| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495150 | A. BUILDING _____ B. WING _____ | C 09/30/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BIRCHWOOD PARK REHABILITATION | 340 LYNN SHORES DRIVE VIRGINIA BEACH, VA 23452 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| E 000 | Initial Comments<br><br>An unannounced Emergency Preparedness survey was conducted 09/20/21 through 09/30/21. Corrections are required for compliance with 42 CFR Part 483.73, Requirements for Long Term Care Facilities. | E 000 | | |
| E 006 SS=C | Plan Based on All Hazards Risk Assessment<br>CFR(s): 483.73(a)(1)-(2)<br><br>§403.748(a)(1)-(2), §416.54(a)(1)-(2), §418.113(a)(1)-(2), §441.184(a)(1)-(2), §460.84(a)(1)-(2), §482.15(a)(1)-(2), §483.73(a)(1)-(2), §483.475(a)(1)-(2), §484.102(a)(1)-(2), §485.68(a)(1)-(2), §485.625(a)(1)-(2), §485.727(a)(1)-(2), §485.920(a)(1)-(2), §486.360(a)(1)-(2), §491.12(a)(1)-(2), §494.62(a)(1)-(2)<br><br>[(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following:]<br><br>(1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach.*<br><br>(2) Include strategies for addressing emergency events identified by the risk assessment.<br><br>* [For Hospices at §418.113(a):] Emergency Plan. The Hospice must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following:<br>(1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach. | E 006 | | |

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

Electronically Signed | 11/02/2021

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495150 | A. BUILDING _____ B. WING _____ | C 09/30/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BIRCHWOOD PARK REHABILITATION | 340 LYNN SHORES DRIVE VIRGINIA BEACH, VA 23452 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| E 006 | Continued From page 1<br>(2) Include strategies for addressing emergency events identified by the risk assessment, including the management of the consequences of power failures, natural disasters, and other emergencies that would affect the hospice's ability to provide care.<br><br>*[For LTC facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following:<br>(1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing residents.<br>(2) Include strategies for addressing emergency events identified by the risk assessment.<br><br>*[For ICF/IIDs at §483.475(a):] Emergency Plan. The ICF/IID must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following:<br><br>(1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing clients.<br>(2) Include strategies for addressing emergency events identified by the risk assessment.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and staff interview, the facility staff failed to have documentation that the Emergency Preparedness Plan included procedures and contracts to provide sewage and waste disposal. | E 006 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495150 | A. BUILDING _____ B. WING _____ | C 09/30/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BIRCHWOOD PARK REHABILITATION | 340 LYNN SHORES DRIVE VIRGINIA BEACH, VA 23452 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| E 006 | Continued From page 2<br>The findings included:<br><br>During an interview on 09/21/21 at 10:52 A.M. with the administrator, was asked for documentation of the facility's Risk Assessment. The administrator provided a Risk Assessment dated 03'/20/20. The administrator stated, the facility's Risk Assessment needed to be updated.<br><br>The facility staff failed to have documentation that the emergency preparedness plan included an up-dated facility Risk Assessment. | E 006 | | |
| E 015 SS=C | Subsistence Needs for Staff and Patients<br>CFR(s): 483.73(b)(1)<br><br>§403.748(b)(1), §418.113(b)(6)(iii), §441.184(b)(1), §460.84(b)(1), §482.15(b)(1), §483.73(b)(1), §483.475(b)(1), §485.625(b)(1)<br><br>[(b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following:<br><br>(1) The provision of subsistence needs for staff and patients whether they evacuate or shelter in place, include, but are not limited to the following:<br>(i) Food, water, medical and pharmaceutical supplies<br>(ii) Alternate sources of energy to maintain the following:<br>(A) Temperatures to protect patient health and | E 015 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495150 | A. BUILDING _____ B. WING _____ | C 09/30/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BIRCHWOOD PARK REHABILITATION | 340 LYNN SHORES DRIVE VIRGINIA BEACH, VA 23452 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| E 015 | Continued From page 3 | E 015 | | |

safety and for the safe and sanitary storage of provisions.
(B) Emergency lighting.
(C) Fire detection, extinguishing, and alarm systems.
(D) Sewage and waste disposal.

*[For Inpatient Hospice at §418.113(b)(6)(iii):] Policies and procedures.
(6) The following are additional requirements for hospice-operated inpatient care facilities only. The policies and procedures must address the following:
(iii) The provision of subsistence needs for hospice employees and patients, whether they evacuate or shelter in place, include, but are not limited to the following:
(A) Food, water, medical, and pharmaceutical supplies.
(B) Alternate sources of energy to maintain the following:
(1) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions.
(2) Emergency lighting.
(3) Fire detection, extinguishing, and alarm systems.
(C) Sewage and waste disposal.
This REQUIREMENT is not met as evidenced by:
Based on record review and staff interview, the facility staff failed to have documentation that the Emergency Preparedness Plan included contracts to provide sewage and waste disposal.

The findings included:

During an interview on 09/21/21 at 10:58 A.M. with the Administrator, he was asked for

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495150 | A. BUILDING _____ B. WING _____ | C 09/30/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BIRCHWOOD PARK REHABILITATION | 340 LYNN SHORES DRIVE VIRGINIA BEACH, VA 23452 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| E 015 | Continued From page 4<br>documentation for the facility's sewage and waste disposal during an emergency. The administrator stated, the facility did not have contracts or procedures for sewage and waste disposal during an emergency.<br><br>The facility staff failed to have documentation that the emergency preparedness plan included contracts to provide sewage and waste disposal during an emergency. | E 015 | | |
| F 000 | INITIAL COMMENTS<br><br>An unannounced Medicare/Medicaid standard survey was conducted 09/20/21 through 09/23/21. An extended survey was conducted 09/24/21 through 09/30/21. Immediate Jeopardy was identified in the area of (F-tags 880 and 886) at a scope and severity level 4 widespread (L) which constituted Substandard Quality of Care. Significant corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. Five complaints (VA00050278), (VA00050252), (VA00050254), (VA00049648), and (VA00048605) were investigated during the survey.<br><br>The census in this 150 certified bed facility was 80 at the time of the survey. The survey sample consisted of 42 current and closed records.<br><br>After accepting the plan for removal of Immediate Jeopardy from the Administrator, and determining that the Immediate Jeopardy was removed, the deficiency was assigned a Scope and Severity level of 2 widespread (F). | F 000 | | |
| F 580 SS=D | Notify of Changes (Injury/Decline/Room, etc.)<br>CFR(s): 483.10(g)(14)(i)-(iv)(15) | F 580 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495150 | A. BUILDING _____ B. WING _____ | C 09/30/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BIRCHWOOD PARK REHABILITATION | 340 LYNN SHORES DRIVE VIRGINIA BEACH, VA 23452 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 580 | Continued From page 5<br><br>§483.10(g)(14) Notification of Changes.<br>(i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is-<br>(A) An accident involving the resident which results in injury and has the potential for requiring physician intervention;<br>(B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications);<br>(C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or<br>(D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii).<br>(ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician.<br>(iii) The facility must also promptly notify the resident and the resident representative, if any, when there is-<br>(A) A change in room or roommate assignment as specified in §483.10(e)(6); or<br>(B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section.<br>(iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). | F 580 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495150 | A. BUILDING _____ B. WING _____ | C 09/30/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BIRCHWOOD PARK REHABILITATION | 340 LYNN SHORES DRIVE VIRGINIA BEACH, VA 23452 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 580 | Continued From page 6 | F 580 | | |

§483.10(g)(15)
Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9).
This REQUIREMENT is not met as evidenced by:
Based on staff interview, clinical record review and facility document review, the facility staff failed to notify the physician and/or responsible party of missed COVID-19 vaccination for Resident #24 and failed to notify the resident's representative of weight loss for Resident #22 in a survey sample of 42 residents.

The findings included:

1. Resident #24 was originally admitted to the nursing facility on 07/15/21. Diagnosis included but not limited to Chronic Obstructive Pulmonary Disease (COPD). The most recent Minimum Data Set (MDS - an assessment protocol) an annual assessment with an Assessment Reference Date (ARD) of 09/14/21 coded Resident #24 with a 14 out of a possible score of 15 on the Brief Interview for Mental Status (BIMS), indicating no cognitive impairment.

The MDS coded Resident #24 total dependence of two with transfer and total dependence of one with dressing, bathing and personal hygiene and extensive assistance of two with bed mobility and toilet use and supervision with limited assistance of one with eating for Activities of Daily Living

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495150 | A. BUILDING _____ B. WING _____ | C 09/30/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BIRCHWOOD PARK REHABILITATION | 340 LYNN SHORES DRIVE VIRGINIA BEACH, VA 23452 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 580 | Continued From page 7 | F 580 | | |

(ADL) care.

Resident #24's comprehensive care plan with a revision date of 08/10/20 document resident at risk for alteration in psychosocial well-being related to restrictions on visitation due to COVID-19. The goal set for the resident by the staff the resident will not experience any adverse effects. Some of the intervention/approaches to manage goal include but not limited resident is on droplet isolation precautions related to dialysis, encourage alternative communication with visitors and provide opportunities for expression of feelings related to situational stressors.

Review of Resident #24's clinical record revealed a COVID-19 vaccination consent form signed and dated by the resident's representative (RR) on 12/18/20. The document was also signed and dated by Registered Nurse (RN) #1 on 01/21/21.

Review of Resident #24's clinical record did not reveal evidence that the COVID-19 vaccination was either offered or declined.

On 09/29/21 at approximately 10:30 a.m., a phone interview was conducted with the Administrator, Regional Director of Clinical Services, RN #1 and Infection Preventionist/Staff Development Coordinator. RN #1 said Resident #24 refused the COVID-19 vaccination but it's wasn't documented in the nurses note or clinical record. RN #1 stated, "I should have written a nurse's note of the refusal and the clinical record should have been updated under vaccination to include Resident #24 refused the COVID-19 vaccination."

An interview was conducted with the

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495150 | A. BUILDING _____ B. WING _____ | C 09/30/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BIRCHWOOD PARK REHABILITATION | 340 LYNN SHORES DRIVE VIRGINIA BEACH, VA 23452 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 580 | Continued From page 8 | F 580 | | |

Administrator on 09/30/21 at approximately 2:27 p.m., who stated, "If Resident #24 refused the COVID-19 vaccination when offered, the nurse should have attempted again, and if the resident still refused, the refusal should have been documented in the nurse's note or someone where in his clinical record." The Administrator said the physician and the resident's (RR) should have been notified Resident #24 did not receive the COVID-19 vaccination.

The Administrator, Interim Director of Nursing, Chief Operating Officer, Regional Director of Operations and Regional Director of Clinical Services was informed of the findings during the exit meeting on 09/30/21 at approximately 7:40 p.m. The facility did not have any further questions or present any further information about the findings.

The facility's policy titled: Charting and Documentation - revision date 07/2017.
Policy statement: All services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional or psychosocial condition, shall be documented in the resident's medical record. The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care.

Policy Interpretation and Implementation read in part:
7. Documentation of procedures and treatments will include care-specific details, including:
e. Whether the resident refused the procedure/treatment.
f. Notification of family, physician or other staff, if

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495150 | A. BUILDING _____ B. WING _____ | C 09/30/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BIRCHWOOD PARK REHABILITATION | 340 LYNN SHORES DRIVE VIRGINIA BEACH, VA 23452 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 580 | Continued From page 9 | F 580 | | |

indicated; and the signature and titles of the individual documenting.

2. The facility staff failed to notify the resident representative of a significant weight loss for Resident #22 in the survey sample.

Resident #22 was originally admitted to the facility on 12/19/19 and readmitted on 7/14/20. Diagnosis for Resident #22 included but not limited Unspecified Dementia with Behavioral Disturbance and Major Depressive Disorder.

The annual Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 07/17/21 coded the resident as not having the ability to complete the Brief Interview for Mental Status (BIMS).

In section "G"(Physical functioning) the resident was coded as extensive assistance of one person with bed mobility, dressing and locomotion on and off the unit. Requiring extensive assistance of two persons transfers. Requiring supervision set-up help with eating and requiring totals dependence of one person with toileting, personal hygiene and bathing.

The Care Plan dated 5/23/21 reads: FOCUS: The resident has nutritional problems or potential nutritional problems r/t Diet restrictions, mechanically altered diet, weight loss. Goals: The resident will tolerate diet and have no significant gain/loss through review date. Interventions: Observe/report to MD (Medical Doctor) PRN (as needed) s/sx (signs and symptoms) of malnutrition: Emaciation, muscle wasting, significant weight loss: 3lbs in 1 week, greater than 5% in 1 month, greater than 7.5% in 3

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495150 | A. BUILDING _____ B. WING _____ | C 09/30/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BIRCHWOOD PARK REHABILITATION | 340 LYNN SHORES DRIVE VIRGINIA BEACH, VA 23452 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 580 | Continued From page 10 | F 580 | | |

months, greater than 10% in 6 months.

MAR (Medication Administration Record) reads: weekly weights one time a day every Wed -Start Date 10/14/2020 at 9:00 AM.
MAR (11/2020). Weights not recorded.
MAR (12/2020) Weights not recorded.

The following weights were recorded in the clinical record under "weights." 10/7/2020 152.8 1bs.
11/15/20 135 lbs.
12/03/20 135.2 lbs.
12/8/21 135.2 lbs.

The above recorded weights were not consistent with the ordered weekly weights).

A review of resident's weight from October 7, 2020 (152.8 lbs) to November 15, 2020 (135.0 lbs.) Resident has lost 17.8 lbs.

According to the complainant the resident had a significant amount of weight loss. The weekly ordered weights were not consistent from 10/07/20-11/15/20 Resident lost 17.8 lbs.

A review of clinical progress notes show no documentation proving the POA (Power of Attorney) or family member were notified of the 17.8 lbs. weight loss.

Review of progress note dated on 11/20/2020 at 9:43 AM from NP (Nurse Practitioner) reads: CC: Weight loss. This is an 81 year old who is residing on Memory Unit for LTC (Long Term Care). She was seen recently due to report of abnormal weight loss and poor appetite. Her weight is down to 135# this month, 152.8 # in

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495150 | A. BUILDING _____ B. WING _____ | C 09/30/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BIRCHWOOD PARK REHABILITATION | 340 LYNN SHORES DRIVE VIRGINIA BEACH, VA 23452 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 580 | Continued From page 11 | F 580 | | |

October. She is seen today to follow up on lab results.

A review of progress notes dated 11/18/2020 13:09 (1:09 PM). Progress Notes reads: CC: Weight loss. She is seen today due to report of abnormal weight loss. Her weight is down to 135# this month, 152.8 # in October. Staff report poor intake, about 25% at meals. No report of diarrhea or GI symptoms. She is a poor historian due to dementia. She says she is "alright" and denies pain or difficulty breathing. She is c/o feeling cold. Weight loss: possible etiologies-thyroid dysfunction, progressing dementia, or depression. Start Eldertonic 15 ml BID. Monitor weight. Weight warning trigger: 11/16/2020 15:31 Nutrition Note Text: WEIGHT WARNING: 135 lbs.

A review of Progress notes dated 11/15/2020 read: RD (Registered Dietician) weight review; resident displays significant weight loss; Re-weigh to verify weight; weekly weights x 1 mo, RD to f/u PRN; RDN.

A review of the clinical record dated 11/24/2020 at approximately 9:27 AM reveal that Resident's daughter spoke to staff about concerns about her mother's/resident's condition days after she was noted to have significant weight loss.

On 9/23/21 at approximately 2:00 PM an interview was conducted with the District Dietary Manager/OSM (Other Staff Member) #6. He stated," A lot of it has to do with her decline with dementia. Her weight has been stable through 6 months. They had a staff member not putting down the proper weights. We found out that she wasn't weighing the resident. Nursing should notify the family of weight loss issues. Quarterly

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495150 | A. BUILDING _____ B. WING _____ | C 09/30/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BIRCHWOOD PARK REHABILITATION | 340 LYNN SHORES DRIVE VIRGINIA BEACH, VA 23452 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 580 | Continued From page 12 | F 580 | | |

nutrition report completed.

On 9/23/21 at approximately 12:10 PM an interview was conducted with resident's daughter. She stated, "We received no calls about her weight loss or her not being able to walk. I spoke to the DON (Director of Nursing) and explained the weight concern she stated they would call me every Monday with weights."

On 9/23/21 at approximately 12:00 PM a telephone interview was conducted with the Registered Dietician/OSM #2 concerning Resident # 22. She stated, "The weights aren't consistent especially since COVID19. I brought it up a few times with the dietary managers. They had gotten better since the new DON came. Mostly from staff shortage. In my note she stabilized (weight) and was at a relative stable weight. I recommended fortified foods because sometimes her po (by mouth) intake is poor. She's now on weekly weights. She was on Remeron for a while for her appetite. House shakes 3 times a day. I also recommended they give her calorie dense snacks. Usually the DON's would call the family members.

On 9/23/21 at approximately 2:00 PM an interview was conducted with the District Dietary Manager/OSM (Other Staff Member) #6. He stated, " A lot of it has to do with her decline with dementia. Her weight has been stable through 6 months. They had a staff member not putting down the proper weights. We found out that she wasn ' t weighing the resident. Nursing should notify the family of weight loss issues. Quarterly nutrition report completed.

On 9/23/21 at approximately 12:10 PM an

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495150 | A. BUILDING _____ B. WING _____ | C 09/30/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BIRCHWOOD PARK REHABILITATION | 340 LYNN SHORES DRIVE VIRGINIA BEACH, VA 23452 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 580 | Continued From page 13<br>interview was conducted with resident ' s daughter. She stated, " We received no calls about her weight loss or her not being able to walk. I spoke to the DON (Director of Nursing) and explained the weight concern she stated they would call me every Monday with weights. "<br><br>On 9/23/21 at approximately 12:00 PM a telephone interview was conducted with the Registered Dietician/OSM #2 concerning Resident # 22. She stated, " The weights aren't consistent especially since COVID19. I brought it up a few times with the dietary managers. They had gotten better since the new DON came. Mostly from staff shortage. In my note she stabilized (weight) and was at a relative stable weight. I recommended fortified foods because sometimes her po (by mouth) intake is poor. She's now on weekly weights. She was on Remeron for a while for her appetite. House shakes 3 times a day. I also recommended they give her calorie dense snacks. Usually the DON's would call the family members.<br><br>On 09/30/21 at approximately 6:20 p.m., the above findings were shared with the Administrator, and Corporate Staff Members. An opportunity was offered to the facility's staff to present additional information but no additional information was provided. | F 580 | | |
| F 582 SS=D | This is a complaint deficiency<br>Medicaid/Medicare Coverage/Liability Notice<br>CFR(s): 483.10(g)(17)(18)(i)-(v)<br><br>§483.10(g)(17) The facility must--<br>(i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing | F 582 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495150 | A. BUILDING _____ B. WING _____ | C 09/30/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BIRCHWOOD PARK REHABILITATION | 340 LYNN SHORES DRIVE VIRGINIA BEACH, VA 23452 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 582 | Continued From page 14 | F 582 | | |

facility and when the resident becomes eligible for Medicaid of-
(A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged;
(B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and
(ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section.

§483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate.
(i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible.
(ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change.
(iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495150 | A. BUILDING _____ B. WING _____ | C 09/30/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BIRCHWOOD PARK REHABILITATION | 340 LYNN SHORES DRIVE VIRGINIA BEACH, VA 23452 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 582 | Continued From page 15 | F 582 | | |

discharge notice requirements.
(iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility.
(v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations.
This REQUIREMENT is not met as evidenced by:
Based on clinical record review, staff interview and facility documentation, the facility staff failed to ensure Medicare Beneficiary Notices in accordance with applicable Federal regulations, were issued to 2 of 2 residents (Resident #5 and Resident #80) in the survey sample.

The findings included:

1. The facility staff failed to issue an Advanced Beneficiary Notice (ABN) letter to Resident #5 who was discharged from skilled services with Medicare days remaining. Resident #5 was admitted to the nursing facility on 07/16/20. Diagnosis for Resident #5 included but not limited to Muscle Weakness. Resident #5's Minimum Data Set (MDS) a Medicare/5 day assessment with an Assessment Reference Date (ARD) date of 09/06/21 coded Resident #5 a 13 out of a possible score of 15 on the Brief Interview for Mental Status (BIMS), indicated no cognitive impairment.

Review of the SNF Beneficiary Notification provided by the facility was noted that Resident #5 was not issued the SNF ABN (Skilled Nursing Facility-Advanced Beneficiary Notice). The resident had received a NOMNC (Notice of

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495150 | A. BUILDING _____ B. WING _____ | C 09/30/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BIRCHWOOD PARK REHABILITATION | 340 LYNN SHORES DRIVE VIRGINIA BEACH, VA 23452 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 582 | Continued From page 16 | F 582 | | |

Medicare Provider Non-Coverage).

Resident #5 started Medicare Part A stay on 08/31/21 and the last covered day was on 09/17/21. Resident #5 was discharged from Medicare Part A services when benefit days were not exhausted. Resident #5 had only used 21 days of his Medicare Part A services with 79 days remaining. Resident #5 should have been issued a SNF ABN and an NOMNC.

A phone interview was conducted with the Social Worker (SW) on 09/23/21 at approximately 9:00 a.m. The SW said only the NOMNC was issued when Resident #5 was discharged from Medicare A services that ended on 09/20/21. She said I should have issued an ABN letter along with the NOMNC letter.

2. Resident #80 was admitted to the nursing facility on 12/07/17. Diagnosis for Resident #80 included but not limited to Lack of Coordination. Resident #80's Minimum Data Set (MDS) a quarterly assessment with an Assessment Reference Date (ARD) date of 09/01/21 coded Resident #14 out of a possible score of 15 on the Brief Interview for Mental Status (BIMS), indicated no cognitive impairment.

Review of the SNF Beneficiary Notification was noted that Resident #80 was not issued the SNF ABN (Skilled Nursing Facility-Advanced Beneficiary Notice.) The resident had received a NOMNC (Notice of Medicare Provider Non-Coverage).

Resident #80 started a Medicare Part A stay on 09/07/21, and the last covered day of this stay was 09/20/21. Resident #80 was discharged

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495150 | A. BUILDING _____ B. WING _____ | C 09/30/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BIRCHWOOD PARK REHABILITATION | 340 LYNN SHORES DRIVE VIRGINIA BEACH, VA 23452 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 582 | Continued From page 17 | F 582 | | |

from Medicare Part A services when benefit days were not exhausted. Resident #80 only used 77 days of her Medicare Part A services with 23 days remaining. Resident #80 should have been issued a SNF ABN and an NOMNC. The resident was only issued an NOMNC.

A phone interview was conducted with the Social Worker (SW) on 09/23/21 at approximately 9:00 a.m. The SW said only the NOMNC was issued when Resident #5 was discharged from Medicare A services ended on 09/17/21. She said I should have issued an ABN letter along with the NOMNC letter.

The Administrator, Interim Director of Nursing, Chief Operating Officer, Regional Director of Operations and Regional Director of Clinical Services was informed of the above findings during the exit meeting on 09/30/21 at approximately 7:40 p.m. The facility did not have any further questions or present any further information about the findings.

The facility's policy titled: Advance Beneficiary Notices, revision date: 11/01/20.
Policy: It is the policy of this facility to provide timely notices regarding Medicare eligibility and coverage.

Policy Explanation and Compliances Guidelines included but not limited to:
1. The Business Office Manager (BOM) is the contact person for information regarding Medicare eligibility, coverage, and applying for benefits.
5. The current CMS-approved revision of the forms shall be used at all time of issuance to the beneficiary (resident or resident representative).

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495150 | A. BUILDING _____ B. WING _____ | C 09/30/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BIRCHWOOD PARK REHABILITATION | 340 LYNN SHORES DRIVE VIRGINIA BEACH, VA 23452 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 582 | Continued From page 18<br>Contents of the form shall comply with related instructions and regulations regarding the use of the form.<br>A. For Part A times and services, the facility shall us the Skilled Nursing facility Advance Beneficiary Notice (SNF ABN). Form CMS-10055. | F 582 | | |
| F 583 SS=D | Personal Privacy/Confidentiality of Records<br>CFR(s): 483.10(h)(1)-(3)(i)(ii)<br><br>§483.10(h) Privacy and Confidentiality.<br>The resident has a right to personal privacy and confidentiality of his or her personal and medical records.<br><br>§483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.<br><br>§483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service.<br><br>§483.10(h)(3) The resident has a right to secure and confidential personal and medical records.<br>(i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws.<br>(ii) The facility must allow representatives of the | F 583 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495150 | A. BUILDING _____ B. WING _____ | C 09/30/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BIRCHWOOD PARK REHABILITATION | 340 LYNN SHORES DRIVE VIRGINIA BEACH, VA 23452 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 583 | Continued From page 19 | F 583 | | |

Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law.
This REQUIREMENT is not met as evidenced by:
Based on observation, resident interview, staff interviews, clinical record review, the facility's staff failed to ensure personal privacy of a resident's physical body during personal care for 1 of 42 residents (Resident #90), in the survey sample.

The findings included:

Resident #90 was originally admitted to the facility 5/14/19 and readmitted 9/3/21 after an acute care hospital stay, returning to the facility 9/9/21. The current diagnoses included; SARS-CoV-2 infection and Multiple Sclerosis.

The quarterly Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 9/16/21 coded the resident as not completing the Brief Interview for Mental Status (BIMS). The staff interview was coded for intact long and short term memory as well as modified independence with daily decision making. In section "G" (Physical functioning) the resident was coded as requiring total care of one person with bathing, extensive assistance of one person with bed mobility, transfers, dressing, toileting, and personal hygiene, limited assistance of one person with transfers, and supervision after set-up with eating.

Upon entering Resident # 90's room on 9/23/21 at approximately 9:45 a.m., a sheet was observed

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495150 | A. BUILDING _____ B. WING _____ | C 09/30/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BIRCHWOOD PARK REHABILITATION | 340 LYNN SHORES DRIVE VIRGINIA BEACH, VA 23452 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 583 | Continued From page 20 | F 583 | | |

on the floor and on top of the sheet were elimination saturated towels, a gown and used gloves. Resident #90; a SARS-CoV-2 infected resident; was in bed uncovered and without clothing. The resident stated he no longer felt sick and presented without shortness of breathe, cough, diaphoresis or fatigue. Resident #90 stated CNA #5 was obtaining towels for him to use for incontinence wear, afterwards she would dress him. The resident stated use of towels was his method of staying dry for it takes the staff too long to provide assistance when he rings the call bell. The resident's window was opened and he was viewable as staff passed by the window. The resident stated when he gets up he closes the blinds but he hadn't been up for a few days and no one had closed the blinds on his behalf.

An interview was conducted with CNA #5 on 9/23/21 at approximately 9:53 a.m. CNA #5 stated she forgot to close the window prior to beginning care for the resident was in a private room. She also stated she should have covered the resident before she stepped out to get towels, it was an oversight.

An interview was conducted with the DON on the COVID-19 positive unit on 9/23/21 at approximately 10:05 a.m. The DON stated her expectation of the CNA is to close doors, privacy curtains and window coverings before personal care is started and that no more of the resident's body be exposed than the area care is being rendered.

On 9/30/21 at approximately 6:30 p.m., the above findings were shared with the Administrator, Director of Nursing and Corporate Consultants. An opportunity was offered to the facility's staff to

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495150 | A. BUILDING _____ B. WING _____ | C 09/30/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BIRCHWOOD PARK REHABILITATION | 340 LYNN SHORES DRIVE VIRGINIA BEACH, VA 23452 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 583 | Continued From page 21<br>present additional information or comment but no additional information was provided. | F 583 | | |
| F 584 SS=D | Safe/Clean/Comfortable/Homelike Environment<br>CFR(s): 483.10(i)(1)-(7)<br><br>§483.10(i) Safe Environment.<br>The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.<br><br>The facility must provide-<br>§483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible.<br>(i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk.<br>(ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft.<br><br>§483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior;<br><br>§483.10(i)(3) Clean bed and bath linens that are in good condition;<br><br>§483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv);<br><br>§483.10(i)(5) Adequate and comfortable lighting levels in all areas;<br><br>§483.10(i)(6) Comfortable and safe temperature | F 584 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495150 | A. BUILDING _____ B. WING _____ | C 09/30/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BIRCHWOOD PARK REHABILITATION | 340 LYNN SHORES DRIVE VIRGINIA BEACH, VA 23452 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 584 | Continued From page 22 | F 584 | | |

levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and

§483.10(i)(7) For the maintenance of comfortable sound levels.
This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview, facility documentation review, and in the course of a complaint investigation, the facility staff failed to provide reasonable care for the protection of residents' property from loss for 2 of 42 residents (Resident #7 and #22) in the survey sample.

The findings included:

1. Resident #7 was originally admitted to the facility on 2/01/2019. Diagnoses for Resident #7 included but not limited to COVID-19 and Cognitive Communication Deficit.

The Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 6/18/21 coded Resident #7 as not having the ability to complete the Brief Interview for Mental Status (BIMS).

A review of the complaint/grievance report dated 2/06/20 filed by POA (Power of Attorney) Reads: Resident is missing significant amount of personal items: Clothes, burgundy/beige comforter, white watch and a gold bracelet. Sister sews name on garments. Resolution reads items returned on 2/21/20.

A review of complaint document/grievance dated 1/01/21 filed by POA reads: Other residents clothing found in the laundry bin when sister picks

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495150 | A. BUILDING _____ B. WING _____ | C 09/30/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BIRCHWOOD PARK REHABILITATION | 340 LYNN SHORES DRIVE VIRGINIA BEACH, VA 23452 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 584 | Continued From page 23 | F 584 | | |

up residents laundry. Resident is missing her gold chain. Findings of Investigation: Gold chain was not able to be located. Residents on unit 5 are in and out of each other's rooms/closets. Plan to resolve complaint: Speak with CNAs on Unit 5 about consolidating resident's clothing only for sister to retrieve every week. Results of action taken: Will continue to look for gold chain. Advised sister of facility policy on missing items. Resolution: Ongoing: Hopes that gold chain will turn up soon.

Received document on 9/27/21(dated 9/24/21) from Social Worker (OSM/Other Staff Member) #8 concerning misplaced items. The document reads: Laundry/Housekeeping recovered burgundy/beige comforter (Initials in the corner) and other items. (Five pairs of pants, four shirts and two bras). Signed laundry personnel. White watch and gold bracelet was not found. The writer (OSM#8) spoke to POA on 9/25/21 to inform her of items found. POA very thankful for call and information via this writer.

During the initial tour on 9/21/21 at approximately 2:25 PM Resident #7 was observed Resting in bed. An interview was attempted with Resident #7 but due to her cognitive communication deficit an interview was not successful.

On 9/23/21 an interview was conducted at 8:25 AM with CNA (Certified Nursing Assistant) #10 concerning Resident #7. She stated, "Her sister did her laundry at first but wasn't coming frequently enough so the resident would run out of clean laundry so we started washing it here. I don't know anything about the resident having a gold chain or remember seeing her wearing a watch."

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495150 | A. BUILDING _____ B. WING _____ | C 09/30/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BIRCHWOOD PARK REHABILITATION | 340 LYNN SHORES DRIVE VIRGINIA BEACH, VA 23452 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 584 | Continued From page 24 | F 584 | | |

On 9/23/21 at approximately 10:30 a.m., an interview was conducted with the Laundry Supervisor. He stated they had a staff member out of work therefore the laundry services were backed-up but it was their intention to get the three large bins of resident personal belongings sorted, folded or hung and returned to the residents very soon. The Laundry Supervisor stated no resident will be without needed personal items affecting their care as a result of the back-up

On 9/23/21 at approximately 1:00 PM a phone call was made to Resident #7's sister concerning her lost belongings. She stated, "The jewelry is at our own risk. She had a gold chain, gold bracelet and a watch when she first came in. It was hard getting things from her. The facility told me I shouldn't leave valuable things here. She lost glasses and they said they would refer her. She's lost wigs. The former Social Worker said they don't replace items. The Laundry wasn't available to me for pick up. Due to resident's incontinence the clothes were sent to laundry. She's lost many clothes and a comforter set that she liked."

On 9/24/21 at approximately 12:20 p.m., the Laundry Supervisor stated he recruited assistance of a previous laundry employee and they managed to get all resident personal laundry sorted and returned to the rightful owners.

On 9/28/21 at 3:45 PM an interview was conducted with Social Worker (OSM/Other Staff Member) #8 concerning Resident #7. She stated, "I didn't locate the resident's watch or bracelet. From the policy we don't reimburse for such items. I didn't see an inventory list in her chart.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495150 | A. BUILDING _____ B. WING _____ | C 09/30/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BIRCHWOOD PARK REHABILITATION | 340 LYNN SHORES DRIVE VIRGINIA BEACH, VA 23452 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 584 | Continued From page 25 | F 584 | | |

We informed the POA (Power of Attorney). I will see if we have a policy."

2. For Resident #22, the facility staff failed to replace a lost hearing aid and assist a hearing impaired resident's hearing aid and dentures needed to hear and eat foods. Per physicians order..

Resident #22 was originally admitted to the facility on 12/19/19 and readmitted on 7/14/20. Diagnosis for Resident #22 included but not limited Unspecified Dementia with Behavioral Disturbance and Major Depressive Disorder.

The annual Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 07/17/21 coded the resident as not having the ability to complete the Brief Interview for Mental Status (BIMS).

In section "G"(Physical functioning) the resident was coded as extensive assistance of one person with bed mobility, dressing and locomotion on and off the unit. Requiring extensive assistance of two persons transfers. Requiring supervision set-up help with eating and requiring totals dependence of one person with toileting, personal hygiene and bathing.

Reveiwed complaint/grievance report dated 3/23/21 filed by son and communicated to Social Services. Concern: During last recent in person visits on 3/19/21 and 3/20/21 resident had no dentures or hearing aid. Family requested resident to have daily. Findings: Hearing aids were being kept on medication cart when not in use. Dentures and hearing aids have been missing for an unknown amount of time. Plan:

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495150 | A. BUILDING _____ B. WING _____ | C 09/30/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BIRCHWOOD PARK REHABILITATION | 340 LYNN SHORES DRIVE VIRGINIA BEACH, VA 23452 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 584 | Continued From page 26 | F 584 | | |

Facility to acquire contract with senior well that offers dental and audiology services for residents. Resolution: Follow-up needed. Remarks: Missing items are a continious issue for this family and son is weery about replacement dentures.

A review of the MAR (Medication Administration Record) reveal the following:

9/10/2021: Remove Dentures ( top & bottom) at bedtime & lock in nurse cart at bedtime. No dentures in the nursing cart.

9/9/2021: Place bilateral hearing aids in resident ears every morning. one time a day for hearing impaired. due to behavior of taking them out and putting them in random places only one remains.

7/8/2020: Medication Administration Note Note Text: Place bilateral hearing aids in resident ears every morning. one time a day for hearing impaired.

12/4/2020: Remove Dentures ( top & bottom) at bedtime & lock in nurse cart at bedtime Only top denture collected from resident. No bottom denture.

A review of progress notes read:

On 11/27/2020 at 11:47 AM Nursing Progress Note: CNA placed residents upper and lower dentures in her mouth this shift. Resident removed her bottom dentures/misplaced them. Hearing aids are in place. Resident met with family this shift through window visit. No concerns noted at this time. Will inform oncoming staff of misplaced bottom dentures.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495150 | A. BUILDING _____ B. WING _____ | C 09/30/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BIRCHWOOD PARK REHABILITATION | 340 LYNN SHORES DRIVE VIRGINIA BEACH, VA 23452 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 584 | Continued From page 27 | F 584 | | |

11/24/2020 at 9:27 AM Progress Note: This Lpn (Licensed Practical Nurse) spoke with daughter, her concerns was resident didn't have dentures, hearing aids, hair and nail cut. Also not knowing her mother is w/c bound and incontinent. I reeducated her on resident condition and that we will make sure on her mother is will groom on a daily basis.

11/21/2020 at 10:53 AM-Medication Administration Note: Place bilateral hearing aids in resident ears every morning.

On 9/22/21 at approximately 10:25 AM., Surveyor observed Resident without dentures and hearing aides as she was sitting at the table in the activities room. No dentures intact. No hearing aide intact. Her CNA stated, "She will take out her own dentures."

On 9/22/21 at approximately 7:10 PM- an interview was conducted with LPN (Licensed Practical Nurse) #6 concerning Resident #22's dentures. She stated, " I haven't seen her dentures in her mouth in a couple of weeks. "

On 9/23/21 at approximately 8:25 AM an interview was conducted with CNA (Certified Nursing Assistant) #10 concerning Resident #22. He stated, "Her dentures should be taken out at night and soaked. They should be left on the sink. Her hearing aid should be locked in the medication cart before she goes to bed."

On 9/23/21 at approximately 9:35 AM an interview was conducted with CNA (Certified Nursing Assistant) #1 concerning Resident #22. She stated, " She doesn't have any dentures. When she did she would take them out.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495150 | A. BUILDING _____ B. WING _____ | C 09/30/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BIRCHWOOD PARK REHABILITATION | 340 LYNN SHORES DRIVE VIRGINIA BEACH, VA 23452 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 584 | Continued From page 28<br><br>On 9/23/21 Resident observed in Activity room at 9:40 AM. No dentures intact.<br><br>On 9/23/21 at approximately 12:44 PM an interview was conducted with Resident #22's son concerning her dentures and weight loss. He stated, "I never saw her pull them out (her dentures) nor the hearing aids. Not wearing the dentures makes her face sunken in. Constant lack of not shaving her.(Whiskers on her face). The dietician would talk about her weight loss at the quarterly meetings."<br><br>Received Investigation document dated on 9/24/21 on 9/27/21 from Social Worker (OSM/Other Staff Member) #8. It reads as follows: During investigation one hearing aid is in place. No dentures found. Appointment was scheduled October 7, 2021 @10:00 AM with Affordable Dentures. Resident's son was called and informed of upcoming appointment. Reached out to ENT (Ear, Nose and Throat) on 9/24/21 office was closed. Will follow up on Monday September 27, 2021 to schedule an appointment.<br><br>On 09/30/21 at approximately 6:20 p.m., the above findings were shared with the Administrator, and Corporate Staff Members. An opportunity was offered to the facility's staff to present additional information but no additional information was provided. | F 584 | | |
| F 622 SS=E | This is a complaint deficiency<br>Transfer and Discharge Requirements<br>CFR(s): 483.15(c)(1)(i)(ii)(2)(i)-(iii)<br><br>§483.15(c) Transfer and discharge- | F 622 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495150 | A. BUILDING _____ B. WING _____ | C 09/30/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BIRCHWOOD PARK REHABILITATION | 340 LYNN SHORES DRIVE VIRGINIA BEACH, VA 23452 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 622 | Continued From page 29<br>§483.15(c)(1) Facility requirements-<br>(i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless-<br>(A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility;<br>(B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility;<br>(C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident;<br>(D) The health of individuals in the facility would otherwise be endangered;<br>(E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or<br>(F) The facility ceases to operate.<br>(ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger | F 622 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495150 | A. BUILDING _____ B. WING _____ | C 09/30/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BIRCHWOOD PARK REHABILITATION | 340 LYNN SHORES DRIVE VIRGINIA BEACH, VA 23452 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 622 | Continued From page 30 | F 622 | | |

that failure to transfer or discharge would pose.

§483.15(c)(2) Documentation.
When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider.
(i) Documentation in the resident's medical record must include:
(A) The basis for the transfer per paragraph (c)(1)(i) of this section.
(B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s).
(ii) The documentation required by paragraph (c)(2)(i) of this section must be made by-
(A) The resident's physician when transfer or discharge is necessary under paragraph (c)(1)(A) or (B) of this section; and
(B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section.
(iii) Information provided to the receiving provider must include a minimum of the following:
(A) Contact information of the practitioner responsible for the care of the resident.
(B) Resident representative information including contact information
(C) Advance Directive information
(D) All special instructions or precautions for ongoing care, as appropriate.
(E) Comprehensive care plan goals;

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495150 | A. BUILDING _____ B. WING _____ | C 09/30/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BIRCHWOOD PARK REHABILITATION | 340 LYNN SHORES DRIVE VIRGINIA BEACH, VA 23452 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 622 | Continued From page 31 | F 622 | | |

(F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care.
This REQUIREMENT is not met as evidenced by:
Based on staff interviews, clinical record review and facility documentation review the facility staff failed to send a copy of the Resident's Care Plan for 3 out of 42 residents (Resident #33, Resident #42 and Resident #21) after being transferred to the hospital.

The findings included:

1. The facility staff failed to ensure Resident #33's Plan of Care Summary to include her care plan goals was sent upon or shortly after transfer/discharge to the hospital on 07/15/21. Resident #33 was originally admitted to the facility on 12/01/16. Diagnosis for Resident #33 included but not limited to Anxiety disorder.

Resident #33's Minimum Data Set (MDS-an assessment protocol) a significant change MDS with an Assessment Reference Date of 07/28/21 coded Resident #33 with short and long-term memory problems and cognitive skills severely impaired-never/rarely made decisions.

The Discharge MDS assessments was dated for 07/15/21 - discharged with return anticipated.

A nurse's note entered on 07/15/21 at approximately 8:02 a.m., revealed the following documentation: "Resident observed in supine position, not easily aroused, eyes unresponsive to light and sternal rub given in order to be

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495150 | A. BUILDING _____ B. WING _____ | C 09/30/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BIRCHWOOD PARK REHABILITATION | 340 LYNN SHORES DRIVE VIRGINIA BEACH, VA 23452 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 622 | Continued From page 32 | F 622 | | |

aroused." The note included the physician was notified of change in condition with Resident #33 with new orders to start Intravenous (IV) fluids and send to the Emergency Room (ER) for evaluation and treatment. The nurse's note indicated the vital signs were but not limited to the following: (BP) 95/60 - (hypotension) (P) 105 - (tachycardia) (R) 12 and oxygen saturation levels at 98%-on room air.

On 09/29/21 at approximately 10:30 a.m., a phone interview was conducted with the Administrator, Regional Director of Clinical Services, MDS Coordinator and Infection Preventionist/Staff Development Coordinator. Corporate said the care plan should have been sent when discharge to the new provider (acute care setting). She said the care plan ensures the new provider knows what kind of care the resident needs to maintain continuity of care.

2. The facility staff failed to ensure Resident #42's Plan of Care Summary to include his care plan goals was sent upon or shortly after transfer/discharge to the hospital on 09/04/21. Resident #42 was originally admitted to the facility on 10/24/16. Diagnosis for Resident #42 included but not limited to Dementia without behavioral disturbance.

Resident #42's Minimum Data Set (MDS-an assessment protocol) a quarterly Medicare 5-day assessment with an Assessment Reference Date of 09/06/21 coded Resident #42 with short and long-term memory problems and cognitive skills severely impaired-never/rarely made decisions.

The MDS assessment was dated for 09/06/21 -

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495150 | A. BUILDING _____ B. WING _____ | C 09/30/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BIRCHWOOD PARK REHABILITATION | 340 LYNN SHORES DRIVE VIRGINIA BEACH, VA 23452 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 622 | Continued From page 33 | F 622 | | |

discharged with return anticipated.

A nurse's note entered by on 09/04/21 at approximately 9:13 a.m., revealed the following documentation: "Resident #42 noted with cough and congestion; lungs sounds noted with crackles in the left upper lobe." The note included resident refusing all medications, fluids and breakfast at this time. The nurse's note indicated the vital signs were but not limited to the following: (BP) 158/92 - (hypertension) (P) 102 - (tachycardia) (R) 20, (T) 100.9 and oxygen saturation levels at 94% on room air. On the same day at approximately 4:28 p.m., the nurse's note indicated the resident was in the Emergency Room (ER).

On 09/05/21 at approximately 7:58 p.m., the nurse's note revealed a note that read, "Resident in hospital."

On 09/29/21 at approximately 10:30 a.m., a phone interview was conducted with the Administrator, Regional Director of Clinical Services, MDS Coordinator and Infection Preventionist/Staff Development Coordinator. Corporate said the care plan should have been sent when discharge to the new provider (acute care setting). She said the care plan ensures the new provider knows what kind of care the resident needs to maintain continuity of care.

The Administrator, Interim Director of Nursing, Chief Operating Officer, Regional Director of Operations and Regional Director of Clinical Services was informed of the above findings during the exit meeting on 09/30/21 at approximately 7:40 p.m. The facility did not have any further questions or present any further

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495150 | A. BUILDING _____ B. WING _____ | C 09/30/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BIRCHWOOD PARK REHABILITATION | 340 LYNN SHORES DRIVE VIRGINIA BEACH, VA 23452 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 622 | Continued From page 34 | F 622 | | |

information about the findings.

The facility policy titled Transfer and Discharge including Against Medical Advice (AMA) revised on 10/20/20.
7. Emergency Transfer/Discharges - initiated by the facility for medical reasons, or for the immediate safety and welfare of a resident (nursing responsibilities unless otherwise specified).
Section D. Complete and send with the resident or provide as soon as practical) a Transfer Form which documents: Comprehensive care plan goals.
3. The facility staff failed to ensure that Comprehensive Care Plan Goals were sent upon transfer to the hospital on 4/26/21 and 8/22/21 for Resident #21.

Resident #21 was admitted on 12/31/19 with diagnoses to include but not limited to Dementia, Paranoid Schizophrenia, Psychosis and Difficulty Swallowing.

Resident #21's most recent Minimum Data Set (MDS) was a quarterly with an Assessment Reference Date (ARD) of 9/7/21. Resident #21's Brief Interview for Mental Status (BIMS) was coded as a 00, indicating severe cognitive impairment and the inability to perform daily decision making.

Resident #21's Clinical Census was reviewed and revealed the resident was discharged on 4/26/21 and 8/22/21.

Resident #21's Nursing Progress Notes were reviewed and are documented in part, as follows:

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495150 | A. BUILDING _____ B. WING _____ | C 09/30/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BIRCHWOOD PARK REHABILITATION | 340 LYNN SHORES DRIVE VIRGINIA BEACH, VA 23452 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 622 | Continued From page 35 | F 622 | | |

4/26/2021 17:12 (5:12 p.m.), eINTERACT SBAR(Situation, Background, Assessment, Recommendations) Summary: The Change In Condition/s reported are/were: Functional decline (worsening function and/or mobility)
- Mental Status Evaluation: Altered level of consciousness (hyperalert, drowsy but easily aroused, difficult to arouse)
Primary Care Provider Feedback: Primary Care Provider responded with the following feedback:
A. Recommendations: SEND OUT VIA 911.

4/26/2021 21:32 (9:39 p.m.), Nursing Progress Note: Nurse was notified by CNA(certified nursing assistant) that patient had been acting different than usual today and has not got up out of bed. This nurse went to assess pt(patient) and noted pt to be having seizure-like movements. Pt was able to respond to verbal stimuli by lifting his head up and looking towards nurse. Pt was non-vocal at this time with grunting noises noted NP(nurse practitioner)/MD(medical doctor) notified, 911 called, pt sent out to hospital. Unit Manager and ADON(assistant director of nursing), were notified. Called the hospital for an update and the ER(emergency room) Nurse stated pt was intubated and being admitted for AMS(altered mental status), Seizures, and Renal Failure. MD(medical doctor)/NP(nurse practitioner) and ADON(assistant director of nursing) made aware.

8/21/2021 19:24 (7:24 p.m.), Nursing Progress Note: Resident noted to have extreme lethargy and weakness and frequent jerking of BUE(bilateral upper extremities) and BLE(bilateral lower extremities) noted and resident extremely pale. Resident pocketing food and difficulty swallowing food and liquids. B/P-83/53. MD on call made aware and new

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495150 | A. BUILDING _____ B. WING _____ | C 09/30/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BIRCHWOOD PARK REHABILITATION | 340 LYNN SHORES DRIVE VIRGINIA BEACH, VA 23452 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 622 | Continued From page 36 | F 622 | | |

order to send patient to hospital to be evaluated for altered mental status.

8/21/2021 19:44 (7:44 p.m.), eINTERACT SBAR Summary: The Change In Condition/s are/were: Altered mental status
- Blood Pressure: BP 83/53
- Mental Status Evaluation: Altered level of consciousness (hyperalert, drowsy but easily aroused, difficult to arouse)
- Functional Status Evaluation: Swallowing difficulty.
- Neurological Status Evaluation: Altered level of consciousness (hyperalert, drowsy but easily aroused, difficult to arouse)
Nursing observations, evaluation, and recommendations are:
Primary Care Provider Feedback: Primary Care Provider responded with the following feedback:
A. Recommendations: Send resident to ER(emergency room) to be evaluated.

8/22/2021 06:25 a.m. Nursing Progress Note: Call placed to ED(emergency department) for admitting diagnosis. Informed there was no admitting diagnosis only that resident was admitted to the ICU(intensive care unit) for further treatment.

There was no documentation in Resident #21's clinical record to indicate that the resident's comprehensive care plan goals were sent with the resident upon transfer from the facility to the hospital on 4/26/21 or 8/22/21.

On 9/28/21 at 10:40 a.m., an interview was conducted with the Director of Nursing (DON) regarding Resident #21's hospital transfers on 4/26/21 and 8/22/21 and if comprehensive care

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495150 | A. BUILDING _____ B. WING _____ | C 09/30/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BIRCHWOOD PARK REHABILITATION | 340 LYNN SHORES DRIVE VIRGINIA BEACH, VA 23452 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 622 | Continued From page 37<br>plan goals were sent with him. The DON stated, "I couldn't find no documentation that the care plan goals were sent to the hospital with him for 4/26/21 or 8/22/21. They should have been sent with him so the hospital staff would know specific information about him and about the care he required."<br><br>On 9/29/21 at 4:10 p.m., an interview was conducted with the Regional Director of Clinical Services regarding what was expected to be sent with resident's upon transfer to the hospital. The Regional Director of Clinical Services stated, "The care plan goals should go with the resident because the receiving provider needs to know the person-centered care required for the resident. It should also be documented in the resident's medical record that it was sent."<br><br>The facility policy titled "Transfer and Discharges" dated 11/1/20 was reviewed and is documented in part, as follows:<br><br>7. Emergency Transfer/Discharges: d. Complete and sent with the resident: viii. Comprehensive care plan goals.<br><br>On 9/30/21 at 6:42 p.m., a pre-exit debriefing was conducted with the Administrator, the acting Director of Nursing, the Regional Director of Clinical Services and the Regional Director of Operations, where the above information was shared. Prior to exit no further information was shared. | F 622 | | |
| F 623 SS=D | Notice Requirements Before Transfer/Discharge<br>CFR(s): 483.15(c)(3)-(6)(8)<br><br>§483.15(c)(3) Notice before transfer. | F 623 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495150 | A. BUILDING _____ B. WING _____ | C 09/30/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BIRCHWOOD PARK REHABILITATION | 340 LYNN SHORES DRIVE VIRGINIA BEACH, VA 23452 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 623 | Continued From page 38 | F 623 | | |

Before a facility transfers or discharges a resident, the facility must-
(i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman.
(ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and
(iii) Include in the notice the items described in paragraph (c)(5) of this section.

§483.15(c)(4) Timing of the notice.
(i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged.
(ii) Notice must be made as soon as practicable before transfer or discharge when-
(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;
(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;
(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;
(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30 days.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495150 | A. BUILDING _____ B. WING _____ | C 09/30/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BIRCHWOOD PARK REHABILITATION | 340 LYNN SHORES DRIVE VIRGINIA BEACH, VA 23452 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 623 | Continued From page 39 | F 623 | | |

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:
(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged;
(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;
(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and
(vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.

§483.15(c)(6) Changes to the notice.
If the information in the notice changes prior to effecting the transfer or discharge, the facility

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495150 | A. BUILDING _____ B. WING _____ | C 09/30/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BIRCHWOOD PARK REHABILITATION | 340 LYNN SHORES DRIVE VIRGINIA BEACH, VA 23452 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 623 | Continued From page 40 | F 623 | | |

must update the recipients of the notice as soon as practicable once the updated information becomes available.

§483.15(c)(8) Notice in advance of facility closure
In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l).
This REQUIREMENT is not met as evidenced by:
Based on resident record review, staff interviews and facility document reviews, the facility staff failed to notify the Office of the State Long-Term Care Ombudsman in writing of discharges for two residents (Resident #22, #21) in the sample of 42 residents.

The findings included:

1. The facility staff failed to notify the Office of the State Long-Term Care Ombudsman of Resident #22's transfer to the local hospital on 07/10/20. Resident #22 was originally admitted to the facility on 12/19/19 and was re-admitted on 7/14/20. Diagnosis for Resident #22 include but not limited to Unspecified Intracapsular Fracture of the Left Femur, Sequela.

The annual Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 07/17/21 coded the resident as not having the ability to complete the Brief Interview for Mental Status (BIMS).

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495150 | A. BUILDING _____ B. WING _____ | C 09/30/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BIRCHWOOD PARK REHABILITATION | 340 LYNN SHORES DRIVE VIRGINIA BEACH, VA 23452 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 623 | Continued From page 41 | F 623 | | |

On 7/10/20, according to the facility's documentation, a change in condition was reported concerning resident's skin color. An X-ray was ordered and showed an acute left hip fracture. Resident was picked up via transportation services and taken to the local ER (Emergency Room).

On 7/14/20, according to the facility's documentation, Resident returned from the hospital. Resident has a Honeycomb dressing at the left hip over incision to repair fracture.

On 9/29/21 at approximately 3:00 PM an interview was conducted with ASM (Administrative Staff Member) #7. She stated, "We don't have a record of an Ombudsman notification being sent."

On 09/30/21 at approximately 6:20 p.m., the above findings were shared with the Administrator, and Corporate Staff Members. An opportunity was offered to the facility's staff to present additional information but no additional information was provided.
2. The facility staff failed to ensure the local State Long-Term Care Ombudsman was notified that Resident #21 was discharged to the hospital on 4/26/21 and 8/22/21.

Resident #21 was admitted on 12/31/19 with diagnoses to include but not limited to Dementia, Paranoid Schizophrenia, Psychosis and Difficulty Swallowing.

Resident #21's most recent Minimum Data Set (MDS) was a quarterly with an Assessment Reference Date (ARD) of 9/7/21. Resident #21's

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495150 | A. BUILDING _____ B. WING _____ | C 09/30/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BIRCHWOOD PARK REHABILITATION | 340 LYNN SHORES DRIVE VIRGINIA BEACH, VA 23452 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 623 | Continued From page 42 | F 623 | | |

Brief Interview for Mental Status (BIMS) was coded as a 00, indicating severe cognitive impairment and the inability to perform daily decision making.

Resident #21's Clinical Census was reviewed and revealed the resident was discharged on 4/26/21 and 8/22/21.

Resident #21's Nursing Progress Notes were reviewed and are documented in part, as follows:

4/26/2021 21:32 (9:39 p.m.), Nursing Progress Note: Called the hospital for an update and the ER(emergency room) Nurse stated pt(patient) was intubated and being admitted for AMS(altered mental status), Seizures, and Renal Failure. MD(medical doctor)/NP(nurse practitioner) and ADON made aware.

8/22/2021 06:25 a.m. Nursing Progress Note: Call placed to ED(emergency department) for admitting diagnosis. Informed there was no admitting diagnosis only that resident was admitted to the ICU(intensive care unit) for further treatment.

On 9/22/21 at 11:00 a.m., the facility Social Worker was asked for documentation to show that the local State Long-Term Care Ombudsman was notified that Resident #21 was discharged to the hospital on 4/26/21 and 8/22/21.

On 9/22/21 at 1:00 P.M. an interview was conducted with the facility Social Worker regarding documentation that the State Long-Term Care Ombudsman was notified by the facility that Resident #21 was discharged to the hospital on 4/26/21 and 8/22/21. The Social

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495150 | A. BUILDING _____ B. WING _____ | C 09/30/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BIRCHWOOD PARK REHABILITATION | 340 LYNN SHORES DRIVE VIRGINIA BEACH, VA 23452 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 623 | Continued From page 43<br>Worker stated, "I was not here in April and can not find any documentation that the ombudsman was notified of that discharge. Also I can not find documentation that I notified the ombudsman of the 8/22/21 discharge. I should have sent that at the beginning of September."<br><br>On 9/22/21 at 2:00 p.m., an interview was conducted with the Regional Director of Clinical Services regarding when and who should notify the State Long-Term Care Ombudsman of discharges. The Regional Director of Clinical Services stated, "The Social Worker should notify the ombudsman at least monthly of all discharges."<br><br>The facility policy titled "Transfer and Discharges" dated 11/1/20 was reviewed and is documented in part, as follows:<br><br>7. Emergency Transfer/Discharges: k. Social Services Director, or designee, shall provide notice of transfer to a representative of the State Long-Term Care Ombudsman via monthly list.<br><br>On 9/30/21 at 6:42 p.m., a pre-exit debriefing was conducted with the Administrator, the acting Director of Nursing, the Regional Director of Clinical Services and the Regional Director of Operations, where the above information was shared. Prior to exit no further information was shared. | F 623 | | |
| F 625 SS=E | Notice of Bed Hold Policy Before/Upon Trnsfr<br>CFR(s): 483.15(d)(1)(2)<br><br>§483.15(d) Notice of bed-hold policy and return-<br><br>§483.15(d)(1) Notice before transfer. Before a | F 625 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495150 | A. BUILDING _____ B. WING _____ | C 09/30/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BIRCHWOOD PARK REHABILITATION | 340 LYNN SHORES DRIVE VIRGINIA BEACH, VA 23452 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 625 | Continued From page 44 | F 625 | | |

nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies-
(i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility;
(ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any;
(iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and
(iv) The information specified in paragraph (e)(1) of this section.

§483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section.
This REQUIREMENT is not met as evidenced by:
Based on staff interview, facility documentation review and clinical record review the facility staff failed send a copy of the Bed-Hold Policy upon discharge/transfer for 4 of 42 resident's (Resident #33, Resident #42, Resident #21 and Resident #92) after being transferred to the hospital.

The findings included:

1. The facility staff failed to ensure that Resident #33 or his resident's representative was provided a copy of the bed hold policy upon

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495150 | A. BUILDING _____ B. WING _____ | C 09/30/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BIRCHWOOD PARK REHABILITATION | 340 LYNN SHORES DRIVE VIRGINIA BEACH, VA 23452 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 625 | Continued From page 45 | F 625 | | |

discharge/transfer to the hospital on 07/15/21. Resident #33 was originally admitted to the facility on 12/01/16. Diagnosis for Resident #33 included but not limited to Anxiety disorder.

Resident #33's Minimum Data Set (MDS-an assessment protocol) a significant change MDS with an Assessment Reference Date of 07/28/21 coded Resident #33 with short and long-term memory problems and cognitive skills severely impaired-never/rarely made decisions.

The Discharge MDS assessments was dated for 07/15/21 - discharged with return anticipated.

A nurse's note entered on 07/15/21 at approximately 8:02 a.m., revealed the following documentation: "Resident observed in supine position, not easily aroused, eyes unresponsive to light and sternal rub given in order to be aroused." The note included the physician was notified of change in condition with the Resident #33 with new orders to start Intravenous (IV) fluids and send to the Emergency Room (ER) for evaluation and treatment. The nurse's note indicated the vital signs were but not limited to the following: (BP) 95/60 - (hypotension) (P) 105 - (tachycardia) (R) 12 and oxygen saturation levels at 98%-on room air.

On 09/29/21 at approximately 10:30 a.m., a phone interview was conducted with the Administrator, Based on staff interviews, clinical record review and facility documentation review the facility staff failed to send a copy of the Resident #33 care plan after being transferred to the hospital.

The facility staff failed to ensure Resident #33's

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495150 | A. BUILDING _____ B. WING _____ | C 09/30/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BIRCHWOOD PARK REHABILITATION | 340 LYNN SHORES DRIVE VIRGINIA BEACH, VA 23452 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 625 | Continued From page 46 | F 625 | | |

Plan of Care Summary to include her care plan goals was sent upon or shortly after transfer/discharge to the hospital on 07/15/21. Resident #33 was originally admitted to the facility on 12/01/16. Diagnosis for Resident #33 included but not limited to Anxiety disorder.

Resident #33's Minimum Data Set (MDS-an assessment protocol) a significant change MDS with an Assessment Reference Date of 07/28/21 coded Resident #33 with short and long-term memory problems and cognitive skills severely impaired-never/rarely made decisions.

The Discharge MDS assessments was dated for 07/15/21 - discharged with return anticipated.

A nurse's note entered on 07/15/21 at approximately 8:02 a.m., revealed the following documentation: "Resident observed in supine position, not easily aroused, eyes unresponsive to light and sternal rub given in order to be aroused." The note included the physician was notified of change in condition with Resident #33 with new orders to start Intravenous (IV) fluids and send to the Emergency Room (ER) for evaluation and treatment. The nurse's note indicated the vital signs were but not limited to the following: (BP) 95/60 - (hypotension) (P) 105 - (tachycardia) (R) 12 and oxygen saturation levels at 98%-on room air.

On 09/29/21 at approximately 10:30 a.m., a phone interview was conducted with the Administrator, Regional Director of Clinical Services, MDS Coordinator and Infection Preventionist/Staff Development Coordinator. Corporate said the care plan should have been sent when discharge to the new provider (acute

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495150 | A. BUILDING _____ B. WING _____ | C 09/30/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BIRCHWOOD PARK REHABILITATION | 340 LYNN SHORES DRIVE VIRGINIA BEACH, VA 23452 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 625 | Continued From page 47 | F 625 | | |

care setting). She said the care plan ensures the new provider knows what kind of care the resident needs to maintain continuity of care.

2. The facility staff failed to ensure Resident #42's Plan of Care Summary to include his care plan goals was sent upon or shortly after transfer/discharge to the hospital on 09/04/21. Resident #42 was originally admitted to the facility on 10/24/16. Diagnosis for Resident #42 included but not limited to Dementia without behavioral disturbance.

Resident #42's Minimum Data Set (MDS-an assessment protocol) a quarterly Medicare 5-day assessment with an Assessment Reference Date of 09/06/21 coded Resident #42 with short and long-term memory problems and cognitive skills severely impaired-never/rarely made decisions.

The MDS assessment was dated for 09/06/21 - discharged with return anticipated.

A nurse's note entered by on 09/04/21 at approximately 9:13 a.m., revealed the following documentation: "Resident #42 noted with cough and congestion; lungs sounds noted with crackles in the left upper lobe." The note included resident refusing all medications, fluids and breakfast at this time. The nurse's note indicated the vital signs were but not limited to the following: (BP) 158/92 - (hypertension) (P) 102 - (tachycardia) (R) 20, (T) 100.9 and oxygen saturation levels at 94% on room air. On the same day at approximately 4:28 p.m., the nurse's note indicated the resident was in the Emergency Room (ER).

On 09/05/21 at approximately 7:58 p.m., the

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495150 | A. BUILDING _____ B. WING _____ | C 09/30/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BIRCHWOOD PARK REHABILITATION | 340 LYNN SHORES DRIVE VIRGINIA BEACH, VA 23452 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 625 | Continued From page 48 | F 625 | | |

nurse's note revealed a note that read, "Resident in hospital."

On 09/29/21 at approximately 10:30 a.m., a phone interview was conducted with the Administrator, Regional Director of Clinical Services, MDS Coordinator and Infection Preventionist/Staff Development Coordinator. Corporate said the care plan should have been sent when discharge to the new provider (acute care setting). She said the care plan ensures the new provider knows what kind of care the resident needs to maintain continuity of care.

The Administrator, Interim Director of Nursing, Chief Operating Officer, Regional Director of Operations and Regional Director of Clinical Services was informed of the above findings during the exit meeting on 09/30/21 at approximately 7:40 p.m. The facility did not have any further questions or present any further information about the findings.

The facility policy titled Transfer and Discharge including Against Medical Advice (AMA) revised on 10/20/20.
7. Emergency Transfer/Discharges - initiated by the facility for medical reasons, or for the immediate safety and welfare of a resident (nursing responsibilities unless otherwise specified).
Section D. Complete and send with the resident or provide as soon as practical) a Transfer Form which documents: Comprehensive care plan goals.

The Administrator, Interim Director of Nursing, Chief Operating Officer, Regional Director of Operations, Regional Director of Clinical Services

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495150 | A. BUILDING _____ B. WING _____ | C 09/30/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BIRCHWOOD PARK REHABILITATION | 340 LYNN SHORES DRIVE VIRGINIA BEACH, VA 23452 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 625 | Continued From page 49 | F 625 | | |

was informed of the findings during the exit meeting on 09/30/21 at approximately 7:40 p.m. The facility did not have any further questions or present any further information about the findings.

2. The facility staff failed to ensure that Resident #42 or his resident's representative was provided a copy of the bed hold policy upon discharge/transfer to the hospital on 09/04/21. Resident #42 was originally admitted to the facility on 10/24/16. Diagnosis for Resident #42 included but not limited to Dementia without behavioral disturbance.

Resident #42's Minimum Data Set (MDS-an assessment protocol) a quarterly Medicare 5-day assessment with an Assessment Reference Date of 09/06/21 coded Resident #42 with short and long-term memory problems and cognitive skills severely impaired-never/rarely made decisions.

The MDS assessment was dated for 09/06/21 - discharged with return anticipated.

A nurse's note entered by on 09/04/21 at approximately 9:13 a.m., revealed the following documentation: "Resident #42 noted with cough and congestion; lungs sounds noted with crackles in the left upper lobe." The note included resident refusing all medications, fluids and breakfast at this time. The nurse's note indicated the vital signs were but not limited to the following: (BP) 158/92 - (hypertension) (P) 102 - (tachycardia) (R) 20, (T) 100.9 and oxygen saturation levels at 94% on room air. On the same day at approximately 4:28 p.m., the nurse's note indicated the resident was in the Emergency Room (ER).

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495150 | A. BUILDING _____ B. WING _____ | C 09/30/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BIRCHWOOD PARK REHABILITATION | 340 LYNN SHORES DRIVE VIRGINIA BEACH, VA 23452 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 625 | Continued From page 50 | F 625 | | |

On 09/05/21 at approximately 7:58 p.m., the nurse's note revealed a note that read, "Resident in hospital."

On 09/29/21 at approximately 10:30 a.m., a phone interview was conducted with the Administrator, Regional Director of Clinical Services, MDS Coordinator and Infection Preventionist/Staff Development Coordinator. The Administrator said the bed is hold policy should have been sent when discharged to the hospital. He said the bed hold policy informs the resident of their rights when returning back to the facility along with the bed hold requirement.

The Administrator, Interim Director of Nursing, Chief Operating Officer, Regional Director of Operations, Regional Director of Clinical Services was informed of the findings during the exit meeting on 09/30/21 at approximately 7:40 p.m. The facility did not have any further questions or present any further information about the findings.

The facility policy titled Transfer and Discharge including Against Medical Advice (AMA) revised on 10/20/20.
7. Emergency Transfer/Discharges - initiated by the facility for medical reasons, or for the immediate safety and welfare of a resident (nursing responsibilities unless otherwise specified).
Section I. Provide a notice of the resident's bed hold policy to the resident and representative at the time of transfer, as possible, but no later than 24 hours of the transfer.
3. The facility staff failed to ensure that a Bed Hold Notice was provided or sent upon transfer to the hospital on 4/26/21 and 8/22/21 for Resident #21.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495150 | A. BUILDING _____ B. WING _____ | C 09/30/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BIRCHWOOD PARK REHABILITATION | 340 LYNN SHORES DRIVE VIRGINIA BEACH, VA 23452 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 625 | Continued From page 51 | F 625 | | |

Resident #21 was admitted on 12/31/19 with diagnoses to include but not limited to Dementia, Paranoid Schizophrenia, Psychosis and Difficulty Swallowing.

Resident #21's most recent Minimum Data Set (MDS) was a quarterly with an Assessment Reference Date (ARD) of 9/7/21. Resident #21's Brief Interview for Mental Status (BIMS) was coded as a 00, indicating severe cognitive impairment and the inability to perform daily decision making.

Resident #21's Clinical Census was reviewed and revealed the resident was discharged on 4/26/21 and 8/22/21.

Resident #21's Nursing Progress Notes were reviewed and are documented in part, as follows:

4/26/2021 17:12 (5:12 p.m.), eINTERACT SBAR(Situation, Background, Assessment, Recommendations) Summary: The Change In Condition/s reported are/were: Functional decline (worsening function and/or mobility)
- Mental Status Evaluation: Altered level of consciousness (hyperalert, drowsy but easily aroused, difficult to arouse)
Primary Care Provider Feedback: Primary Care Provider responded with the following feedback:
A. Recommendations: SEND OUT VIA 911.

4/26/2021 21:32 (9:39 p.m.), Nursing Progress Note: Nurse was notified by CNA(certified nursing assistant) that patient had been acting different than usual today and has not got up out of bed. This nurse went to assess pt(patient) and noted pt to be having seizure-like movements. Pt was

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495150 | A. BUILDING _____ B. WING _____ | C 09/30/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BIRCHWOOD PARK REHABILITATION | 340 LYNN SHORES DRIVE VIRGINIA BEACH, VA 23452 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 625 | Continued From page 52 | F 625 | | |

able to respond to verbal stimuli by lifting his head up and looking towards nurse. Pt was non-vocal at this time with grunting noises noted NP(nurse practitioner)/MD(medical doctor) notified, 911 called, pt sent out to hospital. Unit Manager and ADON(assistant director of nursing), were notified. Called the hospital for an update and the ER(emergency room) Nurse stated pt was intubated and being admitted for AMS(altered mental status), Seizures, and Renal Failure. MD(medical doctor)/NP(nurse practitioner) and ADON(assistant director of nursing) made aware.

8/21/2021 19:24 (7:24 p.m.), Nursing Progress Note: Resident noted to have extreme lethargy and weakness and frequent jerking of BUE(bilateral upper extremities) and BLE(bilateral lower extremities) noted and resident extremely pale. Resident pocketing food and difficulty swallowing food and liquids. B/P-83/53. MD on call made aware and new order to send patient to hospital to be evaluated for altered mental status.

8/21/2021 19:44 (7:44 p.m.), eINTERACT SBAR Summary: The Change In Condition/s are/were: Altered mental status
- Blood Pressure: BP 83/53
- Mental Status Evaluation: Altered level of consciousness (hyperalert, drowsy but easily aroused, difficult to arouse)
- Functional Status Evaluation: Swallowing difficulty.
- Neurological Status Evaluation: Altered level of consciousness (hyperalert, drowsy but easily aroused, difficult to arouse)

Nursing observations, evaluation, and recommendations are:
Primary Care Provider Feedback: Primary Care

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495150 | A. BUILDING _____ B. WING _____ | C 09/30/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BIRCHWOOD PARK REHABILITATION | 340 LYNN SHORES DRIVE VIRGINIA BEACH, VA 23452 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 625 | Continued From page 53 | F 625 | | |

Provider responded with the following feedback: A. Recommendations: Send resident to ER to be evaluated.

8/22/2021 06:25 a.m. Nursing Progress Note: Call placed to ED(emergency department) for admitting diagnosis. Informed there was no admitting diagnosis only that resident was admitted to the ICU(intensive care unit) for further treatment.

There was no documentation in Resident #21's clinical record to indicate that a bed hold notice was provided or sent with Resident #21 upon transfer from the facility to the hospital on 4/26/21 or 8/22/21.

On 9/28/21 at 10:40 a.m., an interview was conducted with the Director of Nursing (DON) regarding Resident #21's hospital transfers on 4/26/21 and 8/22/21 and if a bed hold notice was sent with him. The DON stated, "I couldn't find no documentation that a bed hold notice was sent to the hospital with him for 4/26/21 or 8/22/21."

On 9/29/21 at 4:10 p.m., an interview was conducted with the Regional Director of Clinical Services regarding what was expected to be sent with resident's upon transfer to the hospital. The Regional Director of Clinical Services stated, "The bed hold notice should go with the resident each time they go out. It should also be documented in the resident's medical record that it was sent."

The facility policy titled "Transfer and Discharge" dated 11/1/20 was reviewed and is documented in part, as follows:

7. Emergency Transfer/Discharges: d. Complete

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495150 | A. BUILDING _____ B. WING _____ | C 09/30/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BIRCHWOOD PARK REHABILITATION | 340 LYNN SHORES DRIVE VIRGINIA BEACH, VA 23452 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 625 | Continued From page 54 | F 625 | | |

and sent with the resident: i. Provide a notice of the resident's bed hold policy to the resident and representative at the time of transfer, as possible, but no later than 24 hours of the transfer.

The facility policy titled "Bed Hold Notice Upon Transfer" dated 11/1/20 was reviewed and is documented in part, as follows:

Policy: At the time of transfer for hospitalization or therapeutic leave, the facility will provide to the resident and/or resident representative written notice which specifies the duration of the bed-hold policy and addresses information explaining the return of the resident to the next available bed.

Policy Explanation and Compliance Guidelines:
Bed Hold Notice Upon Transfer.

1. Before a resident is transferred to the hospital or goes on therapeutic leave, the facility will provide to the resident and/or resident representative written information that specifies:
a. The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility.
b. The reserve bed payment policy.
c. The facility policies regarding bed-hold periods to include allowing a resident to return to the next available bed.
d. Conditions upon which the resident would return to the facility.

2. In the event of an emergency transfer of a resident, the facility will provide within 24 hours written notice of the facility's bed-hold policies, as stipulated in the State's plan.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495150 | A. BUILDING _____ B. WING _____ | C 09/30/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BIRCHWOOD PARK REHABILITATION | 340 LYNN SHORES DRIVE VIRGINIA BEACH, VA 23452 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 625 | Continued From page 55 | F 625 | | |

On 9/30/21 at 6:42 p.m., a pre-exit debriefing was conducted with the Administrator, the acting Director of Nursing, the Regional Director of Clinical Services and the Regional Director of Operations, where the above information was shared. Prior to exit no further information was shared.
4. The facility staff failed to provide Resident #92 with a Notice on Bed - Hold Policy and Readmission before transfer.

Resident #92 had an original admission date of 08/19/15. Diagnoses included schizophrenia, anxiety, traumatic brain injury, benign prostatic hyperplasia, dementia, mood disorder, seizures, hypertension,muscle weakness, dysphagia.

This resident was assessed on a quarterly Minimum Data Set (MDS) in the area of Cognitive Patterns as 15 on the BIMS assessment. This resident was assessed as requiring one person physical assist in the area of Activities of Daily Living (ADL's) in the area of transfer, dressing, personal hygiene and toileting.

A Care plan dated 01/15/20 indicated: Focus- No plans to discharge. Goal- Participate in care decisions for long term stay. Interventions- Monitor for signs and symptoms of anxiety, distress, withdrawal or depression relating to not return to previous home environment.

A Nursing Note dated 02:35 on 08/10/20 indicated: " Resident became combative around 0145 threatening roommate waving walking cane in his roommates face. Turning up his radio loud, treating other residents and staff members. Resident went to another unit and called 911.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495150 | A. BUILDING _____ B. WING _____ | C 09/30/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BIRCHWOOD PARK REHABILITATION | 340 LYNN SHORES DRIVE VIRGINIA BEACH, VA 23452 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 625 | Continued From page 56 | F 625 | | |

Officers came to the facility. Resident stated he wanted to go to jail and continued to open lobby door. Police officer called medical transport and resident was sent to ER. RP and NP were notified."

A Social Service note dated 13:39 on 08/10/20 indicated: " IDT met to discuss resident's possible re-admission to facility and decided that a 30 day notice would be the safest option for the facility. Hospital notes indicate that resident is still exhibiting dangerous behaviors and psych concerns still persist even after medication adjustment. Resident made some alarming threats and put both himself and others in danger. 30 day notice was sent to the hospital, and two agency's."

A Social Service note dated 13:39 on 08/10/20 indicated: " IDT met to discuss resident's possible re-admission to facility and decided that a 30 day notice would be the safest option for the facility. Hospital notes indicate that resident is still exhibiting dangerous behaviors and psych concerns still persist even after medication adjustment. Resident made some alarming threats and put both himself and others in danger. 30 day notice was sent to the hospital, and two agency's."

During an interview on 09/22/21 at 11:10 a.m. with the administrator he was asked why Resident #92 was not permitted to return to the facility? The Administrator stated, Resident #92 was a danger to himself and other residents. The Administrator stated, Resident #92 had attempted to set fire to the curtains in his room. When asked for documentation of Resident #92 attempting to set fire to the curtains, the administrator stated,

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495150 | A. BUILDING _____ B. WING _____ | C 09/30/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BIRCHWOOD PARK REHABILITATION | 340 LYNN SHORES DRIVE VIRGINIA BEACH, VA 23452 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 625 | Continued From page 57 | F 625 | | |

"he did not have any documentation to support the allegation." When asked for documentation of the Bed-Hold Notice provided to Resident #92, the administrator stated the resident voluntarily discharged himself from the facility and was not provided a Bed Hold Notice."

During an interview on 9/22/21 at 11:29 a.m. with the Complainant, she stated, "Resident #92 had appealed the facility's ruling and the facility still refused to re admit him."

A review of Department of Medical Assistance Services Appeal Decision dated February 5, 2021 indicated the following: " Issue - Nursing Home Discharge- Endangerment of Staff and Residents; Bed Hold Policy - Appeal filed August 14, 2020 Hearing Date December 16, 2020. Bed Hold - Notice on Bed Hold Policy and Readmission- Notice before transfer. Before a resident of a nursing facility is transferred for hospitalization or therapeutic leave, a nursing facility must provide written information to the resident and an immediate family member or legal representative concerning re-admittion to the facility immediately upon the first availability of a bed in a semiprivate room in the facility.

On August 10, 2020, the Appellant was involuntarily discharged from the Nursing Facility to the hospital for a psychiatric evaluation. As a Medicaid recipient who was discharged to a hospital for medical treatment, the Nursing Facility was required by law to provide the Appellant with bed hold policy and the opportunity to retain his bed at the Nursing Facility for re-entry. The evidence and testimony in the record shows that the Nursing Facility did not do so and never intended to allow the

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495150 | A. BUILDING _____ B. WING _____ | C 09/30/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BIRCHWOOD PARK REHABILITATION | 340 LYNN SHORES DRIVE VIRGINIA BEACH, VA 23452 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 625 | Continued From page 58<br>Appellant's readmission back into the Nursing Facility. This is evidenced by the fact that the Nursing Facility Representatives testified that the Appellant's readmission was denied due to his endangerment of the nursing facility staff and residents. There was evidence provided to show that the Appellant was in fact a danger to the nursing facility staff and residents in this matter.<br><br>The facility did not comply with the required Bed hold regulations, and refused to the Appellant's lawful readmission into the Nursing Facility."<br><br>The facility staff failed to provide Resident #92 with a Bed Hold policy or readmission to the facility.<br><br>Compliant deficiency | F 625 | | |
| F 626 SS=D | Permitting Residents to Return to Facility<br>CFR(s): 483.15(e)(1)(2)<br><br>§483.15(e)(1) Permitting residents to return to facility.<br>A facility must establish and follow a written policy on permitting residents to return to the facility after they are hospitalized or placed on therapeutic leave. The policy must provide for the following.<br>(i) A resident, whose hospitalization or therapeutic leave exceeds the bed-hold period under the State plan, returns to the facility to their previous room if available or immediately upon the first availability of a bed in a semi-private room if the resident-<br>(A) Requires the services provided by the facility; and<br>(B) Is eligible for Medicare skilled nursing facility services or Medicaid | F 626 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495150 | A. BUILDING _____ B. WING _____ | C 09/30/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BIRCHWOOD PARK REHABILITATION | 340 LYNN SHORES DRIVE VIRGINIA BEACH, VA 23452 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 626 | Continued From page 59 | F 626 | | |

nursing facility services.
(ii) If the facility that determines that a resident who was transferred with an expectation of returning to the facility, cannot return to the facility, the facility must comply with the requirements of paragraph (c) as they apply to discharges.

§483.15(e)(2) Readmission to a composite distinct part. When the facility to which a resident returns is a composite distinct part (as defined in § 483.5), the resident must be permitted to return to an available bed in the particular location of the composite distinct part in which he or she resided previously. If a bed is not available in that location at the time of return, the resident must be given the option to return to that location upon the first availability of a bed there.
This REQUIREMENT is not met as evidenced by:
Based on a closed record review, staff interviews, and a complaint investigation, the facility staff failed to re-admit one resident Resident # 92 in the survey sample of 42 residents after they were hospitalized.

The findings included:

Resident #92 had an original admission date of 08/19/15. Diagnoses included schizophrenia, anxiety, traumatic brain injury, benign prostatic hyperplasia, dementia, mood disorder, seizures, hypertension,muscle weakness, dysphagia.

This resident was assessed on a quarterly Minimum Data Set (MDS) in the area of Cognitive Patterns as 15 on the BIMS assessment. This resident was assessed as requiring one person physical assist in the area of Activities of Daily

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495150 | A. BUILDING _____ B. WING _____ | C 09/30/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BIRCHWOOD PARK REHABILITATION | 340 LYNN SHORES DRIVE VIRGINIA BEACH, VA 23452 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 626 | Continued From page 60 | F 626 | | |

Living (ADL's) in the area of transfer, dressing, personal hygiene and toileting.

A Care plan dated 01/15/20 indicated: Focus- No plans to discharge. Goal- Participate in care decisions for long term stay. Interventions- Monitor for signs and symptoms of anxiety, distress, withdrawal or depression relating to not return to previous home environment.

A Nursing Note dated 02:35 on 08/10/20 indicated: " Resident became combative around 0145 threatening roommate waving walking cane in his roommates face. Turning up his radio loud, treating other residents and staff members. Resident went to another unit and called 911. Officers came to the facility. Resident stated he wanted to go to jail and continued to open lobby door. Police officer called medical transport and resident was sent to ER. RP and NP were notified."

A Social Service note dated 13:39 on 08/10/20 indicated: " IDT met to discuss resident's possible re-admission to facility and decided that a 30 day notice would be the safest option for the facility. Hospital notes indicate that resident is still exhibiting dangerous behaviors and psych concerns still persist even after medication adjustment. Resident made some alarming threats and put both himself and others in danger. 30 day notice was sent to the hospital, and two agency's."

During an interview on 09/22/21 at 11:10 a.m. with the administrator he was asked why Resident #92 was not permitted to return to the facility? The Administrator stated, Resident #92 was a danger to himself and other residents. The

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495150 | A. BUILDING _____ B. WING _____ | C 09/30/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BIRCHWOOD PARK REHABILITATION | 340 LYNN SHORES DRIVE VIRGINIA BEACH, VA 23452 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 626 | Continued From page 61 | F 626 | | |

Administrator stated, Resident #92 had attempted to set fire to the curtains in his room. When asked for documentation of Resident #92 attempting to set fire to the curtains, the administrator stated he did not have any documentation to support the allegation.

During an interview on 9/22/21 at 11:29 a.m. with the complainant, she stated, "Resident #92 had appealed the facility's ruling and the facility still refused to re admit him."

A review of Department of Medical Assistance Services Appeal Decision dated February 5, 2021 indicated the following: " Issue - Nursing Home Discharge- Endangerment of Staff and Residents - Appeal filed August 14, 2020 Hearing Date December 16, 2020. The Notice of Discharge stated a reason for discharge that was not supported by the evidence in the record, and it did not provide the required 30 days of notice for transfer or discharge.

The Notice of Discharge states that discharge was "for the health and safety of the residents and staff." That is not one of the permissible basis for discharge provided in the applicable regulation. Code of Federal Regulations, 42 CFR 483.15 (c) 1 (C) and (D). The transfer or discharge must documented in the resident's medical record by a physician and must include the basis for the discharge. 42 CFR 483.15 (c) (2).

The Nursing Facility Representatives did not provide any evidence or testimony to show that the Appellant's attending physician or Nursing Facility's medical director had evaluated the Appellant and determined that discharge was

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495150 | A. BUILDING _____ B. WING _____ | C 09/30/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BIRCHWOOD PARK REHABILITATION | 340 LYNN SHORES DRIVE VIRGINIA BEACH, VA 23452 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 626 | Continued From page 62<br>necessary based on the reason for discharge stated in the Notice of Discharge. There was no signed medical records to establish whether the requirement for such documentation had been met. There was no evidence provided to show that the Appellant's attending physician or the Nursing Facility's medical director had evaluated the Appellant for his potential discharge, notated the Appellant's medical records, drafted medical orders for potential discharge. Accordingly, the Hearing Officer finds that the Nursing Facility's proposed discharge of the Appellant was not in compliance with the applicable law and policy requiring a physician's approval.<br><br>The Nursing Facility failed to follow applicable law and policy for an involuntary discharge/transfer from the Nursing Facility. The Nursing Facility did not provide evidence to show a valid reason for involuntary discharge/transfer, did not provide adequate notice of discharge, did not provide evidence that the Appellant's physician or Nursing Facility's medical director had made a notation in the Appellant's record approving the discharge, and did not conduct a formal discharge planning meeting with the Appellant.<br>Therefore, the Nursing Facility's proposal to involuntarily transfer/discharge the Appellant on August 10, 2020 was not in compliance with the applicable law and regulations. | F 626 | | |
| F 645 SS=D | Complaint deficiency<br>PASARR Screening for MD & ID<br>CFR(s): 483.20(k)(1)-(3)<br><br>§483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability. | F 645 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495150 | A. BUILDING _____ B. WING _____ | C 09/30/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BIRCHWOOD PARK REHABILITATION | 340 LYNN SHORES DRIVE VIRGINIA BEACH, VA 23452 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 645 | Continued From page 63<br><br>§483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with:<br>(i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission,<br>(A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and<br>(B) If the individual requires such level of services, whether the individual requires specialized services; or<br>(ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission-<br>(A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and<br>(B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability.<br><br>§483.20(k)(2) Exceptions. For purposes of this section-<br>(i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital.<br>(ii) The State may choose not to apply the preadmission screening program under | F 645 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495150 | A. BUILDING _____ B. WING _____ | C 09/30/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BIRCHWOOD PARK REHABILITATION | 340 LYNN SHORES DRIVE VIRGINIA BEACH, VA 23452 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 645 | Continued From page 64 | F 645 | | |

paragraph (k)(1) of this section to the admission to a nursing facility of an individual-
(A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital,
(B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and
(C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services.

§483.20(k)(3) Definition. For purposes of this section-
(i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1).
(ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter.
This REQUIREMENT is not met as evidenced by:
Based on clinical record review, facility document review and staff interviews the facility staff failed to initiate a Level II Preadmission Screening and Annual Resident Review (PASARR) after a positive Level I PASARR screening was completed for 2 of 42 residents in the survey sample, Resident #21 and Resident #71.

The findings included:

1. The facility staff failed to initiate a Level II PASARR for Resident #21 after a positive Level I PASARR screening was completed on 4/19/2017

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495150 | A. BUILDING _____ B. WING _____ | C 09/30/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BIRCHWOOD PARK REHABILITATION | 340 LYNN SHORES DRIVE VIRGINIA BEACH, VA 23452 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 645 | Continued From page 65 | F 645 | | |

Resident #21 was originally admitted to the facility on 12/31/19 with diagnoses to include but not limited to Dementia, Paranoid Schizophrenia, and Psychosis.

Resident #21's most recent Minimum Data Set (MDS) was a Quarterly with an Assessment Reference Date (ARD) of 9/7/21. Resident #21's Brief Interview for Mental Status (BIMS) was coded as a 00, indicating severe cognitive impairment and the inability to perform daily decision making.

Resident #21's last comprehensive MDS was a Significant Change with an ARD of 5/21/21. Under Section A1500 Preadmission Screening and Resident Review (PASRR): Is the resident currently considered by the state level II PASRR process to have serious mental illness and/or intellectual disability or a related condition? Resident #21 was coded as No.

Resident #21's Level I PASARR screening completed on 4/19/2017 was reviewed and is documented in part, as follows:

2. Does this individual have a current serious mental illness? YES.
a. Is this major mental disorder diagnosable under DSM-IV (Diagnostic and Statistical Manual of Mental Disorders); (e.g., schizophrenia, mood, paranoid, panic, or other serious anxiety disorder; personality disorder; other psychotic disorder; or mental disorder that may lead to chronic disability)? YES.
b. Has the disorder resulted in functional limitations in major activities within the past 3-6 months, particularly with regard to interpersonal functioning; concentration, persistence, or pace:

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495150 | A. BUILDING _____ B. WING _____ | C 09/30/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BIRCHWOOD PARK REHABILITATION | 340 LYNN SHORES DRIVE VIRGINIA BEACH, VA 23452 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 645 | Continued From page 66 | F 645 | | |

and adaptation to change? YES.
c. Does the treatment history indicate that the individual has experienced psychiatric treatment more intensive than outpatient care more than once in the past 2 years or the individual has experienced within the last 2 years an episode of significant disruption to the normal living situation due to the mental disorder? YES.

5. Recommendation: a; refer for secondary assessment. (NF(nursing facility) Placement = (equals) Level II refer to ASCEND.
*Ascend: Company that provides onsite, independent PASARR level II mental health and intellectual/development evaluations. (https://www.dmas.virginia.gov/media/1294/virginia-pasrr-training).

Resident #21's Progress Notes were reviewed and are documented in part, as follows:

9/22/2021 17:15 (5:15 p.m.), Social Service Progress Note: Documentation for PASARR update faxed to Name at Ascend this date. SS (Social Services) will assist as needed.

9/24/2021 14:02 (2:14 p.m.), Social Service Progress Note: Call rec'd (received) from VA(virginia) PASARR assessment screener requesting a Sunday at 10:00 a.m. visit for Name (Resident #21). Unit manager and Nurse on duty today made aware of tentative visit for resident Sunday. Contact information also provided in writing to nurse on duty this date.

On 9/24/21 at 2:55 p.m., an interview was conducted with the facility Social Worker regarding Resident #21's Level I PASARR completed on 4/19/2017 and if a Level II PASARR

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495150 | A. BUILDING _____ B. WING _____ | C 09/30/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BIRCHWOOD PARK REHABILITATION | 340 LYNN SHORES DRIVE VIRGINIA BEACH, VA 23452 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 645 | Continued From page 67 | F 645 | | |

was indicated. The Social Worker stated, "Name (Resident #21) re-admitted to the facility on 6/3/21. I completed a Level I PASARR on 6/4/21 that indicated no Level II PASARR was required. However, during a re-audit of the resident's chart on 7/31/21 I found the PASARR dated 4/19/17 indicating a Level II. I did another Level I PASARR on 7/21/21 which also indicated a Level II needed to be completed. Name (Resident #21's) medical records were faxed to Ascend on 9/23/21." The Social Worker was asked why Ascend was just being notified on 9/23/21 when she found the Level I PASARR dated 4/19/17 on 7/21/21 indicating a Level II PASARR was needed. The Social Worker stated, "I just got busy with other things that needed my attention and hadn't gotten back to working on it."

On 9/30/2021 at 1:10 p.m., during an interview the Social Worker was asked what was the importance of the PASARR screening. The Social Worker stated, "The PASARR ensures that individuals are provided with the disability services that they need, including rehabilitative and specialized services. The goal of the PASARR is to optimize each individual placement success, treatment and ultimately, the individual's quality of life."

The facility policy titled "Resident Assessment-Coordination with PASARR Program" was reviewed and is documented in part, as follows:

Policy: This facility coordinates assessments with the preadmission screening and resident review (PASARR) program under Medicaid to ensure that individuals with a mental disorder, intellectual disability, or a related condition receives care and

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495150 | A. BUILDING _____ B. WING _____ | C 09/30/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BIRCHWOOD PARK REHABILITATION | 340 LYNN SHORES DRIVE VIRGINIA BEACH, VA 23452 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 645 | Continued From page 68 | F 645 | | |

services in the most integrated setting appropriate to their needs.

Policy Explanation and Compliance Guidelines:
1. All applicants to this facility will be screened for serious mental disorders or intellectual disabilities and related conditions in accordance with the State's Medicaid rules for screening.
a. PASARR Level I-initial pre-screening that is completed prior to admission.
ii. Positive Level I Screen-necessitates a PASARR Level II evaluation prior to admission.
b. PASARR Level II- a comprehensive evaluation by the appropriate state-designated authority (cannot be completed by the facility) that determines whether the individual has mental disorder, intellectual disabilities, or related condition, determines the appropriate setting for the individual, and recommends any specialized services and/or rehabilitative services the individual needs.
6. The Social Services Director shall be responsible for keeping track of each resident's PASARR screening status, and referring to the appropriate authority.

On 9/30/21 at 6:42 p.m., a pre-exit debriefing was conducted with the Administrator, the acting Director of Nursing, the Regional Director of Clinical Services and the Regional Director of Operations, where the above information was shared. Prior to exit no further information was shared.

2. The facility staff failed to initiate a Level II PASARR for Resident #71 after a positive Level I PASARR screening was completed on 7/16/2021

Resident #71 was admitted to the facility on

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495150 | A. BUILDING _____ B. WING _____ | C 09/30/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BIRCHWOOD PARK REHABILITATION | 340 LYNN SHORES DRIVE VIRGINIA BEACH, VA 23452 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 645 | Continued From page 69 | F 645 | | |

6/28/2019 with diagnoses to included but not limited to Dementia, Bipolar Disorder, Anxiety Disorder and Dementia.

Resident #71's most recent Minimum Data Set (MDS) was a Quarterly with an Assessment Reference Date (ARD) of 8/27/21. Resident #71's Brief Interview for Mental Status (BIMS) was coded as a 01, indicating severe cognitive impairment and the inability to perform daily decision making.

Resident #71's Level I PASARR screening completed on 7/16/2021 by the current Social Worker was reviewed and is documented in part, as follows:

2. Does this individual have a current serious mental illness? YES.
a. Is this major mental disorder diagnosable under DSM-IV (Diagnostic and Statistical Manual of Mental Disorders); (e.g., schizophrenia, mood, paranoid, panic, or other serious anxiety disorder; personality disorder; other psychotic disorder; or mental disorder that may lead to chronic disability)? YES.
b. Has the disorder resulted in functional limitations in major activities within the past 3-6 months, particularly with regard to interpersonal functioning; concentration, persistence, or pace: and adaptation to change? YES.
c. Does the treatment history indicate that the individual has experienced psychiatric treatment more intensive than outpatient care more than once in the past 2 years or the individual has experienced within the last 2 years an episode of significant disruption to the normal living situation due to the mental disorder? NO.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495150 | A. BUILDING _____ B. WING _____ | C 09/30/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BIRCHWOOD PARK REHABILITATION | 340 LYNN SHORES DRIVE VIRGINIA BEACH, VA 23452 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 645 | Continued From page 70 | F 645 | | |

5. Recommendation: a; refer for Level II evaluation (NF Placement = Level II refer to ASCEND.

Resident #71's Social Service Progress Notes were reviewed for any entries regarding a Level I PASARR, a Level II PASARR, or any notification to Ascend. No entries were identified in Resident #71's clinical record.

On 9/24/21 at 2:55 p.m., an interview was conducted with the facility Social Worker regarding Resident #71's Level I PASARR completed on 7/16/2021 and if a Level II PASARR was indicated. The Social Worker stated, "Name (Resident #71's) chart was audited on 7/16/21 and I discovered there was no Level I PASARR uploaded in the clinical record. I completed a Level I PASARR on 7/16/21 that indicated a Level II PASARR was required. During a re-audit of the Name (Resident #71's) chart on 7/23/21 I noted that the medical records had not been sent to Ascend. Name (Resident #71's) medical records were faxed to Ascend on 9/23/21." The Social Worker was asked why Ascend was just being notified on 9/23/21 when the Level I PASARR she completed on 7/16/21 indicated that a Level II PASARR was needed. The Social Worker stated, "I just got busy with other things that needed my attention and hadn't gotten back to working on it."

On 9/30/2021 at 1:10 p.m., during an interview the Social Worker was asked what was the importance of the PASARR screening. The Social Worker stated, "The PASARR ensures that individuals are provided with the disability services that they need, including rehabilitative and specialized services. The goal of the

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495150 | A. BUILDING _____ B. WING _____ | C 09/30/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BIRCHWOOD PARK REHABILITATION | 340 LYNN SHORES DRIVE VIRGINIA BEACH, VA 23452 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 645 | Continued From page 71<br>PASARR is to optimize each individual placement success, treatment and ultimately, the individual's quality of life."<br><br>On 9/30/21 at 6:42 p.m., a pre-exit debriefing was conducted with the Administrator, the acting Director of Nursing, the Regional Director of Clinical Services and the Regional Director of Operations, where the above information was shared. Prior to exit no further information was shared. | F 645 | | |
| F 657 SS=E | Care Plan Timing and Revision<br>CFR(s): 483.21(b)(2)(i)-(iii)<br><br>§483.21(b) Comprehensive Care Plans<br>§483.21(b)(2) A comprehensive care plan must be-<br>(i) Developed within 7 days after completion of the comprehensive assessment.<br>(ii) Prepared by an interdisciplinary team, that includes but is not limited to--<br>(A) The attending physician.<br>(B) A registered nurse with responsibility for the resident.<br>(C) A nurse aide with responsibility for the resident.<br>(D) A member of food and nutrition services staff.<br>(E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.<br>(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.<br>(iii)Reviewed and revised by the interdisciplinary | F 657 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495150 | A. BUILDING _____ B. WING _____ | C 09/30/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BIRCHWOOD PARK REHABILITATION | 340 LYNN SHORES DRIVE VIRGINIA BEACH, VA 23452 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 657 | Continued From page 72 | F 657 | | |

team after each assessment, including both the comprehensive and quarterly review assessments.
This REQUIREMENT is not met as evidenced by:
Based on clinical record review, facility document review and staff interviews the facility staff failed to revise a care plan to include an indwelling foley catheter upon re-admission for 1 or 42 residents in the survey sample, Resident #21.

The findings included:

The facility staff failed to revise Resident #21's care plan upon re-admission to the facility on 9/1/21 for 21 days to include an indwelling foley catheter.

Resident #21 was re-admitted to the facility on 9/1/21 with diagnoses to include but not limited to Urinary Tract Infection, and Stage 3 Chronic Kidney Disease.

Resident #21's most recent comprehensive Minimum Data Set (MDS) was a Significant Change with an Assessment Reference Date (ARD) of 5/21/21. Resident #21's Brief Interview for Mental Status (BIMS) was coded as a 02, indicating severe cognitive impairment and the inability to perform daily decision making. Under Section H - Bladder and Bowel H0100 Appliances; A. Indwelling catheter (including suprapubic catheter and nephrostomy tube), Resident #21 was coded as: Yes. H0300. Urinary Continence; Urinary continence - Select the one category that best describes the resident. Resident #21 was coded as: 3. Always incontinent.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495150 | A. BUILDING _____ B. WING _____ | C 09/30/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BIRCHWOOD PARK REHABILITATION | 340 LYNN SHORES DRIVE VIRGINIA BEACH, VA 23452 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 657 | Continued From page 73 | F 657 | | |

The following observations were made of Resident #21's indwelling foley catheter:

On 09/20/21 at 8:00 p.m., Resident noted to have intact foley catheter, draining clear yellow urine.
On 09/21/21 at 10:38 a.m., Resident has indwelling foley catheter in place and covered with privacy bag, Catheter care being performed by Certified Nursing Assistant with no issues noted.
On 09/22/21 at 1:00 p.m., Resident's indwelling foley catheter in place, privacy maintained, and draining clear urine.

Resident #21's Admission/Re-Admission Screening Assessment completed By Licensed Practical Nurse (LPN) #4 dated 9/1/21 at 3:53 p.m., was reviewed and is documented in part, as follows:

SECTION I. Bladder/Bowel
34. Bladder:
a. Residents Continence Status: 7. Admitted with Catheter.
CATHETER
d. Catheter Type/Size: foley 16fr (french) 10cc.

Resident #21's Progress Notes were reviewed and are documented in part, as follows:

9/1/2021 15:58(3:58 p.m.) Nursing Progress Note: Patient admitted to facility from Hospital dx (diagnosis): septic shock d/t (due to) complicated UTI (urinary tract infection). Patient has a 16fr 10cc foley catheter r/t (related to) urinary retention. All orders verified by provider.

On 9/23/21 at 12:28 p.m., an interview was conducted with LPN #4, who was the admitting

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495150 | A. BUILDING _____ B. WING _____ | C 09/30/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BIRCHWOOD PARK REHABILITATION | 340 LYNN SHORES DRIVE VIRGINIA BEACH, VA 23452 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 657 | Continued From page 74 | F 657 | | |

nurse for Resident #21 on 9/1/21. LPN #4 was asked is she updated/revised Resident #21's care plan to include the indwelling foley catheter that was present on re-admission. LPN #4 stated, "No, I have never been educated on who does or that I was to update the care plan. I really thought management would follow-up with the foley and add it to his care plan."

Resident #21's comprehensive care plan was reviewed and is documented in part, as follows:

Focus: The resident has Indwelling Catheter: related to obstructive uropathy and places him at risk for complications. Date Initiated: 9/22/2021 Created on: 9/22/2021

Interventions:
Check tubing for kinks each shift and as needed. Date Initiated: 9/22/2021.
Foley cath care as needed and ordered including positioning and securing. Date Initiated: 9/22/2021.
Monitor/document for pain/discomfort due to catheter. Date Initiated: 9/22/2021.
Monitor/record/report to Medical Doctor for signs and symptoms of UTI: pain, burning, blood tinged urine, cloudiness, no output, deepening of urine color, increased pulse, increased temperature, urinary frequency, foul smelling urine, fever, chills, altered mental status, change in behavior, change in eating patterns. Date Initiated: 9/22/2021.

On 9/23/21 at 2:00 p.m., an interview was conducted with the Regional Director of Operations. The Regional Director of Operations was asked who in the facility is responsible for revising a resident's care plan if there is a change

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495150 | A. BUILDING _____ B. WING _____ | C 09/30/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BIRCHWOOD PARK REHABILITATION | 340 LYNN SHORES DRIVE VIRGINIA BEACH, VA 23452 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 657 | Continued From page 75<br>upon re-admission. Regional Director of Operations stated, "The Charge Nurse should update the care plan if there are changes."<br><br>On 9/29/21 at 4:11 p.m. an interview was conducted with the Regional Director of Clinical Services and the above information was share. The Regional Director of Clinical Services was asked when should a resident care plan be revised and who in the facility was responsible to revise it if there is a change upon re-admission. The Regional Director of Clinical Services stated, "The care plan should be revised whenever there is a change with the resident, quarterly and annually. Upon re-admission the clinical staff should update the care plan within 24 hours. Name (Resident #21's) foley catheter should have been updated on his care plan when he was recently re-admitted."<br><br>The facility policy provided for Care Plan Revision is the Resident Assessment Instrument (RAI) 4.7: The RAI and Care Planning which was reviewed and is documented in part, as follows:<br><br>The care plan should be revised on an ongoing basis to reflect changes in the resident and the care that the resident is receiving.<br><br>On 9/30/21 at 6:42 p.m., a pre-exit debriefing was conducted with the Administrator, the acting Director of Nursing, the Regional Director of Clinical Services and the Regional Director of Operations, where the above information was shared. Prior to exit no further information was shared. | F 657 | | |
| F 660 SS=D | Discharge Planning Process<br>CFR(s): 483.21(c)(1)(i)-(ix) | F 660 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495150 | A. BUILDING _____ B. WING _____ | C 09/30/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BIRCHWOOD PARK REHABILITATION | 340 LYNN SHORES DRIVE VIRGINIA BEACH, VA 23452 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 660 | Continued From page 76 | F 660 | | |

§483.21(c)(1) Discharge Planning Process
The facility must develop and implement an effective discharge planning process that focuses on the resident's discharge goals, the preparation of residents to be active partners and effectively transition them to post-discharge care, and the reduction of factors leading to preventable readmissions. The facility's discharge planning process must be consistent with the discharge rights set forth at 483.15(b) as applicable and-
(i) Ensure that the discharge needs of each resident are identified and result in the development of a discharge plan for each resident.
(ii) Include regular re-evaluation of residents to identify changes that require modification of the discharge plan. The discharge plan must be updated, as needed, to reflect these changes.
(iii) Involve the interdisciplinary team, as defined by §483.21(b)(2)(ii), in the ongoing process of developing the discharge plan.
(iv) Consider caregiver/support person availability and the resident's or caregiver's/support person(s) capacity and capability to perform required care, as part of the identification of discharge needs.
(v) Involve the resident and resident representative in the development of the discharge plan and inform the resident and resident representative of the final plan.
(vi) Address the resident's goals of care and treatment preferences.
(vii) Document that a resident has been asked about their interest in receiving information regarding returning to the community.
(A) If the resident indicates an interest in returning to the community, the facility must document any

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495150 | A. BUILDING _____ B. WING _____ | C 09/30/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BIRCHWOOD PARK REHABILITATION | 340 LYNN SHORES DRIVE VIRGINIA BEACH, VA 23452 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 660 | Continued From page 77 | F 660 | | |

referrals to local contact agencies or other appropriate entities made for this purpose.
(B) Facilities must update a resident's comprehensive care plan and discharge plan, as appropriate, in response to information received from referrals to local contact agencies or other appropriate entities.
(C) If discharge to the community is determined to not be feasible, the facility must document who made the determination and why.
(viii) For residents who are transferred to another SNF or who are discharged to a HHA, IRF, or LTCH, assist residents and their resident representatives in selecting a post-acute care provider by using data that includes, but is not limited to SNF, HHA, IRF, or LTCH standardized patient assessment data, data on quality measures, and data on resource use to the extent the data is available. The facility must ensure that the post-acute care standardized patient assessment data, data on quality measures, and data on resource use is relevant and applicable to the resident's goals of care and treatment preferences.
(ix) Document, complete on a timely basis based on the resident's needs, and include in the clinical record, the evaluation of the resident's discharge needs and discharge plan. The results of the evaluation must be discussed with the resident or resident's representative. All relevant resident information must be incorporated into the discharge plan to facilitate its implementation and to avoid unnecessary delays in the resident's discharge or transfer.
This REQUIREMENT is not met as evidenced by:
Based on resident interview, staff interview, and clinical record review, the facility staff failed to develop a discharge care plan that addressed all

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495150 | A. BUILDING _____ B. WING _____ | C 09/30/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BIRCHWOOD PARK REHABILITATION | 340 LYNN SHORES DRIVE VIRGINIA BEACH, VA 23452 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 660 | Continued From page 78 | F 660 | | |

of the needs for a resident being discharged home; specifically, the resident's need for a wheel chair, hospital bed, bedside commode and activities of daily living (adl) care at home for 1 of 42 residents (Resident 91), in the survey sample.

The findings included:

Resident #91 was originally admitted to the facility 10/30/20 and discharged from the facility return not anticipated 11/30/20. The diagnoses included; a stroke with left hemiparesis, diabetes and high blood pressure.

The quarterly Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 11/27/20 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 15 out of a possible 15. This indicated Resident #91's cognitive abilities for daily decision making were intact. In section"G" (Physical functioning) the resident was coded as requiring total care of two people with transfers, extensive assistance of one person with bed mobility, locomotion, personal hygiene, toileting, bathing and supervision after set-up with eating.

An interview was conducted with Resident #91 by phone on 9/29/21 at approximately 3:15 p.m. Resident #91 stated her first concern was the facility staff didn't begin discharge planning until 11/25/20 for a discharge 11/30/20 and that was Thanksgiving Day week, which complicated the discharge more. Resident #91 also stated the facility staff discharged her from the facility to her apartment without needed equipment for basic functioning. She specifically required a hospital

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495150 | A. BUILDING _____ B. WING _____ | C 09/30/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BIRCHWOOD PARK REHABILITATION | 340 LYNN SHORES DRIVE VIRGINIA BEACH, VA 23452 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 660 | Continued From page 79 | F 660 | | |

bed, bedside commode, bathing equipment, home health staff for activities of daily living (adl) care and things she hadn't anticipated. The resident stated prior to her hospitalization for a stroke with left hemiparesis she functioned independently in an apartment and after the stroke she could only stand and pivot. The resident stated it was stressful just attempting to arrange transportation from the facility to the apartment but she agreed to have a cousin transport her because the Social Worker insisted her insurance wouldn't pay for transportation and she had no idea how to obtain additional insurance benefits. The resident further stated she was discharged to the same apartment without a wheel chair to get from the car to her door and she was unable to navigate the four steps going up to enter the apartment yet the Social Worker assured her that someone would be there to assist with the transfer from the vehicle and assist her to get inside the apartment, that didn't occur therefore; a cousin took her into their home the day of discharge and cared for her a week while arrangements were finalized for her to transition into her apartment.

Review of the clinical record revealed progress notes written by the Social Worker; 11/30/2020 12:07 Resident will be discharging home today at 6 PM and will be transported home by a friend. Resident lives with her son who is able to assist her with tasks and errands. Resident will be receiving Physical and Occupational Therapy through (name of the agency). Resident was advised that she needs a wheelchair and that she does not have insurance that provides durable medical equipment (DME) so this will be an out of pocket expense. Resident was advised that a

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495150 | A. BUILDING _____ B. WING _____ | C 09/30/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BIRCHWOOD PARK REHABILITATION | 340 LYNN SHORES DRIVE VIRGINIA BEACH, VA 23452 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 660 | Continued From page 80 | F 660 | | |

second-hand wheel chair through an online marketplace or thrift store is a cheaper alternative to buying one new through a DME supplier or (name of the store). On Friday, resident advised that a family member or friend will acquire her DME this weekend. Today resident is not pleased with the out of pocket expense for DME and resident and her mother have both expressed this. Apparently none of her contacts looked into acquiring her DME over the weekend. Social Worker Director (SSD) explained to resident several times what her insurance will cover and that (name of her plan) does not cover any DME. Resident has a scheduled appointment with Social Security to complete her disability application over the phone. Resident advised that she will acquire all necessary information and bank statements to complete application. SSD spoke with (name of facility) discharge planner SW at (phone number) and provided all discharge plan information. No other concerns at this time.

11/30/2020 16:39 Social Services Assistant (SSA) met with the resident on today to discuss the resident ' s discharge Resident informed to SSD that DME equipment would be in the home. As of today, after 4:00 PM resident informed that she would not be going home because she stated that DME was not set up for her. Resident was informed by SSD that her insurance and/or (name of insurance) did not cover DME and she will need to pay out of pocket. Resident requested assistance to apply for the FREE Foundation to apply for free medical equipment which requires a physician to fill out a portion of the paperwork. SSA was informed that Adult Protective Services (APS) (name of individual) was on the phone and

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495150 | A. BUILDING _____ B. WING _____ | C 09/30/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BIRCHWOOD PARK REHABILITATION | 340 LYNN SHORES DRIVE VIRGINIA BEACH, VA 23452 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 660 | Continued From page 81 | F 660 | | |

requested notes from SS on today and information on the Free Foundation application request. As of 5:35 PM resident was informed of patient funds if staying at facility past her discharge date. Resident informed she was not going to pay the facility anything and stated she will be going home today. Resident was also informed that (name of the store) offered wheelchairs as well. Resident informed that her (cousin ' s name) along with her (name of son) will be picking up the resident on today. Resident discharged from facility on today at 6:50 PM. SSA made a call to (name of the agency) to reach out to the resident upon returning home. APS was also emailed information requested on today.

An interview was conducted with the current Social Worker on 9/30/21 at approximately 3:45 p.m. The Social Worker stated discharge planning begins on day one and based on the review of Resident #91's record she didn't have a community based insurance plan. The SW stated a community based plan covers most services including durable medical equipment, home health services, transportation, and other health related needs. The Social Worker stated determination of the residents goals and needs as well as type of insurance coverage to meet the defined goals drives discharge planning. The Social Worker also stated regardless of what the resident stated about family providing certain services, it is normal to coordinate the service and allow the resident/family to determine after discharge if there is a need to continue utilizing the services.

On 9/30/21 at approximately 4:40 p.m., the above allegation was discussed with the Administrator.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495150 | A. BUILDING _____ B. WING _____ | C 09/30/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BIRCHWOOD PARK REHABILITATION | 340 LYNN SHORES DRIVE VIRGINIA BEACH, VA 23452 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 660 | Continued From page 82<br>The Administrator stated it was the facility goal to assure transitions from the facility are smooth and meets the needs of the resident.. | F 660 | | |
| F 684 SS=D | Complaint Deficiency<br>Quality of Care<br>CFR(s): 483.25<br><br>§ 483.25 Quality of care<br>Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, staff interview, facility documentation review, and in the course of a complaint investigation, the facility staff failed to monitor daily weights per physician's orders for 1 of 42 residents (Resident #22) in the survey sample.<br><br>The findings included;<br><br>Resident #22 was originally admitted to the facility on 12/19/19 and readmitted on 7/14/20. Diagnosis for Resident #22 included but not limited Unspecified Dementia with Behavioral Disturbance and Major Depressive Disorder.<br><br>The annual Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 07/17/21 coded the resident as not having the ability to complete the Brief Interview | F 684 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495150 | A. BUILDING _____ B. WING _____ | C 09/30/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BIRCHWOOD PARK REHABILITATION | 340 LYNN SHORES DRIVE VIRGINIA BEACH, VA 23452 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 684 | Continued From page 83 | F 684 | | |

for Mental Status (BIMS).

In section "G"(Physical functioning) the resident was coded as extensive assistance of one person with bed mobility, dressing and locomotion on and off the unit. Requiring extensive assistance of two persons transfers. Requiring supervision set-up help with eating and requiring totals dependence of one person with toileting, personal hygiene and bathing.

The Care Plan dated 5/23/21 reads: FOCUS: The resident has nutritional problems or potential nutritional problems r/t Diet restrictions, mechanically altered diet, weight loss. Goals: The resident will tolerate diet and have no significant gain/loss through review date. Interventions: Observe/report to MD (Medical Doctor) PRN (as needed) s/sx (signs and symptoms) of malnutrition: Emaciation, muscle wasting, significant weight loss: 3lbs in 1 week, greater than 5% in 1 month, greater than 7.5% in 3 months, greater than 10% in 6 months.

MAR (Medication Administration Record) reads: weekly weights one time a day every Wed -Start Date 10/14/2020 at 9:00 AM.
MAR (11/2020). Weights not recorded.
MAR (12/2020) Weights not recorded.

The following weights were recorded in the clinical record under "weights." 10/7/2020 152.8 1bs.
11/15/20 135 lbs.
12/03/20 135.2 lbs.
12/8/21 135.2 lbs.

The above recorded weights were not consistent with the ordered weekly weights.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495150 | A. BUILDING _____ B. WING _____ | C 09/30/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BIRCHWOOD PARK REHABILITATION | 340 LYNN SHORES DRIVE VIRGINIA BEACH, VA 23452 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 684 | Continued From page 84 | F 684 | | |

A review of resident's weight from October 7, 2020 (152.8 lbs) to November 15, 2020 (135.0 lbs.) Resident has lost 17.8 lbs.

According to the complainant the resident had a significant amount of weight loss. The weekly ordered weights were not consistent from 10/07/20-11/15/20 Resident lost 17.8 lbs.

A review of clinical progress notes show no documentation proving the POA (Power of Attorney) or family member were notified of the 17.8 lbs. weight loss.

Review of progress note dated on 11/20/2020 at 9:43 AM from NP (Nurse Practitioner) reads: CC: Weight loss. This is an 81 year old who is residing on Memory Unit for LTC (Long Term Care). She was seen recently due to report of abnormal weight loss and poor appetite. Her weight is down to 135# this month, 152.8 # in October. She is seen today to follow up on lab results.

A review of progress notes dated 11/18/2020 13:09 (1:09 PM). Progress Notes reads: CC: Weight loss. She is seen today due to report of abnormal weight loss. Her weight is down to 135# this month, 152.8 # in October. Staff report poor intake, about 25% at meals. No report of diarrhea or GI symptoms. She is a poor historian due to dementia. She says she is "alright" and denies pain or difficulty breathing. She is c/o feeling cold. Weight loss: possible etiologies-thyroid dysfunction, progressing dementia, or depression. Start Eldertonic 15 ml BID. Monitor weight. Weight warning trigger: 11/16/2020 15:31 Nutrition Note Text: WEIGHT WARNING: 135 lbs.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495150 | A. BUILDING _____ B. WING _____ | C 09/30/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BIRCHWOOD PARK REHABILITATION | 340 LYNN SHORES DRIVE VIRGINIA BEACH, VA 23452 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 684 | Continued From page 85 | F 684 | | |

A review of Progress notes dated 11/15/2020 read: RD (Registered Dietician) weight review; resident displays significant weight loss; Re-weigh to verify weight; weekly weights x 1 mo, RD to f/u PRN; RDN.

A review of the clinical record dated 11/24/2020 at approximately 9:27 AM reveal that Resident's daughter spoke to staff about concerns about her mother's/resident's condition days after she was noted to have significant weight loss.

On 9/23/21 at approximately 2:00 PM an interview was conducted with the District Dietary Manager/OSM (Other Staff Member) #6. He stated," A lot of it has to do with her decline with dementia. Her weight has been stable through 6 months. They had a staff member not putting down the proper weights. We found out that she wasn't weighing the resident. Nursing should notify the family of weight loss issues. Quarterly nutrition report completed.

On 9/23/21 at approximately 12:10 PM an interview was conducted with resident's daughter. She stated, "We received no calls about her weight loss or her not being able to walk. I spoke to the DON (Director of Nursing) and explained the weight concern she stated they would call me every Monday with weights."

On 9/23/21 at approximately 12:00 PM a telephone interview was conducted with the Registered Dietician/OSM #2 concerning Resident # 22. She stated, "The weights aren't consistent especially since COVID19. I brought it up a few times with the dietary managers. They had gotten better since the new DON came.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495150 | A. BUILDING _____ B. WING _____ | C 09/30/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BIRCHWOOD PARK REHABILITATION | 340 LYNN SHORES DRIVE VIRGINIA BEACH, VA 23452 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 684 | Continued From page 86<br>Mostly from staff shortage. In my note she stabilized (weight) and was at a relative stable weight. I recommended fortified foods because sometimes her po (by mouth) intake is poor. She's now on weekly weights. She was on Remeron for a while for her appetite. House shakes 3 times a day. I also recommended they give her calorie dense snacks. Usually the DON's would call the family members.<br><br>On 09/30/21 at approximately 6:20 p.m., the above findings were shared with the Administrator, and Corporate Staff Members. An opportunity was offered to the facility's staff to present additional information but no additional information was provided.<br><br>This is a complaint deficiency | F 684 | | |
| F 685 SS=D | Treatment/Devices to Maintain Hearing/Vision CFR(s): 483.25(a)(1)(2)<br><br>§483.25(a) Vision and hearing<br>To ensure that residents receive proper treatment and assistive devices to maintain vision and hearing abilities, the facility must, if necessary, assist the resident-<br><br>§483.25(a)(1) In making appointments, and<br><br>§483.25(a)(2) By arranging for transportation to and from the office of a practitioner specializing in the treatment of vision or hearing impairment or the office of a professional specializing in the provision of vision or hearing assistive devices.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, staff interview, facility documentation review, and in the course of a | F 685 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495150 | A. BUILDING _____ B. WING _____ | C 09/30/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BIRCHWOOD PARK REHABILITATION | 340 LYNN SHORES DRIVE VIRGINIA BEACH, VA 23452 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 685 | Continued From page 87 | F 685 | | |

complaint investigation, the facility staff failed to maintain assistive devices to include hearing aids and dentures for 1 of 42 residents (Resident #22) in the survey sample.

Resident #22 was originally admitted to the facility on 12/19/19 and readmitted on 7/14/20. Diagnosis for Resident #22 included but not limited Unspecified Dementia with Behavioral Disturbance and Major Depressive Disorder.

The annual Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 07/17/21 coded the resident as not having the ability to complete the Brief Interview for Mental Status (BIMS).

In section "G"(Physical functioning) the resident was coded as extensive assistance of one person with bed mobility, dressing and locomotion on and off the unit. Requiring extensive assistance of two persons transfers. Requiring supervision set-up help with eating and requiring totals dependence of one person with toileting, personal hygiene and bathing.

The careplan dated 01/09/20 Reads: ADL (Activity of Daily Living) self-care performance deficit relating to dementia. Goals: The resident will maintain current level of function through the review date. Interventions: Honor resident's preference for rising, going to bed, bathing/showering. The resident is totally dependent on staff for bathing needs.

Physician Order Summary dated 1/09/20 reads: Place bilateral hearing aids in resident ears every morning.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495150 | A. BUILDING _____ B. WING _____ | C 09/30/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BIRCHWOOD PARK REHABILITATION | 340 LYNN SHORES DRIVE VIRGINIA BEACH, VA 23452 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 685 | Continued From page 88 | F 685 | | |

Physician's Order Summary Dated 1/08/20 reads: Remove Dentures (top & bottom) at bedtime & lock in nurse cart.

MAR (Medication Administration Record) reads: Place bilateral hearing aids in resident ears every morning. One time a day for hearing impaired -Start Date 01/09/2020 0900 (9:00 AM.)

A review of the MAR for November 2020 reads: Place bilateral hearing aids in resident ears every morning. One time a day for hearing impaired.

A review of the MAR for September show that staff placement of the hearing aids were completed. The date in question 11/23/21 when family visited was also checked off as completed.

MAR for November 2020 reads: Performed Oral & Denture (top & bottom denture) care every morning.

A review of the September 2021 MAR reveal that staff checked off Yes for placement of hearing aids on the following dates: 9/05/21 and 9/06/21.

MAR reads: Performed Oral & Denture (top & bottom denture) care every morning in the morning -Start Date 01/09/2020 0800 (8:00 AM).

A review of the September 2021 MAR reveal that staff performed oral and denture care every day except on 9/25/21.

A review of the MAR notes reveal the following:

9/25/2021 23:24 (11:24 PM) Medication Administration Note: Remove bilateral hearing aid out of resident in ear at bedtime & lock in nursing

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495150 | A. BUILDING _____ B. WING _____ | C 09/30/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BIRCHWOOD PARK REHABILITATION | 340 LYNN SHORES DRIVE VIRGINIA BEACH, VA 23452 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 685 | Continued From page 89 | F 685 | | |

cart at bedtime for hearing impaired. N/A (Not Applicable).
9/25/2021 10:32 AM Medication Administration Note: Performed Oral & Denture (top & bottom denture)care every morning. Unable to locate dentures.

9/24/2021 22:29 (10:29 AM) Medication Administration Note: Remove Dentures (top & bottom) at bedtime & lock in nurse cart at bedtime No denture in resident's mouth.

9/24/2021 22:27 (10:27 PM) Medication Administration Note: Remove bilateral hearing aid out of resident in ear at bedtime & lock in nursing cart at bedtime for hearing impaired one hearing in the narcotic box.

9/24/2021 9:51 AM-Medication Administration Note: Place bilateral hearing aids in resident ears every morning. one time a day for hearing impaired not available.

9/10/2021 10:24 PMMedication Administration Note Text: Remove Dentures (top & bottom) at bedtime & lock in nurse cart at bedtime. No dentures in the nursing cart.

9/9/2021 10:02 AM Medication Administration Note: Place bilateral hearing aids in resident ears every morning. one time a day for hearing impaired. due to behavior of taking them out and putting them in random places only one remains.

12/4/2020 11:31 PM -Medication Administration Note Text: Remove Dentures (top & bottom) at bedtime & lock in nurse cart at bedtime. Only top denture collected from resident. No bottom denture.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495150 | A. BUILDING _____ B. WING _____ | C 09/30/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BIRCHWOOD PARK REHABILITATION | 340 LYNN SHORES DRIVE VIRGINIA BEACH, VA 23452 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 685 | Continued From page 90 | F 685 | | |

A review of the Complaint/Grievance Report dated 3/23/21 reads: During the last recent in person visits on 3/19/21 and 3/20/21 resident had no dentures or hearing aid. Family requested resident to have daily. Family upset. No management to assist with concerns.
Investigations: Hearing aides were being kept on medication cart when not in use. Dentures and hearing aids have both been missing for an unknown amount of time.

Reviewed complaint/grievance report dated 3/23/21 filed by son and communicated to Social Services. Concern: During last recent in person visits on 3/19/21 and 3/20/21 resident had no dentures or hearing aid. Family requested resident to have daily. Findings: Hearing aids were being kept on medication cart when not in use. Dentures and hearing aids have been missing for an unknown amount of time. Plan: Facility to acquire contract with senior well that offers dental and audiology services for residents. Resolution: Follow-up needed. Remarks: Missing items are a continuous issue for this family and son is weary about replacement dentures.
A review of progress notes read:

11/27/2020 11:47 Nursing Progress Note: CNA placed residents upper and lower dentures in her mouth this shift. Resident removed her bottom dentures/misplaced them. Hearing aids are in place. Resident met with family this shift through window visit. No concerns noted at this time. Will inform oncoming staff of misplaced bottom dentures.

11/24/2020 09:27 Progress Note: This LPN (Licensed Practical Nurse) spoke with daughter,

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495150 | A. BUILDING _____ B. WING _____ | C 09/30/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BIRCHWOOD PARK REHABILITATION | 340 LYNN SHORES DRIVE VIRGINIA BEACH, VA 23452 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 685 | Continued From page 91 | F 685 | | |

her concerns was resident didn't have dentures, hearing aids, hair and nail cut. Also not knowing her mother is w/c (wheel chair) bound and incontinent. I re-educated her on resident condition and that we will make sure on her mother is will groom on a daily basis.

On 09/21/21 at approximately 2:12 PM Resident #22 was observed sitting in her wheel chair in the activity room. Well groomed, hair combed, finger nails trimmed and clean, clothing clean and without body odor. CNA #1 was asked if Resident was wearing her dentures at the moment. She stated, "She's not wearing her dentures."

On 9/22/21 at approximately 10:25 AM., Resident #22 was observed sitting at the table in the activities room engaged in activity. No dentures were intact. No hearing aids was intact. Resident was well groomed, wearing clean clothing, hair combed, finger nails clean. No body odor was present.

On 9/22/21 at approximately 10:30 AM an interview was conducted with CNA #1 concerning Resident #22. She stated, "She will take out her dentures."

On 9/22/21 at approximately 7:10 PM- an interview was conducted with LPN (Licensed Practical Nurse) #6 concerning Resident #22's dentures. She stated, "I haven't seen her dentures in her mouth in a couple of weeks." A medication cart audit was conducted by LPN #6. No dentures were found. She was able to locate 1 hearing aide.

On 9/23/21 at approximately 8:25 AM an interview was conducted with CNA (Certified

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495150 | A. BUILDING _____ B. WING _____ | C 09/30/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BIRCHWOOD PARK REHABILITATION | 340 LYNN SHORES DRIVE VIRGINIA BEACH, VA 23452 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 685 | Continued From page 92 | F 685 | | |

Nursing Assistant) #10 concerning Resident #22. He stated, "Her dentures should be taken out at night and soaked. They should be left on the sink. Her hearing aid should be locked in the medication cart before she goes to bed."

On 9/23/21 at approximately 9:35 AM an interview was conducted with CNA (Certified Nursing Assistant) #1 concerning Resident #22. She stated, "She gets her hair washed on shower days. She doesn't have any dentures. When she did she would take them out. She gets her showers on the 3-11 shift when she doesn't refuse them. She's a picky eater on a puree diet."

On 9/23/21 Resident observed in Activity room at 9:40 AM. No dentures intact.

A review of Social worker progress notes dated 9/28/21 at 12:22 PM reads: Called son to inform of Ear, Nose, Throat appointment for Resident's hearing aids. No answer. Message left on VM (Voice Mail)to return call back re: appointment. Medical Records called to schedule transportation for appointment. To soon to schedule transportation.

On 9/23/21 at approximately 12:44 PM an interview was conducted with Resident #22's son concerning her dentures and weight loss. He stated, "I never saw her pull them out (her dentures) nor the hearing aids. Not wearing the dentures makes her face sunken in. Constant lack of not shaving her.(Whiskers on her face). The dietician would talk about her weight loss at the quarterly meetings."
Received Investigation document dated on 9/24/21 on 9/27/21 from Social Worker (OSM/Other Staff Member) #8. It reads as

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495150 | A. BUILDING _____ B. WING _____ | C 09/30/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BIRCHWOOD PARK REHABILITATION | 340 LYNN SHORES DRIVE VIRGINIA BEACH, VA 23452 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 685 | Continued From page 93<br>follows: During investigation one hearing aid is in place. No dentures found. Appointment was scheduled October 7, 2021 @10:00 AM with Affordable Dentures. Resident's son was called and informed of upcoming appointment. Reached out to ENT (Ear, Nose and Throat) on 9/24/21 office was closed. Will follow up on Monday September 27, 2021 to schedule an appointment.<br><br>On 09/30/21 at approximately 6:20 p.m., the above findings were shared with the Administrator, and Corporate Staff Members. An opportunity was offered to the facility's staff to present additional information but no additional information was provided. | F 685 | | |
| F 690 SS=E | This is a complaint deficiency<br>Bowel/Bladder Incontinence, Catheter, UTI<br>CFR(s): 483.25(e)(1)-(3)<br><br>§483.25(e) Incontinence.<br>§483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain.<br><br>§483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that-<br>(i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary;<br>(ii) A resident who enters the facility with an indwelling catheter or subsequently receives one | F 690 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495150 | A. BUILDING _____ B. WING _____ | C 09/30/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BIRCHWOOD PARK REHABILITATION | 340 LYNN SHORES DRIVE VIRGINIA BEACH, VA 23452 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 690 | Continued From page 94 | F 690 | | |

is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and
(iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible.

§483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible.
This REQUIREMENT is not met as evidenced by:
Based on clinical record review, facility document review and staff interviews the facility staff failed to obtain physician orders upon re-admission for an indwelling foley catheter for 1 or 42 residents in the survey sample, Resident #21.

The findings included:

The facility staff failed to obtain physician orders for an indwelling foley catheter for Resident #21 for 21 days upon re-admission to the facility on 9/1/21.

Resident #21 was re-admitted to the facility on 9/1/21 with diagnoses to include but not limited to Urinary Tract Infection, and Stage 3 Chronic Kidney Disease.

Resident #21's most recent comprehensive Minimum Data Set (MDS) was a Significant Change with an Assessment Reference Date

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495150 | A. BUILDING _____ B. WING _____ | C 09/30/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BIRCHWOOD PARK REHABILITATION | 340 LYNN SHORES DRIVE VIRGINIA BEACH, VA 23452 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 690 | Continued From page 95 | F 690 | | |

(ARD) of 5/21/21. Resident #21's Brief Interview for Mental Status (BIMS) was coded as a 02, indicating severe cognitive impairment and the inability to perform daily decision making. Under Section H - Bladder and Bowel H0100 Appliances; A. Indwelling catheter (including suprapubic catheter and nephrostomy tube), Resident #21 was coded as: Yes. H0300. Urinary Continence; Urinary continence - Select the one category that best describes the resident. Resident #21 was coded as: 3. Always incontinent.

The following observations were made of Resident #21's indwelling foley catheter:

On 09/20/21 at 8:00 p.m., Resident noted to have intact foley catheter, draining clear yellow urine.
On 09/21/21 at 10:38 a.m., Resident has indwelling foley catheter in place and covered with privacy bag, Catheter care being performed by Certified Nursing Assistant with no issues noted.
On 09/22/21 at 1:00 p.m., Resident's indwelling foley catheter in place, privacy maintained, and draining clear urine.

Resident #21's Admission/Re-Admission Screening Assessment completed By Licensed Practical Nurse (LPN) #4 dated 9/1/21 at 3:53 p.m., was reviewed and is documented in part, as follows:

SECTION I. Bladder/Bowel
34. Bladder:
a. Residents Continence Status: 7. Admitted with Catheter.
CATHETER
d. Catheter Type/Size: foley 16fr (french) 10cc.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495150 | A. BUILDING _____ B. WING _____ | C 09/30/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BIRCHWOOD PARK REHABILITATION | 340 LYNN SHORES DRIVE VIRGINIA BEACH, VA 23452 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 690 | Continued From page 96 | F 690 | | |

On 9/22/21 Resident #21's clinical record was reviewed. During the clinical record review no physician orders for Resident #21's indwelling foley catheter or the care of the indwelling catheter were identified.

Resident #21's Progress Notes were reviewed and are documented in part, as follows:

9/1/2021 15:58(3:58 p.m.) Nursing Progress Note: Patient admitted to facility from Hospital dx (diagnosis): septic shock d/t (due to) complicated UTI (urinary tract infection). Patient has a 16fr 10cc foley catheter r/t (related to) urinary retention. All orders verified by provider.

9/2/2021 06:49 a.m. Nursing Progress Note: Foley cath (catheter) intact, draining clear yellow urine. Output 700ml (milliliters).

9/3/2021 14:13 (2:13 p.m.), Nursing Progress Note: Foley draining clear, straw-colored urine. No foul odor or sediment noted. Urine output this shift 750mls.

9/8/2021 11:41 a.m., Nursing Progress Note: Foley draining clear, straw-colored urine.

9/15/2021 22:50 (10:50 p.m.), Nursing Progress Note: Resident foley catheter patent and flowing clear yellow, odorless urine.

9/21/2021 13:27 (1:27 p.m.), Nursing Progress Note: Foley draining clear, straw-colored urine with small amounts of sediment.

On 9/23/21 at 12:28 p.m., an interview was conducted with LPN #4, who was the admitting

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495150 | A. BUILDING _____ B. WING _____ | C 09/30/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BIRCHWOOD PARK REHABILITATION | 340 LYNN SHORES DRIVE VIRGINIA BEACH, VA 23452 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 690 | Continued From page 97 | F 690 | | |

nurse for Resident #21 on 9/1/21. LPN #4 was asked if Resident #21 was readmitted on 9/1/21 with an indwelling foley catheter and if so did she obtain physician orders for the catheter. LPN #4 stated, "Yes, I put that he had a foley on the admission assessment and I documented the foley in my admission nurses note. I assessed the patient upon admission and then I check the discharge summary for the orders. The foley was not mentioned in the discharge orders, but I knew he had a foley before looking at them. I remember telling the Nurse Practitioner (NP) that he had a foley. I just forgot to write the order for the foley. This was my first time doing an admission here and I wasn't sure how the foley orders were to be written. I called the NP and put the catheter orders in today."

Resident #21's Physician Orders were reviewed and are documented in part, as follows:
Order Date: 9/22/21
Order Summary: Foley catheter used for obstructive uropathy 16 Fr 10 cc balloon.

On 9/29/21 at 4:10 p.m. an interview was conducted with the Regional Director of Clinical Services regarding what the expectation was for staff when verifying and transcribing admission orders. The Regional Director of Clinical Services stated, "After doing the physical assessment and reviewing the discharge summary the nurse is expected to enter the orders accurately after verifying them with the physician. If a foley catheter was noted upon assessment the nurse needs to contact the physician to see if the foley is necessary and write the order."

The facility policy titled "Admission Orders" dated

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495150 | A. BUILDING _____ B. WING _____ | C 09/30/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BIRCHWOOD PARK REHABILITATION | 340 LYNN SHORES DRIVE VIRGINIA BEACH, VA 23452 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 690 | Continued From page 98<br>11/1/21 was reviewed and is documented in part, as follows:<br><br>Policy: A physician, physician assistant, nurse practitioner or clinical nurse specialist must provide orders for the residents' immediate care and needs.<br><br>Policy Explanation and Compliance Guidelines:<br>1. The written orders should include at a minimum: c. Routine care orders.<br>2. The orders should allow facility staff to provide essential care to the resident consistent with the resident's mental and physical status on admission.<br><br>On 9/30/21 at 6:42 p.m., a pre-exit debriefing was conducted with the Administrator, the acting Director of Nursing, the Regional Director of Clinical Services and the Regional Director of Operations, where the above information was shared. Prior to exit no further information was shared. | F 690 | | |
| F 712 SS=D | Physician Visits-Frequency/Timeliness/Alt NPP CFR(s): 483.30(c)(1)-(4)<br><br>§483.30(c) Frequency of physician visits<br>§483.30(c)(1) The residents must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 thereafter.<br><br>§483.30(c)(2) A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required.<br><br>§483.30(c)(3) Except as provided in paragraphs (c)(4) and (f) of this section, all required physician | F 712 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495150 | A. BUILDING _____ B. WING _____ | C 09/30/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BIRCHWOOD PARK REHABILITATION | 340 LYNN SHORES DRIVE VIRGINIA BEACH, VA 23452 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 712 | Continued From page 99 | F 712 | | |

visits must be made by the physician personally.

§483.30(c)(4) At the option of the physician, required visits in SNFs, after the initial visit, may alternate between personal visits by the physician and visits by a physician assistant, nurse practitioner or clinical nurse specialist in accordance with paragraph (e) of this section.
This REQUIREMENT is not met as evidenced by:
Based on record review and staff interviews the facility staff failed to provide physician services for two residents in the survey sample (Residents #28 and #83) of 42 residents.

The findings included:

1. Resident #83 was admitted to the facility on 03/08/21 with diagnoses which included atherosclerotic heart disease, benign prostatic hyperplasia, transient cerebral ischemic attack, dysphagia, muscle weakness and dementia. A 9/2/21 Quarterly Minimum Data Set (MDS) indicated this resident was not able to be coded in the Cognitive Pattern area for Brief Interview for Mental status. This resident required extensive assistance in all areas of Activities of Daily Living.

A review of a Care Plan dated 08/02/21 indicated: Focus- Resident is on antibiotic therapy due to infection. Goal- Resident will be free of any discomfort or adverse side effects of antibiotic therapy. Interventions- Administer Antibiotic medication as ordered by physician. Monitor/document side effects and effectiveness Q-shift.

Focus- Resident has dehydration or potential fluid deficit r/t- Goal- The resident will be free of

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495150 | A. BUILDING _____ B. WING _____ | C 09/30/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BIRCHWOOD PARK REHABILITATION | 340 LYNN SHORES DRIVE VIRGINIA BEACH, VA 23452 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 712 | Continued From page 100 | F 712 | | |

symptoms of dehydration and maintain moist mucous membranes, good skin turgor. Interventions- Administer medications as ordered. Monitor/document for side effects and effectiveness. Monitor vital signs as ordered/per protocol and record. Notify MD of significant abnormalities.

A review of the clinical records indicated the physician's last visited Resident #83 on 5/14/21. During an interview on 09/30/21 at 7:15 P.M. with Regional Nurse Consultant she stated, the physician's Nurse Practitioner had been visiting the resident.

The facility staff failed to ensure physician visits were conducted in a time manner.

2. For Resident #28, the facility staff failed to provide physician visits in a timely manner during the month of June 2021.

Resident #28 was originally admitted to the facility 9/14/17 and readmitted 03/10/21 after an acute care hospital stay. The current diagnoses included; Type 2 Diabetes Mellitus with Diabetic Neuropathy, Unspecified and Muscle Weakness.

The annual Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 07/18/21 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 13 out of a possible 15. This indicated Resident #28 cognitive abilities for daily decision making were intact.

In section "G"(Physical functioning) the resident was coded as requiring supervision after set-up only with bed mobility, transfers, locomotion,

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495150 | A. BUILDING _____ B. WING _____ | C 09/30/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BIRCHWOOD PARK REHABILITATION | 340 LYNN SHORES DRIVE VIRGINIA BEACH, VA 23452 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 712 | Continued From page 101<br>dressing, eating, toileting, personal hygiene and bathing June 2021.<br><br>A review of the resident's clinical record show that NP (Nurse Practitioner) visits were conducted on the following dates: 5/05/21, 6/14/2021, 6/18/21.<br><br>A review of the clinical record show that Physician visits were conducted on the following dates: 7/08/21, 7/27/21, 8/03/21 and 9/23/21.<br><br>A review of the clinical record showed that no physician visits were conducted for the month of June 2021.<br><br>On 09/30/21 at approximately 6:20 p.m., the above findings were shared with the Administrator, The Interim Director of Nursing, The Regional Director of Clinical Services and The Regional Director of Operations. The Regional Director of Operations stated, "The Physician Visits are still under a waiver." | F 712 | | |
| F 727 SS=E | RN 8 Hrs/7 days/Wk, Full Time DON<br>CFR(s): 483.35(b)(1)-(3)<br><br>§483.35(b) Registered nurse<br>§483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week.<br><br>§483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis.<br><br>§483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an | F 727 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495150 | A. BUILDING _____ B. WING _____ | C 09/30/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BIRCHWOOD PARK REHABILITATION | 340 LYNN SHORES DRIVE VIRGINIA BEACH, VA 23452 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 727 | Continued From page 102 | F 727 | | |

average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by:
Based on staff interviews and facility information, the facility staff failed to staff a Registered Nurse (RN) for at least 8 consecutive hours a day, 7 days a week.

The findings included:

During review of the facility's staffing for RN coverage in a 60-day lookback revealed the facility did not provide 8 consecutive hours of RN coverage on the following days: 08/07/21, 08/08/21, 08/21/21, 08/22/21 and 09/18/21.

On 09/29/21 at approximately 10:30 a.m., a phone interview was conducted with the Administrator, Regional Director of Clinical Services, MDS Coordinator and Infection Preventionist/Staff Development Coordinator who were informed that the facility did not have 8 consecutive hours of RN coverage on the days mentioned above. The administration team did not have any further questions or present any information about the findings.

An interview was conducted with the Administrator on 09/30/21 at approximately 2:27 p.m., who stated, "I expect RN coverage 8 hours a day, 7 days a week."

The Administrator, Interim Director of Nursing, Chief Operating Officer, Regional Director of Operations and Regional Director of Clinical Services was informed of the findings during the pre-exit meeting on 09/30/21 at approximately 7:40 p.m. The facility did not have any further questions or present any further information

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495150 | A. BUILDING _____ B. WING _____ | C 09/30/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BIRCHWOOD PARK REHABILITATION | 340 LYNN SHORES DRIVE VIRGINIA BEACH, VA 23452 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 727 | Continued From page 103<br>about the findings.<br><br>The facility's policy titled Nursing Services-Registered Nurse (RN) revision date: 10/28/20. Under policy included the intent of the facility to comply with Registered Nurse staffing requirements.<br><br>Policy Explanation and Compliance Guidelines:<br>1. The facility will utilize the services of a Registered Nurse for at least 8 consecutive hours per day, 7 days per week. | F 727 | | |
| F 730 SS=D | Nurse Aide Peform Review-12 hr/yr In-Service<br>CFR(s): 483.35(d)(7)<br><br>§483.35(d)(7) Regular in-service education.<br>The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. In-service training must comply with the requirements of §483.95(g).<br>This REQUIREMENT is not met as evidenced by:<br>Based on extended survey task, staff interview and documentation review the facility staff failed to ensure 3 out of 3 Certified Nursing Assistant (CNA) received their required 12 hours of mandatory annual competencies and 1 out of 3 CNA's completed her mandatory Dementia training.<br><br>The findings included:<br><br>On 09/22/21 at approximately 8:58 a.m., the surveyor requested evidence that CNA #7, CNA #11 and CNA #12 received their required 12 hours of mandatory annual competencies to | F 730 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495150 | A. BUILDING _____ B. WING _____ | C 09/30/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BIRCHWOOD PARK REHABILITATION | 340 LYNN SHORES DRIVE VIRGINIA BEACH, VA 23452 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 730 | Continued From page 104 | F 730 | | |

include abuse and dementia training.

The Admission Coordinator presented the list of Yearly Competency Training completed on 08/17/21. The training showed zero (0) hours. The competency training consisted of the following training:
-Shower/Tub Bath
-Nail Grooming
-Oral Care
-Elastic Stocking (Ted Hose)
-Height & Weight
-Vital Signs
-Sit to Stand Lift / bedside to wheel chair
-Positioning
-SWAT-Full Body Lift (bed to wheel chair)
-Catheter care
-Perineal Care Male and Female
-Heimlich maneuver
-Hand washing
-Intake/output
-Personal protective equipment (PPE)

On 09/29/21 at approximately 1:16 p.m., an phone interview was conducted with the Staff Development Coordinator who said she was not able to locate the 12 hours of mandatory annual competencies on the three (3) CNA's requested and was not able to provide the mandatory dementia training for CNA #12.

The Administrator, Interim Director of Nursing, Chief Operating Officer, Regional Director of Operations and Regional Director of Clinical Services was informed of the findings during the pre-exit meeting on 09/30/21 at approximately 7:40 p.m. The facility did not have any further questions or present any further information about the findings.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495150 | A. BUILDING _____ B. WING _____ | C 09/30/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BIRCHWOOD PARK REHABILITATION | 340 LYNN SHORES DRIVE VIRGINIA BEACH, VA 23452 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 730 | Continued From page 105<br><br>The facility's policy titled Continuing Education - revision date 10/28/20.<br>Compliance with the facility's standards, policies, and procedures is a condition of employment. This includes compliance with the policies and procedures of the facility's training program.<br><br>Policy Explanation and Compliance Guidelines:<br>1. All levels of employees are expected to complete required training within designated time frames. | F 730 | | |
| F 837 SS=F | Governing Body<br>CFR(s): 483.70(d)(1)(2)<br><br>§483.70(d) Governing body.<br>§483.70(d)(1) The facility must have a governing body, or designated persons functioning as a governing body, that is legally responsible for establishing and implementing policies regarding the management and operation of the facility; and<br><br>§483.70(d)(2) The governing body appoints the administrator who is-<br>(i) Licensed by the State, where licensing is required;<br>(ii) Responsible for management of the facility; and<br>(iii) Reports to and is accountable to the governing body.<br>This REQUIREMENT is not met as evidenced by:<br>Based on facility policy, and staff interview, the facility staff failed to have a governing body of persons to ensure policies regarding the management and operations of the facility during COVID-19 outbreak. | F 837 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495150 | A. BUILDING _____ B. WING _____ | C 09/30/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BIRCHWOOD PARK REHABILITATION | 340 LYNN SHORES DRIVE VIRGINIA BEACH, VA 23452 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 837 | Continued From page 106 | F 837 | | |

The findings included:

The facility staff failed to conduct and document a facility wide assessment to determine what resources were necessary to assist in the prevention of the spread of COVID -19.

The facility staff failed to use outside resources including the Local Health Department during a Major COVID-19 outbreak in the facility.

During interaction with the Administrator and Infection Preventionist from 09/20/21 through 09/23/21 resulted in the facility's inability to provide COVID-19 cumulative data (total of COVID-19 positive residents/staff, number of residents/staff hospitalized COVID-19 related, number of resident/staff deaths, current number of quarantined resident/staff and number of affected residents/staff that were vaccinated since the outbreak began and currently) for the facility.

A review of the data presented to the survey team on 09/30/21 indicated: 53 residents were identified with COVID-19. No information was provided as to how many residents were sent to the hospital. Nine residents were identified who expired from COVID-19. Eight staff were identified as COVID-19 positive. One staff was identified as out of work on quarantine. One resident was identified as never returned to work. One resident was identified who expired from COVID-19.

During an interview on 09/23/21 at 3:30 P.M. with the Administrator and Infection Preventionist they were asked if the facility staff had reached out to the local Health Department for assistants and

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495150 | A. BUILDING _____ B. WING _____ | C 09/30/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BIRCHWOOD PARK REHABILITATION | 340 LYNN SHORES DRIVE VIRGINIA BEACH, VA 23452 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 837 | Continued From page 107 | F 837 | | |

guidance. The Administrator stated, the facility had not.

A 09/17/21 Local Health Report on the facility after an unannounced visit indicated: "As of 9:30 am September 17, 2021 we have had notification form the local hospital of 11 total admissions since Sept 4 and 4 known deaths among patients arriving from the facility.

A determination was made for an immediate visit was necessary to:
1. Assess status of patients regarding numbers currently ill
2. Determine vaccination status of patients and staff
3. Assess staffing and medical coverage
4. Explore PPE use and availability; assist with procuring additional if needed
5. Based on the number of patients ill, determine what, if any cohorting possibilities there are within the facility that could help limit transmission
6. Look at any other mitigation strategies the IP and epi team believe could help

It was also determined that Local Health Department staff touch base with the facility's corporate office to let them know of our concerns and request their engagement."

A CDC Interim Infection Prevention and Control Recommendations to Prevent SARS-COV-2 Spread in Nursing Homes dated 09/10/21 indicated: Notify HCP (Health Care Professionals), Residents, and families about Outbreaks, and Report SARS-COV-2 Infections, Facility staffing, Testing, and Supply Information to Public Health Authorities

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495150 | A. BUILDING _____ B. WING _____ | C 09/30/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BIRCHWOOD PARK REHABILITATION | 340 LYNN SHORES DRIVE VIRGINIA BEACH, VA 23452 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 837 | Continued From page 108 | F 837 | | |

Notify the health department promptly about the following:
¢ 1 residents or HCP with suspected or confirmed SAR-Cov-2 infection
¢ Resident with severe respiratory infection resulting in hospitalization or death
¢ 3 residents or HCP with acute illness compatible with COVID-19 with onset within 72 hour period.

Find the contact information for the healthcare-associated infections program in your state health department, as well as your local health department.

Notify HCP, residents and family's promptly about identification of SARS-Cov-2 in the facility and maintain ongoing, frequent communication with HCP, residents, and families with updates on the situation and facility actions.

Report SARS-Cov-2 infections, facility staffing and supply information, and point of care testing data to the National HealthCare Safety Network (NHSN) Long term Care Facility (LTCF) COVID-19 Module weekly. CDC NHSN provides long term care facilities with a secure reporting platform to track infections and prevention process measures in a systematic way. Weekly data submission to NHSN will meet the Centers for Medicare and Medicaid Services (CMS) COVID-19 reporting requirements." Professional Resources:
"https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html"

A review of the Facility Assessment policy dated 10/22/20 indicated:

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495150 | A. BUILDING _____ B. WING _____ | C 09/30/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BIRCHWOOD PARK REHABILITATION | 340 LYNN SHORES DRIVE VIRGINIA BEACH, VA 23452 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 837 | Continued From page 109<br><br>2. The facility assessment is completed at the facility level utilizing the following individuals:<br>a. Administrator<br>b. A representative from the governing body<br>c. The Medical Director<br>d. The Director of Nursing<br><br>A review of the Governing Body Policy dated 10/22/20 indicated:<br><br>The governing body is responsible and accountable for the Quality Assurance and Performance Improvement (QAPI) program/Quality Assurance (QA). | F 837 | | |
| F 838 SS=F | Facility Assessment<br>CFR(s): 483.70(e)(1)-(3)<br><br>§483.70(e) Facility assessment.<br>The facility must conduct and document a facility-wide assessment to determine what resources are necessary to care for its residents competently during both day-to-day operations and emergencies. The facility must review and update that assessment, as necessary, and at least annually. The facility must also review and update this assessment whenever there is, or the facility plans for, any change that would require a substantial modification to any part of this assessment. The facility assessment must address or include:<br><br>§483.70(e)(1) The facility's resident population, including, but not limited to,<br>(i) Both the number of residents and the facility's resident capacity;<br>(ii) The care required by the resident population considering the types of diseases, conditions, | F 838 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495150 | A. BUILDING _____ B. WING _____ | C 09/30/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BIRCHWOOD PARK REHABILITATION | 340 LYNN SHORES DRIVE VIRGINIA BEACH, VA 23452 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 838 | Continued From page 110 | F 838 | | |

physical and cognitive disabilities, overall acuity, and other pertinent facts that are present within that population;
(iii) The staff competencies that are necessary to provide the level and types of care needed for the resident population;
(iv) The physical environment, equipment, services, and other physical plant considerations that are necessary to care for this population; and
(v) Any ethnic, cultural, or religious factors that may potentially affect the care provided by the facility, including, but not limited to, activities and food and nutrition services.

§483.70(e)(2) The facility's resources, including but not limited to,
(i) All buildings and/or other physical structures and vehicles;
(ii) Equipment (medical and non- medical);
(iii) Services provided, such as physical therapy, pharmacy, and specific rehabilitation therapies;
(iv) All personnel, including managers, staff (both employees and those who provide services under contract), and volunteers, as well as their education and/or training and any competencies related to resident care;
(v) Contracts, memorandums of understanding, or other agreements with third parties to provide services or equipment to the facility during both normal operations and emergencies; and
(vi) Health information technology resources, such as systems for electronically managing patient records and electronically sharing information with other organizations.

§483.70(e)(3) A facility-based and community-based risk assessment, utilizing an all-hazards approach.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495150 | A. BUILDING _____ B. WING _____ | C 09/30/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BIRCHWOOD PARK REHABILITATION | 340 LYNN SHORES DRIVE VIRGINIA BEACH, VA 23452 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 838 | Continued From page 111 | F 838 | | |

This REQUIREMENT is not met as evidenced by:
The facility staff failed to conduct and document a facility wide assessment to determine what resources were necessary to assist in the prevention of the spread of COVID -19.

The findings included:

The facility staff failed to use outside resources including the Local Health Department during a Major COVID-19 outbreak in the facility. The level of Community Transmission was noted to be high (Red).

Upon entering the facility the Director of Nursing stated the facility was experiencing a major COVID outbreak. During the entrance conference the Administrator was asked how many COVID -19 positive residents and staff did the facility have. The Administrator stated there were 36 residents in the facility with COVID-19. On 09/21/21 the survey team was present with the 802 Resident matrix that coded three residents with COVID in the Infections section. On 09/22/21 the Infection Preventionist presented to the survey team with a list of residents on the 802 Resident matrix that totaled 21 residents with COVID -19. On 09/22/21 the Administrator presented to the survey team an 802 Resident matrix with 24 residents.

During interaction with the Administrator and Infection Preventionist from 09/20/21 through 09/23/21 resulted in the facility's inability to provide COVID-19 cumulative data (total of COVID-19 positive residents/staff, number of residents/staff hospitalized COVID-19 related, number of resident/staff deaths, current number

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495150 | A. BUILDING _____ B. WING _____ | C 09/30/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BIRCHWOOD PARK REHABILITATION | 340 LYNN SHORES DRIVE VIRGINIA BEACH, VA 23452 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 838 | Continued From page 112 | F 838 | | |

of quarantined resident/staff and number of affected residents/staff that were vaccinated since the outbreak began and currently) for the facility.

A review of the data presented to the survey team on 09/30/21 indicated: 53 residents were identified with COVID-19. No information was provided as to how many residents were sent to the hospital. Nine residents were identified who expired from COVID-19. Eight staff were identified as COVID-19 positive. One staff was identified as out of work on quarantine. One resident was identified as never returned to work. One resident was identified who expired from COVID-19.

A review of the facility's COVID-19 Action Plan stated there would be three units set-up for the resident population in accordance with CDC Guidelines. The Units were described as a Well/Cool Unit, a Quarantine/Warm Unit for new admission and readmissions and an Isolation/Hot Unit for COVID-19 positive Unit. The facility had only one general well unit, one well memory unit, one well/COVID-19 positive memory unit and a full COVID-19 positive unit.

The facility staff failed to follow CDC guidance to ensure Health Care Personal (HCP) to include contract, agencies and vendors required COVID-19 testing was completed based on the level of community transmission and the results of each test was documented. As a result of the non-compliance with testing while the facility was in a major COVID-19 outbreak there had been further transmission, hospitalizations and deaths.

On 09/21/21, staff testing was observed and the

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495150 | A. BUILDING _____ B. WING _____ | C 09/30/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BIRCHWOOD PARK REHABILITATION | 340 LYNN SHORES DRIVE VIRGINIA BEACH, VA 23452 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 838 | Continued From page 113 | F 838 | | |

documentation of the testing was reviewed. The Infection Preventionist stated testing for staff was two times weekly (Tuesday and Thursday). Review of those listed as tested revealed no documentation of their test results. The Infection Preventionist stated that indicated the results were negative. The results remained undocumented.

The Infection Preventionist was not able to provide how the facility HCP's met the requirements to be tested based on the level of community transmission. In accordance to CDC guidance the Facility's Assessment Program failed infection control measures and practices during a major outbreak to prevent further transmission of COVID-19:

1. Entry Notification/Visitation
2. PPE usage during major outbreak
3. COVID-19 surveillance plan
4. Unit set up in accordance with CDC Guidelines and facility policies and procedures

During an interview on 09/23/21 at 3:30 P.M. with the Administrator and Infection Preventionist they were asked if the facility staff had reached out to the local Health Department for assistants and guidance. The Administrator stated, the facility had not.

A 09/17/21 Local Health Report on the facility after an unannounced visit indicated: "As of 9:30 am September 17, 2021 we have had notification form the local hospital of 11 total admissions since Sept 4 and 4 known deaths among patients arriving from the facility.

A determination was made for an immediate visit

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495150 | A. BUILDING _____ B. WING _____ | C 09/30/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BIRCHWOOD PARK REHABILITATION | 340 LYNN SHORES DRIVE VIRGINIA BEACH, VA 23452 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 838 | Continued From page 114 | F 838 | | |

was necessary to:
1. Assess status of patients regarding numbers currently ill
2. Determine vaccination status of patients and staff
3. Assess staffing and medical coverage
4. Explore PPE use and availability; assist with procuring additional if needed
5. Based on the number of patients ill, determine what, if any cohorting possibilities there are within the facility that could help limit transmission
6. Look at any other mitigation strategies the IP and epi team believe could help

It was also determined that Local Health Department staff touch base with the facility's corporate office to let them know of our concerns and request their engagement."

A CDC Interim Infection Prevention and Control Recommendations to Prevent SARS-COV-2 Spread in Nursing Homes dated 09/10/21 indicated: Notify HCP (Health Care Professionals), Residents, and families about Outbreaks, and Report SARS-COV-2 Infections, Facility staffing, Testing, and Supply Information to Public Health Authorities

Notify the health department promptly about the following:
¢ 1 residents or HCP with suspected or confirmed SAR-Cov-2 infection
¢ Resident with severe respiratory infection resulting in hospitalization or death
¢ 3 residents or HCP with acute illness compatible with COVID-19 with onset within 72 hour period

Find the contact information for the

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495150 | A. BUILDING _____ B. WING _____ | C 09/30/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BIRCHWOOD PARK REHABILITATION | 340 LYNN SHORES DRIVE VIRGINIA BEACH, VA 23452 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 838 | Continued From page 115 | F 838 | | |

healthcare-associated infections program in your state health department, as well as your local health department.

Notify HCP, residents and family's promptly about identification of SARS-Cov-2 in the facility and maintain ongoing, frequent communication with HCP, residents, and families with updates on the situation and facility actions.

Report SARS-Cov-2 infections, facility staffing and supply information, and point of care testing data to the National HealthCare Safety Network (NHSN) Long term Care Facility (LTCF) COVID-19 Module weekly. CDC NHSN provides long term care facilities with a secure reporting platform to track infections and prevention process measures in a systematic way. Weekly data submission to NHSN will meet the Centers for Medicare and Medicaid Services (CMS) COVID-19 reporting requirements."

A review of the facility's COVID-19 Action Plan dated 07/30/21 indicated:
COVID Response Plan
1. There will be 3 units set for resident populations in accordance with CDC Guidelines
2. Well/Cool Unit
3. Quarantine/Warm Unit- for new admission and readmissions
4. Isolation/Hot Unit-COVID-19 Positive Residents
5. Goals:
All residents will remain free from complications related to the COVID-19 pandemic
Reduce the transmission of the COVID-19 Virus

A Facility Assessment dated 08/10/21 indicated:

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495150 | A. BUILDING _____ B. WING _____ | C 09/30/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BIRCHWOOD PARK REHABILITATION | 340 LYNN SHORES DRIVE VIRGINIA BEACH, VA 23452 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 838 | Continued From page 116<br>The facility must conduct and document a facility -wide assessment to determine what resources are necessary to care for its residents competently during both day-to-day operations and emergencies. The facility must review and update that assessment, as necessary, and at least annually. The facility must also review and update this assessment whenever there is, or the facility plans for any changes that would require a substantial modification to any part of this assessment. The facility assessment must address or include:<br><br>1. The facility's resident population, including, but not limited to,<br>(ii) The care required by the resident's population considering the type of diseases<br><br>2. The facility's resources\, including but not limited to,<br>(v) Contracts, memorandums of understanding, or other agreements with third parties to provide services or equipment to the facility during both normal operations and emergencies;<br><br>Additional References to the Facility Assessment: Infection Control- Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum,, the following elements:<br>(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to and following accepted national standards. | F 838 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495150 | A. BUILDING _____ B. WING _____ | C 09/30/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BIRCHWOOD PARK REHABILITATION | 340 LYNN SHORES DRIVE VIRGINIA BEACH, VA 23452 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 838 | Continued From page 117 | F 838 | | |

In the area of Special Treatments/Resident Care Needs: Special Services- Transmission Based Precautions (Isolation) zero (0) was indicated in the average number of resident's per-month column.

In the Facility Assessment Section 3.11- indicated: The facility's infection control program is monitored and reviewed at the monthly QAPI meeting. The QAPI team reviews metrics and trends to evaluate the infection prevention and control program as well as monitor effective systems for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, volunteers, and visitors."

During an interview at 2:21 PM on 09/23/21 with the Administrator he was asked for the facility's Risk Assessment and Patient Population Emergency Preparedness Plan including policy's and procedures. The Administrator provided a Facility Assessment Tool 2021. A Facility and Community Risk Assessment - Hazard and Vulnerability Tool for Naturally Occurring Events 2021 was provided. When asked how many residents were identified with COVID-19 and had been hospitalized the Administrator stated he did not know.

A review of the facility's COVID-19 Action Plan stated there would be three units set-up for the resident population in accordance with CDC Guidelines. The Units were described as a Well/Cool Unit, a Quarantine/Warm Unit for new admission and readmissions and an isolation/Hot Unit for COVID-19 positive Unit. The facility had only one general well unit, one well memory unit, one well/COVID-19 positive memory unit and a

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495150 | A. BUILDING _____ B. WING _____ | C 09/30/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BIRCHWOOD PARK REHABILITATION | 340 LYNN SHORES DRIVE VIRGINIA BEACH, VA 23452 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 838 | Continued From page 118<br>full COVID-19 positive unit. | F 838 | | |
| F 840 SS=F | Use of Outside Resources<br>CFR(s): 483.70(g)(1)(2)<br><br>§483.70(g) Use of outside resources.<br>§483.70(g)(1) If the facility does not employ a qualified professional person to furnish a specific service to be provided by the facility, the facility must have that service furnished to residents by a person or agency outside the facility under an arrangement described in section 1861(w) of the Act or an agreement described in paragraph (g)(2) of this section.<br><br>§483.70(g)(2) Arrangements as described in section 1861(w) of the Act or agreements pertaining to services furnished by outside resources must specify in writing that the facility assumes responsibility for-<br>(i) Obtaining services that meet professional standards and principles that apply to professionals providing services in such a facility; and<br>(ii) The timeliness of the services.<br>This REQUIREMENT is not met as evidenced by:<br>The facility staff failed to utilize outside resource to assist in the prevention of the spread of COVID-19 which resulted in hospitalizations and deaths.<br><br>The findings included:<br><br>The facility staff failed to use outside resources including the Local Health Department during a Major COVID-19 outbreak in the facility. The outbreak started on 08/28/21 according to the facility's records. During entrance to the facility on 09/20/21 signage on the front door at the | F 840 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495150 | A. BUILDING _____ B. WING _____ | C 09/30/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BIRCHWOOD PARK REHABILITATION | 340 LYNN SHORES DRIVE VIRGINIA BEACH, VA 23452 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 840 | Continued From page 119 | F 840 | | |

visitor's entrance read "face mask required at all times." The signage lacked clear information/alerts to visitors. Review of other visitor entrances (kitchen, construction unit and the laundry door connecting with Unit 1 revealed no signage).

Upon entering the facility, staff members stated screening was a self-performed task. After multiple days of reviewing the screening logs the team was unable to account for many on duty staff.

Multiple attempts between 09/21/21 and 09/23/21 were made with the infection Preventionist to review the facility's COVID-19 system for capturing COVID-19 cases. Upon entrance on 09/20/21 the Administrator stated there were 36 incidences of COVID-19 in the facility and two staff. A review of the facility's 802 Resident Matrix as presented to the survey team identified (3) residents with COVID-19. Each interaction with the Administrator and Infection Preventionist resulted in the facility's inability to provide COVID-19 cumulative data ( total of COVID 19 positive residents/staff, number of residents/staff hospitalized COVID-19 related, number of resident/staff deaths, current number of quarantined resident/staff and number of affected residents/staff that were vaccinated since the outbreak began and currently) for the facility.

A review of the facility's COVID-19 Action Plan stated there would be three units set-up for the resident population in accordance with CDC Guidelines. The Units were described as a Well/Cool Unit, a Quarantine/Warm Unit for new admission and readmissions and an isolation/Hot Unit for COVID-19 positive Unit. The facility had

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495150 | A. BUILDING _____ B. WING _____ | C 09/30/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BIRCHWOOD PARK REHABILITATION | 340 LYNN SHORES DRIVE VIRGINIA BEACH, VA 23452 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 840 | Continued From page 120 | F 840 | | |

only one general well unit, one well memory unit, one well/COVID-19 positive memory unit and a full COVID-19 positive unit.

Various types of mask were observed donned by the facility staff but regardless of the type of mask worn most staff were observed not appropriately positioned to cover the nose and mouth.

The facility staff failed to follow CDC guidance to ensure Health Care Personal (HCP) to include contract, agencies and vendors required COVID-19 testing was completed based on the level of community transmission and the results of each test was documented. As a result of the non-compliance with testing while the facility was in a major COVID-19 outbreak.

On 09/21/21 staff testing was observed and the documentation of the testing was reviewed. The Infection Preventionist stated testing for staff was two times weekly (Tuesday and Thursday). Review of those listed as tested revealed no documentation of their test results. The Infection Preventionist stated that indicated the results were negative. The results remained undocumented.

During an interview on 09/23/21 at 2:15 P.M. with the administrator he was asked had the Local Health Department been contacted to assist the facility in assessing the status of residents and the number of resident who have been hospitalized. The Administrator, stated, "No the facility had not contacting the Local Health Department for that purpose". The administrator was asked if the facility had outside resources whom he could consult regarding the COVID-19 outbreak. The administrator stated, corporate

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495150 | A. BUILDING _____ B. WING _____ | C 09/30/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BIRCHWOOD PARK REHABILITATION | 340 LYNN SHORES DRIVE VIRGINIA BEACH, VA 23452 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 840 | Continued From page 121 | F 840 | | |

office had sent several regional staff including a Regional Corporate Nurse to assist with the outbreak.

A 09/17/21 Local Health Report on the facility after an unannounced visit indicated: "As of 9:30 am September 17, 2021 we have had notification form the local hospital of 11 total admissions since Sept 4 and 4 known deaths among patients arriving from the facility.

A determination was made for an immediate visit was necessary to:
1. Assess status of patients regarding numbers currently ill
2. Determine vaccination status of patients and staff
3. Assess staffing and medical coverage
4. Explore PPE use and availability; assist with procuring additional if needed
5. Based on the number of patients ill, determine what, if any cohorting possibilities there are within the facility that could help limit transmission
6. Look at any other mitigation strategies the IP and epi team believe could help
It was also determined that Local Health Department staff touch base with the facility's corporate office to let them know of our concerns and request their engagement."

A CDC Interim Infection Prevention and Control Recommendations to Prevent SARS-COV-2 Spread in Nursing Homes dated 09/10/21 indicated: Notify HCP (Health Care Professionals), Residents, and families about Outbreaks, and Report SARS-COV-2 Infections, Facility staffing, Testing, and Supply Information to Public Health Authorities

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495150 | A. BUILDING _____ B. WING _____ | C 09/30/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BIRCHWOOD PARK REHABILITATION | 340 LYNN SHORES DRIVE VIRGINIA BEACH, VA 23452 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 840 | Continued From page 122 | F 840 | | |

Notify the health department promptly about the following:
-1 residents or HCP with suspected or confirmed SAR-Cov-2 infection
-Resident with severe respiratory infection resulting in hospitalization or death
-3 residents or HCP with acute illness compatible with COVID-19 with onset within 72 hour period. Find the contact information for the healthcare-associated infections program in your state health department, as well as your local health department.

Notify HCP, residents and family's promptly about identification of SARS-Cov-2 in the facility and maintain ongoing, frequent communication with HCP, residents, and families with updates on the situation and facility actions.

Report SARS-Cov-2 infections, facility staffing and supply information, and point of care testing data to the National Healthcare Safety Network (NHSN) Long term Care Facility (LTCF) COVID-19 Module weekly. CDC NHSN provides long term care facilities with a secure reporting platform to track infections and prevention process measures in a systematic way. Weekly data submission to NHSN will meet the Centers for Medicare and Medicaid Services (CMS) COVID-19 reporting requirements." Professional source:
"https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html"

An Administration Facility policy revised 10/22/20 Indicated: "The facility will provide polices and systems that it is administered in a manner that will focus on attaining and maintaining the highest

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495150 | A. BUILDING _____ B. WING _____ | C 09/30/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BIRCHWOOD PARK REHABILITATION | 340 LYNN SHORES DRIVE VIRGINIA BEACH, VA 23452 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 840 | Continued From page 123<br>practicable physical, mental and psychosocial well-being of each resident.<br><br>Policy Explanation and Compliance Guidelines:<br><br>The facility will follow the accepted professional standards and principles of the various practice acts and regulations for the various licensed personnel within the facility. The facility will employ professionals necessary to carry out the provisions of requirements. | F 840 | | |
| F 842 SS=D | Resident Records - Identifiable Information<br>CFR(s): 483.20(f)(5), 483.70(i)(1)-(5)<br><br>§483.20(f)(5) Resident-identifiable information.<br>(i) A facility may not release information that is resident-identifiable to the public.<br>(ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so.<br><br>§483.70(i) Medical records.<br>§483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are-<br>(i) Complete;<br>(ii) Accurately documented;<br>(iii) Readily accessible; and<br>(iv) Systematically organized<br><br>§483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- | F 842 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495150 | A. BUILDING _____ B. WING _____ | C 09/30/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BIRCHWOOD PARK REHABILITATION | 340 LYNN SHORES DRIVE VIRGINIA BEACH, VA 23452 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 842 | Continued From page 124 | F 842 | | |

(i) To the individual, or their resident representative where permitted by applicable law;
(ii) Required by Law;
(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;
(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.

§483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.

§483.70(i)(4) Medical records must be retained for-
(i) The period of time required by State law; or
(ii) Five years from the date of discharge when there is no requirement in State law; or
(iii) For a minor, 3 years after a resident reaches legal age under State law.

§483.70(i)(5) The medical record must contain-
(i) Sufficient information to identify the resident;
(ii) A record of the resident's assessments;
(iii) The comprehensive plan of care and services provided;
(iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;
(v) Physician's, nurse's, and other licensed professional's progress notes; and
(vi) Laboratory, radiology and other diagnostic

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495150 | A. BUILDING _____ B. WING _____ | C 09/30/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BIRCHWOOD PARK REHABILITATION | 340 LYNN SHORES DRIVE VIRGINIA BEACH, VA 23452 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 842 | Continued From page 125 | F 842 | | |

services reports as required under §483.50.
This REQUIREMENT is not met as evidenced by:
Based on a clinical record review, staff interviews, facility document review and during the course of a complaint investigation the facility staff failed to ensure a complete and accurate clinical record for 2 of 42 residents in the survey sample, Resident #8 and Resident #93.

The findings included:

1. The facility staff failed to ensure Resident #8's clinical record documentation was complete to include a fall, nursing fall assessment, physician notification and physician order follow-up during the 11-7 shift on 10/23/20.

Resident #8 was originally admitted to the facility on 10/28/2019 and re-admitted on 11/3/2020 with diagnoses to include but not limited to Right Femur Fracture and Dementia.

Resident #8's most recent Minimum Data Set (MDS) was a quarterly with an Assessment Reference Date (ARD) of 9/22/21. Resident #8's Brief Interview for Mental Status (BIMS) was not attempted because the resident was coded as rarely or never understood. Resident #8 was also coded as having long and short term memory recall.

On 9/22/21 at 10:00 a.m., the facility Administrator was asked if he had information

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495150 | A. BUILDING _____ B. WING _____ | C 09/30/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BIRCHWOOD PARK REHABILITATION | 340 LYNN SHORES DRIVE VIRGINIA BEACH, VA 23452 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 842 | Continued From page 126 | F 842 | | |

about a fracture for Resident #8. The Administrator stated, "Yes, I have a FRI(facility reported incident), a follow-up and statements regarding the incident with him for October 2020." The Administrator provided the surveyor with all of the above documents for review.

The Facility Reported Incident dated 10/29/20 was reviewed and is documented in part, as follows:

Residents involved: Name (Resident #8).
Incident Type: Injury of Unknown origin.
Describe incident, including location, and action taken: Resident Name (Resident #8) was noted to have bruising and leg pain. Order for x-ray revealed fracture. Resident sent out 911.
Name of employee involved and their position: Name, (Certified Nursing Assistant #13 (CNA).
Employee action initiated or taken:
Employee suspended based on statements from nurse on duty.

The facility 5-day follow-up to the FRI submitted on 10/29/20 dated 11/3/2020 was reviewed and is documented in part, as follows:

Situation: This is a follow-up to the initial FRI sent on October 29, 2020 concerning an injury of unknown origin for fracture to Name (Resident #8).

Investigation: Based on review of the written statements and interviews with employees it was determined that the CNA (CNA #13) on 11-7 did report a fall to an agency nurse. The agency nurse failed to complete documentation

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495150 | A. BUILDING _____ B. WING _____ | C 09/30/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BIRCHWOOD PARK REHABILITATION | 340 LYNN SHORES DRIVE VIRGINIA BEACH, VA 23452 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 842 | Continued From page 127 | F 842 | | |

concerning the fall and to notify nursing management of a fall. All notifications have been made and the resident is currently in acute care receiving treatment for his injury.

Conclusion: This injury is, in fact, attributed to a fall.
-CNA returned back to work after the internal investigation.
-100% re-education to all nurses on notification and documentation of falls in Name(electronic medical record).
-100% re-education of notification to DON(Director of Nursing)/Administrator with falls with major injuries.

The facility staff interviews obtained during the investigation of Resident#8's injury of unknown injury were reviewed and are documented in part, as follows::

Statement from CNA #13 who worked 11/7 on 10/23/20:
Accident date: 10/24/20
"This morning I was with Name (Resident #8), I directed him to his room. As I was standing in the hall at his (Resident #8's) door, he got up and walked to the sink, got on the floor. I yelled to them (Registered Nurse(RN) #2 and Licensed Practical Nurse #5) Name (Resident #8) is on the floor. I said Name (Resident #8) get up, he did. Then he walked out to the hall, holding on to the rail, then he fell on the floor in the hall. The 2 nurses (RN #2 and LPN #5) came to him. It was change of shift. My relief came, I told her what was going on and I left the floor."

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495150 | A. BUILDING _____ B. WING _____ | C 09/30/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BIRCHWOOD PARK REHABILITATION | 340 LYNN SHORES DRIVE VIRGINIA BEACH, VA 23452 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 842 | Continued From page 128 | F 842 | | |

Statement from LPN #5 who worked 7-3 on 10/24/20:
"On 10/24/2020 I came on shift at 7 a.m., Name (Resident #8) was in his room. Night shift CNA came to desk saying that patient was crying out in pain. Night shift nurse and I went down to see patient and he was crying that his right knee was hurting. Patient was given as needed tylenol throughout the day. patient was limping throughout the hall and I kept redirecting him to sit down and not walk on injured leg. X-ray was done on my shift."

Statement from RN #2 who worked 11-7 on 10/23/20:
Dated 10/29/20
"On 10/21 at around 0400(4:00 a.m.), I noticed resident walking out of his room, Name (CNA #13) was redirecting him back to his room. I continued doing my rounds. When I walked past the resident's room I saw the CNA sitting in a wheelchair watching over him. She said she was making sure that the resident will stay in bed and would not fall. I went to see the resident and asked how's he doing. He said his right knee hurts. I asked him if he fell, he said no. I asked him what happened, he said, "I don't know". I asked him to flex his leg, he said it hurts. I assessed for any visible trauma, there was none. CNA was in the room all this time. So I emailed the MD (medical doctor) requesting for a stat x-ray related to right knee pain, placed the order to Name (mobile x-ray company) and endorsed the incident to the incoming LPN."

CNA #13 is no longer employed with the facility, the Director of Nursing provided the employee's phone number to surveyor. This surveyor

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495150 | A. BUILDING _____ B. WING _____ | C 09/30/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BIRCHWOOD PARK REHABILITATION | 340 LYNN SHORES DRIVE VIRGINIA BEACH, VA 23452 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 842 | Continued From page 129 | F 842 | | |

attempted to call CNA #13 on 9/22/21 a total of 8 times. With each call the phone was answered by someone briefly speaking Spanish, them the call was immediately disconnected. No opportunity was given for a voice message to be left.

On 9/21/21 at 12:06 p.m., a phone interview was conducted with LPN #5. LPN #5 was asked to explain her involvement with Resident #8 on the morning of 10/24/20. LPN #5 stated, "I was the 7-3 nurse that morning and I was relieving Name (RN #2). Name (RN #2) and I were at the nurses desk and the CNA (CNA #13) came up right around 7 because it was shift change and said Name (Resident #8) had fallen in the hall. We (RN #2) and I got up and went to his room. Name (RN #2) assessed him. When she assessed him, he complained of right leg pain. She said she would call the doctor and for me to give him some tylenol. Name (RN #2) told me before she left that she called the doctor and got an order for an x-ray of the right knee. She said she put the order in and for me to watch for them (mobile x-ray) to come. The x-ray was done on my shift. When I left, I told the next shift what happened and that we were waiting on the x-ray results. LPN #5 was asked if she documented anything about the resident's fall or the assessment oh her shift. LPN #5 stated, No, I thought she (RN#2) was going to document everything that happened and that she called the doctor."

On 9/23/21 at 3:06 p.m., an interview was conducted with RN #2. RN #2 was asked to review her written statement dated 9/29/20 and

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495150 | A. BUILDING _____ B. WING _____ | C 09/30/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BIRCHWOOD PARK REHABILITATION | 340 LYNN SHORES DRIVE VIRGINIA BEACH, VA 23452 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 842 | Continued From page 130 | F 842 | | |

asked if her incident date of 10/21 was correct. RN #2 stated, "No, the date on the statement should have been 10/23/20, the 10/21 was the wrong date. RN #2 was asked to explain what care she provided to Resident #8 on the morning of 10/24/20. RN #2 stated, "It was around 3 am, Name (Resident #8) is an early riser and he is in and out of his room all day. Name (CNA #13) redirected him back to his room. I was walking back to the nurses station and I saw Name (CNA #13) and Name (Resident #8) in his room. When I walked by Name (CNA #13) said Name (Resident #8) was complaining of pain in his right or left knee, I can't remember which one. I went into the room and pulled down his pants, there was no bruising. I asked him where the pain was, he said his knee. I asked him if he fell and he said no, I asked Name (CNA #13) if he fell and she said no. I did range of motion on the leg and he said, "oh that hurts". I told him I would email the doctor and get an x-ray. I let the oncoming nurse know that the mobile x-ray had been called to do the x-ray."

RN #2 was asked if CNA #13 came to the nurses station that morning around the change of shift and alerted her and LPN #5 that Resident #8 had fallen in the hall. RN #2 stated, "No he didn't fall in the hall. I did tell the oncoming nurse about what had happened, that he had knee pain and I assessed him."

RN #2 was asked if she documented her assessment of Resident #8, that the physician was called and the orders she received. RN #2 stated, No, I couldn't find anything in the nurses notes, but I did email the doctor.: RN #2 was asked why she didn't document the care she

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495150 | A. BUILDING _____ B. WING _____ | C 09/30/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BIRCHWOOD PARK REHABILITATION | 340 LYNN SHORES DRIVE VIRGINIA BEACH, VA 23452 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 842 | Continued From page 131 | F 842 | | |

provided Resident #8. RN #2 stated, "It just slipped my mind. I was in a rush to get the order from the doctor. I figured that would be my proof that I did something. I know now that emailing does not take the place of documenting because if you don't chart it, then there is no proof the care was given.:

Resident #8's Progress Notes were reviewed and revealed no entries from RN #2 regarding a fall, an assessment, physician notification or follow-up orders for Resident #8 during her 11-7 shift on 10/23/20.

On 9/28/21 at 10:50 a.m., an interview was conducted with the Director of Nursing (DON) regarding RN #2 failing to document a fall, a resident assessment, physician notification or follow-up orders on 10/23/20 for Resident #8. The DON stated, "Name (RN #2) should have documented the fall, her full assessment of the resident, that the physician was called and the follow-up orders she received. Documentation allows for continuity of care to continue for the resident with the next shifts. When there is no documentation we have no idea what has been done."

On 9/29/21 at 1:30 p.m., an interview was conducted with the Administrator and asked what were his expectations for ensuring resident records were complete and accurate. The Administrator stated, "The nurse who the incident was reported to failed to document what she had done. The doctor was notified and the x-rays were done. We just failed to document. I expect

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495150 | A. BUILDING _____ B. WING _____ | C 09/30/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BIRCHWOOD PARK REHABILITATION | 340 LYNN SHORES DRIVE VIRGINIA BEACH, VA 23452 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 842 | Continued From page 132 | F 842 | | |

all staff to document all care rendered to the residents so the clinical record will be complete."

The facility policy titled "Maintenance of Electronic Clinical Records" dated 11/1/20 was reviewed and is documented in part, as follows:

Policy: The facility will maintain electronic clinical records for each resident in accordance with acceptable standards of practice.

Policy Explanation and Compliance Guidelines:
1. A complete and accurate electronic clinical record will be maintained on each resident and kept accessible and systematically organized for appropriate personnel to deliver the appropriate level of care for each resident while maintaining the confidentiality of the resident's information

On 9/30/21 at 6:42 p.m., a pre-exit debriefing was conducted with the Administrator, the acting Director of Nursing, the Regional Director of Clinical Services and the Regional Director of Operations, where the above information was shared. Prior to exit no further information was shared.
2. The facility staff failed to maintain a complete and accurate clinical record for Resident #93. The resident was admitted to the nursing facility on 09/11/19. Diagnosis for Resident #93 included but not limited to Chronic Myeloid Leukemia and Muscle Weakness.

The most recent Minimum Data Set (MDS - an assessment protocol) a Medicare 5-day assessment with an Assessment Reference Date (ARD) of 09/18/19 coded Resident #93 with a 14 out of a possible score of 15 on the Brief

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495150 | A. BUILDING _____ B. WING _____ | C 09/30/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BIRCHWOOD PARK REHABILITATION | 340 LYNN SHORES DRIVE VIRGINIA BEACH, VA 23452 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 842 | Continued From page 133 | F 842 | | |

Interview for Mental Status (BIMS), indicating no cognitive impairment. The MDS coded Resident #93 with total dependence of one with bathing, extensive assistance of one with bed mobility, transfer, dressing, toilet use and personal hygiene and supervision with set-up help only with eating for Activities of Daily Living (ADL) care.

During the review of Resident #93's clinical record revealed the following documents: Vital signs, progress notes and daily skilled notes since admission, pain, mobility and skin assessment dated 09/11/19 and an incomplete list of physician orders. There were no other documents located in the resident's clinical record under their current software program Point Click Care (PCC).

On 09/29/21 at approximately 10:30 a.m., a phone interview was conducted with the Administrator, Regional Director of Clinical Services, MDS Coordinator and Infection Preventionist/Staff Development Coordinator. The MDS Coordinator reviewed Resident #93's clinical record then stated, "His clinical record is not complete, the clinical record is missing the Hospital Discharge Summary, Admission Agreement, hospital Medication Administration Record (MAR) and hospital Treatment Administration Record (TAR), hospital progress notes, insurance information, admission paperwork etc." The Regional Director of Clinical Services said when Resident #93 was admitted to the facility on (09/11/19) the facility was not completely integrated with the software program Point Click Care (PCC) and that paper charting was still being utilized. The Administration team said they will reach out to the Regional Vice

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495150 | A. BUILDING _____ B. WING _____ | C 09/30/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BIRCHWOOD PARK REHABILITATION | 340 LYNN SHORES DRIVE VIRGINIA BEACH, VA 23452 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 842 | Continued From page 134 | F 842 | | |

President of Clinical Services for assistance.

On 09/30/21 at approximately 1:44 p.m., the Regional Vice President of Clinical Services provided a letter that read: "Resident #93 was admitted to the facility on 9/11/2019 and was discharged from the facility on 9/20/2019. During that time period the facility used PCC as the Electric Medical Record (EMR). The PCC was not fully integrated at the time nor did the facility use all the functions of PCC. The facility was acquired on 7/1/2019 from (name of previous nursing home). The facility transitioned the EMR from American HealthTech (AHT) to PCC over the following weeks and much of the medical records during that timeframe would have been completed on paper. These records would have included physician orders, Medication Administration Records, Treatment Administration Records, Care Plans, and paper medical records being scanned into the Documents tab. The facility medical records department has reached out to Iron Mountain (offsite document storage) in an attempt to locate the paper medical record, in addition reached out to (name of pharmacy) to get copies of any documents, physician orders, or hospital records that may have been sent to the pharmacy. If we are able to obtain these records we will reach out to the survey team and provide them with the requested medical records."

On 09/30/21 at approximately 2:03 p.m., an email was received from the Regional Vice President of Clinical Services that read in part: "The only additional documents obtained were the admission physician orders that were faxed to the pharmacy and the manifest. The documents have been uploaded in Resident #93's record and can now can be viewed in PCC."

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495150 | A. BUILDING _____ B. WING _____ | C 09/30/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BIRCHWOOD PARK REHABILITATION | 340 LYNN SHORES DRIVE VIRGINIA BEACH, VA 23452 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 842 | Continued From page 135<br><br>The Administrator, Interim Director of Nursing, Chief Operating Officer, Regional Director of Operations and Regional Director of Clinical Services was informed of the findings during the exit meeting on 09/30/21 at approximately 7:40 p.m. The facility did not have any further questions or present any further information about the findings. | F 842 | | |
| F 867 SS=F | COMPLAINT DEFICIENCY<br>QAPI/QAA Improvement Activities<br>CFR(s): 483.75(g)(2)(ii)<br><br>§483.75(g) Quality assessment and assurance.<br><br>§483.75(g)(2) The quality assessment and assurance committee must:<br>(ii) Develop and implement appropriate plans of action to correct identified quality deficiencies;<br>This REQUIREMENT is not met as evidenced by:<br>Based on deficiencies determined during this survey the QAA (Quality Assessment and Assurance) and Quality Assurance and Performance Improvement (QAPI) committee failed to develop and implement corrective plans of action and monitoring to ensure the necessary systems were in place and correct identified quality deficiencies during a major outbreak of SARS-CoV-2 in the facility beginning 08/28/2021. Immediate Jeopardy to the resident health and safety was identified on 09/23/21 in the area of Infection Control at (F-880 and F886) at a scope and severely level 4 Widespread (L) which constituted Substandard Quality of Care. | F 867 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495150 | A. BUILDING _____ B. WING _____ | C 09/30/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BIRCHWOOD PARK REHABILITATION | 340 LYNN SHORES DRIVE VIRGINIA BEACH, VA 23452 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 867 | Continued From page 136<br>The findings included:<br><br>On 9/23/21 at 8:37 p.m., the facility Administrator, Director of Nursing and three Corporate Consultants were informed of the above Immediate Jeopardy concerns at F-880; Infection Prevention and Control Program secondary to an outbreak of SARS-CoV-2 infections within the facility. On the same day and at the same time, the Administrator, Director of Nursing and three Corporate Consultants were also informed of the above Immediate Jeopardy concerns at F-886; COVID-19 Testing; during an outbreak of SARS-CoV-2 infections within the facility. Observations were made of staff non-compliance with screening, improper use Personal Protective Equipment (PPE), no post visual signs at the entrance and/or in strategic places with instructions about current Infection Prevention Control recommendations related to SARS-CoV-2, staff's inability to provide documentation of staff and resident vaccination status, cumulative clinical data of cases of SARS-CoV-2 infections, and measures/practices and the necessary systems were in place and correct identified quality deficiencies to protect the health and safety of the residents during a major outbreak of SARS-CoV-2 in the facility.<br><br>The QAPI document was received via email from the Admission Coordinator on 09/21/21 at approximately 2:52 p.m. The most recent QAPI meeting was held on 09/14/21, when the facility was already in a major outbreak of SARS-CoV-2. The facility also provided the attendance sheet which showed all the required members were present. | F 867 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495150 | A. BUILDING _____ B. WING _____ | C 09/30/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BIRCHWOOD PARK REHABILITATION | 340 LYNN SHORES DRIVE VIRGINIA BEACH, VA 23452 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 867 | Continued From page 137 | F 867 | | |

Review of the facility's QAPI for 09/14/21 did not provide any evidence a system in place for routine monitoring of managing residents with suspected or confirmed SARS-CoV-2, screening of visitors and healthcare personnel, monitoring of unvaccinated employees, improper wear of Personal Protective Equipment (PPE), cumulative clinical data of cases of SARS-CoV-2 infections and unit set up in accordance with CDC Guidelines.

On 09/29/21 at approximately 10:30 a.m., a phone interview was conducted with the Administrator, Regional Director of Clinical Services, MDS Coordinator and Infection Preventionist (IP)/Staff Development Coordinator (SDC). The IP said the issues related to the most recent outbreak was discussed and acted upon during the QAPI meeting held on 09/14/21. IP stated, "I will get that information to you right away.

After several attempts to reach the IP via phone on 09/29/21, the IP was reached on 09/30/21 at approximately 8:43 a.m., who stated, "I' not able to provide evidence that the issues that were discussed during the QAPI meeting held on 09/14/21 related to the recent outbreak of COVID-19 on 08/28/21 was every addressed by me or the QAA committee.

A phone interview was conducted with the Administrator on 09/30/21 at approximately 2:27 p.m., who stated, "The COVID-19 outbreak

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495150 | A. BUILDING _____ B. WING _____ | C 09/30/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BIRCHWOOD PARK REHABILITATION | 340 LYNN SHORES DRIVE VIRGINIA BEACH, VA 23452 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 867 | Continued From page 138 | F 867 | | |

started in the facility on 08/28/21 and we had our QAPI meeting on 09/14/21. He said IP should have started COVID education once we (QAA meeting) realized there was an outbreak on 08/28/21 and that training and education should have continued until everyone were reeducated and the QAA committee should have put the necessary steps inn place to identify the cause and correct the issue (outbreak of COVID-19) in the building.

A phone interview was conducted with the Administrator on 09/30/21 at approximately 2:27 p.m., who stated that the facility had a QAPI meeting on 09/14/21 but did not address the issues related to the recent outbreak of COVID-19 within the facility. He said an action plan should have been put in place to address the recent outbreak but that did not occur.

The QAA committee is responsible for identify and correcting identified quality deficiencies. The facility was not able to provide evidence that the facilities QAA meeting had a systematic plan in place to maintain and improve the safety and quality in the facility involving the resident and staff and took the necessary steps to identify the cause and correct the problem.

The Administrator, Interim Director of Nursing, Chief Operating Officer, Regional Director of Operations and Regional Director of Clinical Services was informed of the findings during the exit meeting on 09/30/21 at approximately 7:40 p.m. The facility did not have any further questions or present any further information

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495150 | A. BUILDING _____ B. WING _____ | C 09/30/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BIRCHWOOD PARK REHABILITATION | 340 LYNN SHORES DRIVE VIRGINIA BEACH, VA 23452 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 867 | Continued From page 139<br>about the findings.<br><br>The facility's policy titled Quality Assessment and Assurance Committee (QAA) - revision date 10/22/20. This facility will maintain a (QAA) Committee to identify quality issues and develop appropriate plans of action to correct quality deficiencies through an interdisciplinary approach.<br><br>Policy Explanation and Compliance Guidelines include but not limited to:<br><br>4. The QAA committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAA program. The committee will:<br>-Meet at least quarterly and as needed.<br>-Provide oversite of the QAPI program.<br>-Identify and respond to quality deficiencies throughout the facility.<br>-Develop and implement corrective plans of action, and monitor to ensure performance goals or targets are achieved and sustained.<br><br>The facility's policy titled Quality Assurance and Performance Improvement (QAPI) - revision date 12/22/20. It is the policy of the facility to develop, implement, and maintain an effective, comprehensive, data driven QAPI program that focuses on indicators of the outcomes of care and quality of life.<br><br>Policy Explanation and Compliance Guidelines | F 867 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495150 | A. BUILDING _____ B. WING _____ | C 09/30/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BIRCHWOOD PARK REHABILITATION | 340 LYNN SHORES DRIVE VIRGINIA BEACH, VA 23452 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 867 | Continued From page 140<br>include but not limited to:<br>-Develop and implement appropriate plans of action to correct identified quality deficiencies.<br><br>3. The QAPI plan will address the following elements:<br>-Process for addressing how the committee will conduct activities necessary to identify and correct quality deficiencies. Key components of this process include, but are not limited to, the following: Tracking and measuring performances, establishing goals and thresholds for performance improvements, identifying and prioritizing quality deficient, systematically analyzing underlying causes of systemic quality deficiencies, developing and implementing corrective action or performance improvement activities and a process to ensure care and services delivered meet acceptable standards of quality. | F 867 | | |
| F 880 SS=L | Infection Prevention & Control<br>CFR(s): 483.80(a)(1)(2)(4)(e)(f)<br><br>§483.80 Infection Control<br>The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.<br><br>§483.80(a) Infection prevention and control program.<br>The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:<br><br>§483.80(a)(1) A system for preventing, identifying, | F 880 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495150 | A. BUILDING _____ B. WING _____ | C 09/30/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BIRCHWOOD PARK REHABILITATION | 340 LYNN SHORES DRIVE VIRGINIA BEACH, VA 23452 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 880 | Continued From page 141 | F 880 | | |

reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and
(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.

§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495150 | A. BUILDING _____ B. WING _____ | C 09/30/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BIRCHWOOD PARK REHABILITATION | 340 LYNN SHORES DRIVE VIRGINIA BEACH, VA 23452 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 880 | Continued From page 142 | F 880 | | |

corrective actions taken by the facility.

§483.80(e) Linens.
Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.

§483.80(f) Annual review.
The facility will conduct an annual review of its IPCP and update their program, as necessary.
This REQUIREMENT is not met as evidenced by:
Based on observations, resident interviews and staff interviews on all four resident living areas, and review of facility documentation, the facility's staff failed to follow Centers for Disease Control and Prevention (CDC) guidance to establish an infection control program to ensure SARS-CoV-2 infection control measures/practices were in place during a major SARS-CoV-2 outbreak and to prevent further transmission, severe infections, hospitalizations and deaths which constituted immediate jeopardy at F880 (L) in the following specific areas:

The facility failed to provide accurate documentation of their COVID-19 surveillance and data analysis including line listings of infections and vaccination status of resident and HCP; which was necessary for early detection to enable a response to a SARS-CoV-2 outbreak and to report SARS-CoV-2 infections information to Public Health Authorities.

The facility failed to post visual signs at the entrance and/or in strategic places with instructions about current Infection Prevention Control recommendations related to

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495150 | A. BUILDING _____ B. WING _____ | C 09/30/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BIRCHWOOD PARK REHABILITATION | 340 LYNN SHORES DRIVE VIRGINIA BEACH, VA 23452 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 880 | Continued From page 143 | F 880 | | |

SARS-CoV-2.

The facility failed to adhere to the CDC recommended screening process to identify anyone entering the facility who was positive for SARS-CoV-2 or with symptoms of COVID-19.

The facility failed to quarantine residents with suspected or confirmed SARS-CoV-2 infection including new admissions and re-admissions during an outbreak for 6 residents (Resident #21, #73, #90, #53, #16, and #65) of 42 residents in the survey sample.

The facility staff failed to ensure facemasks were well-fitting and worn to cover the nose and mouth, and ensure that HCP caring for SARS-CoV-2 positive residents are using full PPE (gowns, gloves, eye protection, and N95 or higher-level respirator).

On 9/23/21 at 8:37 p.m., the facility Administrator, Director of Nursing and three Corporate Consultants were informed that the above non-compliance constituted Immediate Jeopardy at F-880; Infection Prevention and Control Program secondary to an outbreak of SARS-CoV-2 infections within the facility at a scope and severity level 4 widespread (L) which constituted Substandard Quality of Care.

The survey team validated the plan of removal through observations, interviews and review of facility documents and the Immediate Jeopardy was removed on 9/30/21 at 4:25 p.m. The deficient practice was decreased to an "F" (potential for more than minimal consequence).

The facility's final cumulative of data provided on

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495150 | A. BUILDING _____ B. WING _____ | C 09/30/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BIRCHWOOD PARK REHABILITATION | 340 LYNN SHORES DRIVE VIRGINIA BEACH, VA 23452 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 880 | Continued From page 144 | F 880 | | |

9/30/21 disclosed from 8/28/21 through 9/30/21; there were fifty-three SARS-CoV-2 positive residents, nineteen were hospitalized, one remained in the hospital and nine died. The cumulative of SARS-CoV-2 positive staff was six, one staff was hospitalized and died, four staff returned to work and no staff was still in quarantine. The facility stated they felt this was accurate but was unable to attest it was one hundred percent accurate.

The findings included:

1A. The facility staff failed to provide accurate documentation of their COVID-19 surveillance and data analysis including line listings of infections and vaccination status of resident and HCP; which was necessary for early detection to enable a response to a SARS-CoV-2 outbreak.

Multiple times on 9/21/21 interviews were attempted with the Infection Preventionist (IP) to review the line listing of SARS-CoV-2 cases in the facility including residents and staff. Each time the IP would leave for she desired to review the documents on her computer. Even after bringing in the computer to review the line listing she was unable to definitely provide the requested numbers. She stated the cases are not adding up correctly. The IP stated the outbreak began 8/28/21 when an alert and oriented resident (Resident #90) tested positive after a Rapid test. She was not certain of the symptoms the resident presented with prior to the test but she stated the resident was symptomatic and a PCR test was performed as a result of the positive Rapid test. The PCR test results were also positive.

Another interview was attempted with the IP on

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495150 | A. BUILDING _____ B. WING _____ | C 09/30/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BIRCHWOOD PARK REHABILITATION | 340 LYNN SHORES DRIVE VIRGINIA BEACH, VA 23452 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 880 | Continued From page 145 | F 880 | | |

9/22/21 at approximately 10:10 a.m., to obtain a cumulative of SARS-CoV-2 cases since the beginning of the pandemic was requested as well as the number of cases in-house on 9/20/21, when the survey team entered the facility. The IP stated she thought there were 36 in-house cases on 9/20/21 but the numbers still weren't adding up therefore; she needed to review the line listing to get an official count. The IP was also asked to provide the number of hospitalized residents/staff, number of deceased residents/staff, and the number/name of residents/staff who were vaccinated.

On 9/22/21 at approximately 3:15 p.m., the IP stated she believed there were 19 SARS-CoV-2 cases in the facility when the survey team arrived on 9/20/21 but she still wasn't sure of the cumulative since the pandemic began. At approximately 4:15 p.m., the Regional Clinical Reimbursement Consultant (RCRC) stated the IP wasn't able to assist further with the SARS-CoV-2 statistics because she would be rendering direct care therefore; she would be calculating the numbers.

On 9/24/21 at approximately 11:20 a.m., the RCRC provided the following numbers as an accurate cumulative of the facility SARS-CoV-2 cases and the disposition of the affected residents/staff. The cumulative of Residents who tested positive for SARS-CoV-2 was forty-eight. Seven of the forty-eight resident died including one in the facility, seventeen of the cumulative residents were admitted to the hospital, three of the cumulative residents remained in the hospital and thirty-six of the cumulative residents were quarantined in the facility. The cumulative of staff who tested positive for SARS-CoV-2 was eight,

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495150 | A. BUILDING _____ B. WING _____ | C 09/30/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BIRCHWOOD PARK REHABILITATION | 340 LYNN SHORES DRIVE VIRGINIA BEACH, VA 23452 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 880 | Continued From page 146 | F 880 | | |

one staff died, one staff was hospitalized, no staff remained in the hospital, one staff remained quarantined and six staff had returned to work.

On 9/30/21 at approximately 3:15 p.m., the facility stated they had made additional changes to the cumulative number of residents and staff to account for all affected since the outbreak beginning 8/28/21. The cumulative of SARS-CoV-2 positive residents was fifty-three, nineteen were hospitalized, one remained in the hospital and nine died. Six new resident cases were identified 9/27/21 - 9/29/21. The cumulative of SARS-CoV-2 positive staff was six, one staff was hospitalized and died, four staff returned to work and no staff were still in quarantine.

Three pages of emails were provided to the survey team along with documentation of the cumulative data and line listings. An email dated 9/7/21 at 6:02 a.m., stated; we have eight more staff and two staff members who tested positive for SARS-CoV-2. At 7:47 a.m., an email read; another one just tested positive. Its nine now. Another email dated 9/8/21 read; we have two more residents who tested positive for COVID today. An email dated 9/9/21 read; we have two COVID positive residents who expired at the hospital. We also have some new residents who tested positive. I will send an updated line listing later this evening. Another email dated 9/9/21 at 6:04 p.m. read; Attached is a copy of the COVID-19 line list. It seems like 75% of my September positives are residents who are vaccinated. On 9/13/20 an email read A COVID positive staff death at (name of the facility). Have you done the Occupational Safety and Health Administration investigation to determine work relatedness? We need to document thoroughly.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495150 | A. BUILDING _____ B. WING _____ | C 09/30/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BIRCHWOOD PARK REHABILITATION | 340 LYNN SHORES DRIVE VIRGINIA BEACH, VA 23452 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 880 | Continued From page 147 | F 880 | | |

B. The facility staff failed to report SARS-CoV-2 infections information to Public Health Authorities.

The three pages of email chains above revealed the facility staff had a situation too overwhelming for then to manage, yet they failed to notify the health department promptly of the first positive case of SARS-CoV-2, each suspected or confirmed SARS-CoV-2 infection and of additional cases, including residents with severe respiratory infection resulting in hospitalization or death, three residents or HCP with acute illness compatible with COVID-19 with onset within a 72-hour period.An interview was conducted with the Infection Preventionist on 9/24/21 at approximately 3:20 p.m. The Infection Preventionist stated she had not contacted the local Health Department and/or the Epidemiologist in reference to the facility's outbreak or to ask for assistance in managing their rapid increasing number of SARS-CoV-2 positive cases. The Infection Preventionist further stated approximately one week ago the Local Health Department came in on their own to conduct a site visit and offer assistance.

2. The facility failure to post visual signs at the entrance and/or in strategic places with instructions about current Infection Prevention Control recommendations related to SARS-CoV-2.

On 9/20/21 at approximately 7:05 p.m., upon arriving to the facility the only signage at the visitor's entrance read "face mask required at all times". This signage was located to the sides of the door and at a low position. There was no entrance door signage with clear

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495150 | A. BUILDING _____ B. WING _____ | C 09/30/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BIRCHWOOD PARK REHABILITATION | 340 LYNN SHORES DRIVE VIRGINIA BEACH, VA 23452 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 880 | Continued From page 148 | F 880 | | |

information/alerts to visitors. Review of other visitor entrances (kitchen, construction unit and the laundry door connecting with Unit 1) also disclosed no signage.

CDC had recommended that long term care facilities developed a written COVID-19 plan which included; Facilities should encourage visitors to be aware of signs and symptoms of acute respiratory illness consistent with COVID-19 and not enter the facility if they have such signs and symptoms. Visual alerts, such as signs and posters, should be placed at facility entrances and other strategic areas instructing visitors not to enter as a visitor if they have fever or respiratory symptoms. Signage should include signs and symptoms of COVID-19 and who to notify if visitors/staff/vendors have symptoms. (https://www.cdc.gov/coronavirus/2019-ncov/hcp/non-us-settings/hcf-visitors.html).

3. The facility staff further failed to adhere to the CDC recommended screening process to identify anyone entering the facility who was positive for SARS-CoV-2 or with symptoms of COVID-19.

On 9/20/21 at approximately 7:05 p.m., after ringing the doorbell the survey team was allowed to enter the first set of doors where visitors and staff were screened. The staff member stated screening was a self-performed task but assisted us to obtain our temperatures.

After multiple days of reviewing the screening logs the team was unable to account for many on duty staff therefore a review of the screening logs for 9/12/21 - 9/13/21 were reviewed with the staffing coordinator on 9/23/21. The review of 9/12/21 confirmed eleven direct care staff were

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495150 | A. BUILDING _____ B. WING _____ | C 09/30/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BIRCHWOOD PARK REHABILITATION | 340 LYNN SHORES DRIVE VIRGINIA BEACH, VA 23452 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 880 | Continued From page 149 | F 880 | | |

not signed in as screened. The review of 9/13/21 confirmed there were seven direct care staff who did not sign in as screened. On 9/12/21 - 9/13/21 many support staff wasn't verified. Another screening review was conducted of the facility's personnel on duty 9/20/21. The review disclosed seven direct care staff and eleven support staff had not signed in as screened. Many of the facility Healthcare Personnel (HCP) were foregoing the screening process by entering and exiting the facility through various doors. The outcome of foregoing the screening resulted in a breach in the infection prevention and control (IPC) protocol as evidenced by continuous newly diagnosed residents with SARS-CoV-2 infections, some resulting in hospitalizations and/or death. After this was brought to the facility staff attention on 9/23/21, staff was assigned to carryout screening.

According to the April 27, 2021, Centers for Medicare and Medicaid Services (CMS) Memo QSO20-39-NH, Guidance for Infection Control and Prevention of COVID-19, nursing homes should follow the Core Principles of COVID-19 Infection Prevention. One of the Core Principles read; Screening of all who enter the facility for signs and symptoms of COVID-19 (e.g., temperature checks, questions about and observations of signs or symptoms), and denial of entry of those with signs or symptoms or those who have had close contact with someone with COVID-19 infection in the prior 14 days (regardless of the visitor's vaccination status). HCP should not work while acutely ill, even if SARS-CoV-2 testing is negative, in order to minimize the risk of transmission of other infectious pathogens, including respiratory pathogens such as influenza. All visitors should

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495150 | A. BUILDING _____ B. WING _____ | C 09/30/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BIRCHWOOD PARK REHABILITATION | 340 LYNN SHORES DRIVE VIRGINIA BEACH, VA 23452 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 880 | Continued From page 150 | F 880 | | |

sign in and out on a visitor's log.

4. The facility staff failed to manage residents with suspected or confirmed SARS-CoV-2 infection including new admissions and re-admissions during an outbreak, and to manage staffing of HCP who worked a COVID positive unit and immediately afterward worked a Well unit.

A. On 9/28/21 at approximately 4:00 p.m., a review of resident readmissions/admission was conducted with the DON. The DON stated Resident #21 was readmitted to the facility from the hospital 9/1/21 with a diagnosis of sepsis related to a urinary tract infection and the resident tested negative for SARS-CoV-2 prior to leaving the hospital. The DON stated they elected not to quarantine Resident #21 an unvaccinated resident, after an eight day hospital stay because of the negative SARS-CoV-2 test and for resident safety related to impaired cognition, gait problems and behaviors. Resident #21 was re-admitted to the Memory Unit. The DON further stated they didn't have a quarantine unit for residents who resided on the Memory Unit.

B. On 9/23/21 at approximately 8:30 a.m., Resident #73 was observed sitting in a wheelchair in his doorway.

Resident #73 was originally admitted to the facility 8/24/21 and had never been discharged from the facility. The current diagnoses included; diabetes and high blood pressure.

The admission Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 8/31/21 coded the resident as

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495150 | A. BUILDING _____ B. WING _____ | C 09/30/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BIRCHWOOD PARK REHABILITATION | 340 LYNN SHORES DRIVE VIRGINIA BEACH, VA 23452 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 880 | Continued From page 151 | F 880 | | |

completing the Brief Interview for Mental Status (BIMS) and scoring 13 out of a possible 15. This indicated Resident #73's cognitive abilities for daily decision making were intact.

The resident stated he was moving off the COVID-19 positive unit that day. Resident #73 stated he was vaccinated and had never tested positive for SARS-CoV-2. The resident further stated he was admitted to the room in August and he was told 9/22/21 that he no longer needed to quarantine and he would be moved. Review of the resident's clinical record revealed he was admitted to the facility 8/24/21. Resident #73 a fully vaccinated had resided on a COVID-19 positive unit from 8/28/21 - 9/22/21.

On 9/28/21 at approximately 4:00 p.m., a review of Resident #73's admission was conducted with the Director of Nursing (DON). The DON stated Resident #73 was admitted to the room on the Admitting Unit prior to the outbreak of SARS-CoV-2 cases and he remained there to complete his period of quarantine.

On day one of the survey, the survey team made observations to determine how the facility was managing admissions/re-admission of residents. Designated rooms for quarantine were not identified for residents returning to the facility after hospitalization or for pending and newly confirmed positive resident within the facility. On 9/29/21 at approximately 1:55 p.m., the survey team addressed this concern with the facility's team including five corporate consultants. Corporate Consultant #4 stated there was a designated quarantine unit and ask what happened to it. The Administrator stated the positive cases resulted in them outgrowing the

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495150 | A. BUILDING _____ B. WING _____ | C 09/30/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BIRCHWOOD PARK REHABILITATION | 340 LYNN SHORES DRIVE VIRGINIA BEACH, VA 23452 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 880 | Continued From page 152 | F 880 | | |

COVID-19 positive unit therefore; they didn't have quarantine rooms and new admissions would not be accepted because of the vast number of SARS-CoV-2 positive cases.

An email dated 8/28/21 in reference to the first positive resident case of SARS-CoV-2 read; do you have a COVID unit set up? What will you do if the PCR is positive? Please let us know the results when you know them.

The facility COVID-19 Action Plan dated 7/30/21, read there would be three units set-up for the resident population in accordance with CDC Guidelines. The Units were described as a Well/Cool Unit, a Quarantine/Warm Unit for new admission and readmissions and an Isolation/Hot Unit for COVID-19 positive residents. The facility only had one general well unit, one well memory unit, one COVID-19 positive memory unit and one full COVID-19 positive unit. Facilities should create a plan for managing new admissions and readmissions. In general, all new admissions and readmissions should be placed in a 14-day quarantine, even if they have a negative test upon admission. Exceptions include residents within 3 months of a SARS-CoV-2 infection and fully vaccinated residents. (https://www.vdh.virginia.gov/content/uploads/sites/182/2020/10/VDH-COVID-19-Guidance-for-Nursing-Homes.pdf)

C. Resident #90 was originally admitted to the facility 5/14/19 and readmitted 9/3/21 after an acute care hospital stay, returning to the facility 9/9/21. The current diagnoses included; SARS-CoV-2 infection and Multiple Sclerosis.

The quarterly Minimum Data Set (MDS)

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495150 | A. BUILDING _____ B. WING _____ | C 09/30/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BIRCHWOOD PARK REHABILITATION | 340 LYNN SHORES DRIVE VIRGINIA BEACH, VA 23452 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 880 | Continued From page 153 | F 880 | | |

assessment with an assessment reference date (ARD) of 9/16/21 coded the resident as not completing the Brief Interview for Mental Status (BIMS). The staff interview was coded for intact long and short term memory as well as modified independence with daily decision making.

A physician's progress note dated 9/3/21 at 10:15 a.m., read; Evaluation following positive COVID-19 test. Resident #90 is seen today for follow-up after a positive COVID-19 test. The resident is currently symptomatic with low grade fevers, positive for Shortness of Breath/Cough, Oxygen saturation at 85% on Room Air. Chest X-Ray shows a Left Lower Lobe pneumonia. Facility unable to obtain the monoclonal antibody infusion from Maryland. Advised nursing to send to Emergency Department for infusion. Resident was subsequently admitted for COVID-19 pneumonia. The resident was readmitted to the facility 9/9/21.

Upon entering Resident # 90's room on 9/23/21 at approximately 9:45 a.m., a sheet was observed on the floor and on top of the sheet were elimination saturated towels, a gown and used gloves. Resident #90; a SARS-CoV-2 infected resident; was in bed uncovered and without clothing. The resident stated he no longer felt sick and presented without shortness of breath, cough, diaphoresis or fatigue. Shortly afterwards the wound care Nurse Practitioner and LPN #3 entered the resident's room to assess the resident's impaired skin. After the wound care Nurse Practitioner completed her assessment she stepped on the sheet and soiled linen, proceeded out the room and off the unit with the same dirty shoe protectors on.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495150 | A. BUILDING _____ B. WING _____ | C 09/30/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BIRCHWOOD PARK REHABILITATION | 340 LYNN SHORES DRIVE VIRGINIA BEACH, VA 23452 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 880 | Continued From page 154 | F 880 | | |

D. Observation of multiple resident room on the COVID-19 positive unit revealed no trash bags in the trash cans in most rooms, the hallway was with dried brownish spill areas, paper, used gloves and other debris. There were no clean gowns on the unit to be utilized by the staff, the clean linen cart cover was up exposing all the linen and stacks of what appeared to be clean linen was observed in chairs and sitting on top of furniture in rooms in approximately five rooms.

An interview was conducted with the DON on the COVID-19 positive unit on 9/23/21 at approximately 10:05 a.m. The DON stated she didn't agree with the manner the staff allowed Resident #90 to handle his soiled linen but it was the practice. The DON also stated she would have Environmental Services to come immediately to clean the unit and add liners to the trash cans. As the DON walked the hallway she instructed staff to cover the clean linen and remove linen from resident rooms.

E. Review of staff scheduling revealed on 9/24/21, LPN #7 worked a COVID-19 positive Unit from 11:00 - 7:30 a.m., afterwards working from 7:30 a.m. - 3:30 p.m., on a Well Unit. An interview was conducted with LPN #7 on 9/26/21 at approximately 10:25 a.m. LPN #7 stated she knew it appeared she hadn't been home but she works sixteen hours most days on the same unit and is off for eight hours. LPN #7 didn't say anything about working a positive unit before working a negative unit.

The facility COVID-19 Action Plan update 7/30/21 read; Staff have been assigned to work only on COVID or quarantined or non-affected units/wings/rooms. Staff assignments are

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495150 | A. BUILDING _____ B. WING _____ | C 09/30/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BIRCHWOOD PARK REHABILITATION | 340 LYNN SHORES DRIVE VIRGINIA BEACH, VA 23452 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 880 | Continued From page 155 | F 880 | | |

documented and time reconciled daily.

An interview was conducted with the DON on 9/28/21 at approximately 4:45 p.m. The DON stated staff are scheduled to remain on the COVID positive unit if they worked the COVID positive unit their first shift and they are working a double shift. She further stated if a staff worked the Well unit the first shift they may work the COVID positive unit the second shift.

An interview was conducted with the Medical Director on 9/28/21 at 11:20 a.m. The Medical Director stated the facility staff informed him of the Immediate Jeopardy status on 9/24/21 and they conducted a Quality Assurance meeting 9/26/21 to discuss the SARS-CoV-2 status and means to improve infection control practices in the facility. The Medical Director stated he was aware of the outbreak but he wasn't aware of the cumulative data since the outbreak occurred. He assured us he was notified of cases as they occur but not as cumulative data. The Medical Director stated SARS-CoV-2 infections can be deadly and following CDC guidelines were the expectation of all staff in the facility. The Medical Director further stated education of the staff would be the most effective method to achieve compliance and he would assure regardless of the consequences including disciplinary action that all non-compliance be eradicated.

5. The facility staff failed the implement source control, in accordance with CDC guidance and FDA guidance.

A. On 9/20/21, after the screening process, the team was allowed to enter the second set of doors into the reception area of the facility. The

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495150 | A. BUILDING _____ B. WING _____ | C 09/30/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BIRCHWOOD PARK REHABILITATION | 340 LYNN SHORES DRIVE VIRGINIA BEACH, VA 23452 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 880 | Continued From page 156 | F 880 | | |

team was met by the Director of Nursing who stated the personal protective equipment (PPE) facility wide included an N-95 mask. The Director of Nursing of Nursing was observed wearing an N-95 below her nose at that time and during most interactions with her. Various types of mask were observed donned by the facility staff but regardless of the types of mask, worn most were not appropriately positioned to cover the nose and mouth.

B. On 9/20/21 at approximately 8:05 p.m., LPN # 6 was observed exiting from the zipped wall of the COVID-19 positive unit wearing an N-95 mask not completely covering the nose and she was observed adjusting it.

C. On 9/22/21 at approximately 10:35 a.m., CNA #5 was observed in the hallway wearing an N-95 mask which wasn't well-fitting and clearly without a tight seal.

D. On 9/26/21 at approximately 10:25 a.m., LPN #7 was observed seated at the nursing station on a COVID positive unit with the facemask around her neck leaving her nose and mouth completely uncovered.

E. On 9/26/21 at approximately 10:27 a.m., CNA #9 was observed in the Dayroom on a COVID positive unit talking to another CNA; five residents were present and CNA #9's facemask was off exposing her nose and mouth. CNA #9 stated "I can't breathe when wearing this mask".

An emailed dated 8/12/21 was sent to the facility's Administrator from a Consultant. It read; during a Huddle call (name of the staff member) reminded that all staff must be masked. Meaning

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495150 | A. BUILDING _____ B. WING _____ | C 09/30/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BIRCHWOOD PARK REHABILITATION | 340 LYNN SHORES DRIVE VIRGINIA BEACH, VA 23452 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 880 | Continued From page 157 | F 880 | | |

over the nose. (Name of the staff member) witnessed staff during rounds and nurses sitting at the desk without mask.

F. On 9/23/21 at approximately 8:45 a.m., on a COVID-19 positive Unit CNA #3 was observed putting her gown on the handrail in the hallway. CNA #3 proceeded in the hallway with a water pitcher in hand which was brought off of a SARS-CoV-2 infected resident's room (Resident #47). After filling the water pitcher with ice CNA #3 proceeded back into the resident's room without a gown on (it was still hanging on the handrail). CNA #3 stood in front of the SARS-CoV-2 infected resident and assisted him to drink water afterwards; the resident began to cough weakly. CNA #3 left the resident's bedside washed her hands, picked up a bag of soiled linen from the floor and proceeded into the next room with the soiled linen.

An interview was conducted with CNA #3, on 9/23/21 at approximately 8:55 a.m., she stated she was fully vaccinated and had never tested positive for SARS-CoV-2. CNA #3 stated she had the gown on but forgot to put it back on when she went in to get Resident #47's water pitcher. CNA #3 removed the gown from the handrail and said "here it is".

An interview was conducted with Resident #47 on 9/23/21 at approximately 9:00 a.m.

Resident #47 was originally admitted to the facility 12/26/11 and readmitted 4/29/21 after an acute care hospital stay. The resident was discharged again from the facility 9/23/21 to an acute care hospital "for respiratory distress and wet lungs". The current diagnoses included; SARS-CoV-2

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495150 | A. BUILDING _____ B. WING _____ | C 09/30/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BIRCHWOOD PARK REHABILITATION | 340 LYNN SHORES DRIVE VIRGINIA BEACH, VA 23452 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 880 | Continued From page 158 | F 880 | | |

infection, hemiparesis and urinary retention.

The quarterly Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 8/12/21 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 14 out of a possible 15. This indicated Resident #47's cognitive abilities for daily decision making were intact.

Resident #47 was very short of breath, diaphoretic and constantly requesting water. Observation of the indwelling catheter system revealed a very soiled and coiled catheter leg strap and a catheter drainage bag with approximately 200 milliliters of dark yellow urine.

An interview was conducted with LPN #7 on 9/23/21 at approximately 9:13 a.m., regarding the resident's weak state. LPN #7 stated since the resident was diagnosed with a SARS-CoV-2 infection, the resident's physically abilities had declined to the point he was unable to hold his water pitcher.

On 9/30/21 at approximately 6:30 p.m., the above information was reviewed with the Administrator, Interim Director of Nursing, and Regional Director of Operations, Regional Reimbursement Consultant and the Regional Director of Clinical Services. The Regional Director of Clinical Services stated corrective action had started and compliance of the facility Infection Control COVID-19 policies in accordance with the CDC and the Virginia Department of Health would include ongoing monitoring by the Administrator.

6. The facility staff failed to move Resident #53 a COVID-19 positive resident

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495150 | A. BUILDING _____ B. WING _____ | C 09/30/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BIRCHWOOD PARK REHABILITATION | 340 LYNN SHORES DRIVE VIRGINIA BEACH, VA 23452 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 880 | Continued From page 159 | F 880 | | |

from a non-COVID unit to a COVID positive unit timely (2 days later).

Resident #53 was admitted to the facility on 10/11/13 with diagnoses which included hemiplegia, insomnia, type 2 diabetes, major depression, convulsions, hypothyroidism, cerebral infarction, cognitive impairment and contracture of left hand.

In the area of Cognitive Patterns Brief Interview for Mental Status (BIMS) this resident was coded as a 15. A Care Plan dated 09/25/21 indicated: Focus- COVID-19 active diagnosis. Resident #53 was identified as able to move around using a wheelchair.

Resident #53, who resided on a non-COVID-19 unit, was observed on 09/20/21 at 7:53 P.M. and 09/21/21 at 9:43 A.M. seated in a wheelchair in her room (#25) door way. Resident #53 was also observed using the bathroom in her room that was shared with her roommate at 11:15 A.M. on 09/21/21 who was COVID-19 negative at time. Resident #53 was observed without a mask.

On 09/21/21 Resident #53 was identified as COVID-19 positive. Resident #53 was observed moving in and out of her room with the door open. There was no signage observed on the outside door of this room indicating infection control measures and practices were in place.

Resident #53 remained in her room (#25) for two days before moved on 9/23/21 across the hall to room 26 as the only resident in a semi-private

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495150 | A. BUILDING _____ B. WING _____ | C 09/30/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BIRCHWOOD PARK REHABILITATION | 340 LYNN SHORES DRIVE VIRGINIA BEACH, VA 23452 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 880 | Continued From page 160 | F 880 | | |

room (#26), but still on the non-COVID unit. Resident #53's bed linen, personal items, unfinished orange juice and food container were observed in room #25 until 9/30/21. Resident #53's previous roommate (Resident #65) was identified as COVID-19 positive on 09/27/21.

7. The facility staff failed to move Resident #16, who was COVID-19 Positive and living on a non-COVID unit to a COVID unit in a timely manner (3 days later).

Resident #16 was admitted to the facility on 04/17/12 with diagnoses which included schizoaffective disorder, cervical spinal cord sequela, spinal stenosis, chronic pain, hypertension, dysphasia and mood disorder.

Resident #16 was identified as COVID-19 positive on 09/22/21. Resident #16 was living on Unit II, a non-COVID Unit in room #22.

Resident #16 was not transferred out of bedroom #22 until 09/25/21. Resident #16's bed linen, personal items and food container remained in his room until 09/30/21.

Resident #16's floor, bed and other areas of the room remained un-sanitized and not cleaned. There was no signage observed on the outside door of this room indicating infection control measures and practices were in place.

8. The facility staff failed to move Resident #65, a COVID-19 positive resident, from a non-COVID unit to a COVID unit in a timely manner (2-days).

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495150 | A. BUILDING _____ B. WING _____ | C 09/30/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BIRCHWOOD PARK REHABILITATION | 340 LYNN SHORES DRIVE VIRGINIA BEACH, VA 23452 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 880 | Continued From page 161 | F 880 | | |

Resident #65 was admitted to the facility on 02/27/20. Diagnoses for this resident included dementia, COPD, cerebral infarction, depression, dysphasia, and hypertension.

A Quarterly Minimum Data Set (MDS) coded this resident in the area of Cognitive Patterns - with a BIMS score of 13. Resident #65 was assessed in the area of ADLs as being able to walk and transfer with one person physical assist. This resident was assessed as steady at all times when walking.

A Care Plan dated 09/21/21 indicated: Focus- The resident is an elopement risk/wander due to impaired awareness; Goal- The resident's safety will be maintained through the review date. Interventions- Distract resident from wandering by offering pleasant diversions, activities, food, conversation, television, book.

Resident #65 was identified as COVID-19 positive on 09/27/21. Resident #65's Roommate, Resident #53, was identified as COVID-19 positive on 09/21/21. Resident #53 remained in the room with Resident #65 for two days after testing positive for COVID-19.

Resident #65 was observed moving in and out of her room with the door open at 9:43 A.M. on 09/21/21 and at 2:43 P.M. and 09/22/21. Staff were observed on 09/21/22 at 9:15 A.M. assisting Resident #65 with

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495150 | A. BUILDING _____ B. WING _____ | C 09/30/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BIRCHWOOD PARK REHABILITATION | 340 LYNN SHORES DRIVE VIRGINIA BEACH, VA 23452 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 880 | Continued From page 162 | F 880 | | |

removal of her breakfast tray.
Staff were not wearing PPE. Resident #65 was observed walking around in the room on several occasions. There was no signage observed on the outside door of this room indicating infection control measures and practices were in place.

9. The facility staff failed to ensure infections control measures were consistently implemented to prevent the development and/or transmission of a communicable disease (COVID-19), and other infectious diseases by not wearing the required N95 masks or improperly wearing the required facial coverings.

A. On 09/20/21 at approximately 7:05 p.m., upon facility entrance Dietary Staff member #3 was observed sitting in a chair in the dining room with no facial covering on. Sitting less than four feet near him was dietary staff member #4 with no facial covering. They appeared to be playing a video game. The surveyor was screened at the entrance then entered into the dining area where the two facility staff were seen. She asked Dietary staff member #4 where was his mask. He stated, that he didn't think he needed to wear his mask because he wasn't around residents.

B. On 9/21/21 at approximately 10:10 AM. FSD/OSM (Food Service Director/Other Staff Member) #5 was seen wearing his N95 mask with his nose exposed on several occasions during the kitchen inspection.

C. On 9/21/21 at approximately 12:00 PM, District Dietary Manager (OSM) #6 was interviewed concerning wearing his surgical mask in the kitchen. He stated, "N95 Masks are required only

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495150 | A. BUILDING _____ B. WING _____ | C 09/30/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BIRCHWOOD PARK REHABILITATION | 340 LYNN SHORES DRIVE VIRGINIA BEACH, VA 23452 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 880 | Continued From page 163 | F 880 | | |

inside COVID-19 restricted areas. The dietary staff don't enter those areas."

D. On 9/23/21 at approximately, 10:30 AM Dietary staff (OSM) #18 was interviewed concerning her surgical mask. She stated, " I have a N95 mask that I wear in the hallway. Some people wear this one (Surgical Mask) and some wear the other one (N95). I don't know anything about getting FIT tested. I know that nursing was tested. I got the N95 a month ago. When Unit 1 was shut done everybody had one."

E. On 9/26/21 at 10:50 AM Dietary Aide (OSM) #21 Observed sitting in the dining room with no mask on. She immediately put it on when she saw the said surveyor. The Administrator also witnessed her without a mask on and putting it back on immediately. He said that he had educated her about the importance of wearing a mask at all times while here. He said she told him that she didn't think she needed a mask on because no one was in the dining area but her."

Throughout the survey many of the above staff members were observed not wearing a facial covering or not wearing their facial covering properly.

On 09/30/21 at approximately 6:20 p.m., the above findings were shared with the Administrator, and Corporate Staff Members. An opportunity was offered to the facility's staff to present additional information but no additional information was provided.

10. The facility staff failed to ensure 3 outside Independent (Name) construction workers and 1

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495150 | A. BUILDING _____ B. WING _____ | C 09/30/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BIRCHWOOD PARK REHABILITATION | 340 LYNN SHORES DRIVE VIRGINIA BEACH, VA 23452 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 880 | Continued From page 164 | F 880 | | |

child who were unvaccinated were screened for signs and symptoms of Covid-19 and followed appropriate source control of facemask's when they entered the facility on 9/28/21 through a back door where the building was being refurbished, to prevent the spread of Covid-19.

On 9/28/21 at 10:45 a.m. a walk-through was conducted on Unit 4. Unit 4 was empty due to a facility refurbishment in progress. During the walk-through 3 construction workers and 1 child was observed on Unit 4. In the dining room two of the construction workers and the child were observed painting. The third construction worker was down the short hall installing ceiling tiles. All 4 individuals were observed without facemasks.

On 9/28/21 at 10:50 a.m., at the nurses station on the short hall a clipboard with Covid-19 sign in/out logs was found and reviewed for 9/28/21 screening entries. There were no entries for 9/28/21 on the Covid-19 screening logs and there was no thermometer with the logs either.

On 9/28/21 at 10:55 a.m., Construction worker #10 who was on the short hall was asked if he had completed the Covid-19 screening log when he entered the facility today. Construction worker #10 stated, "No English". Construction worker #10 opened his phone, and was able to speak using a Spanish to English translator application. Construction worker #10 stated, "No, didn't sign in yesterday or today, no ink." Construction worker #10 was asked if he had been vaccinated for Covid-19. Construction worker #10 stated, "No vaccine."

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495150 | A. BUILDING _____ B. WING _____ | C 09/30/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BIRCHWOOD PARK REHABILITATION | 340 LYNN SHORES DRIVE VIRGINIA BEACH, VA 23452 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 880 | Continued From page 165<br><br>On 9/28/21 at 11:05 a.m., Construction worker #11 and Construction worker #9 who were painting in the Unit 4 dining room with the child were asked if they had completed the Covid-19 screening log when they entered the facility today. Construction worker #9 stated, "We forgot to sign in yesterday and today. We just came back yesterday, we haven't been in the building for 30 days." Construction worker #9 was asked if the 3 of them were vaccinated and if anyone in the facility had informed them that the building was experiencing a Covid -19 outbreak and that facemask's were required. Construction worker #9 stated, "No one is vaccinated. We have masks but no one from the facility told us to wear the masks or anything about the covid."<br><br>On 9/28/21 at approximately 4:30 p.m., the Administrator, the Regional Director of Clinical Services and the Regional Director of Operations were made aware of the above observations. The Regional Director of Operations stated, "All construction was supposed to be stopped at the end of August when the outbreak started. There should not be anyone back there at all."<br><br>On 9/29/21 at approximately 3:30 p.m., the Regional Director of Clinical Services stated, "We have place signage at the side construction entrance of the facility indicating to vendors that the facility is in a Covid-19 outbreak status and visitation is restricted as of 7/28/21. Signage in Spanish was also placed on the construction door prohibiting entrance until further notice. The construction supervisor was notified a second time that all construction must stop and workers | F 880 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495150 | A. BUILDING _____ B. WING _____ | C 09/30/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BIRCHWOOD PARK REHABILITATION | 340 LYNN SHORES DRIVE VIRGINIA BEACH, VA 23452 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 880 | Continued From page 166 | F 880 | | |

are not authorized to be in the building until further notice. Also the Administrator will walk the construction unit twice daily to assure workers do not enter."

The facility policy titled "Novel Coronavirus Prevention and Response" dated 3/2020 was reviewed and is documented in part, as follows:

Policy: The facility will respond promptly upon suspicion of illness associated with a novel coronavirus in efforts to identify, treat, and prevent the spread of the virus.

Policy Explanation and Compliance Guidelines:

5. Interventions to prevent the introduction of respiratory germs into the facility:
a. Post signs or posters at the entrance instructing visitors about wearing a cloth face covering or facemask. Restrict visitors in accordance with local, state, and national directives.
f. Assess visitors and healthcare personnel, regardless of vaccination status, for symptoms of Covid-19. This can include, but not limited to:
i. Individual screening on arrival at the facility.
ii. Implementation of an electronic monitoring system in which, prior to arrival at the facility, people report absence of fever and symptoms of Covid-19, absence of a diagnosis of Covid-19 infection in the prior 10 days, and confirmation they have not been exposed to others with Covid-19 infection during the prior 14 days.

On 9/30/21 at 6:42 p.m., a pre-exit debriefing was conducted with the Administrator, the acting Director of Nursing, the Regional Director of

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495150 | A. BUILDING _____ B. WING _____ | C 09/30/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BIRCHWOOD PARK REHABILITATION | 340 LYNN SHORES DRIVE VIRGINIA BEACH, VA 23452 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 880 | Continued From page 167 | F 880 | | |

Clinical Services and the Regional Director of Operations, where the above information was shared. Prior to exit no further information was shared.

The following Immediate Jeopardy Abatement Plan for F-tag 880 signed by the Administrator on 09/30/21 was provided to the survey team:
1. Corrective Actions
"A. The facility placed signage at the front entry door, dietary entrance door and, the side construction entrance indicating to staff, residents, visitors, and vendors that the facility is in a COVID-19 outbreak status and visitation is restricted on 9/28/2021. The signage (also in Spanish) for the construction door prohibits entrance until further notice. The construction supervisor was notified on 9/23/2021 and 9/27/2021 that all construction must stop, and workers are not authorized to be in the building until further notice. The Nursing Home Administrator/designee will walk the construction unit twice daily to assure workers do not enter.

B. The facility staff were provided additional and appropriate PPE for isolation units with enhanced droplet precautions on 9/24/2021. The Regional Director of Clinical Services (RDCS) made rounds and verified PPE was available and that staff were wearing PPE appropriately on 9/29/2021. Surgical masks are required when in the facility. Sign posted at doorway. Signage was posted throughout the facility for donning and doffing procedures, hand hygiene, and masking requirements on 9/25-9/26/2021. Education was provided to unit staff regarding PPE requirements beginning 9/24/2021 and will continue until all covid unit staff are being educated. Education will

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495150 | A. BUILDING _____ B. WING _____ | C 09/30/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BIRCHWOOD PARK REHABILITATION | 340 LYNN SHORES DRIVE VIRGINIA BEACH, VA 23452 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 880 | Continued From page 168 | F 880 | | |

be completed by 10/1/2021.

C. Facility COVID-19 surveillance plan was updated 9/29/21 to accurately reflect the status of residents, staff, vendors, and contractors of the facility which includes vaccination status. Ongoing updates will be provided by the Infection Preventionist as vendors and contractors arrive. Vendors and contractors will be questioned prior to entrance regarding vaccination and testing status. Any person not able to provide proof of this information will be rapid tested upon entrance by the Infection Preventionist or assigned team member. Staff assigned to monitor the front entrance will be educated on the requirements to clarify covid vaccine and/or testing status.

D. Rooms 50-59 are designated as the quarantine unit. Residents have been moved to accommodate this change. Room changes are completed as of 9/30/2021 to create a 10 bed unit for quarantine. The Director of Nursing observed Unit 1 & 5 set up to assure it was in accordance with CDC and VDH Guidelines on 9/27/2021. Enhanced droplet precaution signs were placed on each resident room door and doors were closed on 9/27/2021. Clean and soiled areas were reestablished to separate and identify the two areas more clearly. All covid positive residents were re-established to separate and identify the two areas more clearly. All covid positive residents on Unit 5 have been resolved. Precautions for these residents have been discontinued on 9/27/2021. Dementia residents with a covid positive status will isolate in place. They will be provided increased supervision that will ensure transmission-based precautions are maintained in their current setting to decrease episodes of increased behaviors.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495150 | A. BUILDING _____ B. WING _____ | C 09/30/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BIRCHWOOD PARK REHABILITATION | 340 LYNN SHORES DRIVE VIRGINIA BEACH, VA 23452 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 880 | Continued From page 169<br><br>The survey team validated the plan of removal through observations, interviews and review of facility documents and the Immediate Jeopardy was removed on 9/30/21 at 4:25 p.m. The deficient practice was decreased to an "F" (potential for more than minimal consequence). | F 880 | | |
| F 881 SS=E | Antibiotic Stewardship Program<br>CFR(s): 483.80(a)(3)<br><br>§483.80(a) Infection prevention and control program.<br>The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:<br><br>§483.80(a)(3) An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use.<br>This REQUIREMENT is not met as evidenced by:<br>Based on information gleamed during the Antibiotic Stewardship task, staff interview, and clinical record review, the facility's staff failed to have a system to ensure that an antibiotic was prescribed based on laboratory results and/or clinical signs and symptoms of true infections when prescribing an antibiotic for 1 of 42 residents (Resident #75), in the survey sample.<br><br>The findings included:<br><br>Resident #75 was originally admitted to the facility 1/3/19 and readmitted 6/21/20 after an acute care hospital stay. The current diagnoses included; Alzheimer's disease.<br><br>The quarterly Minimum Data Set (MDS) | F 881 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495150 | A. BUILDING _____ B. WING _____ | C 09/30/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BIRCHWOOD PARK REHABILITATION | 340 LYNN SHORES DRIVE VIRGINIA BEACH, VA 23452 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 881 | Continued From page 170 | F 881 | | |

assessment with an assessment reference date (ARD) of 8/27/21 coded the resident as not having the ability to complete the Brief Interview for Mental Status (BIMS). The staff interview was coded for long and short term memory problems as well as severely impaired daily decision making abilities.

In section "G" (Physical functioning) the resident was coded as requiring total care of two people with transfers, personal hygiene, dressing and bathing, total care of one person with on unit locomotion, extensive assistance of two with bed mobility.

An interview was conducted with the Infection Preventionist (IP) during the Antibiotic Stewardship review on 09/28/21 12:34 p.m. A 7/19/21 Practitioner's progress note read "Her 7/14 UA/CS reported 25,000 CFU/ML Proteus Mirabilis - orders to Repeat UA C&S" (A sensitivity analysis is a method to determine if bacteria are resistant to certain drugs).

The IP stated Resident #75 had a urinalysis/culture and sensitivity (C&S) ordered 7/20/21 and the results were received 7/23/21. The lab results were not available on the resident's clinical record but the IP was able to obtain the information from her records. The results were 100,000 CFU/ML (E-coli) but; the resident was asymptomatic for a UTI and the clinical record offered no signs/symptoms related to an acute infection.

The Practitioner ordered Keflex 500 milligrams, one capsule by mouth four times each day for seven days.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495150 | A. BUILDING _____ B. WING _____ | C 09/30/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BIRCHWOOD PARK REHABILITATION | 340 LYNN SHORES DRIVE VIRGINIA BEACH, VA 23452 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 881 | Continued From page 171<br>The list of antibiotics the bacteria was susceptible (antibiotic is effective against the bacteria.) was reviewed by the IP; the antibiotics Keflex was not listed. The antibiotic was not adjusted to to a drug the bacteria was susceptible to and resident completed the seven day course of Keflex; an antibiotic the bacteria wasn't susceptible.<br><br>On 9/30/21 at approximately 6:30 p.m., the above findings were shared with the Administrator, Director of Nursing and Corporate Consultants. An opportunity was offered to the facility's staff to present additional information or comment but no additional information was provided. | F 881 | | |
| F 883 SS=E | Influenza and Pneumococcal Immunizations<br>CFR(s): 483.80(d)(1)(2)<br><br>§483.80(d) Influenza and pneumococcal immunizations<br>§483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that-<br>(i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization;<br>(ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period;<br>(iii) The resident or the resident's representative has the opportunity to refuse immunization; and<br>(iv)The resident's medical record includes documentation that indicates, at a minimum, the following:<br>(A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza | F 883 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495150 | A. BUILDING _____ B. WING _____ | C 09/30/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BIRCHWOOD PARK REHABILITATION | 340 LYNN SHORES DRIVE VIRGINIA BEACH, VA 23452 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 883 | Continued From page 172 | F 883 | | |

immunization; and
(B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal.

§483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that-
(i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization;
(ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized;
(iii) The resident or the resident's representative has the opportunity to refuse immunization; and
(iv)The resident's medical record includes documentation that indicates, at a minimum, the following:
(A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and
(B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal.
This REQUIREMENT is not met as evidenced by:
Based on resident interview, staff interview, and clinical record review, the facility staff failed to provide documentation in the resident's clinical record of the immunization and the administration or the refusal of or medical contraindications to vaccines for 3 of 42 residents (Resident #50, 24

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495150 | A. BUILDING _____ B. WING _____ | C 09/30/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BIRCHWOOD PARK REHABILITATION | 340 LYNN SHORES DRIVE VIRGINIA BEACH, VA 23452 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 883 | Continued From page 173 | F 883 | | |

and 5 ), in the survey sample.

The findings included:

1. Resident #50 was originally admitted to the facility 8/7/21 and was discharged to an acute care hospital 9/3/21, returning to the facility on 9/8/21. The current diagnoses included; SARS-CoV-2 infection, urinary tract infection, diabetes, high blood pressure and strokes.

The significant change Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 9/15/21 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 7 out of a possible 15. This indicated Resident #50's cognitive abilities for daily decision making were severely impaired. The resident did not answer questions when asked.

Review of Resident #50's 9/8/21 hospital discharge summary revealed the resident received one dose of the Moderna vaccine 2/21 and it would be necessary for the resident to receive the second dose. The clinical record revealed no immunization information except on the MDS. The MDS was coded not in the facility during the flu season to receive the vaccination and the Pneumococcal Immunization wasn't offered.

An interview was conducted with the Regional Reimbursement Consultant (RRC) on 9/23/21 at 11:45 a.m. The RRC stated the resident was offered and declined the Pneumococcal vaccine and a modification had been completed on the 8/12/21 MDS assessment to reflect the new information. Documents were presented as

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495150 | A. BUILDING _____ B. WING _____ | C 09/30/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BIRCHWOOD PARK REHABILITATION | 340 LYNN SHORES DRIVE VIRGINIA BEACH, VA 23452 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 883 | Continued From page 174 | F 883 | | |

printed on 9/23/21 from the hospital data system which provided the following information: Pneumococcal vaccine13 (PCV13) vaccine received 1/29/14, Pneumococcal vaccine23 (PCV23) administered 1/29/13, COVID-19 vaccine Moderna 5/15/21 and Influenza vaccine 8/1/21.

If Pneumococcal vaccine23 (PPSV23) was administered prior to age 65 years, administer 1 dose PPSV23 at least 5 years after previous dose (https://www.cdc.gov/vaccines/schedules/hcp/imz/adult.html#note-pneumo)

On 9/30/21 an additional review of the resident's clinical record was made. The above information still wasn't documented in the record.

On 9/30/21 at approximately 6:30 p.m., the above information was reviewed with the Administrator, Interim Director of Nursing, Regional Director of Operations, Regional Reimbursement Consultant and the Regional Director of Clinical Services. An opportunity was afforded for presentation of additional information but they did not.

2. Resident #24 was originally admitted to the facility 7/15/20 and readmitted 3/22/21 after an acute care hospital stay. The current diagnoses included; stroke with right hemiparesis, COPD and a seizure disorder.

The quarterly, Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 9/14/21 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 14 out of a possible 15. This indicated Resident 24's cognitive abilities for daily

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495150 | A. BUILDING _____ B. WING _____ | C 09/30/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BIRCHWOOD PARK REHABILITATION | 340 LYNN SHORES DRIVE VIRGINIA BEACH, VA 23452 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 883 | Continued From page 175 | F 883 | | |

decision making were intact.

On 9/27/21 at approximately 12:40 p.m. an interview was conducted with Resident #24. The resident stated he hadn't received the COVID-19 vaccination but he wants all three of his shots. The records provided by the Infection Preventionist stated the resident's consent wasn't completed therefore; the vaccine wasn't administered. The clinical record revealed the Influenza vaccine was administered 11/6/20 in the facility, the Pneumococcal vaccine information was only available on the MDS assessment. It was coded as not offered.

On 9/30/21 at approximately 12:05 p.m., the IP provided a consent form indicating the responsible party for Resident #24 authorized administration of the Pneumococcal vaccine23 and the Influenza vaccine for this flu season. Status of consent for the COVID-19 vaccination is unknown. The IP stated if a resident refuses a vaccine at intervals (quarterly) it should be reoffered but this resident's problem was consents.

On 9/30/21 at approximately 6:30 p.m., the above information was reviewed with the Administrator, Interim Director of Nursing, Regional Director of Operations, Regional Reimbursement Consultant and the Regional Director of Clinical Services. An opportunity was afforded for presentation of additional information but they did not.

3. Resident #5 was originally admitted to the facility 7/18/20 and the resident has never been discharged from the facility. The current diagnoses included; dementia, .

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495150 | A. BUILDING _____ B. WING _____ | C 09/30/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BIRCHWOOD PARK REHABILITATION | 340 LYNN SHORES DRIVE VIRGINIA BEACH, VA 23452 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 883 | Continued From page 176 | F 883 | | |

The quarterly Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 9/6/21 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 13 out of a possible 15. This indicated Resident #5's cognitive abilities for daily decision making were intact.

Review of the resident's clinical record revealed no information the COVID-19 was administered. The resident tested COVID-19 positive 8/31/21. The clinical record revealed neither the Pneumococcal vaccine23 or the Influenza vaccine for the previous flu season had been administered. An Influenza consent form dated 11/14/20 was in the clinical record.

An interview was conducted with the RRC on 9/23/21 at 11:45 a.m. The RRC stated the 9/6/21 MDS assessment was coded the resident was not offered the flu vaccine and the Pneumococcal vaccine was offered and decline but the Pneumococcal vaccine coding was incorrect for the resident wasn't offered the vaccine. The RRC stated a modification had been completed on the 9/6/21 MDS assessment to reflect the new information.

On 9/23/21 at 10:20 a.m. and interview was conducted with Resident #5. The resident stated he had not received the COVID-19 vaccine or any other vaccine that he could recall.

The IP stated if a resident doesn't have a consent; at intervals (quarterly) an attempt should be made to obtain consent. Resident #5 needed consents for Pneumococcal vaccine23, this season Influenza vaccine and the COVID-19

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495150 | A. BUILDING _____ B. WING _____ | C 09/30/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BIRCHWOOD PARK REHABILITATION | 340 LYNN SHORES DRIVE VIRGINIA BEACH, VA 23452 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 883 | Continued From page 177<br>vaccine when be becomes eligible to receive it.<br><br>On 9/30/21 at approximately 6:30 p.m., the above information was reviewed with the Administrator, Interim Director of Nursing, Regional Director of Operations, Regional Reimbursement Consultant and the Regional Director of Clinical Services. An opportunity was afforded for presentation of additional information but they did not. | F 883 | | |
| F 885 SS=E | Reporting-Residents,Representatives&Families<br>CFR(s): 483.80(g)(3)(i)-(iii)<br><br>§483.80(g) COVID-19 reporting. The facility must—<br><br>§483.80(g)(3) Inform residents, their representatives, and families of those residing in facilities by 5 p.m. the next calendar day following the occurrence of either a single confirmed infection of COVID-19, or three or more residents or staff with new-onset of respiratory symptoms occurring within 72 hours of each other. This information must—<br><br>(i) Not include personally identifiable information;<br>(ii) Include information on mitigating actions implemented to prevent or reduce the risk of transmission, including if normal operations of the facility will be altered; and<br>(iii) Include any cumulative updates for residents, their representatives, and families at least weekly or by 5 p.m. the next calendar day following the subsequent occurrence of either: each time a confirmed infection of COVID-19 is identified, or whenever three or more residents or staff with new onset of respiratory symptoms occur within 72 hours of each other. | F 885 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495150 | A. BUILDING _____ B. WING _____ | C 09/30/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BIRCHWOOD PARK REHABILITATION | 340 LYNN SHORES DRIVE VIRGINIA BEACH, VA 23452 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 885 | Continued From page 178 | F 885 | | |

This REQUIREMENT is not met as evidenced by:
Based on resident interview, clinical record review, and review of facility documents, the facility staff failed to provide cumulative updates for residents, their representatives, and families at least weekly or by 5 p.m. the next calendar day following the subsequent occurrence of either: each time a confirmed infection of COVID-19 is identified, or whenever three or more residents or staff with new onset of respiratory symptoms occur within 72 hours of each other.

The findings included:

During an interview with the Infection Preventionist (IP) on 9/22/21 at 10:10 a.m., she stated the SARS-CoV-2 outbreak began 8/28/21 when an alert and oriented resident tested positive after a Rapid test. The resident was confirmed positive on 8/31/21 after the Polymerase Chain Reaction (PCR) test results were received.

The IP stated on 8/30/21 all residents in the facility except the first resident who tested positive were tested with the rapid antigen test for the SARS-CoV-2 infection and the test results revealed multiple positive cases. The IP stated as a result of the rapid test, PCR test were performed and the results were available to the facility staff 9/1/21. The IP stated the COVID-19 unit was built because of the number of SARS-CoV-2 positive cases. The facility staff was unable to provide documentation that residents, their representatives, and families were informed of subsequent occurrences.

The IP stated on 9/7/21 outbreak testing

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495150 | A. BUILDING _____ B. WING _____ | C 09/30/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BIRCHWOOD PARK REHABILITATION | 340 LYNN SHORES DRIVE VIRGINIA BEACH, VA 23452 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 885 | Continued From page 179 | F 885 | | |

continued for all residents who previously tested negative and the results were available to the facility 9/9/21. The results disclosed more SARS-CoV-2 positive cases.

The IP stated on 9/13/21 outbreak testing continued for all residents who previously tested negative and the results were available to the facility 9/15/21. The results disclosed more SARS-CoV-2 positive cases.

The IP stated on 9/21/21 outbreak testing continued for all residents who previously tested negative and the results were available to the facility 9/22/21. The results disclosed more SARS-CoV-2 positive cases.

The Regional Director of Clinical Services stated facility wide rapid testing of all negative residents was completed 9/25/21 through 9/29/21 and six residents tested positive for SARS-CoV-2.

A random sample of residents and families revealed they were notified of the 8/28/21 SARS-CoV-2 positive case. Notification of residents, their representatives, and families of subsequent occurrences of SARS-CoV-2 case weren't documented.

On 9/28/21 at approximately 12:59 p.m., the Administer provided a copy of the letter sent to update representatives and families of the facility status. It was dated 8/27/21, the day before the first positive resident SARS-CoV-2 case.

On 9/30/21 at approximately 6:30 p.m., the above information was reviewed with the Administrator, Interim Director of Nursing, Regional Director of Operations, Regional Reimbursement Consultant

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495150 | A. BUILDING _____ B. WING _____ | C 09/30/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BIRCHWOOD PARK REHABILITATION | 340 LYNN SHORES DRIVE VIRGINIA BEACH, VA 23452 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 885 | Continued From page 180<br>and the Regional Director of Clinical Services. The stated they inform residents and some families verbally as well as by email and the 8/27/21 letter was the last update sent. | F 885 | | |
| F 886 SS=L | COVID-19 Testing-Residents & Staff<br>CFR(s): 483.80 (h)(1)-(6)<br><br>§483.80 (h) COVID-19 Testing. The LTC facility must test residents and facility staff, including individuals providing services under arrangement and volunteers, for COVID-19. At a minimum, for all residents and facility staff, including individuals providing services under arrangement and volunteers, the LTC facility must:<br><br>§483.80 (h)((1) Conduct testing based on parameters set forth by the Secretary, including but not<br>limited to:<br>(i) Testing frequency;<br>(ii) The identification of any individual specified in this paragraph diagnosed with<br>COVID-19 in the facility;<br>(iii) The identification of any individual specified in this paragraph with symptoms<br>consistent with COVID-19 or with known or suspected exposure to COVID-19;<br>(iv) The criteria for conducting testing of asymptomatic individuals specified in this paragraph, such as the positivity rate of COVID-19 in a county;<br>(v) The response time for test results; and<br>(vi) Other factors specified by the Secretary that help identify and prevent the<br>transmission of COVID-19.<br><br>§483.80 (h)((2) Conduct testing in a manner that is consistent with current standards of practice for | F 886 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495150 | A. BUILDING _____ B. WING _____ | C 09/30/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BIRCHWOOD PARK REHABILITATION | 340 LYNN SHORES DRIVE VIRGINIA BEACH, VA 23452 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 886 | Continued From page 181<br>conducting COVID-19 tests;<br><br>§483.80 (h)((3) For each instance of testing:<br>(i) Document that testing was completed and the results of each staff test; and<br>(ii) Document in the resident records that testing was offered, completed (as appropriate to the resident's testing status), and the results of each test.<br><br>§483.80 (h)((4) Upon the identification of an individual specified in this paragraph with symptoms<br>consistent with COVID-19, or who tests positive for COVID-19, take actions to prevent the transmission of COVID-19.<br><br>§483.80 (h)((5) Have procedures for addressing residents and staff, including individuals providing services under arrangement and volunteers, who refuse testing or are unable to be tested.<br><br>§483.80 (h)((6) When necessary, such as in emergencies due to testing supply shortages, contact state<br>and local health departments to assist in testing efforts, such as obtaining testing supplies or processing test results.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, resident interviews, staff interviews and review of facility documentation, the facility's staff failed to adhere to the following Centers for Disease Control and Prevention (CDC) guidance to have an established and effective COVID-19 testing program in place during a major SARS-CoV-2 outbreak and to prevent further transmission, severe infections, hospitalizations and deaths which constituted | F 886 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495150 | A. BUILDING _____ B. WING _____ | C 09/30/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BIRCHWOOD PARK REHABILITATION | 340 LYNN SHORES DRIVE VIRGINIA BEACH, VA 23452 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 886 | Continued From page 182 | F 886 | | |

Immediate Jeapardy at a scope and severity level of 4 widespread (L):

The facility failed to ascertain the vaccination status of all Healthcare Personnel (HCP) to determine who was unvaccinated and required expanded screening testing and the facility failed to conduct unvaccinated HCP testing for SARS-CoV-2 infection based on the level of community transmission (high/Red). The facility was broad based testing two times a week.

The facility failed to have documentation that the required testing of the results of unvaccinated HCP including contractors, agencies and vendors was completed and corresponded to the facility's testing frequency.

On 9/23/21 at 8:37 p.m., the facility Administrator, Director of Nursing and three Corporate Consultants were informed of the above Immediate Jeopardy concerns at F-886; COVID-19 Testing; during an outbreak of SARS-CoV-2 infections within the facility which was cited at a scope and severity level of 4 widespread (L) which constituted Substandard Quality of Care.

The survey team validated the plan of removal through observations, interviews and review of facility documents and the Immediate Jeopardy was removed on 9/30/21 at 4:25 p.m. The deficient practice was decreased to an "F" (potential for more than minimum consequence).

During this non-compliance the facility was subject to a major SARS-CoV-2 outbreak with increased transmission of COVID-19, hospitalizations and death. The following

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495150 | A. BUILDING _____ B. WING _____ | C 09/30/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BIRCHWOOD PARK REHABILITATION | 340 LYNN SHORES DRIVE VIRGINIA BEACH, VA 23452 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 886 | Continued From page 183 | F 886 | | |

cumulative data was provided by the facility on 9/30/21. From 8/28/21 to 9/30/21, there were fifty-three SARS-CoV-2 positive residents, nineteen were hospitalized, one remained in the hospital and nine died. The cumulative of SARS-CoV-2 positive staff was six, one staff was hospitalized and died, four staff returned to work and no staff was still in quarantine. The facility stated they felt this was accurate but was unable to attest it was one hundred percent accurate.

The findings included:

1. The facility failed to ascertain the vaccination status of all Healthcare Personnel (HCP) to determine who was unvaccinated and required expanded screening testing and the facility failed to conduct unvaccinated HCP testing for SARS-CoV-2 infection based on the level of community transmission.

Interviews with many of the HCP revealed based on CDC guidelines they met the requirements to be tested (they were unvaccinated) but were not tested based on the level of community transmission for they lacked knowledge related to the testing requirements.

On 9/21/21, the level of community transmission was reviewed for the facility's city's level data. The level was HIGH and the community had been at that level during our review period of 9/12/21 - 9/30/21. The guidance stated when the level of community transmission is HIGH unvaccinated staff must be tested two times each week.

Many of the facility HCP interviewed 9/21/21 - 9/26/21 stated they were unvaccinated and had not tested two times per week from 9/12/21 -

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495150 | A. BUILDING _____ B. WING _____ | C 09/30/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BIRCHWOOD PARK REHABILITATION | 340 LYNN SHORES DRIVE VIRGINIA BEACH, VA 23452 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 886 | Continued From page 184 | F 886 | | |

9/25/21 for various reasons (specifics for each individual).

An interview was conducted with Certified Nursing Assistant (CNA) #4 on 9/23/21 at 2:27 p.m., CNA #4 stated she was unvaccinated, had never tested positive for SARS-CoV-2 and she usually tested approximately one time each week.

An interview was conducted with Physical Therapist Assistant (PTA) #4 on 9/23/21 at 2:33 p.m., PTA #2 stated she was unvaccinated, had never tested positive for SARS-CoV-2 and she had not recently tested but she only worked at the facility as needed.

An interview was conducted with Certified Nursing Assistant (CNA) #6 on 9/26/21 at 10:00 a.m., CNA #6 stated she was unvaccinated, had never tested positive for SARS-CoV-2 and she usually test approximately one time each week. CNA #6 stated she thinks she was lasted tested 9/22/21 by the IP.

An interview was conducted with Dietary staff #15 on 9/24/21 at approximately 12:20 p.m., Dietary staff #15 stated she was unvaccinated, had never tested positive for SARS-CoV-2 and was last tested approximately one week ago because the facility administration doesn't want them walking through the building to get tested.

An interview was conducted with LPN #11 on 9/26/21 at 10:04 a.m., LPN #11 stated she was unvaccinated, had never tested positive for SARS-CoV-2 and she usually tested one to two time each week and she was lasted 9/22/21 at a CVS pharmacy and prior to that 9/18/21 but no one at the facility had ever asked her to provide

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495150 | A. BUILDING _____ B. WING _____ | C 09/30/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BIRCHWOOD PARK REHABILITATION | 340 LYNN SHORES DRIVE VIRGINIA BEACH, VA 23452 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 886 | Continued From page 185 | F 886 | | |

documentation of testing.

An interview was conducted with Certified Nursing Assistant (CNA) #13 on 9/26/21 at 10:19 a.m., CNA #13 stated she was unvaccinated, had tested positive for SARS-CoV-2 February 2021 and she tested 9/25/21 and prior to that she hadn't tested for over a week.

An interview was conducted with LPN #10 on 9/26/21 at 10:27 a.m., LPN #10 stated she was unvaccinated, had never tested positive for SARS-CoV-2 and she was last tested approximately 9/20/21 and hadn't tested since then.

An interview was conducted with Certified Nursing Assistant (CNA) #8 on 9/26/21 at 10:30 a.m., CNA #8 stated she was unvaccinated, had never tested positive for SARS-CoV-2 and she was tested 9/25/21 when she arrived for her shift but prior to that she hadn't been tested since approximately 8/10/21.

An interview was conducted with Dietary staff #20 on 9/28/21 at approximately 10:55 a.m. The Dietary staff #20 stated she was unvaccinated, had tested positive for SARS-CoV-2, January 2021 and was last tested approximately six weeks ago for another.

Dietary staff #20 stated the facility had never asked about the vaccination or requested testing status.

An interview was conducted with Dietary staff #19 on 9/28/21 at approximately 11:05 a.m. The Dietary staff #19 stated she was unvaccinated, had never tested positive for SARS-CoV-2 and

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495150 | A. BUILDING _____ B. WING _____ | C 09/30/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BIRCHWOOD PARK REHABILITATION | 340 LYNN SHORES DRIVE VIRGINIA BEACH, VA 23452 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 886 | Continued From page 186 | F 886 | | |

was last tested approximately two weeks ago for another entity. Dietary staff #19 stated the facility had never asked about her vaccination or requested testing status.

2. The facility failed to have documentation that the required testing of the results of unvaccinated HCP was completed and corresponded to the facility's testing frequency.

On 9/21/21 at approximately 10:25 a.m., HCP testing was observed and the documentation of the testing was reviewed. A review of those listed as tested revealed the HCP name/signature only, no documentation of their test results.

An interview was conducted with the Infection Preventionist (IP) on 9/21/21 at approximately 3:20 p.m., the Infection Preventionist stated testing for HCP was two times weekly (Tuesday and Thursday) based on the level of community transmission and that an undocumented test result indicated the result was negative. The tested HCP results for 9/21/21 remained undocumented throughout the survey.

During an interview with the IP on 9/21/21 at approximately 3:20 p.m., the IP stated all staff testing isn't documented because the licensed nurses who performs the testing often test direct care HCP during their shift and solely provide the HCP with the result. The IP had no documentation indicating which HCP should have been tested, if they had been tested based on the level of community transmission from 9/12/21 - 9/25/21, or documentation the testing was completed along with the results. The IP stated she never followed-up with the licensed nurses to gleam information of HCP testing and results

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495150 | A. BUILDING _____ B. WING _____ | C 09/30/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BIRCHWOOD PARK REHABILITATION | 340 LYNN SHORES DRIVE VIRGINIA BEACH, VA 23452 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 886 | Continued From page 187<br>except if a staff member tested positive.<br><br>An interview was conducted with Licensed Practical Nurse (LPN) #3 on 9/23/21 at 12:04 p.m., LPN #3 stated the Rapid test (The BinaxNOW COVID-19 Ag Card) are used for staff testing and if there is a positive result it is followed-up with a polymerase chain reaction (PCR) test. LPN #3 also stated that the current practice for staff testing is to delegate it to licensed nurses on various shifts and only the Director of Nursing and IP knows where the results are documented for the prior system of documentation was discontinued for the computerized line listing method.<br><br>On 9/30/21 at approximately 6:30 p.m., the above information was reviewed with the Administrator, Interim Director of Nursing, and Regional Director of Operations, Regional Reimbursement Consultant and the Regional Director of Clinical Services. The Regional Director of Operations stated beginning 9/30/21 staff testing and results of unvaccinated employees will be tracked on COVID testing logs. The IP will provide a weekly updated vaccination list to the Administrator/designee who will audit testing three times each week for eight weeks to ensure all unvaccinated staff are in compliance with routine testing according to the level of community transmission<br>3. The facility staff failed to ensure that 3 Independent Contracted Construction Workers and 1 child who were observed on Unit 4 on 9/28/21 working, who admitted to working in the building on 9/27/21 and 30 days prior were tested for Covid-19 based on the facility's testing frequency to coincide with the level of community transmission (HIGH/RED) twice a week. | F 886 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495150 | A. BUILDING _____ B. WING _____ | C 09/30/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BIRCHWOOD PARK REHABILITATION | 340 LYNN SHORES DRIVE VIRGINIA BEACH, VA 23452 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 886 | Continued From page 188 | F 886 | | |

On 9/28/21 at 10:45 a.m. a walk-through was conducted on Unit 4. Unit 4 was empty due to a facility refurbishment in progress. During the walk-through 3 construction workers and 1 child was observed on Unit 4. In the dining room two of the construction workers and the child were observed painting. The third construction worker was down the short hall installing ceiling tiles. All 4 individuals were observed without facemasks.

On 9/28/21 at 10:55 a.m., Construction Worker #10 who was on the short hall was asked if he had ever been tested for Covid-19 by anyone at the facility. Construction Worker #10 stated, "No English". Construction Worker #10 opened his phone, and was able to speak using a Spanish to English translator application. Construction Worker #10 stated, "No tested, no vaccine."

On 9/28/21 at 11:05 a.m., Construction Worker #11 and Construction Worker #9 who were painting in the Unit 4 dining room with the child were asked if they had completed the Covid-19 screening log when they entered the facility today. Construction Worker #9 stated, "We forgot to sign in yesterday and today. We just came back yesterday, we haven't been in the building for 30 days." Construction Worker #9 was asked if the 3 of them were vaccinated and if anyone in the facility had informed them that the building was experiencing a Covid -19 outbreak and that facemask's were required. Construction Worker #9 stated, "No one is vaccinated. We have masks but no one from the facility told us to wear the masks or anything about the covid." Construction Worker #9 was asked if anyone in the facility had ever tested them for Covid-10. Construction Worker #9 stated, "No, we have not

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495150 | A. BUILDING _____ B. WING _____ | C 09/30/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BIRCHWOOD PARK REHABILITATION | 340 LYNN SHORES DRIVE VIRGINIA BEACH, VA 23452 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 886 | Continued From page 189 | F 886 | | |

been tested."

On 9/28/21 at approximately 1:30 p.m., the Infection Preventionist was asked if she has any documentation to show that the 3 construction workers or the 1 child had been tested when they were in the facility 30 days ago or any results that they had been tested on 9/27/21 or 9/28/21 prior to working. The Infection Preventionist was unable to provide the information that was requested.

On 9/28/21 at approximately 4:30 p.m., the Administrator, the Regional Director of Clinical Services and the Regional Director of Operations were made aware of the above observations. The Regional Director of Operations stated, "All construction was supposed to be stopped at the end of August when the outbreak started. There should not be anyone back there at all."

On 9/29/21 at approximately 3:30 p.m., the Regional Director of Clinical Services stated, "We have place signage at the side construction entrance of the facility indicating to vendors that the facility is in a Covid-19 outbreak status and visitation is restricted as of 7/28/21. Signage in Spanish was also placed on the construction door prohibiting entrance until further notice. The construction supervisor was notified a second time that all construction must stop and workers are not authorized to be in the building until further notice. Also the Administrator will walk the construction unit twice daily to assure workers do not enter." The Regional Director of Operations stated, "Beginning 9/31/21 all staff including contracted employees and vendors reporting to work will be required to submit to routine testing per community transmission rates, provide proof

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495150 | A. BUILDING _____ B. WING _____ | C 09/30/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BIRCHWOOD PARK REHABILITATION | 340 LYNN SHORES DRIVE VIRGINIA BEACH, VA 23452 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 886 | Continued From page 190 | F 886 | | |

of recent testing (within 3 days), provide proof of vaccination status, or get tested on their scheduled shift."

The facility policy titled "Novel Coronavirus Prevention and Response" dated 3/2020 was reviewed and is documented in part, as follows:

Policy: The facility will respond promptly upon suspicion of illness associated with a novel coronavirus in efforts to identify, treat, and prevent the spread of the virus.

Policy Explanation and Compliance Guidelines:

4. Considerations/priorities for testing.
c. Testing for COVID-19 will occur for staff or residents with signs and symptoms of COVID-19, outbreaks within the facility and routinely following the frequency guidance according to the facility's level of community transmission.

On 9/30/21 at 6:42 p.m., a pre-exit debriefing was conducted with the Administrator, the acting Director of Nursing, the Regional Director of Clinical Services and the Regional Director of Operations, where the above information was shared. Prior to exit no further information was shared.

An Immediate Jeopardy Abatement Plan for F-tag 886 signed by the Administrator on 09/30/21 was provided to the survey team.

1. The facility performed staff testing of scheduled employees and agency staff 9/25/21-9/30/21. It was discovered that two unvaccinated dietary staff members did not follow

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495150 | A. BUILDING _____ B. WING _____ | C 09/30/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BIRCHWOOD PARK REHABILITATION | 340 LYNN SHORES DRIVE VIRGINIA BEACH, VA 23452 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 886 | Continued From page 191 | F 886 | | |

policy for testing and screening and worked on 9/29/21. Both employees had received education on 9/28/21 and one employee received an additional test reminder on 9/28/21 by the regional director of dining services. Both employees were subsequently tested on 9/29/21 with negative results. Reeducation on policy for testing and screening was provided to dietary staff members on 9/30/21. All staff including contracted employees and vendors reporting to work as of 9/30/21 will be required to submit to routine testing per community transmission rates, provide proof of recent testing (within 3 days), provide proof of vaccination status, or get tested on their scheduled shift. Per CMS guidelines, vaccinated staff members will not be required to submit to routine testing.

2. There was a cumulative total of 53 resident who have tested positive for Covid-19. 9 residents died, 1 died while still at the facility. 19 residents were hospitalized. 1 resident remains hospitalized. 6 staff tested positive for Covid-19. 1 staff member was hospitalized and passed. 4 staff have returned to work, none are on quarantine. Residents on this list who remain in the facility will continue to be monitored and treated under current COVID protocols until their cases have resolved. The center conducted facility wide rapid testing of negative residents 9/25/21 -9/29/21 and six new resident cases were identified. All six residents currently reside on the COVID unit. All residents of the facility have the potential to be affected by the this practice.

3. Staff education was provided on 9/28/21 to employees in the following departments; nursing, environmental services, dietary, maintenance, and administrative staff. Staff education included

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495150 | A. BUILDING _____ B. WING _____ | C 09/30/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BIRCHWOOD PARK REHABILITATION | 340 LYNN SHORES DRIVE VIRGINIA BEACH, VA 23452 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 886 | Continued From page 192<br>CMS guidelines regarding frequency of testing for unvaccinated employees based on level of community transmission. Beginning 9/30/21 no employees will be allowed to return to work until the training has been completed. Training will be provided by the SDC in person or by phone. Staffing coordinator will ensure proof of vaccination status or a recent negative test (within three days) for all agency employees prior to scheduling them to work. Unvaccinated agency staff who have not had a recent test must be tested on their scheduled shift in order to be able to work. Scheduled staff testing will be held Monday and Thursday, however a nurse will be assigned to conduct testing seven days a week for all staff in order to remain in compliance with the testing guidelines. The frequency of scheduled staff will be adjusted to reflect current community transmission rates.<br><br>4. Beginning 9/30/21 staff testing and results for unvaccinated employees will be tracked on COVID testing log. Infection preventionist will provide a weekly updated vaccinated staff list to Administrator or designee who will audit testing log 3 x per week for 8 weeks to ensure all unvaccinated facility staff and unvaccinated contracted staff are in compliance with routine testing according to community transmission rates. Any identified concerns will be immediately corrected. Additional education and disciplinary actions will be taken as appropriate. Results of audits will be summarized and submitted by the Nursing Home Administrator to the QAPI committee for oversight and additional recommendations to this plan. The next QAPI meeting is scheduled for October 13, 2021 and will continue monthly x 6 months to assure ongoing compliance. | F 886 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495150 | A. BUILDING _____ B. WING _____ | C 09/30/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BIRCHWOOD PARK REHABILITATION | 340 LYNN SHORES DRIVE VIRGINIA BEACH, VA 23452 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 886 | Continued From page 193<br><br>5. Medical Director was notified on 9/24/21 of the Immediate Jeopardy status of the facility and actions taken to abate. The facility conducted an AdHoc QAPI meeting on 9/26/21 reviewing and approving the Allegation of Compliance and corrective actions.<br><br>Facility alleges compliance as of 9/30/2021, signed by the Administrator.<br><br>The survey team validated the plan of removal through observations, interviews and review of facility documents and the Immediate Jeopardy was removed on 9/30/21 at 4:25 p.m. The deficient practice was decreased to an "F" (Potential for more than minimal consequence). | F 886 | | |
| F 921 SS=E | Safe/Functional/Sanitary/Comfortable Environ CFR(s): 483.90(i)<br><br>§483.90(i) Other Environmental Conditions<br>The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, record reviews and staff interviews, the facility staff failed to ensure resident rooms who were identified as COVID-19 positive (Resident #16, #27 and #53) were cleaned and sanitized.<br><br>The findings included:<br><br>During the survey on 09/21/21-through 09/30/21 observations were made on Unit II. Resident #16, #27 and #53 were identified as being COVID-19 | F 921 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495150 | A. BUILDING _____ B. WING _____ | C 09/30/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BIRCHWOOD PARK REHABILITATION | 340 LYNN SHORES DRIVE VIRGINIA BEACH, VA 23452 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 921 | Continued From page 194 | F 921 | | |

positive during this time period.

1. Resident #53 was admitted to the facility on 10/11/13 with diagnoses which included hemiplegia, insomnia, type 2 diabetes, major depression, convulsions, hypothyroidism, cerebral infarction, cognitive impairment and contracture of left hand. In the area of Cognitive Patterns Basis Interview for Mental Status this resident was coded as a 15. A Care Plan dated 09/25/21 indicated: Focus- COVID-19 active diagnosis. Resident #53 was identified as able to move around using a wheelchair.

Resident #53 was observed on 09/20/21 at 7:53 P.M. and 09/21/20 at 9:43 A.M. seated in a wheelchair in room #25 door way. This resident was observed without a mask. On 09/21/20 Resident #53 was identified as COVID-19 positive. Resident #53 was observed moving in and out of her room with the door open. Resident #53 remained in room #25 bed A until 09/23/21. Resident #53's bed linen, personal items, unfinished orange juice and food container were observed in the room for days after she vacated her room.

This resident was observed to be moved across the hall way to room #26. Observations made during the survey indicated Resident #53 bed at 25-A remained uncleaned and unsanitized. Resident #53's roommate Resident #65 was idenitifiied as COVID-19 positive on 09/27/21.

2. Resident #16 was admitted to the facility on 04/17/12 with diagnoses which included schizoaffective disorder, cervical spinal cord sequela, spinal stenosis, chronic pain, hypertension, dysphagia and mood disorder.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495150 | A. BUILDING _____ B. WING _____ | C 09/30/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BIRCHWOOD PARK REHABILITATION | 340 LYNN SHORES DRIVE VIRGINIA BEACH, VA 23452 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 921 | Continued From page 195 | F 921 | | |

Resident #16 was identified as COVID-19 positive on 09/22/21. Resident #16 was a resident living on Unit II in room #22.

Resident #16's was transferred out of bedroom #22 on 09/25/21. Resident #16's bed linen, personal items and food container remained in his room until 09/30/21. Resident #16's floor, bed and other areas of the room remained unsanitized and not cleaned after she vacated the room.

3. Resident #27 was admitted to the facility on 09/08/11 and re-admitted on 11/28/19. Diagnoses for this resident included Multiple Sclerosis, Rhabomylysis, muscle weakness, epilepsy, ataxia, dysphagia, dementia, traumatic subduaral hemorrhage without loss of consciousness, major depression, cerebral vascular disease, and altered mental status. Resident #27 was identified as COVID-19 positive on 09/27/21. Resident #27 was transferred out of his bedroom #15 on 09/27/21. Resident #27's floor, bed, linen, personal items, and other areas of the room remained unsanitized and not cleaned afte she vacated her room.

On 09/30/21 11:29 A.M. during an interview with the Regional Director of Housekeeping and the Administrator. They were asked how long should a resident's room remain uncleaned and unsanitized after the resident tested Positive for COVID-19. The Regional Director of Housekeeping stated, the room be deep cleaned as soon as the resident moves out. The Administrator and the Regional Director of Housekeeping were shown the condition of Resident rooms, 25, 22, and 15.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495150 | A. BUILDING _____ B. WING _____ | C 09/30/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BIRCHWOOD PARK REHABILITATION | 340 LYNN SHORES DRIVE VIRGINIA BEACH, VA 23452 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 921 | Continued From page 196<br>A facility policy and procedure dated 11/1/20 indicated: Routine Cleaning and Disinfection: Policy: It is the policy of this facility to ensure the ensure the provision of routine cleaning and disinfection in order to provide a safe, sanitary environment and to prevent the development and transmission of infections to the extent possible. Definitions: "Transmission Based Precautions" refers to a group of infection prevention and control practices that are used in addition to standard precautions for residents who may be infected or colonized with infectious agents that require additional control measures to prevent transmission effectively. | F 921 | | |
| F 925 SS=F | Maintains Effective Pest Control Program<br>CFR(s): 483.90(i)(4)<br><br>§483.90(i)(4) Maintain an effective pest control program so that the facility is free of pests and rodents.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, record review, and staff interview, the facility staff failed to maintain an effective pest control program.<br><br>The findings included:<br><br>Roaches and fly's were observed through the facility on all days of the survey and on all units. These units included: The closed unit 4, Rehab Unit, locked units 3 and 5, as well as Unit 1 COVID-19.<br><br>Roaches were observed in the front corridor bathrooms, as well as the wall ways. A brownish waste like matter was observed oozing from the roaches leaving a trail like substance on the floor. | F 925 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495150 | A. BUILDING _____ B. WING _____ | C 09/30/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BIRCHWOOD PARK REHABILITATION | 340 LYNN SHORES DRIVE VIRGINIA BEACH, VA 23452 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 925 | Continued From page 197 | F 925 | | |

A house keeper was observed walking around with a spray container daily, spraying various areas of the facility. During an interview on 09/22/21 at 10:00 A.M. with the house keeper he stated, "his job was to spray the building daily to help control the roaches".

A customer service report of a pest control firm dated 4/13/21 indicated: Treated rooms, 9, 11, 13, 15, 17, 21, 23, 25, 26, 28, 29, and 30 for roaches. Rats noted during service bait station 1-8. A pest Sighting Log dated 7/28/21 indicated: Roaches- Unit 1 room 38- several roaches in room. Sighting Log dated 6/9/21 indicated Roaches Unit 1 Nurses Station. A Sighting Log dated 7/21/21 and 8/2/21 indicated Kitchen prep area: mouse in back storage area near bread rack.

A 7/30/21 Pest Sighting Log indicated: Roaches nest in nursing med cart Unit 2.

During an interview on 09/29/21 with the Administrator he stated, "I have a staff member going around daily spraying all areas of the facility to help control the roaches."

A Pest Control policy and procedure revised 10/28/20 indicated: " It is the policy of this facility to maintain an effective pest control program that eradicates and contains common household pests and rodents. An effective pest control program is defined as measures to eradicate and contain common household pests (e.g. bed bugs, lice, roaches, ants, mosquitos, flies, mice and rats).