STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495232	A. BUILDING ______ B. WING ______	C 01/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KEMPSVILLE HEALTH & REHAB CENTER	5520 INDIAN RIVER ROAD VIRGINIA BEACH, VA 23464

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 01/11/22 through 01/14/22 and 01/18/22. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities. No emergency preparedness complaints were investigated during the survey.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 01/11/22 through 01/14/22 and 01/18/22. Significant corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. Nine complaints were investigated during the survey. The census in this 90 certified bed facility was 75 at the time of the survey. The survey sample consisted of 37 current Resident reviews and records reviews.	F 000		
F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observations, resident interview, staff interviews, clinical record review, and facility document review the facility staff failed to reassess resident for self-administration of medication for 1 of 37 residents (Resident #46) in the survey sample.	F 554	RECEIVED FEB 17 2022 VDH/OLC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature]
TITLE: Administrator
(X6) DATE: 2/16/22

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495232	A. BUILDING ______ B. WING ______	C 01/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KEMPSVILLE HEALTH & REHAB CENTER	5520 INDIAN RIVER ROAD VIRGINIA BEACH, VA 23464

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC 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 554	Continued From page 1 The findings included: The facility staff failed to reassess Resident #46 for self-administration of medication ProAir HFA (Albuterol) inhaler. Resident #46 was originally admitted to the facility on 01/08/16. Diagnosis for Resident #46 included but not limited to Chronic Obstructive Pulmonary Disease (COPD) and Major Depression. Resident #46's Minimum Data Set (an assessment protocol) a quarterly assessment with an Assessment Reference Date (ARD) of 12/13/21 coded the resident's Brief Interview for Mental Status (BIMS) score 15 of a possible 15 with no cognitive impairment for daily decision-making. In section "G" (Physical functioning) the MDS coded Resident #46 requiring total dependence of one with bathing, limited assistance of one with dressing, hygiene, bed mobility and toilet use and supervision with one assist with transfer and eating for Activities of Daily Living (ADL) care. The care plan with a created on 01/20/16 and a revision date of 01/04/20 identified Resident #46 with altered respiratory status, difficulty breathing related to (r/t) chronic respiratory failure and emphysema. The goal set for the resident by the staff to maintain normal breathing pattern as evidenced by normal respirations, normal skin color, and regular respiratory rate/pattern through the review date of 03/27/2022. Some of the interventions/approaches the staff would use to accomplish this goal is administer medication/puffers as ordered, monitor for effectiveness and side effects, assess /document changes in orientation, increased restlessness, anxiety, and air hungry.	F 554	F554 1 Resident #46 was reassessed for self-administration of medication. 2. Residents who have previously been assessed for self-administration of medication have the potential to be affected by this deficient practice and have been reassessed for ability to self-administering medications. 3. Licensed nurses were reeducated on policy of self-administration of mediations by the DON or designee. Newly hired licensed nurses and agency nurses will be educated prior to providing direct resident care. 4. DON or designee will audit residents self-administering medications weekly to ensure of ability to self-administer medications for 12 weeks. DON or designee will interview new admissions weekly for desire/capability of self-administering medications for 12 weeks. Results of audits will be taken to QAPI committee monthly for 3 months for review and revision as needed. 5. 2/17/2022	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495232	A. BUILDING ____ B. WING ____	C 01/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KEMPSVILLE HEALTH & REHAB CENTER	5520 INDIAN RIVER ROAD VIRGINIA BEACH, VA 23464

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC 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 554	Continued From page 2	F 554		

During the initial tour of the facility on 01/11/22 at approximately 1:30 p.m., observed on Resident #46's overbed table was an open inhaler (also known as a puffer, pump or allergy spray).

On 01/12/22 at approximately 10:35 a.m., the open inhaler remains on Resident #46's overbed table. On the same day at approximately 11:55 a.m., an interview was conducted with Resident #46 who stated, "I try not to use the inhaler no more once or than twice a day." When asked if she informed her nurse when she self-administers her inhaler, she replied, "No, I don't say anything and they don't ask."

Review of Resident #46's January Order Summary Report revealed the following as needed inhaler: ProAir HFA Aerosol Solution 180 - give 2 puffs inhale orally every 4 hours as needed for COPD with a start date of 01/19/21.

A nurse's note entered by License Practical Nurse (LPN) #6 on 01/12/22 at approximately 5:14 p.m., revealed the following: "This writer noticed that resident's Albuterol inhaler was in her room. Resident stated that she uses it when she needs it, and she needed it today per resident. This writer then went to check the order of the inhaler and the inhaler is not self-administered. The medicine is now in the med cart and will be given to resident as scheduled."

A nurses' note entered by the corporate nurse on 01/13/22 at approximately 8:52 a.m., revealed the following "Spoke with Resident #46 this morning regarding if she had a desire to be able to self-administer as needed inhaler. Resident educated on the assessment process, securing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495232	A. BUILDING ______ B. WING ______	C 01/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KEMPSVILLE HEALTH & REHAB CENTER	5520 INDIAN RIVER ROAD VIRGINIA BEACH, VA 23464

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC 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 554	Continued From page 3	F 554		

medication in lock box, informing staff when used so administration can be documented, and the need to obtain approval and order from MD, She voiced interest in being able to start that process. Resident reported the nurse secured the inhaler in med cart yesterday was one that she had received from community pharmacy. Informed resident that this nurse would return after breakfast to perform assessment."

A nurses' note entered by the corporate nurse on 1/13/22 at approximately 11:06 p.m., revealed the following: "A self-administration assessment performed. Assessment results indicate resident is not a candidate for self-administration. The results of the assessment findings were discussed with resident who voiced understanding. Resident #46 was re-educated on not bringing outside medications into the center who voiced understanding."

A debriefing was conducted with the Administrator, Director of Nursing and corporate nurse on 01/17/22 at approximately 4:12 p.m. Corporate said on 01/13/22, a self-administer assessment was completed on Resident #46 01/13/22, which she did not pass because she has a diagnosis of major depression. On the self-administer medications assessment, the 2nd question ask if the resident has a diagnosis of depression and if you coded yes, then the resident is not a candidate to self-administer. She stated, "Resident #46 failed the self-administer medication assessment due to having a diagnosis of major depression."

The facility policy titled Self-Administration of Medication with a revision date of 02/09/21. Residents who have the desire to, and who have

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495232	A. BUILDING ______ B. WING ______	C 01/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KEMPSVILLE HEALTH & REHAB CENTER	5520 INDIAN RIVER ROAD VIRGINIA BEACH, VA 23464

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC 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 554	Continued From page 4	F 554		

been assessed to be capable and safe to, may self-administer medications.

Procedure read in part:
4. If the Interdisciplinary Team (IDT) has determined the resident safe to administer medications (s), administration of medication(s) will be Care Planned for approved self-administered medications.
5. Self-administration of medications must be reviewed by the (IDT) with each quarterly review.
6. When a resident is unable to self-administer medications, the medication will be held by the nurse until the resident can be reassessed by the (IDT).
7. The MAR must identity medications that are self-administered, and the medication nurse will need to follow-up with the resident as the documentation and storage of medications during each medication pass. Medication(s) kept at the bedside must be kept in a locked drawer.

Definitions:
-COPD is a group of lung diseases (Emphysema and Chronic bronchitis) that make it hard to breathe and get worse over time. Normally, the airways and air sacs in your lungs are elastic or stretchy. When you breathe in, the airways bring air to the air sacs. The air sacs fill up with air, like a small balloon. When you breathe out, the air sacs deflate, and the air goes out (https://medlineplus.gov/copd.htmllf).

Major depression is a mood disorder. It occurs when feelings of sadness, loss, anger, or frustration get in the way of your life over a long period of time. It also changes how your body works (https://medlineplus.gov/ency/article/000945.htm).

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495232	A. BUILDING _____ B. WING _____	C 01/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KEMPSVILLE HEALTH & REHAB CENTER	5520 INDIAN RIVER ROAD VIRGINIA BEACH, VA 23464

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide	F 578	F578 1. Residents #15 and #45 have been assisted with formulating an advanced directive. Resident #281 no longer resides at the facility. 2. All residents who have not formulated an advanced directive have the potential to be affected. Audit completed of current residents 1/19/2022 for advanced directives and competed as needed. 3. The facility social workers were educated on Advanced Directives and were provided with a copy of the Virginia Healthcare Advanced Directive form Corporate Nurse. 4. Social worker/designee will audit new admissions and 5 residents weekly for 12 weeks to ensure advanced directives were reviewed and/or developed as needed. Results of audits will be taken to QAPI committee monthly for 3 months for review and revision as needed. 5. 2/17/2022	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495232	A. BUILDING ______ B. WING ______	C 01/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KEMPSVILLE HEALTH & REHAB CENTER	5520 INDIAN RIVER ROAD VIRGINIA BEACH, VA 23464

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 578	Continued From page 6	F 578		

the information to the individual directly at the appropriate time.
This REQUIREMENT is not met as evidenced by:
Based on clinical record review, staff interviews and facility documentation review, the facility staff failed to ensure residents were afforded the opportunity to formulate an advance directive for 3 of 37 residents (#15, 281, and 45), in the survey sample

The findings included:

1. The facility staff failed to afford Resident #15 and/or her representative to formulate an advanced directive.

Resident #15 was originally admitted to the facility 03/29/2021 and readmitted 10/06/2021 after an acute care hospital stay. The current diagnoses included; Malnutrition, Cirrhosis, Heart failure and Anemia.

The quarterly Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 10/30/2021 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 10 out of a possible 15. This indicated Resident #15's cognitive abilities for daily decision making were moderately impaired.

A review of the Resident #15's clinical record didn't reveal a written Advance Directive which would have included what to do if the resident becomes incapacitated, a designated health care surrogate, medical/surgical treatments, feeding restrictions, organ donation, autopsy request or other but; the Physician's Order Summary revealed an order written 10/6/21 reading Full

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495232	A. BUILDING ______ B. WING ______	C 01/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KEMPSVILLE HEALTH & REHAB CENTER	5520 INDIAN RIVER ROAD VIRGINIA BEACH, VA 23464

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 578	Continued From page 7 Code and it was documented on the physician's progress dated 11/24/21, Code Status: Full Code. An interview was conducted with Licensed Practical Nurse (LPN) #2 on 1/13/22 at approximately 10:10 a.m. LPN #2 she would look in the chart to obtain Advanced Directive information to convey to the receiving facility but LPN #2 was only able to locate information on the Physician's Order Summary not the Advanced Directive. On 1/13/22 at approximately 10:45 a.m., an interview was conducted with the Social Worker. The Social Worker stated he reviewed the previous Advanced Care Tracking Form upon the resident's readmission to the facility from a hospital and the resident was to remain a Full Code. In the documents provided by the facility staff on 1/18/22 at approximately 9:00 a.m., an Advanced Care Tracking Form dated 10/7/22 read; reviewed existing Advanced Care Plan upon readmission. The discussion was held with the resident and resident representative, confirmed code status Full and preference to be sent to the hospital if deemed medically necessary. It was handwritten and not viewable in the clinical record and no information was provided on how the direct care staff would be able to obtain it when needed. On 1/14/22 at approximately 1:30 p.m., the above information was shared with the Administrator, Director of Nursing and Corporate Consultant. They provided additional documents on 1/18/22 at approximately 9:00 a.m., for consideration regarding the above information. That	F 578		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495232	A. BUILDING ______ B. WING ______	C 01/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KEMPSVILLE HEALTH & REHAB CENTER	5520 INDIAN RIVER ROAD VIRGINIA BEACH, VA 23464

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 578	Continued From page 8	F 578		

information is reflected in this report.

2. The facility staff failed to afford Resident #281 and/or her representative to formulate an advanced directive.

Resident #281 was originally admitted to the facility 01/7/22 and had not been discharged. The current diagnoses included; new stroke with left side weakness and dysphasia.

The Minimum Data Set (MDS) assessment had not been completed therefore; information was gained from Licensed Practical Nurse (LPN) #3. LPN #3 stated the resident was alert and oriented to person, family, situation and place but required assistance to make daily decisions. LPN #3 also stated the resident required total care with all care including eating and she required use of an indwelling catheter because of urinary retention.

A review of Resident #281's clinical record didn't reveal a written Advance Directive which would have included what to do if the resident becomes incapacitated, a designated health care surrogate, medical/surgical treatments, feeding restrictions, organ donation, autopsy request or other but; the Physician's Order Summary revealed an order written 1/7/21 which read; Do Not Resuscitate (DNR).

Review of the baseline care plan dated 01/09/22 was a problem which read; Resident is DNR. The goals read; Resident's wishes will be followed. The interventions included; Document resident's advanced directives. Involve Physician/NP in advanced directives conversations. Review advanced directives with resident/family periodically

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495232	A. BUILDING ______ B. WING ______	C 01/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KEMPSVILLE HEALTH & REHAB CENTER	5520 INDIAN RIVER ROAD VIRGINIA BEACH, VA 23464

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 578	Continued From page 9	F 578		

Continued From page 9

On 1/13/22 at approximately 10:45 a.m., an interview was conducted with the Social Worker. The Social Worker stated the resident Advanced Care Tracking Form was completed but the resident and/or representative didn't make any decisions.

A copy of the Advanced Care Tracking Form wasn't available on the clinical record for viewing therefore; an interview was conducted LPN #2. After looking through the clinical record LPN #2 stated she would have to contact the Social Worker to obtain documents to convey to a receiving facility for she was unable to locate any in the clinical record.

On 1/14/22 at approximately 1:30 p.m., the above information was shared with the Administrator, Director of Nursing and Corporate Consultant. They provided additional documents on 1/18/22 at approximately 9:00 a.m., for consideration regarding the above information. The folder contained a copy of a Durable Do Not Resuscitate Form completed at a local hospital 12/28/21. The boxes checked read the patient is incapable of making an informed decision about providing, withholding, or withdrawing a specific medical treatment. The document also stated the patient had not executed a written advanced directive (living will or durable power of attorney for health care).

3. The facility staff failed to execute the opportunity to provide an advance directive for Resident #45.
Resident #45 was originally admitted to the facility 08/03/2015 and readmitted 11/16/2021 after an acute care hospital stay. The current diagnoses

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495232	A. BUILDING ______ B. WING ______	C 01/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KEMPSVILLE HEALTH & REHAB CENTER	5520 INDIAN RIVER ROAD VIRGINIA BEACH, VA 23464

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 578	Continued From page 10 included; Essential Hypertension, Paroxysmal Atrial Fibrillation. The significant change Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 12/12/2021 coded the resident coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 14 out of a possible 15. This indicated Resident #45 cognitive abilities for daily decision making were intact. In section"G"(Physical functioning) the resident was coded as requiring extensive assistance of two person for bed mobility, transfers and dressing. The resident was coded as requiring extensive assistance of one person with personal hygiene. Supervision after set-up with eating. A review of the clinical record on 1/14/22 revealed there were no advance directives in the clinical record on the above resident. On 1/14/22 at approximately 2:08 PM., an interview was conducted with the Social Worker (Other Staff Member/OSM) #4 concerning the above resident. He stated, "The resident is under hospice care and has a DNR (Do Not Resuscitate) order. We leave that up to the discretion of the family who's able to say what she needs." On 1/18/22 at approximately 5:45 PM., the above findings were shared with the Administrator, The Corporate Consultant and the DON (Director of Nursing). The administrator stated, "We need to ask the question if they have one."	F 578		
F 585	Grievances	F 585		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495232	A. BUILDING ______ B. WING ______	C 01/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KEMPSVILLE HEALTH & REHAB CENTER	5520 INDIAN RIVER ROAD VIRGINIA BEACH, VA 23464

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 585 SS=D	Continued From page 11 CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone	F 585	F585 1. Resident #279 no longer resides at the center. The facility LNHA reviewed the past 30 days of grievance forms and met with facility department heads on 2/7/2022 to validate no outstanding grievances awaiting corrective action and/or written decision. 2. All residents have the potential to be affected. Review of grievance/concern forms for past 3o days to ensure concerns have been addressed; areas addressed as needed. 3. The facility staff and department heads have been educated on the grievance process and personal property policy by the DON or designee. 4. The facility LNHA or designee will review grievances 5x per week for 12 weeks to ensure addressed timely. Results of audits will be taken to the QAPI committee monthly for 3 months for review and revision as needed. 5. 2/17/2022	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495232	A. BUILDING ______ B. WING ______	C 01/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KEMPSVILLE HEALTH & REHAB CENTER	5520 INDIAN RIVER ROAD VIRGINIA BEACH, VA 23464

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 585	Continued From page 12 number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations; (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not	F 585		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495232	A. BUILDING ______ B. WING ______	C 01/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KEMPSVILLE HEALTH & REHAB CENTER	5520 INDIAN RIVER ROAD VIRGINIA BEACH, VA 23464

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 585	Continued From page 13	F 585		

Continued From page 13

confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued;
(vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and
(vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision.
This REQUIREMENT is not met as evidenced by:
Based on information gleamed during a complaint investigation, staff interview, clinical record review, and review of facility documents, the facility staff failed to resolve a grievance of missing personal items the resident and/or representative reported for 1 of 37 residents (Resident 279), in the survey sample.

The findings included:

Resident #279 was originally admitted to the facility 11/19/20 and was discharged return not anticipated from the facility 12/31/20. The Resident's diagnoses included; end stage renal disease, diabetes and peripheral vascular disease.

The quarterly Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 11/25/20 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 15 out of a possible 15. This

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495232	A. BUILDING ______ B. WING ______	C 01/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KEMPSVILLE HEALTH & REHAB CENTER	5520 INDIAN RIVER ROAD VIRGINIA BEACH, VA 23464

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 585	Continued From page 14	F 585		

indicated Resident #279's cognitive abilities for daily decision making were intact. In section "G" (Physical functioning) the resident was coded as requiring total care of one person with bathing, extensive assistance of two people with transfers and toileting, extensive assistance of one person with bed mobility and personal hygiene, limited assistance with dressing and supervision after set-up with eating.

A complaint was filed 12/15/20 on behalf of Resident #279 by a friend. The grievance stated Resident #279 had missing personal items to include undergarments and a phone charger which were lost after the Resident was placed in isolation.

An interview was conducted with the Adult Protective Services (APS) representative on 1/14/22 at approximately 9:30 a.m., who notified the Office of Licensure and Certification regarding grievances. The APS representative stated he had closed the case for Resident #279.

An interview was conducted with the Administrator 1/13/22 at approximately 6:20 p.m. The Administrator stated he had no grievance on behalf of Resident #279.

Interviews were attempted with several staff members during the survey but no one remembered the resident and phone calls were made to the Resident and friend but there was no answer or return call regarding messages left.

On 1/18/22 a folder of papers were provided by the facility. Inside the folder was a grievance dated 12/28/20 based on an email sent to social services from Resident #279's friend. The

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495232	A. BUILDING ______ B. WING ______	C 01/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KEMPSVILLE HEALTH & REHAB CENTER	5520 INDIAN RIVER ROAD VIRGINIA BEACH, VA 23464

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 585	Continued From page 15	F 585		

grievance stated the Resident had missing underwear and tee shirts and a concern of not getting enough to eat on the trays. The document stated the grievance related to the dietary needs were forwarded to the dietary staff and resolved with providing the resident with double portions but the grievance forwarded to the laundry stated clothing not found.

A complaint was filed 12/15/20 on behalf of Resident #279 by a friend. The grievance stated Resident #279 had missing personal items to include undergarments and a phone charger which were lost after the Resident was placed in isolation.

An interview was conducted with the Adult Protective Services (APS) representative on 1/14/22 at approximately 9:30 a.m., who notified the Office of Licensure and Certification regarding grievances. The APS representative stated he had closed the case for Resident #279.

An interview was conducted with the Administrator 1/13/22 at approximately 6:20 p.m. The Administrator stated he had no grievance on behalf of Resident #279.

Interviews were attempted with several staff members during the survey but no one remembered the resident and phone calls were made to the Resident and friend but there was no answer or return call regarding messages left.

On 1/18/22 a folder of papers were provided by the facility. Inside the folder was a grievance dated 12/28/20 based on an email sent to social services from Resident #279's friend. The grievance stated the Resident had missing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495232	A. BUILDING ______ B. WING ______	C 01/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KEMPSVILLE HEALTH & REHAB CENTER	5520 INDIAN RIVER ROAD VIRGINIA BEACH, VA 23464

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 585	Continued From page 16 underwear and tee shirts and a concern of not getting enough to eat on the trays. The document stated the grievance related to the dietary needs were forwarded to the dietary staff and resolved with providing the resident with double portions but the grievance forwarded to the laundry stated clothing not found. The facility staff provided no corrective action taken or to be taken by the facility as a result of the grievance, and there was no evidence that a written decision was issued.	F 585		
F 602 SS=D	COMPLAINT DEFICIENCY Free from Misappropriation/Exploitation CFR(s): 483.12 §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on complaint investigation, observation, staff interviews, clinical record review and facility documentation, the acuity staff failed to ensure 1 of 37 residents (Resident #277) to be free from misappropriation of the resident's narcotic medication. The findings included: The facility staff failed to ensure Resident #277's was free from the misappropriation of their	F 602	F602 1. Resident #277 no longer resides at the facility. 2. All residents have the potential to be affected by this deficient practice. Narcotic records and narcotic medications were audited for any discrepancies by Director of Nurses 1/19/2022.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495232	A. BUILDING ______ B. WING ______	C 01/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KEMPSVILLE HEALTH & REHAB CENTER	5520 INDIAN RIVER ROAD VIRGINIA BEACH, VA 23464

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC 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 602	Continued From page 17 narcotic medication HYDROcodone-Acetaminophen (Norco). Resident #277 was originally admitted to the nursing facility on 05/15/19. Resident #277's diagnosis included but not limited to Major Depression and osteoarthritis to right and left knee. Resident #277's Minimum Data Set (an assessment protocol) a significant change assessment with an Assessment Reference Date (ARD) of 04/28/21 coded the resident's Brief Interview for Mental Status (BIMS) score 08 of a possible 15 with moderate impairment for daily decision-making. In section "G" (Physical functioning) the MDS coded Resident #277 requiring total dependence of one with hygiene, bathing and toilet use, extensive assistance of two with bed mobility and transfer, extensive assistance of one with dressing and eating for Activities of Daily Living (ADL) care. In section "J" (Health Condition for Pain Management) was coded zero for pain. The care plan with a created on 09/24/20 and a revision date of 05/25/21 identified Resident #277 with the potential for pain and discomfort secondary to osteoarthritis. The goal set for the resident by the staff is express pain level within satisfactory limits. One of the interventions/approaches the staff would use to accomplish this goal is administer pharmacological interventions as indicated per physician and monitor the effectiveness. Review of the Resident #277's Order Summary Report for February 2021 revealed an order with a start date of 12/08/20: -Norco tablet 5/325 mg - give 1 tablet by mouth	F 602	3. Licensed nursing staff have been re-educated on documentation of narcotic records, which includes receiving from pharmacy, administering, process for removing any discontinued narcotics and on misappropriation the DON or Designee. Newly hired licensed nurses and agency nurses will be educated prior to providing resident care. 4. The facility DON or designee will visually validate and audit the accuracy of 2 medication carts ,5 days a week for 12 weeks to verify narcotic records are accurate and completed. Results of audits will be taken to the QAPI committee monthly for 3 months for review and revision as needed. 5. 2/17/2022	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495232	A. BUILDING ______ B. WING ______	C 01/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KEMPSVILLE HEALTH & REHAB CENTER	5520 INDIAN RIVER ROAD VIRGINIA BEACH, VA 23464

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC 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 602	Continued From page 18 every 4 hours as needed for pain. Review of pharmacy manifest dated 12/28/20 indicated 86 tablets of HYDROcodone-Acetaminophen 5mg/325mg tablets were delivered to the facility on 01/02/21. The manifest on 01/02/21 was signed as received by License Practical Nurse (LPN) #6. An interview was conducted with the Director of Nursing and Corporate Nurse on 01/13/22 at approximately 1:47 p.m. The DON said she received a call from the previous Unit Manager on 02/04/21 stating that a card of 30 Norco belonging to Resident #277 was missing. The DON provided a copy of the facility's investigation indicated the following: "The DON immediately initiated and a facility wide search performed as well as a review of all other narcotic sheets with no further issues identified and narcotic counts were verified as correct. All nurses who had access to the medication cart and keys were interviewed any all denied any knowledge of where the missing care could be. The nursing staff who had access to that cart as well as the Unit Manager completed a urine drug screen performed in house with no pertinent findings." During the interview, the DON said there was one nurse, LPN #12 who worked on the medication cart on 02/02/21 (7-3 shift) who was running late and did not count the cart upon her retrieving the keys from the Unit Manager. The DON said, LPN #12 was informed that all the staff who had access to the medication cart came in for a drug test and she was asked to come into the facility to do a urine drug test also which she decline. LPN #12 said she was would go to (name of doctor's office) to get her urine drug test done but we never heard back from LPN #12; the LPN was	F 602		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495232	A. BUILDING ______ B. WING ______	C 01/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KEMPSVILLE HEALTH & REHAB CENTER	5520 INDIAN RIVER ROAD VIRGINIA BEACH, VA 23464

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC 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 602	Continued From page 19	F 602		

terminated." The DON said Adult Protective Services (APS) and the local police department were notified.

A phone interview was conducted with LPN #6 on 01/12/22 at approximately 8:19 p.m. The LPN said he signed for 3 cards of Norco (86 pills) for Resident #277 on 01/02/21 (3-11 shift). He said there were 3 cards of Norco when hen got off on 02/01/21 (3-11 shift). The LPN said he did not return to work until 02/04/21 (3-11 shift). LPN #6 stated, "I did not realize there was a missing card until at the end of the shift on 02/04/21. The LPN stated he was the oncoming nurse on 02/04/21 (3-11 shift), so I counted the Controlled Narcotics and the off going nurse counted the Controlled Narcotic Sheets. The LPN stated, "At the end of my shift, I was counting with the oncoming nurse and as I was counting the Controlled Narcotic Sheets, I realized the number on the Narcotic sheet was changed from the number 86 to 56 and instead of there being 3 cards of Norco there were only cards. The LPN stated, "I only remembered there were 86 Norco for Resident #277 because I was the nurse who signed for the medications when they were delivered to the facility on 02/01/21. LPN #6 said the oncoming nurse, LPN #11 reported the missing card of Norco to the Unit Manager.

A phone call was placed LPN #11 on 01/15/21 at approximately 9:51 p.m. The LPN was assigned to Resident #277 on 01/31/21 and 02/01/21 (11-7 shift). The LPN stated, "I can't remember back that far but I gave a statement to the DON. Review of LPN #11's statement indicated there were 86 Norco tablets at the end of her shift on 02/01/21.

RECEIVED
FEB 17 2022
VDH/OLC

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495232	A. BUILDING ______ B. WING ______	C 01/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KEMPSVILLE HEALTH & REHAB CENTER	5520 INDIAN RIVER ROAD VIRGINIA BEACH, VA 23464

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC 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 602	Continued From page 20	F 602		

An interview was conducted with LPN #3 on 01/14/22 at approximately 11:05 a.m., who stated, "The Controlled Narcotic are counted at the change of each shift (the off going has the narcotic book and the oncoming has the controlled narcotic and the two are counted together and the keys are not exchanged until we make sure the count is correct." When asked, what is the process for discontinued controlled narcotic, she replied, "They remain on the cart and is counted until picked up by the DON. She said the DON will count the controlled narcotic and the Controlled Narcotic Sheet is signed by the DON and the nurse.

An interview was conducted with LPN #10 on 01/14/22 at approximately 11:23 a.m.,who stated, "The oncoming nurse and the off going nurse count the narcotic book along with the narcotic together and only after the count is correct does the oncoming nurse accept the keys." The LPN said all discontinued controlled medications are counted on each shift until they are picked up by the DON. The LPN provided a Controlled drug shift/shift count sheet that is to completed at then end and beginning of each shift. The Controlled drug shift/shift count sheet included the following information: Signing below acknowledges that you have counted the controlled drugs on hand and have found that the quality of each medication counted is in agreement with the quantity stated on the Controlled Drugs-Count Record. Any discrepancies need to be reported immediately to the supervisor and the Director of Nursing. Random Controlled drug shift/shift count sheet were reviewed with no discrepancies.

During the 4 days on survey, random narcotic counts were conducted by this surveyor with all

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495232	A. BUILDING ______ B. WING ______	C 01/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KEMPSVILLE HEALTH & REHAB CENTER	5520 INDIAN RIVER ROAD VIRGINIA BEACH, VA 23464

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC 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 602	Continued From page 21	F 602		

narcotics located behind a double lock located in the medication cart. There were discontinued medications in the narcotic lock box that were being counted for at the beginning and end of each shift. Nursing staff were also interviewed on the process for counting Controlled Narcotics and received the same response from all staff interviewed, "The oncoming and off going nurse have to count the Controlled Narcotic cards and the Controlled Narcotic Sheets together and cannot accept the keys without receiving report and counting the Controlled Narcotics.

An interview was conducted with DON and Corporate nurse on 01/17/22 at approximately 4:00 p.m., When asked what is the process for removing discontinued medications with the potential for abuse from the medication cart, the DON stated, "If I remove the Controlled Narcotic from the medication cart, the narcotics are counted by the nurse as well as my self and we both sign together and if the medication are bought to my office; they are removed from the cart by 2 nurses who will signed off on the controlled sheet, bought to me and I will count the medications and sign the Controlled Narcotic sheet also to include how many medications are left on the card.

A debriefing was conducted with the Administrator, Director of Nursing and Corporate on 01/17/22 at approximately 4:05 p.m. The Administration team were informed of the above finding. The surveyor requested all discontinued medications with the potential for abuse for the month of 01/22.

Review of all discontinued medications with the potential for abuse were reviewed after the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495232	A. BUILDING ______ B. WING ______	C 01/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KEMPSVILLE HEALTH & REHAB CENTER	5520 INDIAN RIVER ROAD VIRGINIA BEACH, VA 23464

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC 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 602	Continued From page 22	F 602		

debriefing on 01/17/22 at 4:05 p.m. The facility provided 6 resident's Controlled Narcotic Sheets on 01/18/22 at approximately 10:38 a.m., which revealed the following:

-Narcotic sheet #1 - Alprazolam 0.5 mg last administered on 01/13/22 with 20 tabs remaining; the document indicated the Alprazolam was removed from the medication cart on 01/07/22, prior to the last dose being administered on 01/13/22. The DON did not signed the Narcotic Controlled sheet or document how many were remaining in the section for disposition of unused drugs.

-Narcotic sheet #2 - Oxycodone-Acetainophen 5mg/325 mg last administered on 01/13/22 with 25 tablets remaining; the document revealed the medication was removed from the medication cart on 01/07/22, prior the the last dose being administered on 01/13/22.

-Narcotic sheet #3 - Gabapentin 500 mg - last administered on 01/13/22 with 4 tablets remaining; disposition on 01/07/22, the document revealed the medication was removed from the medication cart on 01/07/22, prior the the last dose being administered on 01/13/22.

-Narcotic sheet #4 - Clonaepam 0.25 mg - last administered on 01/13/22 with 14 tablets remaining; disposition on 01/07/22, the document revealed the medication was removed from the medication cart on 01/07/22, prior the the last dose being administered on 01/13/22.

Definitions:
HYDROcodone-Acetaminophen is used to relieve pain severe enough to require opioid treatment

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495232	A. BUILDING ______ B. WING ______	C 01/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KEMPSVILLE HEALTH & REHAB CENTER	5520 INDIAN RIVER ROAD VIRGINIA BEACH, VA 23464

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC 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 602	Continued From page 23	F 602		

and when other pain medicines did not work well enough or cannot be tolerated (https://www.mayoclinic.org/drugs-supplements/hydrocodone-and-acetaminophen-oral-route/description/drg).

Alprazolam is used to treat anxiety disorders and panic disorder (sudden, unexpected attacks of extreme fear and worry about these attacks). Alprazolam is in a class of medications called benzodiazepines. It works by decreasing abnormal excitement in the brain (https://www.drugs.com/alprazolam.htm).

Oxycodone-Acetaminophen is a combination medicine used to relieve moderate to severe pain. Oxycodone may be habit-forming and should be used only by the person it was prescribed for. Keep the medication in a secure place where others cannot get to it. Acetaminophen and oxycodone can cause side effects that may impair your thinking or reactions (https://www.drugs.com/acetaminophen-and-oxycodone.html).

Gabapentin is used with other medications to prevent and control seizures. It is also used to relieve nerve pain (https://www.drugs.com/gabapentin).

Clonaepam is used alone or in combination with other medications to control certain types of seizures. It is also used to relieve panic attacks (sudden, unexpected attacks of extreme fear and worry about these attacks (https://medlineplus.gov/druginfo/meds).

Complaint deficiency

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495232	A. BUILDING ______ B. WING ______	C 01/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KEMPSVILLE HEALTH & REHAB CENTER	5520 INDIAN RIVER ROAD VIRGINIA BEACH, VA 23464

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC 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 607	Continued From page 24	F 607		
F 607 SS=D	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(3) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by: Based on staff interview and facility documentation review, the facility staff failed to implement their abuse policy regarding the screening of employees for 2 employees, Dietary Employee #3 and LPN #2, in a sample of 20 employee records reviewed. The findings included: On 1/12/22, a review of 20 employee files was conducted and revealed the following: 1. The facility staff failed to obtain a criminal background check within 30 days of hire for 1 Employee, Dietary Employee #3. A criminal background check request for Dietary Employee #3 was received on 11/23/20 by The Central Criminal Records Exchange of the Virginia State Police and indicated, "Transaction being Processed". Dietary Employee #3 was hired by the facility on 11/24/20.	F 607	F607 1. Employee #3 criminal background check was received on 1/13/22, Employee #2 licensure verification was completed on 1/13/22. 2. All residents have the potential to be affected. Audit completed of current employees to ensure files are complete. 3. Facility HR director and department heads were re-educated on abuse policy, which includes hiring process by the facility LNHA. 4. The facility LNHA or designee will audit all new hire records weekly x 12 weeks to validate criminal background checks complete and licensure validated. Results of audits to be presented in QAPI monthly times three months for review and revision as needed. 5. 2/17/2022	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495232	A. BUILDING ______ B. WING ______	C 01/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KEMPSVILLE HEALTH & REHAB CENTER	5520 INDIAN RIVER ROAD VIRGINIA BEACH, VA 23464

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC 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 607	Continued From page 25	F 607		

On 1/12/22, the findings for Dietary Employee #3 were shared with the HR Director and the Facility Administrator who stated they were unable to locate any results for the Criminal Background Check that was submitted on 11/23/20 for Dietary Employee #3, therefore, facility staff have not confirmed Dietary Employee #3's criminal background status.

Review of the facility's policy entitled, "Virginia Resident Abuse Policy", last revision date 5/26/2021, subheading, "Procedure--Screening", item 1 read, "It is the policy of the Facility to undertake background checks of all employees and to retain on file applicable records of current employees regarding such checks...a. The Facility will do the following prior to hiring a new employee:....iv. Conduct a criminal background check in accordance with State law and Facility policy...".

2. The facility staff failed to verify the professional license was active and in good standing for LPN #2 prior to allowing LPN #2 to provide direct resident care.

LPN #2 was hired on 5/13/21. LPN #2's professional license verification was dated 9/8/21. Therefore, from 5/13/21-9/8/21, facility staff was unaware if LPN #2's license was active and in good standing.

Additionally, on the license verification dated 9/8/21, there was no indication that LPN #2's professional license was unencumbered and in good standing. LPN #2 was permitted to provide direct care to Residents beginning on 5/20/21 which was confirmed by the Human Resources

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495232	A. BUILDING ______ B. WING ______	C 01/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KEMPSVILLE HEALTH & REHAB CENTER	5520 INDIAN RIVER ROAD VIRGINIA BEACH, VA 23464

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC 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 607	Continued From page 26 Director. An interview was conducted with the Human Resources (HR) Director and the Facility Administrator who confirmed the hire date for LPN #2. The Human Resources Director stated, "The purpose of obtaining a license verification is to make sure that they [nursing staff] have an active license that is in good standing, that there is no disciplinary action against their professional license". The HR Director confirmed that the license verification for LPN #2 had not occurred until 9/8/21 and there was no indication of whether or not the license was in good standing. Review of the facility's policy entitled, "Virginia Resident Abuse Policy", last revision date 5/26/2021, subheading, "Procedure--Screening", item 1 read, "It is the policy of the Facility to undertake background checks of all employees and to retain on file applicable records of current employees regarding such checks...a. The Facility will do the following prior to hiring a new employee:....iii. Check with all applicable licensing and certification authorities to ensure that employees hold the requisite license and/or certification status to perform their job functions and have no disciplinary action as a result of abuse or neglect...". The findings were shared with the Facility Administrator and HR Director. No further information was received.	F 607		
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care	F 655		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495232	A. BUILDING ______ B. WING ______	C 01/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KEMPSVILLE HEALTH & REHAB CENTER	5520 INDIAN RIVER ROAD VIRGINIA BEACH, VA 23464

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC 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 655	Continued From page 27 Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting	F 655	1. Resident #281 no longer resides at the center. An order for resident #251 for the indwelling catheter was obtained on 1/13/22, care plan reviewed and revised as needed. Resident #47 was provided a baseline care plan on 12/15/2021. 2. All residents with indwelling catheters have the potential to be affected. Audit of residents with foley catheters completed for appropriate orders, justification and care plan. All newly admitted/re-admitted have the potential to be affected. Audit of admissions from 12/19/21 to 1/18/22 was conducted to identify any baseline care plan concerns; 3. Facility licensed nursing staff were educated on obtaining complete orders for the use and maintenance of indwelling catheters which includes justification for use and care plan in place by DON or designee. The centers MDS staff were educated on the development and implementation of a baseline care plan within 48 hours of	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495232	A. BUILDING ______ B. WING ______	C 01/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KEMPSVILLE HEALTH & REHAB CENTER	5520 INDIAN RIVER ROAD VIRGINIA BEACH, VA 23464

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC 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 655	Continued From page 28 on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff interviews and facility documentation, the facility staff failed to develop a baseline care plan and/or ensure the indwelling catheter was addressed in the admission orders for Resident #281 and the facility staff failed to provide a baseline care plan to Resident #47 within 48 hours out of a sample of 37. The findings included: 1. Resident #281 was originally admitted to the facility 01/7/22 and had not been discharged. The current diagnoses included; new stroke with left side weakness, dysphasia and urinary retention. The Minimum Data Set (MDS) assessment had not been completed therefore; information was gained from Licensed Practical Nurse (LPN) #3. LPN #3 stated the resident was alert and oriented to person, family, situation and place but required assistance to make daily decisions. LPN #3 also stated the resident required total care with all care including eating and she required use of an indwelling catheter. On 1/12/22 at approximately 10:15 a.m., Resident #281 was observed sitting across from the nursing station. The resident's head was lowered and her nose was draining a large amount of thick light yellow mucus which the Resident wiped away with the back of her hand. The Resident appeared very pale, had facial bruising and spoke	F 655	admission by the DON or designee. Newly hired licensed nurses and agency licensed nurses will be educated prior to providing direct resident care. 4. The Director of Nursing/designee will audit new admissions 5 times a week for 12 weeks to ensure base line care plan completed timely. Director of Nurses/designee will audit new admissions 5 times a week for 12 weeks for use of indwelling foley catheter, foley justification, appropriate orders and care plan. Results of audits will be taken to the QAPI committee monthly for 3 months for review and revision as needed. 5. 2/17/2022	

RECEIVED
FEB 17 2022
VDH/OLC

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495232	A. BUILDING ______ B. WING ______	C 01/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KEMPSVILLE HEALTH & REHAB CENTER	5520 INDIAN RIVER ROAD VIRGINIA BEACH, VA 23464

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC 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 655	Continued From page 29 very softly. She was wearing an untied hospital gown, had a blanket over her lap, her hair was severely matted and the catheter drainage bag was very full, containing approximately 800 milliliter of light but cloudy urine. The Resident stated she had a stroke and was found on the floor by her daughter and she had come to the facility to regain her strength after hospitalization. On 1/13/22 at approximately 9:50 a.m., Resident #281 was observed in bed. The floor near the catheter drainage bag had a large amount of fluid on the floor. Certified Nursing Assistant (CNA)#1 stated she saw what was wrong the drainage bag and proceeded to clean the fluid off of the floor. Review of the Admission assessment completed 1/7/22 was coded to indicate Resident #281 had bladder incontinence and the box for urinary catheter was not coded. Review of the hospital's discharge summary dated 1/7/22 revealed the resident had urinary retention requiring placement of a Foley. Review of a progress note dated 1/8/22 at 13:53 which read; Urinary Elimination: Resident has voided this shift: within normal limits, Resident has urinary catheter. Urinary catheter was noted to be patent. A progress note on 1/10/22 read; Urinary Elimination: Resident has voided this shift: yellow Resident has urinary catheter. Urinary catheter was noted to be patent. Urinary catheter is draining. Urinary catheter is anchored. A progress note on 1/10/22 read; Urinary Elimination: Resident has voided this shift: within	F 655		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495232	A. BUILDING ______ B. WING ______	C 01/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KEMPSVILLE HEALTH & REHAB CENTER	5520 INDIAN RIVER ROAD VIRGINIA BEACH, VA 23464

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC 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 655	Continued From page 30 normal limits. Resident has urinary catheter. Urinary catheter was noted to be patent. Urinary catheter is draining. Urinary catheter is anchored. The physician order summary revealed an orders dated 1/11/22 as follows; Anchor catheter tubing and check placement every shift, a voiding trial in five days, change the catheter bag every thirty days. Document Foley output every shift. Foley catheter care every shift and as needed. Further review of the Physician order summary failed to provide evidence of an order for use of an indwelling catheter including the size of the catheter to insert and a valid medical justification for use. Review of the baseline care plan dated 01/09/22 which read; Resident is incontinent of bladder. The goal read; Resident will receive assistance with toileting, maintain comfortable, clean and dry, and free from skin breakdown. The interventions included; Assess resident pattern of urination and episodes of incontinence. Provide incontinence care as needed. Monitor peri-area for redness, irritation, skin excoriation/breakdown. The baseline care plan didn't address requiring the use of an indwelling catheter. On 1/13/22 at approximately 10:25 a.m., an observation was made of the indwelling catheter currently inserted in Resident #281 with LPN #2. It revealed a 16 french with a 30 cubic centimeter balloon. An interview was conducted with LPN #2. LPN #2 stated there wasn't an order for the actual indwelling catheter and it was because there was	F 655		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495232	A. BUILDING ______ B. WING ______	C 01/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KEMPSVILLE HEALTH & REHAB CENTER	5520 INDIAN RIVER ROAD VIRGINIA BEACH, VA 23464

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC 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 655	Continued From page 31	F 655		

system problem when writing the urinary indwelling catheter orders. LPN #2 obtained an order on 1/13/22 for the indwelling catheter use of an indwelling catheter 16 french with a 30 cc balloon secondary to urinary retention.

On 1/14/22 at approximately 1:30 p.m., the above information was shared with the Administrator, Director of Nursing and Corporate Consultant. The facility's staff was offered the opportunity to provide additional information but they did not.

2. The facility staff failed to complete and implement a baseline care plan within 48 hours of admission. Resident #47 was originally admitted to the facility 12/10/21 then readmitted 12/15/21 after an acute care hospital stay. The current diagnoses included; Sepsis unspecified Organism and Urinary Tract Infection.

The admission, Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 12/14/21 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 13 out of a possible. This indicated Resident #47 cognitive abilities for daily decision making were intact.

In section"G"(Physical functioning) the resident was coded as requiring
Extensive assistance of one person with bed mobility, dressing and personal hygiene. Total dependence of one person with eating, toilet use and bathing.

The current Minimum Data Set (MDS) an admission assessment MDS with an Assessment Reference Date (ARD) of 12/14/21 coded the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495232	A. BUILDING _____ B. WING _____	C 01/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KEMPSVILLE HEALTH & REHAB CENTER	5520 INDIAN RIVER ROAD VIRGINIA BEACH, VA 23464

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC 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 655

Continued From page 32

resident with a 13 of a total possible 15.

A Review of the MDS (Minimum Data Set) Section A, A1600-Entry Date of 12/10/21. Section A, A1700 Reads: Type of Entry: Admission.

A review of resident's clinical records reveals that resident was admitted on 12/10/21. According to the clinical record Resident's Baseline Care Plan Checklist completed on 12/15/2021.

A pre-exit interview was conducted on 1/18/22 at approximately 5:45 PM., the above findings were shared with the Administrator, The Corporate Consultant and the DON (Director of Nursing). The DON stated, "The nurses should complete the care plan."

F 656 SS=D

Develop/Implement Comprehensive Care Plan
CFR(s): 483.21(b)(1)

§483.21(b) Comprehensive Care Plans
§483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -
(i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and
(ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights

F 656

F656

1. Resident #1 had a care plan update on 1/13/22 to include a diagnosis of COPD with the use of oxygen therapy.
2. All residents have the potential to be affected by this deficient practice. An audit of residents was completed of Comprehensive care plans for 2 weeks 1/5/22 – 1/18/22. Care plans reviewed and revised as needed.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495232	A. BUILDING ______ B. WING ______	C 01/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KEMPSVILLE HEALTH & REHAB CENTER	5520 INDIAN RIVER ROAD VIRGINIA BEACH, VA 23464

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC 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 656	Continued From page 33 under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review and facility document review the facility staff failed to develop a care plan for 1 of 37 residents (Resident #1) in the survey sample. The findings included: The facility staff failed to develop a person-centered care plan to include a diagnosis of Chronic Obstructive Pulmonary Disease (COPD) with the use of oxygen therapy. Resident #1 was admitted to the nursing facility on 11/22/16. Resident #1's diagnosis included but not limited to Chronic Obstructive Pulmonary Disease.	F 656	3. MDS nurses were educated on the development and implementation of comprehensive care plan Regional corporate nurse. 4. MDS/Designee to audit and validate weekly for 12 weeks completeness of Comprehensive care plans completed on new admissions, residents with significant change and residents with annual assessments. The results of audits will be taken to the QAPI committee for review and revision as needed. 5. 2/17/2022	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495232	A. BUILDING ______ B. WING ______	C 01/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KEMPSVILLE HEALTH & REHAB CENTER	5520 INDIAN RIVER ROAD VIRGINIA BEACH, VA 23464

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC 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 656 Continued From page 34 F 656

Resident #1's Minimum Data Set (an assessment protocol) a quarterly assessment with an Assessment Reference Date (ARD) of 10/05/21 coded the resident's Brief Interview for Mental Status (BIMS) score 15 of a possible 15 with no cognitive impairment for daily decision-making. In section "G" (Physical functioning) the MDS coded Resident #1 requiring total dependence of one with hygiene, bathing and toilet use, extensive assistance of two with bed mobility and extensive assistance of one with dressing for Activities of Daily Living (ADL) care. In section "O" (Special Treatment and Programs) was coded for oxygen therapy.

During the initial on 01/11/22 at approximately 3:38 p.m. Resident #1 was observed lying in bed with oxygen on at 2 liters minute via nasal cannula. On 01/12/22 at approximately 10:48 a.m., Resident #1 was observed sitting up in the wheel chair with oxygen on at 2 liters minute via nasal cannula.

Review of the Order Summary Report for January 2022 revealed an order with a start date of 12/09/20: Oxygen to keep oxygen saturation above or equal to 92% each shift.

The review of Resident #1's comprehensive care plan did not include a care plan for COPD with the use of oxygen therapy.

An interview was conducted with the Director of Nursing on 01/13/22 at approximately 9:40 a.m., who stated, "If Resident #1 has a diagnosis of COPD with the use of oxygen then there should be a respiratory care plan."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495232	A. BUILDING ______ B. WING ______	C 01/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KEMPSVILLE HEALTH & REHAB CENTER	5520 INDIAN RIVER ROAD VIRGINIA BEACH, VA 23464

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC 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 656	Continued From page 35	F 656		

A COPD care plan with the use of oxygen therapy was created and given to the surveyor on 01/13/22, but created after it was requested by the surveyor. The care plan identified Resident #1 on oxygen therapy with a diagnosis of COPD. The goal set for the resident by the staff is to be free from signs and symptoms of hypoxia thru the next review date of 02/26/22. Some of the interventions/approaches the staff would use to accomplish this goal is to administer oxygen as ordered (2 liters via nasal cannula) to maintain oxygen saturation greater than 92% and to assess, monitor and educate resident on sign/symptoms of distress, increased heart rate, restlessness, lethargy, confusion, blood in the sputum, use of accessory muscles and change in skin color.

A debriefing was conducted with the Administrator, Director of Nursing and Cooperate support on 01/17/22 at approximately 4:05 p.m. The Administration team were informed of the above findings; no further information was provided prior to exit.

Definition:
COPD is a group of lung diseases (Emphysema and Chronic bronchitis) that make it hard to breathe and get worse over time. Normally, the airways and air sacs in your lungs are elastic or stretchy. When you breathe in, the airways bring air to the air sacs. The air sacs fill up with air, like a small balloon. When you breathe out, the air sacs deflate, and the air goes out (https://medlineplus.gov/copd.htmllf).

Hypoxemia is a below-normal level of oxygen in your blood, specifically in the arteries. Hypoxemia is a sign of a problem related to breathing or

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495232	A. BUILDING ______ B. WING ______	C 01/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KEMPSVILLE HEALTH & REHAB CENTER	5520 INDIAN RIVER ROAD VIRGINIA BEACH, VA 23464

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC 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 656	Continued From page 36 circulation, and may result in various symptoms, such as shortness of breath (mayoclinic.org).	F 656	F657	
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on staff interviews, clinical record review and facility documentation the facility staff failed to revise 1 of 37 residents (Resident #47) comprehensive personal centered care plan in	F 657	1. Resident #47 is not receiving antibiotic therapy at this time. 2. All residents receiving antibiotic therapy have the potential to be affected. 3. An audit completed on residents receiving antibiotic therapy to ensure care plans are current. The MDS nurses have been reeducated on care plan timing and revision to include intervention of monitoring side effects of antibiotic use for those receiving ABT by the regional corporate nurse. 4. The Director of Nurses/designee will audit physician orders, 24 hour report 5 times a week for 12 weeks to ensure care plans are reviewed and revised as needed. Results of audits will be taken to the QAPI committee monthly for 3 months for review and revision as needed. 5. 2/17/2022	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495232	A. BUILDING ______ B. WING ______	C 01/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KEMPSVILLE HEALTH & REHAB CENTER	5520 INDIAN RIVER ROAD VIRGINIA BEACH, VA 23464

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 37 the survey sample. The finding include: The facility staff failed to revise Resident #47's comprehensive person centered care plan to include parameters of antibiotics, monitoring for side effects of antibiotics. (Keflex and Levaquin). The current diagnoses included; Sepsis unspecified Organism and Urinary Tract Infection. The admission, Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 12/14/21 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 13 out of a possible. This indicated Resident #47 cognitive abilities for daily decision making were intact. The resident's MDS was coded for the usage of antibiotic medications. Section N on the MDS under medications reads as follows: Indicate the number of DAYS the resident receiving the medication during the last 7 days, the MDS was coded for receiving an antibiotics for 2 days In section"G"(Physical functioning) the resident was coded as requiring Extensive assistance of one person with bed mobility, dressing and personal hygiene. Total dependence of one person with eating, toilet use and bathing. According to the Physician Order Summary for December 2021, Resident #47 was started on Keflex Capsule 500 MG (Cephalexin) Give 1 capsule by mouth every 8 hours for sepsis until 12/19/2021. 23:59 (11:59 PM) for 27 doses Verbal Order Date: 12/10/2021. Start Date: 12/10/2021 End Date: 12/19/2021.	F 657		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495232	A. BUILDING ______ B. WING ______	C 01/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KEMPSVILLE HEALTH & REHAB CENTER	5520 INDIAN RIVER ROAD VIRGINIA BEACH, VA 23464

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC 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 38	F 657		

Levaquin Tablet 500 MG (levoFLOXacin) Give 1 tablet by mouth in the morning for UTI (Urinary Tract Infection) until 12/14/2021 23:59 (11:59 PM).
Order Date: 12/10/2021. Start Date:12/11/2021
End Date: 12/14/2021.

*Cephalexin (Keflex) is used to treat certain infections caused by bacteria such as pneumonia and other respiratory tract infections; and infections of the bone, skin, ears, , genital, and urinary tract. Cephalexin is in a class of medications called cephalosporin antibiotics. It works by killing bacteria. Antibiotics such as cephalexin will not work for colds, flu, or other viral infections. Using antibiotics when they are not needed increases your risk of getting an infection later that resists antibiotic treatment. https://medlineplus.gov/druginfo/meds/a682733.html

Levofloxacin is used to treat certain infections such as pneumonia, and kidney, prostate (a male reproductive gland), and skin infections. Levofloxacin is also used to prevent anthrax (a serious infection that may be spread on purpose as part of a bioterror attack) in people who may have been exposed to anthrax germs in the air, and treat and prevent plague (a serious infection that may be spread on purpose as part of a bioterror attack. Levofloxacin may also be used to treat bronchitis, sinus infections, or urinary tract infections but should not be used for bronchitis and certain types of urinary tract infections if there are other treatment options available. Levofloxacin is in a class of antibiotics called fluoroquinolones. It works by killing bacteria that cause infections. Antibiotics such as levofloxacin

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495232	A. BUILDING ______ B. WING ______	C 01/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KEMPSVILLE HEALTH & REHAB CENTER	5520 INDIAN RIVER ROAD VIRGINIA BEACH, VA 23464

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC 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 39 will not work for colds, flu, or other viral infections. Using antibiotics when they are not needed increases your risk of getting an infection later that resists antibiotic treatment. https://medlineplus.gov/druginfo/meds/a697040.html#:~:text=Levofloxacin%20is%20in%20a%20class,flu%2C%20or%20other%20viral%20infections The review of the Resident #47's comprehensive care plan did not include a care plan to include parameters of antibiotics, monitoring for side effects of antibiotics. On 1/18/22 at approximately 5:30 PM., an interview was conducted with the MDS Coordinator/LPN (Licensed Practical Nurse) #5. She stated, It's listed in the care plan that resident has pneumonia. Interventions are listed." The MDS Coordinator handed the surveyor the care plan. A pre-exit interview was conducted on 1/18/22 at approximately 5:45 PM., the above findings were shared with the Administrator, The Corporate Consultant and the DON (Director of Nursing). The DON stated, "The nurses should complete the care plan."	F 657		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff	F 677	F677 1. Resident # 281 no longer resides at the facility. Resident received a shower on 1/13/2022.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495232	A. BUILDING _______ B. WING _______	C 01/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KEMPSVILLE HEALTH & REHAB CENTER	5520 INDIAN RIVER ROAD VIRGINIA BEACH, VA 23464

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 677	Continued From page 40 interviews, and clinical record review, the facility staff failed to ensure a Resident dependent in activities of daily living received good grooming, personal hygiene and dressing care for 1 of 37 residents (Resident #281), in the survey sample. The findings included: Resident #281 was originally admitted to the facility 01/7/22 and had not been discharged. The current diagnoses included; new stroke with left side weakness, dysphasia and urinary retention. The Minimum Data Set (MDS) assessment had not been completed therefore; information was gained from Licensed Practical Nurse (LPN) #3 on 1/13/22 at approximately 10:30 a.m. LPN #3 stated the resident was alert and oriented to person, family, situation and place but required assistance to make daily decisions. LPN #3 also stated the resident required total care with all care including eating and she required use of an indwelling catheter. On 1/12/22 at approximately 10:15 a.m., Resident #281 was observed sitting across from the nursing station. The resident's head was lowered and her nose was draining a large amount of thick light yellow mucus which the Resident wiped away with the back of her hand. The Resident appeared very pale, had facial bruising and spoke very softly. She was wearing an untied hospital gown, had a blanket over her lap, her hair was severely matted and the catheter drainage bag was very full, containing approximately 800 milliliter of light but cloudy urine. The Resident stated she had a stroke and was found on the floor by her daughter and she had come to the	F 677	2. All residents have the potential to be affected by this deficient practice. Observation rounds conducted on 1/14/2022 to validate no other residents affected. 3. Licensed Nurses/CNA'S have been re-educated on ADL care and documentation of care provided by the DON or designee 4. The facility DON or designee will observe 5 residents x 5 days a week for 12 weeks to validate ADL care provided to include documentation. Results of audits will be taken to the QAPI committee monthly for 3 months for review and revision as needed. 5. 2/17/2022	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495232	A. BUILDING ______ B. WING ______	C 01/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KEMPSVILLE HEALTH & REHAB CENTER	5520 INDIAN RIVER ROAD VIRGINIA BEACH, VA 23464

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

F 677 Continued From page 41 F 677

facility to regain her strength after hospitalization.

Review othe Resident's baseline care plan dated 1/9/22 was a problem which read; Resident has self-care deficit. The goal read; Resident needs will be met through 4/9/22. The interventions included; Assist with activities of daily living, dressing, grooming, toileting, and feeding, oral care. Promote independence, provide positive reinforcement for all activities attempted.

On 1/13/22 at approximately 9:40 a.m., the Resident stated she wanted to shower but she didn't feel she was strong enough to shower herself. She stated if someone would help her she would take a shower and wash her hair.

An interview was conducted with Certified Nursing Assistant (CNA) #1 on 1/13/22 at approximately 9:50 a.m. CNA #1 stated the resident rejected a shower therefore she would give her a bed bath. CNA #1 also stated she would try to get the tangles out of the Resident's hair but her hair likely needs to be cut for when the Resident arrived to the facility it was tangled and matted just as we saw it that day.

During the interview with LPN #3 on 1/13/22 at approximately 10:30 a.m., she stated the Resident's daughter was telephoned about the condition of her hair and she stated on 1/15/22 the Resident would go to the beauty parlor to have it done. LPN #3 also stated the daughter wouldn't bring the resident clothing to wear therefore she only had the gowns provided by the facility.

Resident #281 was visited again on 1/13/22 at approximately 12:30 p.m. The Resident stated

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495232	A. BUILDING ______ B. WING ______	C 01/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KEMPSVILLE HEALTH & REHAB CENTER	5520 INDIAN RIVER ROAD VIRGINIA BEACH, VA 23464

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 677	Continued From page 42 she felt so much better after having a shower but she was tired. Her hair remained matted at the bun but soft and brush able at the scalp, her skin appeared clean and moisturized. She was still dressed in a hospital gown but it was tied at the back of her neck. On 1/14/22 at approximately 1:30 p.m., the above information was shared with the Administrator, Director of Nursing and Corporate Consultant. The facility's staff provided a progress note on 1/18/22 at approximately 9:00 in a folder. The progress note dated 1/14/22 at 15:23 which read; spoke with daughter and asked if she could bring in some personal clothing for resident. Daughter states her mother is comfortable in the gowns and is expected to have a decline. She felt hospital gowns may be more comfortable for her mother. This nurse encouraged the daughter to bring in comfortable clothing and informed her that we would continue to provide clean gowns per her request until personal clothing were provided if she wishes.	F 677		
F 685 SS=D	Treatment/Devices to Maintain Hearing/Vision CFR(s): 483.25(a)(1)(2) §483.25(a) Vision and hearing To ensure that residents receive proper treatment and assistive devices to maintain vision and hearing abilities, the facility must, if necessary, assist the resident- §483.25(a)(1) In making appointments, and §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	F 685	F685 1. Resident #46 has had recommended appointment scheduled for 2/21/2022. A review of hearing/vision consultation reports obtained over the past 14 days was reviewed by DON/designee on 2/4/2022 to validate no other recommendations outlying.	

RECEIVED
FEB 17 2022
VDH/OLC

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495232	A. BUILDING ______ B. WING ______	C 01/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KEMPSVILLE HEALTH & REHAB CENTER	5520 INDIAN RIVER ROAD VIRGINIA BEACH, VA 23464

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC 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 43 provision of vision or hearing assistive devices. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interviews and clinical record review, the facility staff failed to ensure a recommended referral from the Ophthalmologist for cataract extraction was provided for 1 of 37 residents (Resident #46) in the survey sample. The findings included: Resident #46 was originally admitted to the facility on 01/08/16. Diagnosis for Resident #46 included but not limited to Cataract. Resident #46's Minimum Data Set (an assessment protocol) a quarterly assessment with an Assessment Reference Date (ARD) of 12/13/21 coded the resident's Brief Interview for Mental Status (BIMS) score 15 of a possible 15 with no cognitive impairment for daily decision-making. In section "G" (Physical functioning) the MDS coded Resident #46 requiring total dependence of one with bathing, limited assistance of one with dressing, hygiene, bed mobility and toilet use and supervision with one assist with transfer and eating for Activities of Daily Living (ADL) care. The care plan with a created on 01/13/22 identified Resident #46 with the potential to decline in her visual status related to her cataract. The goal set for the resident by the staff is to be able to safely participate in ADL's and remain free from complications related to cataract. Some of the interventions/approaches the staff would use to accomplish this goal is schedule appointment for a cataract follow up, maintain	F 685	2. All residents have the potential to be affected. Review of hearing/vision consultation reports for last 14 days reviewed on 2/4/2022 for any recommendations, no concerns noted. 3. Licensed staff and SW were educated on follow up needs of the resident in regards to consultation recommendations by the DON or Designee. Newly hired licensed nurses and agency licensed nurses will be educated prior to providing direct resident care. 4. The facility DON/designee will review all consultation reports with 5x per week x 12 weeks to validate recommendation needs and follow-up. Results of audits will be reviewed in QAPI committee for review and revision as needed. 5. 2/17/2022	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495232	A. BUILDING ______ B. WING ______	C 01/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KEMPSVILLE HEALTH & REHAB CENTER	5520 INDIAN RIVER ROAD VIRGINIA BEACH, VA 23464

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC 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 44	F 685		

room free of clutter and place call bell, water pitcher, personal belongings always in the same place.

On 01/12/22 at approximately 11:55 a.m., an interview was conducted with Resident #46 who stated, "The eye doctor saw me about (3-4 months) and said I needed to come to his office because I may need to have cataract surgery. She said I never heard anything back related to my follow up appointment with the eye doctor.

Review of Resident #46's clinical record a Summary Ocular Progress Note dated 09/24/21 revealed the following information:
-Chief compliant: blurred vision; hard to see at a distance.
-Physician orders: Cataract OU (both eyes) moderate progressive - recommended referral for cataract extraction.

An interview was conducted with the Social Worker on 01/12/22 at approximatley 3:19 p.m. He (SW) said the information related to the referral for cataract extraction was given to the old Unit Manager. The SW reviewed the resident clinical record then stated, "I do not see a follow-up note or an upcoming appointment."

A nurses' note entered by the Social Worker on 1/13/22 at approximately 5:22 p.m., revealed the following: "Social Worker called (name of eye center) to make an appointment for resident to have a cataract evaluation as requested by (name of Ophthalmologist). Social Worker scheduled the appointment for 1/19/22 at 8:00 AM and faxed referral paperwork to the office. Social Worker informed the resident of her appointment and confirmed resident was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495232	A. BUILDING ____ B. WING ____	C 01/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KEMPSVILLE HEALTH & REHAB CENTER	5520 INDIAN RIVER ROAD VIRGINIA BEACH, VA 23464

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC 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 45 agreeable to the early appointment time. Transportation arranged through resident's Medicaid with a 7:00 AM pickup time. Social Worker called the resident's daughter and informed her of the appointment." A debriefing was conducted with the Administrator, Director of Nursing and Corporate on 01/17/22 at approximately 4:05 p.m. The Administration team were informed of the above findings; no further information was provided prior to exit. The facility's policy titled Social Services Policy with a revision date of 04/16/21. Policy: The facility provides social services to assure that each resident can attain or maintain his/her highest practicable physical, mental and/or psychosocial well-being. -Procedure: K. Responsible to coordinating needed ancillary services (ie Dental, Audiologist, and Optometrist), including ensuring consent forms are completed. (1) Social Services/designee will ensure referrals are made when need and (2) Social Services/designee will ensure follow up on any ancillary needs. Definitions: A Cataract is a clouding of the lens in your eye. It affects your vision. Cataracts are very common in older people (https://medlineplus.gov/cataract.html).	F 685		
F 686 SS=G	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity	F 686	F686 1. Resident #15 has been assessed for any skin concerns; treatments as ordered and care plan reviewed and revised as needed. A house wide skin sweep performed on 1/21/22 to identify any additional residents with potential for or actual skin breakdown followed by verification of treatment orders. No new areas of concern were identified. 2. All residents have the potential to be affected by this deficient practices. Current residents have been assessed for new and/or existing areas; validation of current treatments, implementation	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495232	A. BUILDING ______ B. WING ______	C 01/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KEMPSVILLE HEALTH & REHAB CENTER	5520 INDIAN RIVER ROAD VIRGINIA BEACH, VA 23464

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 46 §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews, and clinical record review, the facility staff failed to provide care and services to prevent pressure ulcer development and to identify a pressure ulcer prior to progression to an advanced stage for 1 of 37 residents, (Resident #15) and the facility staff failed to ensure the necessary assessment, treatment, care, and services was provided for 1 of 37 Residents (Resident #278) impaired skin to prevent deterioration, necessitating surgical debridement which constituted harm. The findings included: 1. The facility staff failed to provide care and services to prevent a pressure ulcer and to identify the pressure ulcer at an early stage; Resident #15's sacral pressure ulcer was first identified on 10/12/21 as unstageable (due to containing 70 percent of necrotic tissue). Resident #15 was originally admitted to the facility 03/29/2021 and readmitted 10/06/2021 after an	F 686	of new treatments as needed; care plans reviewed and revised as needed. 3. Facility clinical staff have been re-educated on skin and wound process to include recognition and preventive measures the DON or designee. 4. The facility DON or designee will review the results of all weekly skin evaluation 5x per week for 12 weeks for any skin concerns and will assess 5 residents weekly for 12 weeks for any skin concerns; will assess newly admitted residents weekly for 12 weeks to ensure any skin concerns are addressed. Results of audits will be taken to the QAPI committee monthly for 3 months for review and revision as needed. 5. 2/17/2022	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495232	A. BUILDING ______ B. WING ______	C 01/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KEMPSVILLE HEALTH & REHAB CENTER	5520 INDIAN RIVER ROAD VIRGINIA BEACH, VA 23464

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

acute care hospital stay. The current diagnoses included; Malnutrition, Cirrhosis, Heart failure and Anemia.

The quarterly Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 10/30/2021 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 10 out of a possible 15. This indicated Resident #15's cognitive abilities for daily decision making were moderately impaired. In section "G" (Physical functioning) the resident was coded as requiring total care of one person with toileting and bathing, extensive assistance of one person with bed mobility, personal hygiene and dressing, limited assistance of one person with eating and she was coded activity didn't occur for transfers, walking and locomotion.

The Braden Scale for Prediction of Pressure completed on 10/6/21; revealed Resident #15 had responds only to painful stimuli. Cannot communicate discomfort except by moaning or restlessness or has a sensory impairment which limits the ability to feel pain or discomfort over half of the body, skin most often moist and linen must be changed at least once a shift, is bedfast-confined to bed, mobility is very limited-makes occasional slight changes in body or extremity position but unable to make frequent or significant changes independently, rarely eats a complete meal and generally eats only half of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement, and moves feebly or requires minimum. During a move, skin probably slides to some extent against sheets, chair, restraints or other devices. Maintains relatively good position in chair or bed

F 686 Continued From page 48 F 686

most of the time but occasionally slides down. The score was 14; indicating a high risk.

On 1/13/21 at approximately an interview was conducted with Certified Nursing Assistant (CNA) #6 at approximately 2:15 p.m., who stated resident #15 requires total care, exhibited no behavioral concerns, is usually quiet, and enjoys eating. CNA #6 also stated the resident doesn't get out of bed to the wheelchair or participate in group activities.

An observation was made on 1/12/21 at approximately 11:30 a.m. The resident was lying in a low air loss bed turned to partially face in the direction of the window. She appeared very pale, weak, fatigued, and with cachexia. The resident's speech was limited and she paused before she answered simple questions.

The Resident was observed again 1/13/21 at approximately 9:00 a.m., in bed consuming breakfast. She was being fed by staff and appeared to enjoy the meal. She accepted 100 percent of the oatmeal, bread, and thickened water and tolerated only two small spoonful's of the eggs. On 1/13/21 at approximately 12:35 p.m., the resident was observed being fed the midday meal by staff. She accepted 100% of the pureed bread, magic cup, fortified potatoes, and rejected the puree chocolate cake.

Neither of the two observed meals had protein or a protein substitute on the tray other than the eggs at breakfast. The resident asked if there was any milk at the midday meal.

Review of the facility's matrix revealed Resident #15 had a facility acquired pressure ulcer,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495232	A. BUILDING ______ B. WING ______	C 01/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KEMPSVILLE HEALTH & REHAB CENTER	5520 INDIAN RIVER ROAD VIRGINIA BEACH, VA 23464

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

currently staged at a stage III.

Review of the clinical record revealed upon admission from the hospital on 10/6/21, Resident #15 had redness to the sacrum.

Further review of the weekly skin evaluations provided no evidence that the redness to Resident #15 sacrum on 10/6/21 was a pressure ulcer. An additional skin evaluation completed on 10/7/21 read blanchable redness (indicates an area of skin that has been subjected to pressure and other forces) to the sacrum and the 10/8/21 skin evaluation read new onset; open area to the coccyx measuring 1.5 cm x 1.5 cm. The documentation further read the opened area was covered with bruised tissue with a small amount of serosanginous discharge but there was no odor. After the 10/8/21 weekly skin assessment there wasn't evidence of another until 11/29/21. The weekly skin evaluation continued through 12/27/21 and stopped again. No weekly skin assessments were available on the clinical record for January 2022.

Blanchable erythema is not considered a pressure injury but an important warning sign that preventive measures are needed. If, however, the forces are not removed, blanching erythema can quickly develop into a pressure injury (https://www.ncbi.nlm.nih.gov/books/NBK543831/#:~:text=Blanchable%20erythema%20is%20not%20considered,blanchable%20erythema%20of%20intact%20skin.)

Review of Resident #15's physician's orders summary for 10/6/21 - 10/12/21 revealed the following skin related orders; 10/7/21, turn and re-position every 2 hours as tolerated while in bed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495232	A. BUILDING ______ B. WING ______	C 01/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KEMPSVILLE HEALTH & REHAB CENTER	5520 INDIAN RIVER ROAD VIRGINIA BEACH, VA 23464

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 50 every shift. 10/11/21, skin checks weekly day shift on Monday. Notify the physician of any abnormal findings. Review of the physician order summary for revealed there were no orders to treat a pressure ulcer between 10/6/21 and 10/12/21 and there was no evidence of a baseline care plan or any other care plan to address redness/ blanchable redness to the sacrum or a coccyx pressure ulcer. There was also no weekly wound assessment on the clinical record until 10/8/21, for the new onset coccyx wound and it had no treatment plan. An interview was conducted with Licensed Practical Nurse (LPN) #1 on 1/13/21 at approximately 2:40 p.m. LPN #1 stated Resident #15 was re-admitted to the facility 10/6/21 with blanchable redness to the sacrum which progressed to the current pressure. LPN #1 also stated pressure ulcer are assessed weekly by the wound care physician if no other outside practice is treating the specified area but if for some reason the wound care physician can't keep the regular visit LPN #1 assesses and documents on the wounds. Review of the in-house weekly wound assessment dated 10/12/2021 12:00 a.m., read as follows; Wound type is pressure. Stage: Unstagable Wound Location coccyx. The measurements are Length (cm) 2.0, Width (cm) 1.5, and Depth (cm) 0.0. The area is community acquired. Skin impairment was present on admission, 10/06/2021 Drainage type: No Drainage Wound bed has Slough, No odor.	F 686		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495232	A. BUILDING ______ B. WING ______	C 01/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KEMPSVILLE HEALTH & REHAB CENTER	5520 INDIAN RIVER ROAD VIRGINIA BEACH, VA 23464

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 51 Periwound appearance is Pink. Wound is unchanged. Pain Level is zero. The treatment is Santyl. Review of the wound care physician's progress note dated 10/12 21 read initial evaluation; Full Thickness. Resident presents with a wound on her sacrum; at the request of the referring provider, (name of the provider) a thorough wound care assessment and evaluation was performed today. The sacral wound is unstageable (due to necrosis). There is light serous exudate. The patient appears to have associated pain evidenced by restlessness and grimacing. The etiology was pressure. The pressure ulcer measured 2.0 centimeter by 1.5 centimeters and presented with 40 percent necrotic tissue, 30 percent devitalized necrotic tissue and 30 percent granulation tissue. The treatment plan was Dakins apply once daily for 30 days, Santyl apply once daily for 30 days, Gauze island with a border apply once daily for 30 days and Skin prep apply once daily for 30 days. The wound care physician's 10/19/21 wound care progress continued to address treatment to an unstageable sacral pressure ulcer which; was debrided that day to remove necrotic tissue and establish the margins of viable tissue. Resident #15 remained under the wound care physician's care for treatment of a pressure wound to the sacrum which was reclassified from unstageable to a stage III pressure ulcer on 11/9/21. An observation was made of Resident #15's sacral wound on 1/13/21 at approximately 10:10 a.m. The wound bed was clean, beefy red and	F 686		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495232	A. BUILDING ______ B. WING ______	C 01/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KEMPSVILLE HEALTH & REHAB CENTER	5520 INDIAN RIVER ROAD VIRGINIA BEACH, VA 23464

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 52	F 686		

with a small amount of drainage. The wound care was tolerated well by the resident. She was wearing pressure relieving boots to bilateral lower extremities.

An interview was conducted with the wound care physician by phone on 1/14/21 at approximately 11:40 a.m. The wound care physician stated it appears the delay in notifying her of the areas of concern compromised Resident #15. The wound care physician stated there is no reason for delays in wound care assessment and treatment for she is very flexible to ensure necessary care is available such as; routine visits to the facility, making an additional visit to the facility on unscheduled days and/or telemedicine. The wound care physician stated she would have been instituted orders immediately for pressure ulcer prevention.

On 1/14/22 at approximately 1:30 p.m., the above information was shared with the Administrator, Director of Nursing and Corporate Consultant. They provided additional documents on 1/18/22 at approximately 9:00 a.m., for consideration regarding the above information. That information is reflected in this report.

The below information was obtained 1/21/22 from (https://medlineplus.gov/ency/patientinstructions/000147.htm)

Preventing pressure ulcers
Pressure ulcers are also called bedsores, or pressure sores. They can form when your skin and soft tissue press against a harder surface, such as a chair or bed, for a prolonged time. This pressure reduces blood supply to that area. Lack of blood supply can cause the skin tissue in this

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495232	A. BUILDING ____ B. WING ____	C 01/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KEMPSVILLE HEALTH & REHAB CENTER	5520 INDIAN RIVER ROAD VIRGINIA BEACH, VA 23464

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

F 686 Continued From page 53 — F 686

area to become damaged or die. When this happens, a pressure ulcer may form.

You have a risk of developing a pressure ulcer if you:
· Spend most of your day in a bed or a chair with minimal movement
· Are overweight or underweight
· Are not able to control your bowels or bladder
· Have decreased feeling in an area of your body
· Spend a lot of time in one position

You will need to take steps to prevent these problems; you, or your caregiver, need to check your body every day from head to toe. Pay special attention to the areas where pressure ulcers often form. These areas are the; heels and ankles, knees, hips, spine, tailbone area, elbows, shoulders and shoulder blades, back of the head, and the ears.

After urinating or having a bowel movement; clean the area right away. Dry well, and ask your provider about creams to help protect your skin in this area.

Call your health care provider if you see early signs of pressure ulcers. These signs are: Skin redness, Warm areas, Spongy or hard skin, Breakdown of the top layers of skin or a sore.

The below information was obtained 1/21/22 from (https://www.ncbi.nlm.nih.gov/books/NBK2650/table/ch12.t2/)
National Pressure Ulcer Staging System
Stage III - Full thickness skin loss involving damage or necrosis of subcutaneous tissue that

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495232	A. BUILDING _____ B. WING _____	C 01/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KEMPSVILLE HEALTH & REHAB CENTER	5520 INDIAN RIVER ROAD VIRGINIA BEACH, VA 23464

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 54	F 686		

Continued From page 54

may extend down to, but not through, underlying fascia. The ulcer presents clinically as a deep crater with or without undermining of adjacent tissue.

Unstageable - Full thickness tissue loss in which actual depth of the ulcer is completely obscured by slough (yellow, tan, gray, green, or brown) and/or eschar (tan, brown, or black) in the wound bed.

2. The facility staff failed to ensure the necessary assessment, treatment, care, and services was provided to Resident #278 to promote healing of excoriations, and intact and opened blisters of bilateral buttocks. The deterioration of the right buttock resulted in an unstageable pressure ulcer and the deterioration of the left buttock resulted in a stage III pressure ulcer; both presenting with necrotic tissue necessitating surgical debridement.

Resident #278 was originally admitted to the facility 5/14/21 and discharged from the facility 5/28/21 after becoming ill during a dialysis session. The diagnoses prior to discharge included; a left hip fracture, end-stage renal disease and diabetes.

The admission Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 5/20/21 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 11 out of a possible 15. This indicated Resident #278's cognitive abilities for daily decision making were moderately impaired.

In section "G" (Physical functioning) the resident was coded as requiring total care of one person

RECEIVED
FEB 17 2022
VDH/OLC

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495232	A. BUILDING ______ B. WING ______	C 01/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KEMPSVILLE HEALTH & REHAB CENTER	5520 INDIAN RIVER ROAD VIRGINIA BEACH, VA 23464

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 55	F 686		

with bathing, extensive assistance of two people with bed mobility, extensive assistance of one person, with toileting, supervision of two people with transfers, and supervision after set-up with eating.

In Section "M" (Skin Conditions) the resident was coded for having one stage III pressure ulcer on admission and one unstageable pressure ulcer present on admission.

The Braden Scale for Prediction of Pressure Ulcers was completed 5/21/21. The Resident scored 18.0, which indicated he was a Low Risk Resident. The resultes revealed Resident # 278; Responds to verbal commands. Has no sensory deficit which would limit ability to feel or voice pain. Skin is usually dry, linen only requires changing at routine intervals. Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair. Makes frequent though slight changes in body or extremity position independently. Eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products per day. Moves feebly or requires minimum assistance. During a move skin probably slides to some extent against sheets, chair, restraints or other devices. Maintains relatively good position in chair or bed most of the time but occasionally slides down.

Review of the admission weekly skin assessment revealed the following skin impairments; a tunneled dialysis catheter to the chest, left upper area has bruises/discoloration, scattered tiny bruises to the abdomen, an old scar to the mid abdomen, redness, irritation with excoriations to the groin, excoriations and blisters

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495232	A. BUILDING ______ B. WING ______	C 01/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KEMPSVILLE HEALTH & REHAB CENTER	5520 INDIAN RIVER ROAD VIRGINIA BEACH, VA 23464

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 56	F 686		

some are intact and some burst at different shapes and sizes of the right buttock, excoriations, blisters of the left buttock; some are intact and some burst open at different sizes and shapes, moist, reddened and excoriated sacrum, moist, reddened and excoriated coccyx, red and moist areas to the left inner leg, left hip has surgical incision with staples, well approximated, left upper outer thigh has short surgical incision with 2 staples, left lower outer thigh has surgical incision with 2 staple, well approximated, a left outer heel scab, a middle left toe scab, right first and 4th toes has scab on top of each, and old amputations of the 2nd and 3rd toes.

Review of the active care plan dated 5/15/21 revealed a problem which read; Resident has impaired skin integrity; surgical wound to the left upper outer thigh/left hip. The goal read; area will show signs of improvement and be free of signs/symptoms of infection. The interventions included; Administer medications as ordered. Administer treatments as ordered. Assess and document the status of the area (healing vs declining. Monitor and report to the physician, redness, swelling, local warmth, tenderness, discharge, elevated temperature.

Another care plan dated 5/15/21 revealed a problem which read; Resident has a potential for skin breakdown due to decreased mobility. The goal read; the resident will maintain intact skin. The interventions included; complete the Braden scale per protocol. Complete the skin assessment per protocol. Diet as ordered. Turn and reposition as indicated. Use pressure relieving devices as indicated.

Review of the resident's admission physician

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495232	A. BUILDING ______ B. WING ______	C 01/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KEMPSVILLE HEALTH & REHAB CENTER	5520 INDIAN RIVER ROAD VIRGINIA BEACH, VA 23464

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 57	F 686		

orders dated 5/14/21 revealed the following skin treatment orders; Calmoseptine Ointment 0.44-20.6 % (Menthol-Zinc Oxide) Apply to sacrum/buttocks topically every shift for excoriations/opened blisters Cleanse area with soap and water, pat dry and apply Calmoseptine. Skin checks twice weekly every day shift on Monday and Thursday for prevention report to the physician any abnormalities. Turn and re-position every two hours as tolerated while in bed, every shift for prevention.

An excoriation is a scratch/abrasion to the skin. Opened blisters to the buttock are classified as pressure ulcers.

A stage II pressure ulcer is a partial thickness skin loss involving the epidermis and/or dermis. The ulcer is superficial and presents clinically as an abrasion, blister, or shallow crater; partial thickness loss of dermis presenting as a shallow open ulcer with a red, pink wound bed without slough. May also present as an intact or open/ruptured serum-filled blister. (Obtained from the following website 1/25/22; https://www.ncbi.nlm.nih.gov/books/NBK2650/table/ch12.t2/)

Calmoseptine Ointment 0.44-20.6 % (Menthol-Zinc Oxide); this medication is used to treat and prevent minor skin irritations (such as from diarrhea, burns, cuts, scrapes). It works by forming a barrier on the skin to protect it from irritants/moisture. (https://healthy.kaiserpermanente.org/health-wellness/drug-encyclopedia/drug.calmoseptine-0-44-20-6-topical-ointment.560016).

No further wound care orders were noted to the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495232	A. BUILDING ______ B. WING ______	C 01/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KEMPSVILLE HEALTH & REHAB CENTER	5520 INDIAN RIVER ROAD VIRGINIA BEACH, VA 23464

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 58 buttocks until 5/18/21. New orders for wound care dated 5/18/21 read as follows; Santyl Ointment 250 UNIT/GM (Collagenase) Apply to the left buttock topically every day shift for wound care. Cleanse with normal saline, pat dry, apply Santyl followed by calcium alginate, cover with a dry dressing, and change every day and as needed. Santyl Ointment 250 UNIT/GM (Collagenase) Apply to the right buttock topically every day shift for wound care. Cleanse with normal saline, apply betadine to eschar areas, and apply Santyl to open areas, cover with dry dressing, change every day and as needed. Resident #278 was seen by the wound care physician on 5/19/21. The documentation revealed the following; the etiology of the wound to the left buttock was pressure. It was classified as a stage III pressure ulcer measuring 5.5 centimeters by 3.0 centimeters by 0.2 centimeters. It was with a moderate amount of serosanguinous drainage, 40 percent thick adherent devitalized necrotic tissue and 60 percent granulation tissue. The etiology of the wound to the right buttock was also pressure and it consisted of a cluster of wounds. It was classified as unstageable, measuring 9.0 centimeters by 13.0 centimeters. It was with a moderate amount of serosanguinous drainage, 50 percent thick adherent black necrotic tissue (eschar), 20 percent granulation tissue and 30 percent skin. The left buttock pressure ulcer treatment orders for 5/19/21 were as follows; Alginate calcium	F 686		

F 686 | F 686

Continued From page 59
apply once daily for 30 days; Santyl apply once daily for 30 days. Gauze island with a border, apply once daily for 30 days. Skin prep apply once daily for 30 days. The recommendations were as follows; Low air loss mattress; Off-load wound; Reposition per facility protocol.

The right buttock pressure ulcer treatment orders for 5/19/21 were as follows; Alginate calcium apply once daily for 30 day: to all medial open areas; Santyl apply once daily for 30 days: to all medial open areas. Betadine apply once daily for 30 days : to all eschar areas. Gauze island with a border, apply once daily for 30 days. Skin prep apply once daily for 30 days. The recommendations were to off-load the wound and reposition per facility protocol.

The wound care physician assessed Resident #278's bilateral buttock pressure ulcer again on 5/25/21. The left buttock measured 4.5 cm by 1.0 cm by 0.2 cm, with a Moderate amount of serosanguinous drainage 40 percent thick adherent devitalized necrotic tissue and 60 percent granulation tissue. The right buttock measured 10.5 cm by 11.0 cm by not measurable cm with 50 percent thick adherent black necrotic tissue (eschar), 20 percent granulation tissue and 30 percent skin.

Review of the hospital records dated 5/28/21 revealed the resident was admitted with a right buttock pressure ulcer which included multiple skin necrosis and overall redness. The infected pressure ulcer may be contributing to his leukocytosis. Will plan for the operating room tomorrow for debridement (removal of necrotic tissue from a wound) of the right buttock ulcers. The plan is to remove the necrotic skin and

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495232	A. BUILDING ____ B. WING ____	C 01/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KEMPSVILLE HEALTH & REHAB CENTER	5520 INDIAN RIVER ROAD VIRGINIA BEACH, VA 23464

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 60 debride unhealthy tissue underneath. An interview was conducted with Resident #278's daughter on 1/14/22 at approximately 10:45 a.m. The daughter stated she was unable to visit the resident because of COVID-19 restrictions and when she called the facility the nurses dismissed her concerns and talked negatively about her father. The daughter also stated she wasn't informed about her father's pressure ulcers by the facility's staff. The daughter further stated her father never recovered from the pressure ulcers acquired even after multiple surgeries. An interview was conducted with the wound care physician by phone on 1/14/21 at approximately 11:40 a.m. The wound care physician stated it appeared the delay in notifying her of the areas of concern compromised Resident #278's coordination of care. The wound care physician stated there is no reason for delays in wound care assessment and treatment for she is very flexible to ensure necessary care is available such as; routine visits to the facility, making an additional visit to the facility on unscheduled days and/or telemedicine. On 1/14/22 at approximately 1:30 p.m., the above information was shared with the Administrator, Director of Nursing and Corporate Consultant. They provided additional documents on 1/18/22 at approximately 9:00 a.m., for consideration regarding the above information. That information is reflected in this report. COMPLAINT DEFICIENCY	F 686	F690 1. Resident #281 no longer resides at the facility. 2. All residents with an indwelling foley catheter have the potential to be affected. Audit of residents with indwelling foley catheters completed to validate appropriate orders, justification and accurate care plan.	
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3)	F 690		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495232	A. BUILDING ______ B. WING ______	C 01/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KEMPSVILLE HEALTH & REHAB CENTER	5520 INDIAN RIVER ROAD VIRGINIA BEACH, VA 23464

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC 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 61 §483.25(e) Incontinence. §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. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (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; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one 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, staff interviews and facility documentation, the facility staff failed	F 690	3. Licensed nursing staff have been re-educated on indwelling urinary catheter process including having complete orders and medical justification by the DON or designee. Newly hired licensed nurses and agency licensed nurses will be educated prior to providing direct resident care. 4. MDS nurse/designee will audit residents and new admissions who have indwelling catheters weekly x 12 weeks to validate appropriate justification, orders and care plans are current. Results of audits will be taken to the QAPI committee monthly for 3 months for review and revision as needed. . 5. 2/17/2022	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495232	A. BUILDING ______ B. WING ______	C 01/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KEMPSVILLE HEALTH & REHAB CENTER	5520 INDIAN RIVER ROAD VIRGINIA BEACH, VA 23464

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC 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 62 to obtain an order for use of an indwelling catheter including a valid medical justification for 1 of 37 Resident's (Resident #281), in the survey summary. The findings included: Resident #281 was originally admitted to the facility 01/7/22 and had not been discharged. The current diagnoses included; new stroke with left side weakness, dysphasia and urinary retention. The Minimum Data Set (MDS) assessment had not been completed therefore; information was gained from Licensed Practical Nurse (LPN) #3. LPN #3 stated the resident was alert and oriented to person, family, situation and place but required assistance to make daily decisions. LPN #3 also stated the resident required total care with all care including eating and she required use of an indwelling catheter. On 1/12/22 at approximately 10:15 a.m., Resident #281 was observed sitting across from the nursing station. The resident's head was lowered and her nose was draining a large amount of thick light yellow mucus which the Resident wiped away with the back of her hand. The Resident appeared very pale, had facial bruising and spoke very softly. She was wearing an untied hospital gown, had a blanket over her lap, her hair was severely matted and the catheter drainage bag was very full, containing approximately 800 milliliter of light but cloudy urine. The Resident stated she had a stroke and was found on the floor by her daughter and she had come to the facility to regain her strength after hospitalization.	F 690		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495232	A. BUILDING ______ B. WING ______	C 01/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KEMPSVILLE HEALTH & REHAB CENTER	5520 INDIAN RIVER ROAD VIRGINIA BEACH, VA 23464

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC 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 63	F 690		

On 1/13/22 at approximately 9:50 a.m., Resident #281 was observed in bed. The floor near the catheter drainage bag had a large amount of fluid on the floor. Certified Nursing Assistant (CNA)#1 stated she saw what was wrong the drainage bag and proceeded to clean the fluid off of the floor.

Review of the Admission assessment completed 1/7/22 was coded to indicate Resident #281 had bladder incontinence and the box for urinary catheter was not coded.

Review of the hospital's discharge summary dated 1/7/22 revealed the resident had urinary retention requiring placement of a Foley.

Review of a progress note dated 1/8/22 at 13:53 which read; Urinary Elimination: Resident has voided this shift: within normal limits, Resident has urinary catheter. Urinary catheter was noted to be patent.

A progress note on 1/10/22 read; Urinary Elimination: Resident has voided this shift: yellow Resident has urinary catheter. Urinary catheter was noted to be patent. Urinary catheter is draining. Urinary catheter is anchored.

A progress note on 1/10/22 read; Urinary Elimination: Resident has voided this shift: within normal limits. Resident has urinary catheter. Urinary catheter was noted to be patent. Urinary catheter is draining. Urinary catheter is anchored.

The physician order summary revealed an orders dated 1/11/22 as follows; Anchor catheter tubing and check placement every shift, a voiding trial in five days, change the catheter bag every thirty days. Document Foley output every shift. Foley

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495232	A. BUILDING _____ B. WING _____	C 01/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KEMPSVILLE HEALTH & REHAB CENTER	5520 INDIAN RIVER ROAD VIRGINIA BEACH, VA 23464

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC 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 64	F 690		

catheter care every shift and as needed.

Further review of the Physician order summary failed to provide evidence of an order for use of an indwelling catheter including the size of the catheter to insert and a valid medical justification for use.

Review of the baseline care plan dated 01/09/22 which read; Resident is incontinent of bladder. The goal read; Resident will receive assistance with toileting, maintain comfortable, clean and dry, and free from skin breakdown. The interventions included; Assess resident pattern of urination and episodes of incontinence. Provide incontinence care as needed. Monitor peri-area for redness, irritation, skin excoriation/breakdown.

The baseline care plan didn't address requiring the use of an indwelling catheter.

On 1/13/22 at approximately 10:25 a.m., an observation was made of the indwelling catheter currently inserted in Resident #281 with LPN #2. It revealed a 16 french with a 30 cubic centimeter balloon.

An interview was conducted with LPN #2. LPN #2 stated there wasn't an order for the actual indwelling catheter and it was because there was system problem when writing the urinary indwelling catheter orders. LPN #2 obtained an order on 1/13/22 for the indwelling catheter use of an indwelling catheter 16 french with a 30 cc balloon secondary to urinary retention.

On 1/14/22 at approximately 1:30 p.m., the above information was shared with the Administrator, Director of Nursing and Corporate Consultant.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495232	A. BUILDING ______ B. WING ______	C 01/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KEMPSVILLE HEALTH & REHAB CENTER	5520 INDIAN RIVER ROAD VIRGINIA BEACH, VA 23464

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC 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 65 The facility's staff was offered the opportunity to provide additional information but they did not.	F 690		
F 692 SS=G	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: The facility staff failed to ensure one resident with a potential for weight loss received adequate protein, portion sizes, and preferences at each meal, and to obtain weights as a means of measuring weight management for Resident #15. This failure resulted in a weight loss of 51.7 pounds from admission weight 3/30/21, (150 pounds) to a current weight 1/13/22, of (98.3 pounds) which constituted harm, and the facility staff failed to obtain weekly weights for Resident	F 692	F692 1. Resident #15 had diet reviewed and addressed to ensure adequate protein, portion sizes and preferences with meals are offered, these residents were weighed and care plans reviewed and revised as needed. Resident #47 weighed, diet reviewed, care plan reviewed and revised as needed. 2. All residents have the potential to be affected. Weights reviewed for any residents effected by this deficient practice and concerns addressed. 3. Nursing staff have been educated on weight policy, documenting meal percentages and re-weights for weight variances by the DON or designee. The facility DON, RD, and dietary manager	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495232	A. BUILDING ______ B. WING ______	C 01/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KEMPSVILLE HEALTH & REHAB CENTER	5520 INDIAN RIVER ROAD VIRGINIA BEACH, VA 23464

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC 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 692	Continued From page 66 #47. The findings included: 1. Resident #15 was originally admitted to the facility 03/29/2021 and readmitted 10/06/2021 after an acute care hospital stay. The current diagnoses included; Malnutrition, Cirrhosis, Heart failure and Anemia. The quarterly Minimum Data Set (MDS) assessment with an assessment reference date (ARID) of 10/30/2021 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 10 out of a possible 15. This indicated Resident #15's cognitive abilities for daily decision making were moderately impaired. In section "G" (Physical functioning) the resident was coded as requiring total care of one with toileting and bathing, extensive assistance of one person with bed mobility, personal hygiene and dressing, limited assistance of one person with eating and coded activity didn't occur for transfers, walking and locomotion. In section "K" Swallowing/Nutritional Status the resident was coded no loss of liquids/solids from mouth when eating or drinking, no holding food in mouth/cheeks or residual food in mouth after meals, no coughing or choking during meals or when swallowing medications and no complaints of difficulty or pain when swallowing but the resident was coded for weight Loss of 5% or more in the last month or loss of 10% or more in last 6 months without being on a prescribed weight loss regimen. The current physician ordered diet dated	F 692	have also been educated on weight policy to include following dietary recommendations and implementations by the DON or designee. Newly hired nursing staff and agency nursing staff will be educated prior to providing direct resident care. 4. The facility DON or designee will review daily/weekly/monthly weights weekly for 12 weeks to validate weights obtained per order, appropriate interventions in place as needed, care plans accurate. Facility Registered Dietician will audit 7 trays weekly for 12 weeks to ensure appropriate diet in place. Results of audits will be taken to the QAPI committee monthly for 3 months for review and revision as needed. 5. 2/17/2022	