	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION	. ,	TE SURVEY MPLETED
		495247	B. WING _		1	2/21/2020
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZI		
NANS POI	NTE REHABILITATIO	N AND NURSING		200 WEST CONSTANCE ROAD SUFFOLK, VA 23434		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN	OF CORRECTION	(X5)
PREFIX TAG	(EACH DEFICIEI	NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFIX TAG		ACTION SHOULD BE TO THE APPROPRIATE	COMPLETION
E 000	Initial Comments		E 0	000		
F 000	COVID-19 Focused on 12-17-20 and co 12-18-20 and 12-2 compliance with EC	Emergency Preparedness d Survey was conducted onsite ontinued with offsite review 1-20. The facility was in 0024 of 42 CFR Part 483.73, ong-Term Care Facilities. FS	F0	000		
	was conducted ons with offsite review of facility was not in co 483.80 infection co implementation of Medicaid Services	COVID-19 Focused Survey site 12-17-20 and continued on 12-18-20 and 12-21-20. The compliance with 42 CFR Part ntrol regulations, for the The Centers for Medicare & and Centers for Disease ded practices to prepare for				
F 880	84 at the time of su were tested for CO confirmed cases of the pandemic. A to COVID-19 resulting COVID-19 since the were zero resident recoveries at the tin staff and seven res COVID-19. Infection Prevention		F 8	80		
SS=D	CFR(s): 483.80(a)(§483.80 Infection C The facility must es infection preventior	Control stablish and maintain an				

01/11/2021

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.

	-	ID HUMAN SERVICES				FORM): 01/19/2022 APPROVED
STATEMENT (DF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /	E CONSTRUCTION	-	(X3) DATE	0. 0938-0391 SURVEY LETED
		495247	B. WING			12/:	21/2020
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, S	TATE, ZIP CODE	-	
NANS PO	INTE REHABILITATION A	ND NURSING		200 WEST CONSTANCE F SUFFOLK, VA 23434	ROAD		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION ECTIVE ACTION SHOULD B ENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 880	development and tran diseases and infection §483.80(a) Infection p program. The facility must estal and control program (a minimum, the follow §483.80(a)(1) A syste reporting, investigatin and communicable dis staff, volunteers, visito providing services und arrangement based u conducted according accepted national star §483.80(a)(2) Written procedures for the pro- but are not limited to: (i) A system of surveil possible communicable infections before they persons in the facility; (ii) When and to whom communicable diseas reported; (iii) Standard and tran to be followed to prev (iv)When and how iso resident; including but (A) The type and dura depending upon the ir involved, and (B) A requirement tha	ent and to help prevent the asmission of communicable ns. prevention and control blish an infection prevention (IPCP) that must include, at ving elements: em for preventing, identifying, g, and controlling infections seases for all residents, ors, and other individuals der a contractual pon the facility assessment to §483.70(e) and following ndards; estandards, policies, and ogram, which must include, lance designed to identify ble diseases or c can spread to other ; n possible incidents of se or infections should be asmission-based precautions ent spread of infections; blation should be used for a t not limited to:	F 880				

Facility ID: VA0169

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		E CONSTRUCTION	(X3) DATE	
		495247	B. WING			12	/21/2020
NAME OF P	ROVIDER OR SUPPLIER		I	5	STREET ADDRESS, CITY, STATE, ZIP CODE		
NANS PO	INTE REHABILITATION A	ND NURSING			200 WEST CONSTANCE ROAD SUFFOLK, VA 23434		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 880	circumstances. (v) The circumstance must prohibit employed disease or infected sk contact with residents contact will transmit th (vi)The hand hygiene by staff involved in dir §483.80(a)(4) A syste identified under the fa corrective actions tak §483.80(e) Linens. Personnel must hand transport linens so as infection. §483.80(f) Annual rev The facility will condu IPCP and update their This REQUIREMENT by: Based on staff interv review, it was determ to ensure three staff in Assistant-CNA #1 thre prior to the start and a symptoms of COVID- The findings included Review of the facility's In and Sign Out log" of questions to be asked and leave their shift: ' Time in; Temp in three symptoms of sore three	s under which the facility ees with a communicable in lesions from direct a or their food, if direct he disease; and procedures to be followed rect resident contact. em for recording incidents acility's IPCP and the en by the facility. le, store, process, and to prevent the spread of view. ct an annual review of its r program, as necessary. ' is not met as evidenced iew and facility document ined that facility staff failed nembers (Certified Nursing ough #3) were screened after their shift for signs and 19.	F	880			

Facility ID: VA0169

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		ID HUMAN SERVICES MEDICAID SERVICES					FORM	D: 01/19/2022 MAPPROVED D: 0938-0391
STATEMENT (OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /				(X3) DATE	
		495247	B. WING				12/	21/2020
NAME OF PI	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP C	ODE		
NANS POL	NTE REHABILITATION A				200 WEST CONSTANCE ROAD			
					SUFFOLK, VA 23434			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE		(X5) COMPLETION DATE
F 880	well in the last 72 hou location or around an confirmed case of CC If yes, please see cha threshold 99.6; Time Review of the "As Wo 11/27/20 through 12/7 worked on 12/12/20 t AM (11-7) shift; and 1 shift. Review of the facility confirmed that CNA # nights/shifts. Review of the employ 11/25/20 through 12/7 signature on the "CO and Sign Out log" prio 5 dates. Further review of the revealed that CNA #2 Review of the facility confirmed she had wo	ess of generally not feeling urs; Have you been in any yone that has had a DVID-19 in the last 14 days. arge nurse Temp out Out." orked schedules" from 17/20 revealed CNA #1, hrough 12/14/20 11 PM-7 12/16/20 and 12/17/20 11-7 time punch sheets #1 had worked the above yee screening logs from 17/20 failed to evidence his VID-19 employee Sign In or to and after working on all "As-Worked Schedules" 2 had worked on 12/15/20.	F	88	0			
	12/15/20; failed to evi on the "COVID-19 en Out log" prior to and a night.	idence CNA #2's signature nployee Sign In and Sign after working her shift that						
	revealed that CNA #3 and 12/17/20. Review	"As-Worked Schedules" 3 had worked on 12/14/20 v of the facility time punch e had worked these dates on						

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		D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		495247	B. WING _			12/	21/2020
	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE 00 WEST CONSTANCE ROAD		
NANS POI	NTE REHABILITATION A	ND NURSING		s	UFFOLK, VA 23434		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 880	Continued From page	2 4	F٤	380			
	#3's signature on the	ee screening logs for 0; failed to evidence CNA "COVID-19 employee Sign prior to and after working her					
	for signs and symptor stated that staff shoul and after their shift. A consisted of temperat the questionnaire reg. symptoms), and COV there was only one er ASM #2 stated that the staff conducted scree	(Administrative Staff ctor of Nursing (DON). on staff should be screened ms of COVID, ASM #2 d be screened at the start of SM #2 stated that screening cure checks and filling out					
	all employees will be reporting to the start of they time they end sh monitoring and/or rep minimum vital signs a	e following: "ensure that screened at the time of of their shift and at the time ift. This will include tracking, orting of fever (at a re taken per shift), d/or other signs/symptoms					
F 882 SS=D	No further information Infection Preventionis CFR(s): 483.80(b)(1)-		F٤	382			
	§483.80(b) Infection p The facility must desig						

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		ND HUMAN SERVICES MEDICAID SERVICES				F	NTED: 01/19/2022 ORM APPROVED 3 NO. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		LE CONSTRUCTION	(X3)	DATE SURVEY COMPLETED
		495247	B. WING				12/21/2020
NAME OF P	ROVIDER OR SUPPLIER		I		STREET ADDRESS, CITY, STATE, ZIP CODE	•	
NANS PO	INTE REHABILITATION	AND NURSING			200 WEST CONSTANCE ROAD		
	1				SUFFOLK, VA 23434		
(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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 882	individual(s) as the in (s) who are responsit The IP must: §483.80(b)(1) Have p in nursing, medical te epidemiology, or othe §483.80(b)(2) Be qua experience or certific §483.80(b)(3) Work a facility; and §483.80(b)(4) Have of training in infection p §483.80 (c) IP partici and assurance comm The individual design one of the individuals must be a member of assessment and assi to the committee on to This REQUIREMENT by: Based on staff interv review; it was determ Infection Control Prev	fection preventionist(s) (IP) obe for the facility's IPCP. primary professional training echnology, microbiology, er related field; alified by education, training, ation; at least part-time at the completed specialized revention and control. pation on quality assessment nittee. pation on quality assessm	F	88	2		
	Infection Control Prev specialized training in Control. The findings included On 12/17/20 at 9:56 a conference, it was de (Administrative Staff (Director of Nursing)	ventionist did not receive n Infection Prevention and l: a.m. during entrance					

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		ID HUMAN SERVICES MEDICAID SERVICES				FOF	ED: 01/19/2022 RM APPROVED IO. 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		LE CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
		495247	B. WING			1:	2/21/2020
NAME OF PF	ROVIDER OR SUPPLIER		•		STREET ADDRESS, CITY, STATE, ZIP CODE		
	NTE REHABILITATION A				200 WEST CONSTANCE ROAD		
					SUFFOLK, VA 23434		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 882	helped with Infection morning entrance, it we evidence that ASM #2 training in Infection C On 12/18/20 at 2:43 p Administrator provide completed Modules 1 Disease Control) Infe Program Training Consurvey had been star modules to this cours ASM #1 also presente had completed Modul for Disease Control) I Control Program Train On 12/18/20 at 4:08 p conducted with ASM why she had to comp Training if she was no "To be honest we need even though she is no DON with infection constated that she takes DON is not available, started her training the stated that she had se modules and told the should be trained on that the training was a she couldn't finish it a On 12/18/20 at 4:23 p	tant Director of Nursing) Control as well. During this vas requested to see 2 had received specialized ontrol. o.m., ASM #1, the facility d evidence that ASM #2 had -3 of the CDC (Center for ction Prevention and Control urse on 12/18/20 (after ted). There are a total of 23 e. ed evidence that the ADON les 1-3 of the CDC (Center nfection Prevention and hing Course on 12/18/20. o.m., an interview was #3, the ADON. When asked lete the Infection Control of the ICP; ASM #3 stated, ed to." ASM #3 stated that of the ICP, she helps the ontrol related tasks. ASM #3 on the ICP role when the When asked why she at day on 12/18/20; ASM #3 een the DON completing the DON that she felt she it as well. ASM #3 stated a 23 module course and that II that day.	F	88			
		not completed until that day ated that she was not aware					

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		MEDICAID SERVICES	-			IO. 0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION		TE SURVEY MPLETED
		495247	B. WING		1	2/21/2020
NAME OF PI	ROVIDER OR SUPPLIER	•	5	STREET ADDRESS, CITY, STATE, ZIP CO	DDE	
			2	200 WEST CONSTANCE ROAD		
NANS PU	NTE REHABILITATION /	and norsing	5	SUFFOLK, VA 23434		
(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 ACTION CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 882	ASM #2 stated that h coordinator) left a few normally alerts her w trainings. When aske had left, ASM #2 stat also stated that the S leaving her employm was going to complet and that it was an "ow On 12/21/20 at 9:44 a conducted with ASM who the previous Infe was prior to the DON was the SDC who hat then stated the Infect team effort. AMS #3 responsible for provio education but that sh responsible for maint surveillance. ASM #3 managing Infection C she started working a how long she has be facility, ASM #3 state On 12/21/20 at appro- the Administrator and made aware of the all Review of the facility Preventionist Job De the following: "Expe	any specialized training. er SDC (inservice v months ago and the SDC hen she needs to do any d how long ago her SDC ed 3-4 months ago. ASM #2 DC was the ICP prior to ent. ASM #2 stated that she te the rest of the modules versight." a.m., further interview was #3, the ADON. When asked ection Control Preventionist ; ASM #3 stated that the ICP d just recently left. ASM #3 ion Control Program was a stated that the SDC was ding Infection Control related e (ASM #3) has always been aining infection control stated that she has been control Surveillance since at the facility. When asked en an employee with the d, "2.5 years." oximately 5 p.m., ASM #1, I ASM #2, the DON were pove concerns. s "Infection Control scription," documents in part erienceMust have	F 882			
F 883	completed specialize Prevention and Contr Influenza and Pneum CFR(s): 483.80(d)(1)	-	F 883			

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	
		495247	B. WING			12/	21/2020
NAME OF P	ROVIDER OR SUPPLIER		I	:	STREET ADDRESS, CITY, STATE, ZIP CODE	•	
NANS PO	INTE REHABILITATION A	ND NURSING			200 WEST CONSTANCE ROAD SUFFOLK, VA 23434		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 883	Continued From page §483.80(d) Influenza immunizations §483.80(d)(1) Influenza policies and procedur (i) Before offering the each resident or the r receives education re potential side effects (ii) Each resident is or immunization Octobe annually, unless the in contraindicated or the immunized during this (iii) The resident or the has the opportunity to (iv)The resident's med documentation that in following: (A) That the resident was provided educati and potential side effect immunization; and (B) That the resident immunization or did n immunization due to r refusal. §483.80(d)(2) Pneum must develop policies that- (i) Before offering the immunization; and potential immunization;	and pneumococcal za. The facility must develop res to ensure that- influenza immunization, esident's representative garding the benefits and of the immunization; ffered an influenza r 1 through March 31 mmunization is medically e resident has already been s time period; e resident's representative o refuse immunization; and dical record includes dicates, at a minimum, the or resident's representative on regarding the benefits ects of influenza either received the influenza ot receive the influenza medical contraindications or ococccal disease. The facility and procedures to ensure pneumococcal esident or the resident's es education regarding the		883	DEFICIENCY)		
	immunization; and (B) That the resident immunization or did n immunization due to n refusal. §483.80(d)(2) Pneum must develop policies that- (i) Before offering the immunization, each re representative receive benefits and potential immunization;	either received the influenza ot receive the influenza medical contraindications or ococcal disease. The facility and procedures to ensure pneumococcal esident or the resident's es education regarding the side effects of the ffered a pneumococcal					

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		ND HUMAN SERVICES MEDICAID SERVICES				FOR	D: 01/19/2022 MAPPROVEE D. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		495247	B. WING			12	/21/2020
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	•	
NANS PO	INTE REHABILITATION	AND NURSING		:	200 WEST CONSTANCE ROAD		
					SUFFOLK, VA 23434		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 883	Continued From page	_ 0	F	883	3		
		ated or the resident has	•	000			
	already been immuni						
		ne resident's representative					
		o refuse immunization; and					
	(iv)The resident's me	ndicates, at a minimum, the					
	following:						
		or resident's representative					
		ion regarding the benefits					
	immunization; and	ects of pneumococcal					
	(B) That the resident	either received the					
		nization or did not receive					
	-	munization due to medical					
	contraindication or re	T is not met as evidenced					
	by:						
		iew, family interview, clinical					
		cility document review, it was					
	the clinical record evi	ty staff failed to document in					
		inistered; and also failed to					
	have Flu Education a	and Consent forms readily					
		al record for five of six					
	sampled residents; R	tesidents #1 through #5.					
	The findings included	l:					
		dmitted to the facility on					
	12/18/18 and readmi	tted on 3/23/20 with led but were not limited to					
	•	essure, and high cholesterol.					
	Resident #1's most re	ecent MDS (Minimum data					
		s a quarterly assessment					
		ment Reference Date) of 1 was coded as being					
		in cognitive function scoring					
	• •	IMS (Brief Interview for					
	Mental Status) exam	. Resident #1 was coded in					

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATE	
		495247	B. WING			12/	21/2020
NAME OF P	ROVIDER OR SUPPLIER		I		STREET ADDRESS, CITY, STATE, ZIP CODE	<u>. </u>	
NANS PO	INTE REHABILITATION A	ND NURSING			200 WEST CONSTANCE ROAD SUFFOLK, VA 23434		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE
F 883	Section O.0250 (Influreceiving the Flu Vaca documented under Section Review of the facilities for Resident #1 docur "Flucevax 2020-2021 Expiration dated 6/20 11-6-20; 7-3 shift." Review of Resident # evidence that the flu vaca was administered on (Medication Administr (Treatment Administranursing notes dated N December 2020. Review of the "Immur #1's clinical record re- documented flu vaccion There was no evidend the resident or reside provided flu education prior to receiving the fa- asked to provide evid was administered as a consent. On 12/18/20 at 4:23 p was conducted with A DON (Director of Nurs- the unit manager had	enza Vaccine) as not cination. "Not offered" was ection O.0250. s' "Flu Vaccination Record" mented the following: ; Lot number 279828; 21; Date Administered 1's clinical record failed to vaccination was given. ce that the flu vaccination the November 2020 MARS ration Record) and TARS ation Record) or in the November 2020 through hizations" tab of Resident vealed that his last nation was on "10/19/2018." ce in the clinical record that nt representative was n and consent was obtained	F	883	3		

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			0.00			O. 0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			E SURVEY IPLETED
		495247	B. WING		12	2/21/2020
NAME OF P	ROVIDER OR SUPPLIER	-		STREET ADDRESS, CITY, STATE, ZIP CODE		
NANS PO	INTE REHABILITATION	AND NURSING		200 WEST CONSTANCE ROAD SUFFOLK, VA 23434		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
	manager had left for his family. ASM #2 a records personnel wi also at a funeral. ASI be able to provide flu Monday 12/21/20. On 12/18/20 at 6:18 conducted with Resid #1's brother was ask by the facility and asi brother the flu vaccin education was provid Resident #1's brothe and asked about con given. I gave conser On 12/21/20 at 9:44 conducted with ASM Director of Nursing).	the day related to a death in lso stated that the medical no also carries a key was M #2 stated that they would information on the following p.m., an interview was dent #1's brother. Resident ed if he had been contacted ked for consent to give his e and if any flu vaccine led to him from the facility. r stated, "I was only called sent, there was no education	F 88	3		
	providing education; administration will dir have their floor nurse consents for the flu v that education is give resident will sign a co give or do not give co the education. ASM # responsible party will the resident cannot g that education is also When asked where t ASM #3 stated that the either be filed in the f electronic system. W access to the hard ch not available, ASM #	ASM #3 stated that rect the unit managers to es educate and obtain accinations. ASM #3 stated en to each resident and the ponsent form that they either ponsent and that they received				

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	-	D HUMAN SERVICES MEDICAID SERVICES					FORM	0: 01/19/2022 APPROVED 0. 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		495247	B. WING			_	12/	21/2020
NAME OF P	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE	-	
NANS PO	INTE REHABILITATION A	ND NURSING			00 WEST CONSTANCE R UFFOLK, VA 23434	OAD		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	(EACH CORRE) CROSS-REFEREI	B PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 883	should be documente under the "Immunizat record. ASM #3 state location of the vaccina the solution etc. shou When asked how she vaccination was giver documented in the cli "Good Question. The under the tab." On 12/21/20 at 10:15 the consent form for F consent form revealed consent to receive the obtained by Resident still no evidence that I vaccination on the cor On 12/21/20 at 10:38 conducted with ASM as asked where they had education forms for the stated that her one un locked up in a file. Wh form and education sl in the clinical record, a everything is suppose record. ASM #2 also supposed to document administered under the nursing note. ASM #1 aware of the above fin going to address it."	 a flu vaccination was B stated that this information d either in a nurse's note or ions Tab" in the clinical d that information such as ation given; lot number of ld also be documented. a would know if the flu a to a resident if it is not nical record, ASM #3 stated, y are supposed to document a.m., ASM #1 had emailed Resident #1. Review of the d that education and a flu vaccine was given and #1 on 11/5/20. There was Resident #1 received the flu nsent form. a.m., an interview was #1 and ASM #2. When d found the consent and he flu vaccination, ASM #2 nit manager had them hen asked if the consent hould be readily accessible 	F	883				

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT O	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` <i>'</i>		E CONSTRUCTION	(X3) DATE	
		495247	B. WING			12/	21/2020
NAME OF PI	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
NANS PO	INTE REHABILITATION A	AND NURSING			200 WEST CONSTANCE ROAD SUFFOLK, VA 23434		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 883	Continued From page	9 13	F	883			
	given to Resident #2's administering the flux readily accessible in t Resident #2 was adm 3/30/1992 and readm diagnoses that include stroke, coronary arter seizure disorder. Res (Minimum data set) w with an ARD (Assessi 10/1/20. Resident #1' vaccination informatic the 10/1/20 MDS. Review of the facilities for Resident #1 docur of Immunization: Influ Consented, Administe 11/5/2020." Review of immunizati clinical record docume Vaccination Record" f the following: "Type o	itted on 10/4/2014 with ed but were not limited to y disease, Dementia, and ident #2's most recent MDS vas a quarterly assessment ment Reference Date) of s most updated influenza on was not yet reflected on s' "Flu Vaccination Record" mented the following: "Type enza; Consent Status: ered info: Left forearm on tab in Resident #1's ented the following: "Flu for Resident #1 documented f Immunization: Influenza; sented, Administered info:					
		wing: "Note text: Resident's erbal consent via telephone					
	the resident or reside	ce in the clinical record that nt representative was n prior to receiving the flu					

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		E CONSTRUCTION	(X3) DATE	
		495247	B. WING			12	21/2020
NAME OF PI	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE	1 12	21/2020
					200 WEST CONSTANCE ROAD		
NANS PO	INTE REHABILITATION A	IND NURSING			SUFFOLK, VA 23434		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE
F 883	Continued From page	÷ 14	F	883	3		
	Staff Member), the Fa	o.m., ASM #1 (Administrative acility Administrator was ence that education was inistering the flu vaccination					
	was conducted with A DON (Director of Nurs the unit manager had education locked up i manager had left for t his family. ASM #2 sta records personnel wh cabinets was also at a	o carries a key to the locked a funeral. ASM #2 stated le to provide flu information					
	conducted with ASM is Director of Nursing). No obtaining the flu vacci providing education; A administration will dire have their floor nurses consents for the flu va that education is give resident will sign a co give or do not give co the education. ASM # responsible party will the resident cannot gi that education is also When asked where th ASM #3 stated that the either be filed in the h	ASM #3 stated that ect the unit managers to s educate and obtain accinations. ASM #2 stated n to each resident and the insent form that they either insent and that they received					

Facility ID: VA0169

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			0.00			<u>0. 0938-039</u>
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /	LE CONSTRUCTION	· · ·	E SURVEY PLETED
		495247	B. WING		12	/21/2020
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
NANS PO	INTE REHABILITATION	AND NURSING		200 WEST CONSTANCE ROAD SUFFOLK, VA 23434		
(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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETIO DATE
F 883	not available, ASM # #3 stated that a nursi documented once the administered. ASM # should be documente under the "Immunizar record. ASM #3 state location of the vaccin the solution etc. shou On 12/21/20 at 10:15 the consent form for consent form reveale consent to receive th obtained by Resident 11/5/2020. On 12/21/20 at 10:16 conducted with Resid Resident #2's sister v contacted by the facil give her sister the flu vaccine education wa facility. Resident #2's and ask for consent, education with me." On 12/21/20 at 10:38 conducted with ASM asked where they ha education forms for the stated that her one un locked up in a file. W form and education s in the clinical record, everything is suppose record. ASM #2 also	3 stated that they did. ASM ing note should also be e flu vaccination was 3 stated that this information ed either in a nurse's note or tions Tab" in the clinical ed that information such as ation given; lot number of ald also be documented. 5 a.m., ASM #1 had emailed Resident #2. Review of the ed that education and e flu vaccine was given and t #2's representative on 6 a.m. an interview was dent #2's representative. was asked if she had been lity and asked for consent to vaccine and if any flu as provided to her from the s sister stated, "They did call but never went over any 8 a.m., an interview was #1 and ASM #2. When d found the consent and he flu vaccination, ASM #2 nit manager had them hen asked if the consent should be readily accessible	F 88	3		

Facility ID: VA0169

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING (X3) DATE SURVEY COMPLETED MAME OF PROVIDER OR SUPPLIER 495247 B. WING 12/21/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 200 WEST CONSTANCE ROAD SUFFOLK, VA 23434 200 WEST CONSTANCE ROAD SUFFOLK, VA 23434 10		-	ID HUMAN SERVICES				FORM): 01/19/2022 APPROVED 0. 0938-0391
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZP CODE NAME OF PROVIDER REHABILITATION AND NURSING STREET ADDRESS, CITY, STATE, ZP CODE (MAI) D SUMMARY STATEMENT OF DEFICIENCIES (EACH COMPARIANCE RAD RESULTION ON LOC DEFICIENCIES TREE D PREVIDER'S PLAN OF CORRECTION RESULTION ON LOC DEFICIENCIES TREE D PREVIDER'S PLAN OF CORRECTION RESULTION ON LOC DEFICIENCIES (EACH COMPARIANCE RAD DEFICIENCY) D F 883 Continued From page 16 nursing note, ASM #1 and ASM #2 was made aware of the above findings, ASM #2 stated, "I'm going to address it." F 883 No further information was presented prior to exit. 3. Resident #3 was admitted to the facility on 5/14/18 with diagnoses that included but were not limited to Schizophrenia, Biploat Disorder, Dementia, Alzheimer's Disease, and Hypertension. Resident #3's most recent MDS (minimum data set) assessment was a quarterly assessment with an ARD (assessment reference date) of 9/11/20. Resident #3 was coded a becidin O,0250A (Influenza Vaccination Record" for Resident #3 was coded in Section O,0250A (Influenza Vaccination Record" for Resident #3 documented the following: "Fluewax 2020-2021; Lot number 278282, Expiration dated 60/2021; Date Administered 11-6-20; 7-3 shift." Review of the fabilities' "Flu Vaccination Record" for Resident #3 documented the following: "Fluewax 2020-2021; Lot number 278282, Expiration dated 60/2021; Date Administered 11-6-20; 7-3 shift." Review of the fabilitiest in Flow Vaccination was administration Record/TARS	STATEMENT C	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	· · ·		-	(X3) DATE	SURVEY
NANS POINTE REHABILITATION AND NURSING 200 WEST CONSTANCE ROAD SUFFOLK, VA 2343 YMJ D PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DERICENCY MIST BE PRECEDED BY FULL RECULTORY OR LSC IDENTRYING INFORMATION) PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE OROSS-REFERENCE TO THE APPROPRIATE DEFICIENCY) COMMENT PREFIX F 883 Continued From page 16 nursing note. ASM #1 and ASM #2 was made aware of the above findings, ASM #2 stated, "I'm going to address it." F 883 No further information was presented prior to exit. 3. Resident #3 was admitted to the facility on 5/14/18 with diagnoses that included but were not limited to Schicophrenia, Bipland Disorder, Dementia, Alzheimer's Disease, and Hypertension. F Resident #3's most recent MDS (minimum data set) assessment was a quarterly assessment with an ARD (assessment reference date) of 9/11/20. Resident #3 was coded as being intact in cognitive function, scoring 13 out of possible 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #3 was coded as being intact in cognitive function, scoring 13 out of possible 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #3 was coded and Section 0.0250A (Influenza Vaccination Record* for Resident #3 documented the following: "TiLuewax 2020-2021; Lot number 279828; Expiration dated 60/2021; Date Administered 11-6-20; 7.3 shift." Review of Resident #3 colinical record failed to evidence that the FLU vaccination was administration Record// TARS Here was no evidence that the FLU vaccination was administered on the November 2020 MARS			495247	B. WING		_	12/2	21/2020
MARS POINTE REHABILITATION AND NURSING SUFFOLK. VA 23434 (M) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCM WIST BE RECEDED BY FULL RESULATORY OR LSC IDENTIFYING INFORMATION) D D PREFIX TAG PREFIX (EACH DEFICIENCM WIST BE RECEDED BY FULL RESULATORY OR LSC IDENTIFYING INFORMATION) D D DEFICIENCY F 883 Continued From page 16 nursing note. ASM #1 and ASM #2 was made aware of the above findings, ASM #2 stated, "I'm going to address it." F 883 No further information was presented prior to exit. S. Resident #3 was admitted to the facility on 5/14/18 with diagnoses that included but were not limited to Schizophrenia, Bipolar Disorder, Dementia, Alzheimer's Disease, and Hypertension. F 883 Resident #3's most recent MDS (minimum data set) assessment was a quarterly assessment with an ARD (assessment reference date) of 9/11/20. Resident #3 was coded a being inlact in cognitive function, scoring 13 out of possible 15 on the BIMS (Birle Interview for Mental Status) exam. Resident #3 was coded in Section 0.0250A (Influenza Vaccine) as "Yes" receiving the Flu Vaccination. Review of the facilities" "Flu Vaccination Record" for Resident #3 documented the following: "Flucewax 2020-2021; Lot number 279828; Expiration dated 6/2021; Date Administered 11-6-20; 7.3 shift." Review of the Flu vaccination was given. There was no evidence that the Flu vaccination was administration Record/JTARS Review of the Rouries" Flu Vaccination was administration Record/JTARS	NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, S	TATE, ZIP CODE	•	
PREFX TXG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC DENTIFYING INFORMATION) PREFX TXG (EACH ORRECTIVE ACTION SHOULD BE CROSS-REFERENCE TO THE APPROPRIATE DEFICIENCY) COMPLETM INFE F 883 Continued From page 16 nursing note. ASM #1 and ASM #2 was made aware of the above findings, ASM #2 stated, "I'm going to address it." F 883 F 883 No further information was presented prior to exit. 3. Resident #3 was admitted to the facility on 5/14/18 with diagnoses that included but were not limited to Schizophrenia, Bipolar Disorder, Demetia, ALPheimer's Disease, and Hypertension. F 883 Resident #3's most recent MDS (minimum data set) assessment reference date) of 9/11/20. Resident #3 was coded as being intact in cognitive function, scoring 13 out of possible 15 on the BIMS (pifer Interview for Mental Status) exam. Resident #3 was coded in Section 0.0250A (influenza Vaccine) as "Yes" receiving the Flu Vaccination. Fereive of the facilities "Flu Vaccination Record" for Resident #3 documented the following: "Fluewax 2020-2021; Lot number 279828; Expiration dated 6/2021; Date Administered 11-6-20, 7-3 shift." Review of Resident #3's clinical record failed to evidence that the Flu vaccination was administered on the November 2020 MARS (Medication Administration Record/TARS Ferein Provide Content of the November 2020 MARS	NANS POI	NTE REHABILITATION A	ND NURSING			ROAD		
nursing note. ASM #1 and ASM #2 was made aware of the above findings, ASM #2 stated, "I'm going to address it." No further information was presented prior to exit. 3. Resident #3 was admitted to the facility on 5/14/18 with diagnoses that included but were not limited to Schizophrenia, Bipolar Disorder, Dementia, Alzheimer's Disease, and Hypertension. Resident #3's most recent MDS (minimum data set) assessment was a quartery assessment with an ARD (assessment reference date) of 9/11/20. Resident #3 was coded as being intact in cognitive function, scoring 13 out of possible 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #3 was coded in Section 0.0250A (Influenza Vaccine) as "Yes" receiving the Flu Vaccination. Review of the facilities' "Flu Vaccination Record" for Resident #3 documented the following: "Flucevax 2020-2021; Lot number 279828; Expiration dated 6/2021; Date Administered 11-6-20; 7-3 shift." Review of Resident #3's clinical record failed to evidence that the Flu vaccination was given. There was no evidence that the Flu vaccination was administered on the November 2020 MARS (Medication Administration Record)/TARS	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRE CROSS-REFERE	CTIVE ACTION SHOULD B		COMPLETION
nursing notes dated November 2020 through December 2020. Review of the "Immunizations" tab of Resident #3's clinical record revealed that her last	F 883	nursing note. ASM #1 aware of the above fir going to address it." No further information 3. Resident #3 was a 5/14/18 with diagnose limited to Schizophrer Dementia, Alzheimer' Hypertension. Resident #3's most re- set) assessment was an ARD (assessment Resident #3 was code cognitive function, scc on the BIMS (Brief Int exam. Resident #3 was 0.0250A (Influenza V the Flu Vaccination. Review of the facilities for Resident #3 docur "Flucevax 2020-2021" Expiration dated 6/20 11-6-20; 7-3 shift." Review of Resident # evidence that the Flu There was no evidence was administered on (Medication Administra nursing notes dated N December 2020. Review of the "Immur	and ASM #2 was made ndings, ASM #2 stated, "I'm a was presented prior to exit. admitted to the facility on es that included but were not hia, Bipolar Disorder, s Disease, and ecent MDS (minimum data a quarterly assessment with reference date) of 9/11/20. ed as being intact in oring 13 out of possible 15 rerview for Mental Status) as coded in Section faccine) as "Yes" receiving s' "Flu Vaccination Record" mented the following: ; Lot number 279828; 21; Date Administered 3's clinical record failed to vaccination was given. the November 2020 MARS ration Record)/TARS ation Record) or in the lovember 2020 through	F 88	3			

Facility ID: VA0169

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		ID HUMAN SERVICES MEDICAID SERVICES				FC	NO. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DA	ATE SURVEY DMPLETED
		495247	B. WING				12/21/2020
NAME OF PI	ROVIDER OR SUPPLIER	I		:	STREET ADDRESS, CITY, STATE, ZIP CODE		
NANS PO	INTE REHABILITATION A	AND NURSING			200 WEST CONSTANCE ROAD SUFFOLK, VA 23434		
(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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 883	There was no evidend the resident or reside provided flu education prior to receiving the f On 12/18/at 3:40 p.m Staff Member), the Fa asked by the onsite s that the Flu vaccination as family education a On 12/18/2020 at 12: was conducted with F #3's son was asked if the facility and asked brother the flu vaccina education was provid Resident #3's son stat couple months ago an it, but I didn't get any whether she received On 12/18/20 at 4:23 p was conducted with A DON (Director of Num the unit manager had education locked up i manager had left for this family. ASM #2 all records personnel wha also at a funeral. ASM be able to provide Flu Monday 12/21/20 at 9:44 a	cination was on "9/25/19." ce in the clinical record that in representative was in and consent was obtained flu vaccination. ., ASM #1 (Administrative acility Administrator was urveyor to provide evidence on was administered as well ind consent. 25 P.M. a phone interview Resident #3's son. Resident The had been contacted by for consent to give his e and if any flu vaccine ed to him from the facility. Ited, "They called me a and asked if she could have education. I was never told If to rnot." D.m., a telephone interview ASM #1 and ASM #2, the sing). ASM #2 stated that all the consent forms and in his office and that the unit the day related to a death in so stated that the medical to also carries a key was A #2 stated that they would a information on the following	F	883	3		
		#3, the ADON (Assistant When asked the process for					

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DEPARTMENT OF HEALTH AN CENTERS FOR MEDICARE & M				FORM): 01/19/2022 /I APPROVED). 0938-0391
	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE	
	495247	B. WING		12/	21/2020
NAME OF PROVIDER OR SUPPLIER		- I	STREET ADDRESS, CITY, STATE, ZIP CODE	•	
			200 WEST CONSTANCE ROAD		
NANS POINTE REHABILITATION A	ND NURSING		SUFFOLK, VA 23434		
PREFIX (EACH DEFICIENCY	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
 have their floor nurses consents for the Flu variable that education is giver resident will sign a congive or do not give conthe education. ASM #aresponsible party will the resident cannot give that education is also. When asked where the ASM #3 stated that the either be filed in the hare electronic system. What access to the hard charnot available, ASM #3 stated that a nursind documented once the administered. ASM #3 stated that a nursind councenter of the vaccination of the vaccination of the vaccination of the vaccination was given documented in the climate of the consent form for Fic consent form revealed consent to receive the obtained by Resident 	ASM #3 stated that ect the unit managers to seducate and obtain accinations. ASM #2 stated in to each resident and the insent form that they either insent and that they received 3 stated that the be notified over the phone if we consent. ASM #3 stated given over the phone. the consent forms are kept; e consent forms are kept; e consent forms should and chart or uploaded to the nen asked if nurses had arts if the unit manager was a stated that they did. ASM ing note should also be flu vaccination was b stated that this information d either in a nurse's note or ions Tab" in the clinical d that information such as ation given; lot number of id also be documented. would know if the flu to a resident if it is not inical record, ASM #3 stated, y are supposed to document a.m., ASM #1 had emailed Resident #3. Review of the d that education and e Flu vaccine was given and #3's son on 11/5/20. There that Resident #3 received	F 88			

Facility ID: VA0169

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		495247	B. WING			12	/21/2020
NAME OF PI	ROVIDER OR SUPPLIER	1		S	STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	•_•
NANS PO	INTE REHABILITATION A	AND NURSING			200 WEST CONSTANCE ROAD SUFFOLK, VA 23434		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 883	Continued From page On 12/21/20 at 10:38 conducted via phone ASM #1 and ASM #2. had found the consert the Flu vaccination, A unit manager had the asked if the consent f be readily accessible #2 stated that everyth the clinical record. AS nurses were suppose vaccination was admi immunization tab or in and ASM #2 was mad findings, ASM #2 state Prior to exit no further 4. Resident #4 was a 3/29/19 with diagnose limited to Dementia, I Kidney Disorder and Resident #4's most re- set) assessment was an ARD (assessment Resident #4 was code cognitive function, scoon on the BIMS (Brief Inte exam. Resident #4 was	a.m., an interview was by the onsite surveyor with . When asked where they at and education forms for .SM #2 stated that her one m locked up in a file. When form and education should in the clinical record, ASM ning is supposed to go into SM #2 also stated that do document when the inistered under the m a nursing note. ASM #1 de aware of the above red, "I'm going to address it." r information was provided. admitted to the facility on es that included but were not Delusional Disorder, Chronic Hypertension. ecent MDS (minimum data a quarterly assessment with reference date) of 10/14/20. ed as being intact in oring 12 out of possible 15 terview for Mental Status)		883	DEFICIENCY)	ATE	
	for Resident #4 docur "Flucevax 2020-2021	s' "Flu Vaccination Record" mented the following: ; Lot number 279828; 21; Date Administered					

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		CONSTRUCTION	(X3) DATE	
		495247	B. WING			12/	21/2020
NAME OF PF	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
NANS POI	NTE REHABILITATION A	ND NURSING			00 WEST CONSTANCE ROAD		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 883	Continued From page	20	F	383			
	evidence that the Flu There was no evidence was administered on (Medication Administr (Treatment Administr nursing notes dated N December 2020. Review of the "Immur #4's clinical record re- documented Flu vacco There was no evidence the resident or reside provided flu education prior to receiving the f On 12/18/20 at 3:40 p Staff Member), the Fa asked by the onsite s that the Flu vaccination as family education a On 12/18/2020 at 1:4 was conducted with F #4's son was asked if the facility and asked father the flu vaccine education was provid Resident #4's son stat a month ago and asket shot, but no I never re- it."	ation Record) or in the November 2020 through nizations" tab of Resident vealed that her last ination was on "9/26/19." the in the clinical record that in representative was in and consent was obtained flu vaccination. b.m., ASM #1 (Administrative acility Administrator was urveyor to provide evidence on was administered as well ind consent. 6 P.M. a phone interview Resident #4's son. Resident if he had been contacted by for consent to give his					
	was conducted with A	SM #1 and ASM #2, the sing) by the onsite surveyor.					

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			(10)			<u>10. 0938-039</u>
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION G	· · · ·	TE SURVEY MPLETED
		495247	B. WING		1	2/21/2020
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	θE	
NANS POI	NTE REHABILITATION	AND NURSING		200 WEST CONSTANCE ROAD SUFFOLK, VA 23434		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE APPROPRIATE	(X5) COMPLETION DATE
F 883	Continued From pag	e 21	F 8	83		
		he unit manager had all the ducation locked up in his				
		hit manager had left for the				
		h in his family. ASM #2 also				
		al records personnel who				
		as also at a funeral. ASM #2				
		d be able to provide Flu				
	-	llowing Monday 12/21/20.				
	On 12/21/20 at 9:44	a.m., an interview was				
		#3, the ADON (Assistant				
		When asked the process for				
	÷.	cination consents and				
	providing education;					
		ect the unit managers to				
		es educate and obtain				
	consents for the Flu	vaccinations. ASM #2 stated				
		en to each resident and the				
		onsent form that they either				
	•	onsent and that they received				
	the education. ASM #					
	responsible party will	be notified over the phone if				
		ive consent. ASM #3 stated				
	that education is also	given over the phone.				
	When asked where t	he consent forms are kept;				
		he consent forms should				
	either be filed in the l	hard chart or uploaded to the				
	•	hen asked if nurses had				
		narts if the unit manager was				
		3 stated that they did. ASM				
		ing note should also be				
	documented once the					
		3 stated that this information				
		ed either in a nurse's note or				
		tions Tab" in the clinical				
		ed that information such as				
		nation given; lot number of				
		uld also be documented. e would know if the flu				

Facility ID: VA0169

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		MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA		PLE CONSTRUCTION		IO. 0938-039
	F CORRECTION	IDENTIFICATION NUMBER:		G	· · ·	IE SURVEY MPLETED
		495247	B. WING		1	2/21/2020
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
NANS PO	INTE REHABILITATION	AND NURSING		200 WEST CONSTANCE ROAD SUFFOLK, VA 23434		
(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 CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETIOI DATE
F 883	vaccination was give documented in the cl "Good Question. The under the tab." On 12/21/20 at 10:15 the consent form reveale consent form reveale consent to receive th obtained by Resident was still no evidence the Flu vaccination of On 12/21/20 at 10:38 was conducted with A asked where they ha education forms for th stated that her one un locked up in a file. W form and education s in the clinical record, everything is suppose record. ASM #2 also supposed to docume administered under th nursing note. ASM #7	n to a resident if it is not inical record, ASM #3 stated, by are supposed to document is a.m., ASM #1 had emailed Resident #4. Review of the d that education and e Flu vaccine was given and t #4's son on 11/5/20. There that Resident #3 received in the consent form. a.m., a telephone interview ASM #1 and ASM #2. When d found the consent and the Flu vaccination, ASM #2 nit manager had them hen asked if the consent hould be readily accessible	F 88	33		
	Prior to exit no furthe	r information was provided.				
	8/6/16 and readmitter that included but wer Schizophrenia, high t seizure disorder, and #6's most recent MD	dmitted to the facility on d on 3/30/20 with diagnoses e not limited to blood pressure, dementia, diabetes mellitus. Resident S (minimum data set) uarterly assessment with an				

Facility ID: VA0169

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						NO. 0938-039
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	· · · ·	TE SURVEY MPLETED
		495247	B. WING		1	2/21/2020
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
NANS PO	INTE REHABILITATION A	AND NURSING		200 WEST CONSTANCE ROAD SUFFOLK, VA 23434		
(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 COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
F 883	ARD (assessment ref Resident #6 was cod cognitive function scc on the BIMS (Brief In exam. Resident #6 w (Influenza Vaccine) a Vaccination. "Not offe Section O.0250. Review of the facilitie for Resident #1 docu "Flucevax 2020-2021 Expiration dated 6/20 11-6-20; 7-3 shift." Review of Resident # evidence that the flue There was no eviden was administered on (Medication Administr nursing notes dated N December 2020. Review of the "Immun #1's clinical record re documented flu vacci There was no eviden the resident or reside provided flu education prior to receiving the On 12/18/20 at 3:40 p Staff Member), the Fa asked by the onsite s	ference date) of 11/9/20. ed as being intact in oring 14 out of possible 15 terview for Mental Status) as coded in Section O.0250 s not receiving the flu ered" was documented under s' "Flu Vaccination Record" mented the following: ; Lot number 279828; 21; Date Administered 6's clinical record failed to vaccination was given. ce that the flu vaccination the November 2020 MARS ration Record)/TARS ation Record) or in the November 2020 through hizations" tab of Resident vealed that his last nation was on "9/25/19." ce in the clinical record that nt representative was n and consent was obtained flu vaccination.	F 883	3		

Facility ID: VA0169

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(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495247 AND NURSING	A. BUILDING B. WING			E SURVEY PLETED
AND NURSING				
			12	/21/2020
		STREET ADDRESS, CITY, STATE, ZIP CODE		
		200 WEST CONSTANCE ROAD SUFFOLK, VA 23434		
TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETIO DATE
e 24 46 P.M. a phone interview Resident #6's sister. was asked if she had been ility and asked for consent to flu vaccine and if any flu as provided to her from the 's sister stated, "They did call ent to give the flu shot, but no ation about it." p.m., a telephone interview ASM #1 and ASM #2, the rsing) by the onsite surveyor. he unit manager had all the ducation locked up in his nit manager had left for the th in his family. ASM #2 also cal records personnel who as also at a funeral. ASM #2 Id be able to provide flu llowing Monday 12/21/20. a.m., a telephone interview ASM #3, the ADON f Nursing). When asked the g the Flu vaccination ing education; ASM #3 stated vill direct the unit managers to es educate and obtain vaccinations. ASM #2 stated en to each resident and the onsent form that they either onsent and that they received #3 stated that the	F 883	3		
	e 24 46 P.M. a phone interview Resident #6's sister. was asked if she had been lity and asked for consent to flu vaccine and if any flu as provided to her from the s sister stated, "They did call ent to give the flu shot, but no ation about it." p.m., a telephone interview ASM #1 and ASM #2, the rsing) by the onsite surveyor. he unit manager had all the ducation locked up in his nit manager had left for the h in his family. ASM #2 also cal records personnel who as also at a funeral. ASM #2 d be able to provide flu llowing Monday 12/21/20. a.m., a telephone interview ASM #3, the ADON f Nursing). When asked the g the Flu vaccination ng education; ASM #3 stated ill direct the unit managers to as educate and obtain raccinations. ASM #2 stated en to each resident and the onsent form that they either	e 24 F 88: A6 P.M. a phone interview Resident #6's sister. was asked if she had been lity and asked for consent to flu vaccine and if any flu as provided to her from the s sister stated, "They did call ent to give the flu shot, but no ation about it." p.m., a telephone interview ASM #1 and ASM #2, the rsing) by the onsite surveyor. he unit manager had all the ducation locked up in his nit manager had left for the h in his family. ASM #2 also cal records personnel who as also at a funeral. ASM #2 d be able to provide flu llowing Monday 12/21/20. a.m., a telephone interview ASM #3, the ADON f Nursing). When asked the the Flu vaccination ng education; ASM #3 stated ill direct the unit managers to es educate and obtain raccinations. ASM #2 stated en to each resident and the onsent form that they either onsent and that they received #3 stated that the I be notified over the phone if give consent. ASM #3 stated o given over the phone.	e 24 F 883 6 P.M. a phone interview Resident #6's sister. was asked if she had been lity and asked for consent to lu vaccine and if any flu as provided to her from the s sister stated, "They did call ent to give the flu shot, but no ation about it." p.m., a telephone interview ASM #1 and ASM #2, the rsing) by the onsite surveyor. he unit manager had all the ducation locked up in his it manager had all the ducation locked up in his it manager had left for the h in his family. ASM #2 also all records personnel who as also at a funeral. ASM #2 d be able to provide flu llowing Monday 12/21/20. a.m., a telephone interview ASM #3, the ADON f Nursing). When asked the t the Flu vaccination ng education; ASM #3 stated ill direct the unit managers to as educate and obtain raccinations. ASM #2 stated en to each resident and the onsent form that they received #3 stated that the I be notified over the phone.	e 24 F 883 86 P.M. a phone interview Resident #6's sister. was asked if she had been Iity and asked for consent to 1/u vaccine and if any flu as provided to her from the s sister stated, "They did call ent to give the flu shot, but no ation about it." p.m., a telephone interview ASM #1 and ASM #2, the rsing) by the onsite surveyor. he unit manager had left for the h in his family. ASM #2 also all records personnel who is also at a funeral. ASM #2 d be able to provide flu Ilowing Monday 12/21/20. a.m., a telephone interview ASM #3, the ADON fNursing). When asked the t he Flu vaccination ng education; ASM #3 stated ill direct the unit managers to as educate and obtain accinations. ASM #3 stated ill direct the unit they either onsent and that they received #3 stated that the I be notified over the phone if pive consent. ASM #3 stated ip of unor work the phone.

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	· · ·	FE SURVEY MPLETED
		495247	B. WING		1	2/21/2020
NAME OF P	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP COD	E	
NANS PO	INTE REHABILITATION	AND NURSING		00 WEST CONSTANCE ROAD UFFOLK, VA 23434		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
F 883	either be filed in the l electronic system. W access to the hard cl not available, ASM # #3 stated that a nurs documented once th administered. ASM # should be document under the "Immuniza record. ASM #3 state location of the vaccir the solution etc. shou When asked how sho vaccination was give documented in the cl "Good Question. The under the tab." On 12/21/20 at 10:15 the consent form for consent form reveale consent to receive th obtained by Residen still no evidence that vaccination on the co On 12/21/20 at 10:35 conducted with ASM asked where they ha education forms for t stated that her one u locked up in a file. W form and education s in the clinical record, everything is suppos	hard chart or uploaded to the /hen asked if nurses had harts if the unit manager was 3 stated that they did. ASM ing note should also be e flu vaccination was 43 stated that this information ed either in a nurse's note or ations Tab" in the clinical ed that information such as hation given; lot number of uld also be documented. e would know if the flu en to a resident if it is not linical record, ASM #3 stated, ey are supposed to document 5 a.m., ASM #1 had emailed Resident #6. Review of the ed that education and he flu vaccine was given and t #6 on 11/5/20. There was Resident #6 received the flu onsent form. 8 a.m., an interview was #1 and ASM #2. When hd found the consent and he flu vaccination, ASM #2 wit manager had them /hen asked if the consent should be readily accessible	F 883			

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						O. 0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		· · ·	e survey Ipleted
		495247	B. WING		1:	2/21/2020
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
NANS PO	INTE REHABILITATION	AND NURSING		200 WEST CONSTANCE ROAD SUFFOLK, VA 23434		
(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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE
F 883		e 26 indings, ASM #2 stated, "I'm	F 885	3		
		Influenza, prevention and did not address the above				
F 885 SS=E	Reporting-Residents	n was presented prior to exit. ,Representatives&Families (i)-(iii)	F 88	5		
	§483.80(g) COVID-1 must—	9 reporting. The facility				
n S ru fa tt ir o o ir (i (i (i tt fa	facilities by 5 p.m. the the occurrence of eith infection of COVID-1 or staff with new-ons	residents, their families of those residing in e next calendar day following her a single confirmed 9, or three or more residents et of respiratory symptoms ours of each other. This				
	(ii) Include informatio implemented to preve transmission, includir facility will be altered					
	their representatives, or by 5 p.m. the next subsequent occurren confirmed infection o whenever three or m new onset of respirat	alative updates for residents, , and families at least weekly calendar day following the ace of either: each time a f COVID-19 is identified, or ore residents or staff with cory symptoms occur within				
	72 hours of each othe This REQUIREMENT by:	er. Γ is not met as evidenced				

If continuation sheet Page 27 of 43

EXTENDENT OF DEFICIENCIES [X1] PROVIDERGUEPUERCLA. IDENTIFICATION NUMBER (22) MULTIFILE CONSTRUCTION A BUILDING (23) DATE SURVEY COMPLETED NAME OF PROVIDER OR SUMPLER STREETADDRESS, CITY, STATE ZP CODE ZOWEST CONSTANCE ROAD SUFFOLK, VA 23343 [221/2020] NAME OF PROVIDER OR SUMPLER STREETADDRESS, CITY, STATE ZP CODE ZOWEST CONSTANCE ROAD SUFFOLK, VA 23434 [201/01/01/01/01/01/01/01/01/01/01/01/01/0			ID HUMAN SERVICES MEDICAID SERVICES				FOF	ED: 01/19/2022 RM APPROVED O. 0938-0391
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE NANS POINTE REHABILITATION AND NURSING ZOW VEST CONSTANCE RAD SUFFOLK, VA 23434 Image: Constant of the constant of the precedeb by Full, REGULATORY OR LSC IDENTFYING INFORMATION) Image: Constant of Consten Constant of Constant of Constant of Constant of Const	STATEMENT (OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	· , ,				
NANS POINTE REHABILITATION AND NURSING 200 WEST CONSTANCE ROAD SUFFOLK, VA. 23434 Image: Construct and the construction of the precedence of the construction of the constructin of the construction of the construction of the constr			495247	B. WING			1:	2/21/2020
NANS POINTE REHABILITATION AND NURSING SUFFOLK, VA 2343 103/10 PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EAOH ORREPTICE VAD USE PRECEDED BY FULL REDULATORY OR LSC IDENTIFYING INFORMATION) IP PREFIX TAG PREFIX (EAOH ORREPTIVE ATION SHOULD BE cross-references to the APROPRIATE DEFICIENCY) COMELETION (EAOH ORREPTIVE) COMELETION (EAOH ORREPTINE)	NAME OF PI	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
Support No. 23434 Party TAG EACH DEFICIENCY MUST BE PERCENDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREEX TAG PROVIDERS FLAN OF CORRECTION (EACH OBERCINE ACTION SHOLD BE (EACH OBERCINE ACTION SHOLD BE CROSS-REFERENCE TO THE APPROPRIATE DEFICIENCY) ID OWER THAN DEFICIENCY F 885 Continued From page 27 Based on staff interview, family interview, clinical record review and facility document review, it was determined that facility taff failed to inform residents, their representatives, and families of suspected or confirmed COVID cases in the facility after the date of 121/12/12 for six of six sampled residents; Resident #1 through #6. F 885 The findings included: 1. Resident #1 was admitted to the facility on 12/18/18 and readmitted on 3/23/20 with diagnoses that included but were not limited to stroke, high blood pressure, and high cholesterol. Resident #1's most recent MDS (Minimum data Set) assessment was a quarterfly assessment with an ARD (Assessment Reference Date) of 11/17/20. Resident #1 was coded as being moderately impaired in cognitive function scoring 13 out of 15 on the BMS (Brief Interview for Mental Status) exam. Review of the facility's resident COVID-19 testing line ist from 11/30/20 through 12/19/20 revealed positive COVID cases were identified on the following dates: 11/30/20, 12/20/20, 12/11/20, 12/7/20, 12/18/20, 12/19/20, 12/10/20, 12/11/20, 12/1/20, 12/18/20, 12/19/20, 12/10/20, 12/11/20, 12/1/20, 12/18/20, 12/19/20, 12/11/20,	NANS PO	NTE REHABILITATION A	AND NURSING			200 WEST CONSTANCE ROAD		
PREFIX TAG RECULTORY ONLIST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG CACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COMPLETION DATE F 885 Continued From page 27 Based on staff interview, family interview, clinical record review and facility document review, it was determined that facility staff failed to inform residents, their representatives, and families of suspected or confirmed COVID cases in the facility after the date of 12/1/20 for six of six sampled residents; Resident #1 through #6. F 885 The findings included 1. Resident #1 was admitted to the facility on 12/18/18 and readmitted on 3/23/20 with diagnoses that included but were not limited to stroke, high blood pressure, and high cholesterol. Resident #1's most recent MDS (Minimum data Set) assessment was a quarterly assessment with an ARD (Assessment Reference Date) of 11/17/20. Resident #1 was coded as being moderately impaired in cognitive function scoring 13 out of 15 on the BIMS (Brief Interview for Mental Status) exam. Review of the facility's resident COVID-19 testing line list from 11/30/20 through 12/19/20 revealed positive COVID cases were identified on the following dates: 11/30/20, 12/10/20, 12/11/20, 12/12/20, 12/15/20, 12/12/20, 12/15/20, and 12/19/20.						SUFFOLK, VA 23434		
Based on staff interview, family interview, clinical record review and facility document review, it was determined that facility document review, it was determined that facility after facility and families of suspected or confirmed COVID cases in the facility after the date of 12/1/20 for six of six sampled residents; Resident #1 through #6. The findings included: 1. Resident #1 was admitted to the facility on 12/18/18 and readmitted on 3/23/20 with diagnoses that included but were not limited to stroke, high blood pressure, and high cholesterol. Resident #1's most recent MDS (Minimum data Set) assessment was a quarterly assessment was a quarterly assessment with an ARD (Assessment Reference Date) of 11/17/120. Resident #1 was coded as being moderately impaired in cognitive function scoring 13 out of 15 on the BIMS (Brief Interview for Mental Status) exam. Review of the facility's resident COVID-19 testing line list from 11/30/20 through 12/19/20, 12/20/20, 12/20/20, 12/11/20, 12/14/20, 12/16/20, 12/10/20, 12/11/20, 12/14/20, 12/14/20, 12/16/20, 12/11/20, 1	PRÉFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO	LD BE	COMPLETION
list from 11/20/20 through 12/19/20 revealed positive COVID cases were identified on the following dates: 11/30/20, 12/3/20, 12/4/20, 12/7/20, 12/8/20, 12/11/20, 12/12/20, 12/14/20, 12/18/20 and 12/19/20. Review of Resident #1's clinical record revealed that his family was notified on 12/1/20 for the first identified COVID-19 case. The following was	F 885	Based on staff interv record review and fac determined that facilit residents, their repress suspected or confirme facility after the date of sampled residents; R The findings included 1. Resident #1 was an 12/18/18 and readmit diagnoses that includ stroke, high blood press Resident #1's most ress Set) assessment was with an ARD (Assess 11/17/20. Resident #7 moderately impaired 13 out of 15 on the B1 Mental Status) exam. Review of the facility's line list from 11/30/20 positive COVID cases following dates: 11/30 12/7/20, 12/8/20, 12/5 12/14/20, 12/15/20, a Review of the facility's list from 11/20/20 throp positive COVID cases following dates: 11/30 12/7/20, 12/8/20, 12/5 12/18/20 and 12/19/2 Review of Resident # that his family was no	iew, family interview, clinical cility document review, it was by staff failed to inform sentatives, and families of ed COVID cases in the of 12/1/20 for six of six esident #1 through #6. .: .: .: .: .: .: .: .: .: .: .: .: .:	F	88	5		

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		D HUMAN SERVICES MEDICAID SERVICES					FORM	D: 01/19/2022 MAPPROVED D. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION		(X3) DATE	
		495247	B. WING			_	12/	21/2020
NAME OF PI	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, ST	ATE, ZIP CODE		
	NTE REHABILITATION A			20	0 WEST CONSTANCE RC	DAD		
NANOTO				SL	JFFOLK, VA 23434			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD B ICED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 885	(Name of Represental has one Resident test that the Resident is in will be tested on Dece no concerns at this tim Further review of Res revealed that he had 1 on 12/5/20 and arrive 12/10/20. There was representative, and fa 12/10/20 of further po COVID cases. On 12/18/2020 at 6:19 was conducted with R Resident #1's brother received any updates the facility regarding 0 staff results in the fact stated, "I had a call or letting me know that t person. Then my bro Saturday December 5 home on December 1 was then asked since facility on December 5 home on December 1 was then asked since facility. Resident only call and update I the facility. Resident only call and update I the facility on the 1st of On 12/21/20 at 8:20 a conducted with ASM 0 member) #2, the DOM	nical record: "Staff made tive) aware that the facility ted positive for Covid and a quarantine. All Residents ember 1, 2020. Family has ne." ident #1's clinical record been sent out to the hospital d back to the facility on no evidence of any resident, amily notification after sitive resident and staff 5 P.M. a phone interview Resident #1's brother. was asked if he had , notifications or calls from Covid positive residents and ility. Resident #1's brother n the 1st of December hey had one positive ther went to the hospital on 5th and came back to the 0th." Resident #1's brother his brother returned to the 10th had he received any ications from the facility hal positive Covid cases in #1's brother stated, "No, the got was the one positive in of December."	F 8	85				
		he process of notifying tives and family members						

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CENTERS FOR MEDICARE & M STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /	PLE CONSTRUCTION		
IND PLAN OF CORRECTION		A. BUILDIN	G		E SURVEY PLETED
	495247	B. WING		12	2/21/2020
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
NANS POINTE REHABILITATION A	ND NURSING		200 WEST CONSTANCE ROAD		
			SUFFOLK, VA 23434		
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
they did notify family in COVID numbers. ASM social workers were re- family members with e document in the electr notification had occurr On 12/21/20 at 11:03 a conducted with OSM (the Social Worker via process of notifying re- and family members re- cases; OSM #1 stated everyone on 12/1/20 r 11/30/20. OSM #1 stat she had just been noti members/representati (resident) was positive week; the week of 12/2 notify all family member numbers through ema asked why she was no OSM #1 stated, "Only them a weekly update updates were not give 12/21/20; OSM #1 stat aware she had to do w week. On 12/21/20 at approx the facility Administrate (Director of Nursing) w above concerns. No further information	cases; ASM #2 stated that nembers with updated A #2 then stated that the esponsible for notifying the every known case and to ronic record that this red. a.m., an interview was (Other Staff Member) #1, phone. When asked the sidents, representatives egarding new COVID I that the facility had notified egarding the first case on ted that after that first case, fying family ves if their loved one e. OSM #1 stated that this 21/20; she was going to ers of updated COVID il and phone calls. When otifying family members, because I want to give ." When asked why weekly	F 84	85		

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		D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	
		495247	B. WING			12/	21/2020
NAME OF P	ROVIDER OR SUPPLIER		I	S	STREET ADDRESS, CITY, STATE, ZIP CODE	•	
NANS PO	INTE REHABILITATION A	ND NURSING			200 WEST CONSTANCE ROAD SUFFOLK, VA 23434		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE
F 885	3/30/1992 and readm diagnoses that include stroke, coronary arter seizure disorder. Ress (Minimum data set) w with an ARD (Assessed 10/1/20. Review of the facility's line list from 11/30/20 positive COVID cases following dates: 11/30 12/7/20, 12/8/20, 12/5 12/14/20, 12/15/20, a Review of the facility's list from 11/20/20 thro positive COVID-19 cases following dates: 11/30 12/7/20, 12/8/20, 12/5 12/18/20 and 12/19/2 Review of Resident # that his family was no identified COVID cases documented in her cli (Name of Representa has one Resident tha Covid and that the Res Residents will be test Family has no concer Further review of Res revealed that she bec 12/5/20. The represent Resident #2's Covid se evidence of resident,	itted on 10/4/2014 with ed but were not limited to y disease, Dementia, and ident #2's most recent MDS vas a quarterly assessment ment Reference Date) of s resident COVID-19 testing through 12/19/20 revealed s were identified on the //20, 12/2/20, 12/5/20, 0/20, 12/10/20, 12/11/20, nd 12/19/20. s staff COVID-19 testing line bugh 12/19/20 revealed uses were identified on the //20, 12/3/20, 12/4/20, 11/20, 12/12/20, 12/14/20, 0. 2's clinical record revealed tified on 12/1/20 for the first e. The following was nical record: "Staff made tive) aware that the facility t has tested Positive for esident is in quarantine. All ed on December 1, 2020.	F	885			

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	
		495247	B. WING			12/	/21/2020
NAME OF PI	ROVIDER OR SUPPLIER		I	S	STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	•_•
NANS PO	INTE REHABILITATION A	ND NURSING			200 WEST CONSTANCE ROAD SUFFOLK, VA 23434		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 885	On 12/21/20 at 8:20 at conducted with ASM member) #2, the DON When asked the proc representatives and fa new COVID cases; A notify family members numbers. ASM #2 the workers were respons members with every b document in the elect notification had occur	a.m., an interview was (Administrative staff N (Director of Nursing). ess of notifying residents, amily members regarding SM #2 stated that they did s with updated COVID en stated that the social sible for notifying the family known case and to ronic record that this	F	885			
	the facility regarding (staff results in the fac stated, "I have not rec positive Covid results December. I try and time they do not answ call you back with any horrible and will lie sti I know there was just called me to tell me m being moved to anoth On 12/21/20 at 11:03 conducted with OSM the Social Worker via process of notifying re and family members cases; OSM #1 stated everyone on 12/1/20	vas asked if she had , notifications or calls from Covid positive residents and ility. Resident #2's sister ceived any calls about in the home since the 1st of call up there and most of the ver and if they do they never v answers. They are just raight to you face. As far as one positive case until they ny sister was positive and ter room." a.m., an interview was (Other Staff Member) #1, phone. When asked the esidents, representatives regarding new COVID d that the facility had notified regarding the first case,					

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	D: 01/19/2022 APPROVED D: 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION		(X3) DATE	
		495247	B. WING		_	12/	21/2020
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, S	TATE, ZIP CODE	•	
NANS PO	INTE REHABILITATION A	ND NURSING		200 WEST CONSTANCE R SUFFOLK, VA 23434	OAD		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 885	week; the week of 12, notify all family memb numbers through ema asked why she was n OSM #1 stated, "Only them a weekly update updates were not give 12/21/20; OSM #1 sta aware she had to do week. On 12/21/20 at appro- the facility Administration (Director of Nursing) week. No further information 3. Resident #3 was a 5/14/18 with diagnose limited to Schizophrer Dementia, Alzheimer' Hypertension. Resident #3's most re- set) assessment was an ARD (assessment Resident #3 was code cognitive function, sco on the BIMS (Brief Int- exam. Review of the facility's line list from 11/30/20 positive COVID cases following dates: 11/30	ives if their loved one e. OSM #1 stated that this /21/20; she was going to ers of updated COVID all and phone calls. When otifying family members, because I want to give e." When asked why weekly en before the week of ated that she was not made weekly updates until last ximately 5 p.m., ASM #1, for and ASM #2, the DON were made aware if the e was presented prior to exit. dmitted to the facility on es that included but were not hia, Bipolar Disorder, s Disease, and cent MDS (minimum data a quarterly assessment with reference date) of 9/11/20. ed as being intact in oring 13 out of possible 15 erview for Mental Status) s resident COVID-19 testing through 12/19/20 revealed s were identified on the /20, 12/2/20, 12/5/20, b/20, 12/10/20, 12/11/20,	F 885				

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	
		495247	B. WING			12/	21/2020
NAME OF PI	ROVIDER OR SUPPLIER		I	5	STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NANS PO	INTE REHABILITATION A	AND NURSING			200 WEST CONSTANCE ROAD SUFFOLK, VA 23434		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE	(X5) COMPLETION DATE
TAG F 885	Continued From page Review of the facility's list from 11/20/20 thro positive COVID-19 ca following dates: 11/30 12/7/20, 12/8/20, 12/ 12/18/20 and 12/19/2 Review of Resident # completed and provid family was notified of cases from 11/30/20 f On 12/18/2020 at 12: was conducted with F #3's son was asked if updates, notifications regarding Covid posit results in the facility. was called on Decem there was 1 Covid po called again this Tues Worker and told my n Resident #3's son wa received any other no facility about positive December 2nd up to stated, "No I didn't, th	 a 33 as staff COVID-19 testing line ough 12/19/20 revealed ases were identified on the 0/20, 12/3/20, 12/4/20, 11/20, 12/12/20, 12/14/20, 0. 3's clinical record was led no evidence that her any facility identified COVID through 12/14/20. 52 P.M. a phone interview Resident #3's son. Resident #3's son. Resident #3's son stated, "I be had received any or calls from the facility ive residents and staff Resident #3's son stated, "I ber 1st and made aware sitive person and then I was aday the 15th by the Social nom tested positive." s also asked if he had otifications or calls from the Covid cases from today. Resident #3's son and then I was not didn't happen." 		885	DEFICIENCY)	ATE	DATE
	member) #2, the DON When asked the proc representatives and fa new COVID cases; A notify family members numbers. ASM #2 the	N (Director of Nursing). ess of notifying residents, amily members regarding SM #2 stated that they did s with updated COVID en stated that the social sible for notifying the family					

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		495247	B. WING			12/	21/2020
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NANS PO	INTE REHABILITATION A	ND NURSING			200 WEST CONSTANCE ROAD SUFFOLK, VA 23434		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE
F 885	document in the elect notification had occur On 12/21/20 at 11:03 conducted with OSM the Social Worker via process of notifying re and family members in cases; OSM #1 stated everyone on 12/1/20 11/30/20. OSM #1 stated everyone on 12/1/20 11/30/20. OSM #1 stated (resident) was positiv week; the week of 12 notify all family members numbers through ema asked why she was in OSM #1 stated, "Only them a weekly update updates were not give 12/21/20; OSM #1 stated aware she had to do week. No further information 4. Resident #4 was a 3/29/19 with diagnose limited to Dementia, I Kidney Disorder and Resident #4's most re set) assessment was an ARD (assessment Resident #4 was code cognitive function, sco	ronic record that this red. a.m., an interview was (Other Staff Member) #1, phone. When asked the esidents, representatives regarding new COVID d that the facility had notified regarding the first case on ated that after that first case, tifying family ives if their loved one e. OSM #1 stated that this /21/20; she was going to bers of updated COVID ail and phone calls. When otifying family members, / because I want to give e." When asked why weekly en before the week of ated that she was not made weekly updates until last in was presented prior to exit.	F	885			

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		ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 01/19/2022 MAPPROVED O. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		LE CONSTRUCTION		e survey IPleted
		495247	B. WING			12	2/21/2020
NAME OF P	ROVIDER OR SUPPLIER	L			STREET ADDRESS, CITY, STATE, ZIP CODE	•	
NANS PO	INTE REHABILITATION A	AND NURSING			200 WEST CONSTANCE ROAD		
			1		SUFFOLK, VA 23434		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 885	Continued From page exam.	9 35	F	88	15		
	line list from 11/30/20 positive COVID-19 ca following dates: 11/30 12/7/20, 12/8/20, 12/8 12/14/20, 12/15/20, a Review of the facility' from 11/20/20 throug COVID-19 cases wer dates: 11/30/20, 12/3 12/8/20, 12/11/20, 12 and 12/19/20. Review of Resident # that his family was no identified COVID-19 c documented in his cli voice male for (Name him aware that the fa has tested positive fo Resident is in quaran tested on December evidence of any resid family notification after resident and staff CO On 12/18/2020 at 1:4 was conducted with F #4's son was asked if updates, notifications regarding Covid posit results in the facility. was called on Decempon one positive resident Resident #4's son was	s staff COVID testing line list n 12/19/20 revealed positive e identified on the following /20, 12/4/20, 12/7/20, /12/20, 12/14/20, 12/18/20 4's clinical record revealed tified on 12/1/20 for the first case. The following was nical record: "Staff left a e of Representative) making cility has one Resident that r Covid and that the tine. All Residents will be 1, 2020. There was no ent, representative, and er 12/1/20 of further positive VID cases. 6 P.M. a phone interview Resident #4's son. Resident					

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	S FOR MEDICARE &					IO. 0938-039		
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING				
		495247	B. WING		12/21/2020			
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE				
NANS POINTE REHABILITATION AND NURSING				200 WEST CONSTANCE ROAD SUFFOLK, VA 23434				
(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 CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE		
F 885	REGULATORY OR LSC IDENTIFYING INFORMATION)		F 88	5				
	(resident) was positiv week; the week of 12 notify all family memi numbers through em asked why she was r OSM #1 stated, "On!	tives if their loved one re. OSM #1 stated that this t/21/20; she was going to bers of updated COVID ail and phone calls. When notifying family members, y because I want to give e." When asked why weekly						

Facility ID: VA0169

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED D. 0938-0391	
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	E SURVEY PLETED	
		495247	B. WING			12/21/2020		
NAME OF PI	NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE			
NANS PO	NANS POINTE REHABILITATION AND NURSING				200 WEST CONSTANCE ROAD SUFFOLK, VA 23434			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			IX i	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 885	week. No further information 5. Resident #5 was a 3/22/19 with diagnose limited to Congestive Osteoarthritis and Hy Resident #5's most re- set) assessment was an ARD (assessment Resident #5 was code cognitive function, so on the BIMS (Brief Inf- exam. Review of the facility's line list from 11/30/20 positive COVID-19 ca following dates: 11/30 12/7/20, 12/8/20, 12/8 12/14/20, 12/15/20, a Review of the facility's from 11/20/20 through COVID-19 cases wer dates: 11/30/20, 12/3, 12/8/20, 12/11/20, 12 and 12/19/20. Review of Resident # completed and provid family was notified of	weekly updates until last a was presented prior to exit. admitted to the facility on es that included but were not Heart Failure, Anemia, pertension. ecent MDS (minimum data a quarterly assessment with reference date) of 9/21/20. ed as being intact in oring 14 out of possible 15 terview for Mental Status) s resident COVID testing through 12/19/20 revealed ases were identified on the 0/20, 12/2/20, 12/5/20, 0/20, 12/10/20, 12/11/20, nd 12/19/20. s staff COVID testing line list n 12/19/20 revealed positive e identified on the following /20, 12/4/20, 12/7/20, /12/20, 12/14/20, 12/18/20 5's clinical record was led no evidence that her	F	885				
		2 P.M. a phone interview Resident #5's daughter.						

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		ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 01/19/2022 M APPROVED D. 0938-0391	
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` <i>`</i>		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495247	B. WING			12/21/2020		
NAME OF PI	ROVIDER OR SUPPLIER	l	I	ST	REET ADDRESS, CITY, STATE, ZIP CODE	•		
NANS POINTE REHABILITATION AND NURSING				200	0 WEST CONSTANCE ROAD			
NANG FOINTE REHABIENATION AND NORGING			SU	JFFOLK, VA 23434		1		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE	
F 885	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		F	885				

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391		
STATEMENT O	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		495247	B. WING			12/21/2020			
NAME OF PI	ROVIDER OR SUPPLIER	L		S	TREET ADDRESS, CITY, STATE, ZIP CODE				
NANS PO	IANS POINTE REHABILITATION AND NURSING				00 WEST CONSTANCE ROAD SUFFOLK, VA 23434				
(X4) ID PREFIX TAG	SUMMARY ST (EACH DEFICIENC REGULATORY OR I	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE			
F 885	notify all family membrates asked why she was most wasked why she was most wasked why she was most weekly updates were not give 12/21/20; OSM #1 states aware she had to do week. No further information asked where the second states were not give 12/21/20; OSM #1 states aware she had to do week. No further information asked week. No further information asked week as a given and readmitted that included but were schizophrenia, high to seizure disorder, and #6's most recent MDS assessment was a quark ARD (assessment was a quark ARD (assessment was a quark ARD (assessment was a quark and the BIMS (Brief Information scoler) on the BIMS (Brief Information scoler) on the BIMS (Brief Information 11/30/20 positive COVID-19 cates following dates: 11/30 12/7/20, 12/8/20, 12/8/20, 12/8/20, 12/8/20, 12/8/20, 12/14/20, 12/15/20, ask and the facility? Sist from 11/20/20 through the facility? Sist from	/21/20; she was going to bers of updated COVID ail and phone calls. When outifying family members, y because I want to give e." When asked why weekly en before the week of ated that she was not made weekly updates until last in was presented prior to exit. dmitted to the facility on d on 3/30/20 with diagnoses e not limited to blood pressure, dementia, diabetes mellitus. Resident S (minimum data set) uarterly assessment with an ference date) of 11/9/20. ed as being intact in oring 14 out of possible 15 terview for Mental Status) s resident COVID testing through 12/19/20 revealed ases were identified on the b/20, 12/2/20, 12/5/20, b/20, 12/10/20, 12/11/20, nd 12/19/20. s staff COVID-19 testing line bugh 12/19/20 revealed as were identified on the	F	885					
		0/20, 12/3/20, 12/4/20, 11/20, 12/12/20, 12/14/20,							

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED D. 0938-0391		
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	NULTIPLE CONSTRUCTION			E SURVEY PLETED		
		495247	B. WING			12/21/2020			
NAME OF PI	NAME OF PROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE				
NANS PO	INTE REHABILITATION A	AND NURSING			200 WEST CONSTANCE ROAD SUFFOLK, VA 23434				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ıx	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION			
F 885	12/18/20 and 12/19/2 Review of Resident # that his family was no identified COVID-19 of documented in his clii (Name of representat has one Resident tha Covid and that the Re Residents will be test Family has no concer There was no further clinical record of resid notification regarding after 12/1/20. Further review of Res revealed that he had on 12/14/20 and had facility. Review of a n documented that Res sepsis and possible O Further review of the tracking log revealed passed away at the h On 12/18/2020 at 3:4 was conducted with F Resident #1's sister w received any updates the facility regarding O staff results in the fac stated, "The last call I social worker on 12/1	0. 6's clinical record revealed bified on 12/1/20 for the first case. The following was nical record: "Staff made ive aware that the facility t has tested positive for esident is in quarantine. All ed on December 1, 2020. rns at this time." evidence in Resident #6's dent, representative or family COVID cases in the facility sident #6's clinical record been sent out to the hospital not returned back to the ursing note dated 12/15/20 ident #6 was admitted for COVID-19. facility's COVID infection that Resident #6 had ospital. 6 P.M. a phone interview Resident #6's sister.	F	885					
	-	alled me on December 14th							

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		D HUMAN SERVICES MEDICAID SERVICES				FORM): 01/19/2022 APPROVED). 0938-0391	
STATEMENT OF DEFICIENCIES (X1)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			E SURVEY PLETED	
		495247	B. WING			12/21/2020		
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, S	TATE, ZIP CODE			
				200 WEST CONSTANCE R	OAD			
NANS POINTE REHABILITATION AND NURSING				SUFFOLK, VA 23434				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
PREFIX	(EACH DEFICIENCY REGULATORY OR L REGULATORY OR L Continued From page hospital and he died of positive." On 12/21/20 at 8:20 at conducted with ASM (member) #2, the DON When asked the proci- representatives and fa- new COVID cases; At notify family members numbers. ASM #2 the workers were response members with every H document in the elect notification had occur On 12/21/20 at 11:03 conducted with OSM the Social Worker. Wi notifying residents, re- members regarding n stated that the facility 12/1/20 regarding the OSM #1 stated that at just been notifying far members/representat (resident) was positive week; the week of 12/ notify all family memb numbers through ema- asked why she was n OSM #1 stated, "Only	A MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION) 4 41 on the 15th. He was Covid 1, an interview was (Administrative staff 1 (Director of Nursing). ess of notifying residents, amily members regarding SM #2 stated that they did s with updated COVID on stated that the social sible for notifying the family crown case and to ronic record that this red. a.m., an interview was (Other Staff Member) #1, hen asked the process of presentatives and family ew COVID cases; OSM #1 had notified everyone on first case on 11/30/20. fter that first case, she had nily	PREFIX	(EACH CORRE CROSS-REFERE	CTIVE ACTION SHOULD B		COMPLETION	
	updates were not give 12/21/20; OSM #1 sta aware she had to do v week.							

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	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM): 01/19/2022 MAPPROVED). 0938-0391	
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED		
		495247	B. WING			_	12/21/2020		
NAME OF P	ROVIDER OR SUPPLIER		•	5	STREET ADDRESS, CITY, STA	ATE, ZIP CODE			
NANS POINTE REHABILITATION AND NURSING					200 WEST CONSTANCE RC SUFFOLK, VA 23434	DAD			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	ix.	PROVIDER'S (EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BI ICED TO THE APPROPRIA IEFICIENCY)		(X5) COMPLETION DATE	
F 885	the facility Administra (Director of Nursing) above concerns. No further information Facility policy titled, "I a. Specific guidance in change; a. Due to the spread-residents, fan of a single case posit healthcare worker and the day following notif the event of 3 or more each other will be not	tor and ASM #2, the DON were made aware if the n was presented prior to exit. Notification of Changes7. notice of COVID-19 status a potential for rapid nily and staff will be notified ive COVID-19 of a d/or a residents by 5:00 PM fications to the facilities. b. In e occurring 72 hours from ified by 5 PM the day to the facilities. c. On a	F	885					

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