer. Resident #23's most (MDS) assessment with 12/21/20 and coded.	ent representative that e state bed-hold policy, if e resident is permitted to esidence in the nursing payment policy in the state of this chapter, if any; ty's policies regarding ich must be consistent with his section, permitting a d especified in paragraph (e)(1) cold notice upon transfer. At f a resident for rapeutic leave, a nursing to the resident and the eve written notice which h of the bed-hold policy ph (d)(1) of this section. T is not met as evidenced cold to include a bed-hold policy rege to the local hospital on possible to the actual time of #23. Imitted to the nursing facility gnoses that included lung recent Minimum Data Set	F 62	F625 SS=D Notice of Bed Hold Policy Before/Upg Transfer CFR(s): 483.15(d)(1)(2) cross tag 12 5-371-150 B1 (C, D, G, & F) 1. Resident #23 no longer resides facility and was discharged on 1/6/20 the hospital and expired. 2. By 3/19/2021, the Business Office/Designee will complete an aud all hospital discharges since 2/25/20 ensure that the bed hold policy was issued to the resident/Resident	at the 021 to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		495332	B. WING			1	C 25/2021
NAME OF P	ROVIDER OR SUPPLIER	1111		S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 02/	23/2021
DI (500)				10	01 JOHN ROLFE DRIVE		
RIVERSID	E HEALTHY LIVING COM	MMUNITY-SMITHFIELD			MITHFIELD, VA 23430		
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F 625	Continued From page	e 19	F	625			
	the resident was seve daily decision making				Representative who are currently hospitalized. All results will be reported the QAPI Committee. 3. DON/Designee will re-educate the		
	daily decision making. The nurse's notes dated 1/6/21 indicated the nurse was called to the room by other clinical staff members. Resident was sitting in a wheelchair in obvious distress. He was transferred back to bed via a Hoyer (brand name mechanical lift) and 2 person CPR started while 911 was called at approximately 7:31 a.m. Paramedics arrived at 07:45 a.m. and took over CPR. The daughter and physician was notified of the situation. Paramedics were able to get a pulse and the resident left the building to be transferred to (name of local hospital). There was no documentation in the clinical record that facility staff conveyed to the receiving providers the resident's comprehensive care plan goals at the time of discharge or soon thereafter to the local hospital.				3. DON/Designee will re-educate the Licensed Clinical Staff and IDT concerning bed hold requirements and process for issuing and confirming a behold. The Business Office/Designee with check daily to ensure the bed hold policy was appropriately issued to each resident/Resident Representative by the discharging nurse/designee. 4. The Admissions Coordinator/Designee will audit 3 hosp discharges for 4 weeks and then 1 hospital discharge per week for 8 weeks to ensure the bed hold policy was issued to ensure the bed hold policy was issued to ensure the QAPI meeting by the Admissions Coordinator/Designee for evaluation of compliance and ongoing monitoring for continuous improvement and analysis after the implementation. 5. All corrective actions will be	the ed rill cy ne ital as ed.	
	of Nursing (DON). The policy/notice in the case would have not been notice, we would make Representative (RR) policy/notice and it was They said, "When a reached list in the confession that in turn grammary that include with goals as well as there is no way to confession to the policy/notice and it was the policy/notice in the policy/notice	received our bed hold as documented accordingly. esident is transferred to the enurse is prompted through inputer for the specific enerates the transfer es the care plan summary the bed hold notice, but infirm the documents was e transfer or that it was sent			completed by 4/9/2021.		

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495332	B. WING			C / 25/2021
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 02	123/2021
RIVERSID	E HEALTHY LIVING COM	MMUNITY-SMITHFIELD		101 JOHN ROLFE DRIVE SMITHFIELD, VA 23430		
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F 625	Continued From page The facility's policy tit Discharge/Transfer P indicated that the resi provided with all appli notices at the time of as soon as possible in Discharge Summary CFR(s): 483.21(c)(2)(2)(2)(2)(3)(4)(4)(4)(4)(4)(4)(4)(4)(4)(4)(4)(4)(4)	led Nursing Home olicy dated 12/11/19 dent/representative will be icable state and federal transfer or leave of absence including the bed hold policy. (i)-(iv) rge Summary cipates discharge, a resident e summary that includes, ine following: the resident's stay that inited to, diagnoses, course interapy, and pertinent lab, tation results. If the resident's status to graph (b)(1) of §483.20, at rge that is available for persons and agencies, with sident or resident's all pre-discharge resident's post-discharge resident's post-discharge resident's post-discharge	F		RIATE	4/9/21
	and, with the resident representative(s), whi adjust to his or her ne post-discharge plan of the individual plans to	d's consent, the resident ich will assist the resident to ew living environment. The of care must indicate where or reside, any arrangements for the resident's follow up ocharge medical and				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		495332	B. WING				25/2021
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F 661	Continued From page	2 1	F	361			
	This REQUIREMENT by:	is not met as evidenced					
	Based on information complaint investigation staff interviews, and continues the staff interviews and continues the staff interviews and continues the staff interviews are staff in the st	on, a complainant interview, clinical record review, the communicate pertinent ident and resident			F661 SS=D Discharge Summary CFR(s): 483.21 (c)(2)(i)-(iv) 1. Resident #21 no longer resides at	the	
		residents (Resident #21), in			facility and was discharged on 5/15/202 The nurse was educated 1:1 by the DC on providing instructions to the Resider	20. DN	
	The findings included: Resident #21 was originally admitted to the facility 4/24/20, and was discharged 5/4/20, return not anticipated therefore; a closed record review was conducted. Resident #21's diagnoses included; a total right knee replacement, diabetes and hyperlipidemia.				Representative on pertinent information time of discharge on 2/24/2021.		
					2. All planned discharges since 2/25/2021 will be reviewed by the DON/Designee to ensure that pertinent information to the resident/Resident Representatives at the time of the anticipated discharge was communicat 3. The Clinical Educator/Designee will	ed.	
	(ARD) of 4/30/21 cod completing the Brief I (BIMS) and scoring 1 indicated Resident #2 daily decision making (Physical functioning) requiring extensive as bed mobility, extensive with bathing, toileting assistance of one per significant to the state of the Brief III of the state of the Brief III of the Brief II o	assessment reference date ed the resident as interview for Mental Status 5 out of a possible 15. This 21's cognitive abilities for were intact. In section "G" the resident was coded as assistance of two people with we assistance of one person and dressing, limited son with transfers, walking hygiene and independent			review discharge instructions of resider with skin integrity concerns prior to anticipated discharge. The Clinical Educator/Designee will provide educati to the nursing staff on communicating pertinent information to the resident/Resident Representative at the time of discharge by 4/9/2021. 4. The DON/Designee will conduct audits on 3 discharged (planned) residents per week for 4 weeks, then 2 discharged residents for 8 weeks to verthat pertinent information related to skill integrity has been communicated to the	rify	
	2/23/21 at 1:20 p.m., facility's staff never no	vith the complainant on the complainant stated the otified her that Resident #21 ure ulcer while at the facility.			resident/Resident Representative. The results of the audits will be reported quarterly at the QAPI meeting by the DON/Designee for evaluation of compliance and ongoing monitoring for		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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F 661	Continued From page	e 22	F 6	661				
r 001	The complainant state the resident was very to sit on her behind we the facility therefore; and that was when shareas to her behind. To open area were unco complainant stated share the facility to inquire complainant stated share the staff didn't see had been discharged. Review of Resident # she was admitted with buttock. The Braden and 5/8/20 indicated for development of a notes stated the residuant continent of her bladd required assistance with mobility because of the Further review of Resident was obtained to treat read; cleanse the right saline and pat dry. A dressing to the open every three days. Review of Resident #	ed on the day of discharge uncomfortable and unable then they arrived home from she assisted her to undress he first learned of the open The complainant stated the vered and large. The he immediately telephoned of the open areas to the lasked how to care for them to care since the resident hout a open areas to her scale completed on 4/24/20 the resident was a mild risk pressure ulcer. Nurses's lent toileted and was mostly der and bowels but she with transfers and bed he right knee limitations. Sident #21's clinical record e staff identified an open entimeters by 0.5 ht lower buttock. An order the open area. The order the open area. The order the open area. The order the open area and a foam dressing		001	continuous improvement and analysis after the implementation. 5. All corrective actions will be completed by 4/9/2021.			
	An interview was con Practical Nurse (LPN							

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDI	FIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED		
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F 661	the nurse who origing to Resident #21's but initial order for care, hadn't been trained or staging therefore wound assessment an in-depth assessmappropriate treatme. An interview was converse of Nursing on 2/25/21. The Director of Nursing on 2/25/21. The Director of Nursing on the preparent of Nursing on 2/25/21. The Director of Nursing on 2/25/21 at approximately was of the open area or time of Resident #2 representative was wound and was madopen area. On 2/25/21 at approximately of Nursing Stated the expectation of Nursing Stated States of Nursing S	p.m. LPN #1 stated she was nally assessed the open area attock and she obtained the She further stated she to determine types of wounds; a staff member trained in was responsible to complete ment and determine the most nt. Inducted with the Director of at approximately 11:30 a.m. sing stated LPN #1 duties ately assess and measure the ovider and resident to the ordered treatment, uments, a nurses note, write n, notify nursing the on-coming shift until the she Director of Nursing further mess day the nurse pion's investigation report and the etiology wasn't was the Director of Nursing mentation the resident motified of the original finding documentation stating at the 1's discharge that the resident motified of the residents open de aware of orders to treat the eximately 3:00 p.m., the above divith the Administrator and ing. The Director of Nursing on is for the nurse to explain on from the discharge	F	661			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ′	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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	NAME OF PROVIDER OR SUPPLIER RIVERSIDE HEALTHY LIVING COMMUNITY-SMITHFIELD SUMMARY STATEMENT OF DEFICIENCIES			STREET ADDRESS, CITY, STATE, ZIP CODE 101 JOHN ROLFE DRIVE SMITHFIELD, VA 23430	02/25/2021		
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F 661	to refer to if needed. understood the cond information to offer. Complaint Deficiency	nmary so there is something The Administrator stated she ern and had no additional	F6				
F 686 SS=D	CFR(s): 483.25(b)(1 §483.25(b) Skin Inte §483.25(b)(1) Press Based on the compression of the compression	grity ure ulcers. ehensive assessment of a must ensure that- s care, consistent with ds of practice, to prevent does not develop pressure ividual's clinical condition ey were unavoidable; and essure ulcers receives and services, consistent ndards of practice, to event infection and prevent eloping. T is not met as evidenced on gleamed during a on, a complainant interview,	F6	F686 SS=D	4/9/21		
	staff interviews, and facility's staff failed to pressure ulcers rece and services to promoresidents (Residents). The findings included Resident #21 was or 4/24/20, and was dis	clinical record review, the consure a resident with ived necessary treatment note healing for 1 of 20 #21), in the survey sample.		Treatment/Svcs to Prevent/Heal I Ulcer CFR(s): 483.25(b)(1)(i)(ii) cross to VAC 5-371-220(B,D,H) 1. Resident #21 no longer reside facility and was discharged on 5/2 The nurse was educated 1:1 by to on notification of changes in concern new orders for treatments on 2/2 The nurse was educated 1:1 by the nurse was educated 1:1 by the nurse was educated 1:1 by the surface of the nurse was educated 1:1 by the surface of the nurse was educated 1:1 by the surface of the nurse was educated 1:1 by the surface of the nurse was educated 1:1 by the surface of the nurse was educated 1:1 by the surface of the nurse was educated 1:1 by the surface of the nurse was educated 1:1 by the surface of the nurse was educated 1:1 by the surface of the nurse was educated 1:1 by the surface of the nurse was educated 1:1 by the nu	ag 12 des at the 15/2020. he DON dition and 4/2021.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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F 686	Continued From page	⊋ 25	F 6	386			
	conducted. Resident total right knee replac hyperlipidemia.	#21's diagnoses included; a cement, diabetes and			on providing instructions to the Reside Representative on pertinent informatio time of discharge on 2/24/2021. 2. All TARs on current residents will I	n at	
	(ARD) of 4/30/21 cod completing the Brief I (BIMS) and scoring 1 indicated Resident #2 daily decision making (Physical functioning) requiring extensive as bed mobility, extensive with bathing, toileting assistance of one per side of the Brief Indicated Property of Indicated Prope	assessment reference date ed the resident as nterview for Mental Status 5 out of a possible 15. This 21's cognitive abilities for were intact. In section "G" the resident was coded as essistance of two people with we assistance of one person and dressing, limited rson with transfers, walking hygiene and independent			reviewed by the DON/Designee since 2/25/2021 to ensure that residents with pressure injuries Responsible Representatives have been notified of changes in treatment orders and notification has been documented. All planned discharges since 2/25/2021 who be reviewed by the DON/Designee to ensure that pertinent information related to treatments are communicated to the resident/Resident Representatives at the time of the anticipated discharge. 3. The DON/Designee will review the 24HR report during morning huddle to	ill ed he	
	During the interview of 2/23/21 at 1:20 p.m., facility's staff never not had acquired a press. The complainant state the resident was very to sit on her behind with the facility therefore; and that was when shareas to her behind. To open area were unco complainant stated share facility to inquire of resident's behind and but the staff didn't see had been discharged.	with the complainant on the complainant stated the otified her that Resident #21 ure ulcer while at the facility. ed on the day of discharge runcomfortable and unable when they arrived home from she assisted her to undress he first learned of the open The complainant stated the vered and large. The he immediately telephoned of the open areas to the lasked how to care for them them to care since the resident with the complainant stated the vered and large. The he immediately telephoned of the open areas to the lasked how to care for them them to care since the resident with the complainant stated the lasked how to care for them the same to care since the resident with the complainant stated the lasked how to care for them the same to care since the resident with the complainant stated the lasked how to care for them the same to care since the resident with the complainant stated the lasked how to care for them the care since the resident with the complainant stated the lasked how to care for them the care since the resident with the complainant stated the lasked how to care for them the care since the resident with the complainant stated the lasked how to care for them the care since the resident with the care since t			identify new orders and treatment changes requiring Resident Representative notification, change in condition and verify notifications are communicated and documented to the Resident Representative. The Clinical Educator/Designee will provide educat to the nursing staff on compliance with Resident Representative notification of current skin integrity concerns and changes in treatment orders by 4/9/202 The Clinical Educator/Designee will review discharge instructions of reside with skin integrity concerns prior to anticipated discharge. The Clinical Educator/Designee will provide educat to the nursing staff on communicating pertinent information related to treatment to the resident/Resident Representative	ion 21. nts ion	
		hout a open areas to her scale completed on 4/24/20			the time of discharge by 4/9/2021. 4. The DON/Designee will conduct		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		` IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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RIVERSIDE HEALTHY LIVING COMMUNITY-SMITHFIELD				MITHFIELD, VA 23430				
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F 686	Continued From page	e 26	F 6	686				
F 686	and 5/8/20 indicated for development of a notes stated the residence continent of her bladd required assistance with mobility because of the Further review of Resident area measuring 0.5 coentimeters to the right was obtained to treat read; cleanse the right saline and pat dry. A dressing to the open every three days. Review of Resident # revealed the right but performed 5/10/20 are An interview was con Practical Nurse (LPN approximately 3:40 p the nurse who originate to Resident #21's but initial order for care. hadn't been trained to or staging therefore;	the resident was a mild risk pressure ulcer. Nurses's lent toileted and was mostly der and bowels but she with transfers and bed ne right knee limitations. Sident #21's clinical record e staff identified an open entimeters by 0.5 ht lower buttock. An order the open area. The order the open area. The order not buttock gently with normal pply an oil emulsion area and a foam dressing #21's treatment record tock dressing change was not 5/13/20.	F	866	audits on 6 residents per week for 4 weeks and then 3 residents per week for 8 weeks to verify that changes in cond have been communicated to the Resid Representative and documented in the medical record. The DON/Designee we conduct audits on 3 discharged (plannaresidents per week for 4 weeks, then 2 discharged residents for 8 weeks to verthat pertinent information related to ski integrity has been communicated to the resident/Resident Representative. The results of the audits will be reported quarterly at the QAPI meeting by the DON/Designee for evaluation of compliance and ongoing monitoring for continuous improvement and analysis after the implementation. 5. All corrective actions will be completed by 4/9/2021.	ition ent eill ed) rify n		
	an in-depth assessment appropriate treatment. An interview was con Nursing on 2/25/21 at The Director of Nursing included to immediate wound, notify the pro-	ent and determine the most t. ducted with the Director of t approximately 11:30 a.m. ng stated LPN #1 duties ely assess and measure the						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	PLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED		
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F 686	complete rCare docu the nursing care plan management, and the area was healed. The stated the next busing leader/wound champ wasn't completed and determined. Neither wable to locate docume representative was not time of Resident #21' representative was new wound and was made open area. Review of a Physician 5/16/21, revealed Repractice with two stage each buttock, more some asurements were were obtained to kee possible with dry ban Bactroban ointment to times per day and allepossible. On 2/25/21 at approxed findings were shared the Director of Nursing stated the expectation and it appeared that the wound care measure plant in the control of the control of the control of the nurse leader/wou investigation and etion and it appeared that the wound care measure	ments, a nurses note, write, notify nursing e on-coming shift until the e Director of Nursing further less day the nurse ion's investigation report of the etiology wasn't was the Director of Nursing entation the resident offied of the original finding ocumentation stating at the statistic difference of the resident of the residents open e aware of orders to treat the original finding ocumentation stating at the statistic difference of the residents open e aware of orders to treat the original finding ocumented. New orders of the area clean and dry as dages, apply a light layer of the affected areas three ow the area to air out if the limitately 3:00 p.m., the above with the Administrator and g. The Director of Nursing of was for the nurse to notify and champion so a through logy could be determined didn't occur therefore; all is were not instituted. The she understood the concern thinformation to offer.	F 6	86			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		02/25/2021	
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RIVERSIDE HEALTHY LIVING COMMUNITY-SMITHFIELD				SMITHFIELD, VA 23430			
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F 687 SS=D	and care to maintain health, the facility mu (i) Provide foot care a with professional star to prevent complicati medical condition(s) (ii) If necessary, assi appointments with a	are. ents receive proper treatment mobility and good foot ust: and treatment, in accordance ndards of practice, including ons from the resident's and st the resident in making	F6	87		4/9/21	
	This REQUIREMENT by: Based on observation clinical record review ensure one resident sample of twenty Re- carry out activities of	r is not met as evidenced ons, staff interviews and the facility staff failed to (Resident #15, in the survey sidents) who is unable to daily living receives the maintain toenail care.		F687 SS=D Foot Care CFR(s): 483.25 (b)(2)(i)(ii) cros VAC 5-371-220(B,D,H) 1. Resident #15 had his toe r	-		
	The findings included Resident #15 was or on 07/31/20. Diagnos but not limited to Typ Onychomycosis and The most recent Min quarterly revision wit Date (ARD) of 01/19. Brief Interview for Me			trimmed by the DON on 3/5/20 resident will be seen by the poor the next scheduled visit on 3/1 2. DON completed a 100% a resident toe nails on 3/11/2021 identified concerns will be see podiatrist on the next schedule 3/17/2021. 3. The DON/Designee will exclinical staff regarding foot care and the importance of routine points by 4/9/2021. 4. The Educator/Designee will excline the importance of routine points by 4/9/2021. 4. The Educator/Designee will excline the importance of routine points by 4/9/2021.	diatrist on 7/2021. audit of all . Any by the d visit on ducation the e/nail care codiatry ill audit 6 and then 3		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
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NAME OF PROVIDER OR SUPPLIER RIVERSIDE HEALTHY LIVING COMMUNITY-SMITHFIELD				10	TREET ADDRESS, CITY, STATE, ZIP CODE 01 JOHN ROLFE DRIVE MITHFIELD, VA 23430	1 02	20/2021
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX		PROVIDER'S PLAN OF CORRECTION		(X5) COMPLETION DATE
F 687	Continued From page coded to require exter with personal hygiened. During the initial tour 1:48 p.m., an intervier Resident #15. He was toenail care. No respect then asked by the surfeet. He stated, "Yes. (Licensed Practical Nassist in removing the Resident's feet. An optoenails revealed the curving into the skin of feet) except for the right 1 stated that she will a review of progress #15 was seen by a per Resident received Elected debrided digits 1-10. The Care Plan reveal has had a decline in a ability secondary to regoals: Resident will in the control of the right 1 stated that she will in the care Plan reveal has had a decline in the control of the con	e 29 Insive assistance of one staff e. on 2/23/21 at approximately w was conducted with s asked if he received bonse was made. He was reveyor if she could see his "The Resident's nurse, LPN lurse) #1 was asked to be covers from off of the beservation of the resident's y were long, thick and on all of his digits/toes (both ght and left great toe. LPN I put him on the podiatry list. Inotes revealed that Resident odiatrist on 8/16/20. Descrical and Mechanical Dystrophic toenails were led the following: Resident ADL (Activity of Daily Living) ecent hospitalization S/P fall.		687	The results of the audits will be reported quarterly at the QAPI meeting by the Educator/Designee for evaluation of compliance and ongoing monitoring for continuous improvement and analysis after the implementation. 5. All corrective actions will be completed by 4/9/2021.		
	met through next revi Resident know that y with his ADL'S. An interview was con approximately, 9:56 A Nurse's Aide) #1 con toenails. She stated, of Daily Living) care v	of staff will have ADL needs lew. Interventions: Let ou are there to assist him ducted on 02/25/21 at AM with CNA (Certified cerning care of resident #15 "When we do ADL (Activities we check to see if they I care then we let the nurse					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED		
		495332	B. WING _			C 02/25/2021	
NAME OF PROVIDER OR SUPPLIER RIVERSIDE HEALTHY LIVING COMMUNITY-SMITHFIELD				STREET ADDRESS, CITY, STATE, ZIP COD 101 JOHN ROLFE DRIVE SMITHFIELD, VA 23430	E	02/23/2021	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 687	approximately, 10:4 of Nursing) concern Resident #15. She so coordinated through concern about a resident #15 if he will add to the can only bill quarter RN's could have progresidents? She state Resident #15 if he will yes." The facility revised Only a licensed nurse the residents' to file the residents' to the residents' to the resident's toena Nails are soft and elementary of the Administration above issues with promise were voiced on the fingernails makes the nails loot thickened, and brittle symptoms other that Reference: https://search.yahoo.akhsimp=yhs-pty_enumerts.	anducted on 2/25/21 at 5 a.m. with the DON (Director ing podiatry services for stated, "Our podiatry is a the Podiatrist. If we have a sident we will send it to him hat list. He comes monthly but ly. She was asked if facility by	F6	887			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		495332	B. WING _			C 02/25/2021	
NAME OF PROVIDER OR SUPPLIER RIVERSIDE HEALTHY LIVING COMMUNITY-SMITHFIELD				STREET ADDRESS, CITY, STATE, ZIP O 101 JOHN ROLFE DRIVE SMITHFIELD, VA 23430	CODE	02/20/2021	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 687	10¶m1=2019110 homycosis+definition www.rxlist.com/script 66#:~:text=Onychomy nfection%20of%20the produces%20no%20s %20a%20cosmetic% Dystrophic nails are n misshapen, thickened destroyed nail plate. I by too much keratin in causing the nail to lift Dystrophic nails are of fungal infection of the onychomycosis. Othe psoriasis and trauma chronic, repetitive mid Reference: https://www.bergdpm ~:text=Dystrophic%20 %20caused%20by%2	24E9800998ECF8427E~Win 18&us_privacy=1&p=onyc 24type=em_appfocus1_ie 25/main/art.asp?articlekey=117 25/cosis%3A%20Fungus%20i 25/20nail%20bed%20under, 25/20nail%20bed%20under, 25/20nail%20bed%20than 20problem. 20problem	F	587			