State

State of Virginia

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	VA0179	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) COMPLETE DATE
F 000	Initial Comments An unannounced biennial State Licensure Inspection was conducted 01/11/22 through 01/14/22 and 01/18/22. The facility was not in compliance with the Virginia Rules and Regulations for the Licensure of Nursing Facilities. No complaints were investigated during the survey. The census in this 90 licensed bed facility was 75 at the time of the survey. The survey sample consisted of 37 current and closed Resident reviews.	F 000	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. 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	
F 001	Non Compliance The facility was out of compliance with the following state licensure requirements: This RULE: is not met as evidenced by: The facility staff was not in compliance with the Rules and Regulations for the Licensure of Nursing Facilities: COV32.1-126.01(A). Cross reference to F-602. 12VAC5-371-150 (B3). Resident Rights. Cross reference to F-585. 12VAC5-371-180. Infection Control. Cross reference to F-880. 12VAC5-371-220 (B. C. F. and H). Nursing Services. Cross reference to F-580, F-677, F-685, F-686, F-690, F-692, F-881. 12VAC5-371-250 (F). Resident Assessment & Care Planning. Cross reference to F-637, F-655 and F-656.	F 001		

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

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
	VA0179	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) COMPLETE DATE
F 001	Continued From page 1 12VAC5-371-300 (B). Pharmaceutical services. Cross reference to F-554 and F-761. 12 VAC 5-371-140 (E)(3)(b) and COV § 32.1-126.01 (A) Based on staff interview and facility documentation review, the facility staff failed to obtain a criminal background check with the Central Criminal Records Exchange within 30 days of hire for 1 employee, Dietary Employee #3, in a sample of 20 employee records. The facility staff failed to obtain a criminal background check within 30 days of hire for Dietary Employee #3. The findings included: On 1/11/22, a group interview was conducted with the Human Resources [HR] Director and the Facility Administrator who confirmed the hire date for Dietary Employee #3. The HR Director stated, "We conduct criminal background checks to be sure that we are not hiring any felons, sex offenders, or anyone with barrier crimes in order to protect our residents" and "We can obtain the criminal background check within 30 days of hire". On 1/12/22, a review of personnel records for Dietary Employee #3 was conducted. A criminal background check request 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. On 1/12/22, the findings for Dietary Employee #3 were shared with the HR Director and the Facility	F 001	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
	VA0179	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) COMPLETE DATE
F 001	Continued From page 2 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...". No further information was provided. Cross-reference to F-607 12 VAC 5-371-210 (E) Based on staff interview and facility documentation review, the facility staff failed to verify the professional license, prior to providing direct resident care, for 1 licensed professional nurse, LPN #2, in a sample of 20 employee records reviewed. 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. The findings included:	F 001	F880 1. No known resident was affected by deficient practice. The involved staff member was immediately educated on completing the screening tool accurately and completely. 2. All residents have the potential to be affected by deficient practice. The facility administrator reviewed screen logs 1/13/2022 to validate completeness 3. The Nursing staff were educated on screening process with emphasis on the importance of completing form in entirety and for all individuals entering center by the DON or designee. This will include newly hired staff and agency staff prior to working on the floor. 4. Medical Records/designee will review and audit daily screening sheets 5x per week for 12 weeks to validate accuracy. Medical records or designee will visually audit 5 screenings per day, 5 days a week for 12 weeks to validate appropriate process utilized. Audit results to be taken to the QAPI committee monthly for 3 months for review and revision as needed. 5. 2/17/2022	

State of Virginia

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	VA0179	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) COMPLETE DATE
F 001	Continued From page 3 On 1/12/22, a review of LPN #2's employee record was conducted. 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 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	F 001	F677 1. Resident # 281 no longer resides at the facility. Resident received a shower on 1/13/2022. 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
	VA0179	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) COMPLETE DATE
F 001	Continued From page 4 abuse or neglect...". The findings were discussed with the Facility Administrator and HR Director. No further information was provided. Cross-reference to F-607 12 VAC 5-371-220 (F). Quality of Life. ADL Care Provided for Dependent Residents. Under section (F). Each resident shall receive tub or shower baths as often as needed, but not less than twice weekly. Based on resident interview, staff interviews and clinical record review the facility staff failed to provide personal care to include showers for 1 resident (Resident #6 and #177) who was unable to independently carry out activities of daily living (ADL) care. The findings included: 1. The facility staff failed to ensure Resident #6 was offered and received a scheduled twice-weekly showers to maintain good personal hygiene. Resident #6 was originally admitted to the facility on 04/05/18. Diagnosis for Resident #6 included but not limited to muscle weakness. Resident #6's Minimum Data Set (an assessment protocol) a quarterly assessment with an Assessment Reference Date (ARD) of 10/12/21 coded the resident's Brief Interview for Mental Status (BIMS) score 10 of a possible 15 with moderate cognitive impairment for daily decision-making. In section "G" (Physical functioning) the MDS coded Resident #6 requiring total dependence of one with bathing, extensive assistance of one two with bed mobility	F 001	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. 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.	

State of Virginia

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	VA0179	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) COMPLETE DATE
F 001	Continued From page 5 and extensive assistance of one with hygiene and toilet use. In section "H" (Bladder and Bowel) was coded for always incontinent of bladder and bowel. The comprehensive care plan with a created date of 05/01/19 and a revision date of 10/23/20 documented Resident #6 with ADL self-care performance deficit related to impaired mobility, cognitive deficit and often refuses ADL care. The goal set by the staff is that resident will maintain current level of function in ADL's through the next review date of 03/08/22. One of the intervention to manage goal include is to assist with bathing and dressing as needed. Review of the shower schedule evidenced Resident #6 was scheduled for showers twice weekly on Monday and Thursday (3-11 shift). Review of Resident 6's ADL Documentation Survey Report revealed the showers were not given on the following shower days: November 2021 (11/13, 11/17, 11/20, 11/24 and 11/27/21). December 2021 (12/01, 12/04, 12/11, 12/15, 12/18, 12/22, 12/25 and 12/29/21). January 2022 (01/05 and 01/08/22). An interview was conducted with Certified Nursing Assistant #1 (CNA) on 01/13/22 at approximately 3:45 p.m., who stated, "Resident #6 can't refuse his showers because they are not being offered or given." She said the residents are to be offered their showers at least twice a week and if they refuse, the nurse is to be made aware and we are to document their refusal as well as the nurse.	F 001	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 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 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.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	VA0179	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) COMPLETE DATE
F 001	Continued From page 6 A phone call was placed Certified Nursing Assistant (CNA) #2 on 01/14/22 at approximately 10:20 a.m. The CNA was assigned to provide care and services to Resident #6 on 02/01/21 (3p-11p shift). A message was left, the CNA never returned the call. A debriefing was conducted with the Administrator, Director of Nursing (DON) and corporate on 01/17/22 at approximately 4:05 p.m. Corporate stated, "Residents are set up with scheduled shower days." She said Resident #6 should have the opportunity to receive a shower or tub bath twice a week. She said if the resident refuses his/her shower there should be a note in the CNA documentation and the nurse is to document the refusal in his/her clinical record. 2. The facility staff failed to ensure Resident #177 was offered and received a scheduled twice-weekly showers to maintain good personal hygiene. Resident #177 was admitted to the nursing facility on 01/29/21. Diagnosis for Resident #177 included but not limited to Osteomyelitis in the right ankle and foot. The Minimum Data Set (MDS - an assessment protocol) a 14-day assessment with an Assessment Reference Date (ARD) of 09/29/21 coded Resident #177 with a 15 out of a possible score of 15 on the Brief Interview for Mental Status (BIMS), indicating no cognitive impairment. In section "G" (Physical functioning) the MDS coded Resident #177 requiring extensive assistance of one with hygiene, limited assistance of one with transfer, supervision with limited assistance of one with transfer, hygiene and bed mobility for Activities of Daily Living (ADL) care.	F 001	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 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. 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.	

State of Virginia

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	VA0179	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) COMPLETE DATE
F 001	Continued From page 7 The comprehensive care plan with a created date of 01/30/21 documented Resident #177 with self-care deficit. The goal set for the resident by the staff is to meet his needs by 05/18/21. One of the interventions to manage goal include to assist with activities of daily living with dressing, grooming, toileting, feeding and oral care. Review of the shower schedule evidenced Resident #177 was scheduled for showers twice weekly on Monday and Thursday (3-11 shift). Review of Resident 177's Activities of Daily Living (ADL) Documentation Survey Report revealed the showers were not given on the following shower days: February 2021 (02/01, 02/08, 02/11, 02/15 and 02/18/21). A phone call was placed Certified Nursing Assistant (CNA) #2 on 01/14/22 at approximately 10:20 a.m. The CNA was assigned to provide care and services to Resident #177 on 02/01/21 (3p-11p shift). A message was left, the CNA never returned the call. A debriefing was conducted with the Administrator, Director of Nursing and corporate on 01/17/22 at approximately 4:05 p.m. Corporate stated residents are set up with scheduled shower days. She said Resident #177 should have the opportunity to receive a shower or tub bath twice a week. She said if the resident refuses his/her shower there should be a note from the CNA documentation or the nurse is to document their refusal in his/her clinical record. The facility policy titled Resident Bath/Showering/Scheduling with a revision date: 02/02/21. -Policy: Residents will be bathed or showered	F 001	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 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.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: VA0179	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING	(X3) DATE SURVEY COMPLETED C 01/18/2022

NAME OF PROVIDER OR SUPPLIER: **KEMPSVILLE HEALTH & REHAB CENTER**

STREET ADDRESS, CITY, STATE, ZIP CODE: **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) COMPLETE DATE
F 001	Continued From page 8 according to their preferences in order to maintain healthy hygiene and skin conditions. Staff who have demonstrated competence may bathe the resident via shower, tub bath, whirlpool bath, or bed bath. (G) If the bath/shower cannot be given or the resident refuses, the nursing assistant will promptly report this to the Charge Nurse. (H) The Charge Nurse will speak with the resident who refuses to ascertain why they are refusing and to determine if alternative arrangements that suit the resident can be made. If the resident continues to refuse the Charge Nurse will inform the DON and document the resident's refusal in the Nurses Notes and on the 24-Hour Report. Further attempts and interventions will be documented in the Nurses Notes and on the 24-Hour Report. The facility policy titled Resident Bath/Showering/Scheduling with a revision date: 02/02/21. -Policy: Residents will be bathed or showered according to their preferences in order to maintain healthy hygiene and skin conditions. Staff who have demonstrated competence may bathe the resident via shower, tub bath, whirlpool bath, or bed bath. (G) If the bath/shower cannot be given or the resident refuses, the nursing assistant will promptly report this to the Charge Nurse. (H) The Charge Nurse will speak with the resident who refuses to ascertain why they are refusing and to determine if alternative arrangements that suit the resident can be made. If the resident continues to refuse the Charge Nurse will inform	F 001	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 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	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	VA0179	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) COMPLETE DATE
F 001	Continued From page 9 the DON and document the resident's refusal in the Nurses Notes and on the 24-Hour Report. Further attempts and interventions will be documented in the Nurses Notes and on the 24-Hour Report.	F 001	F881 1. Resident #47 was assessed and no issues at this time and continues to reside at the facility. 2. All residents on antibiotic therapy have the potential to be affected. Assessment completed of current residents on antibiotic therapy to ensure appropriate documentation, which includes effectiveness and current care plan. 3. The facility DON and Unit Manager have been re-educated on the antibiotic stewardship program which includes tracking, and monitoring effectiveness of antibiotics by the Regional Corporate nurse. 4. An audit of the facility IC log to be completed weekly for 12 weeks by the facility RDCS or designee. The RDCS /designee will review 3 residents on ABT weekly x 12 weeks to validate effectiveness of ABT is monitored. Results of audits will be taken to the QAPI committee monthly for 3 months for review and revision as needed. 5. 2/17/2022	

State of Virginia

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	VA0179	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) COMPLETE DATE
F 000	Initial Comments An unannounced biennial State Licensure Inspection was conducted 01/11/22 through 01/14/22 and 01/18/22. The facility was not in compliance with the Virginia Rules and Regulations for the Licensure of Nursing Facilities. No complaints were investigated during the survey. The census in this 90 licensed bed facility was 75 at the time of the survey. The survey sample consisted of 37 current and closed Resident reviews.	F 000	F655 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	
F 001	Non Compliance The facility was out of compliance with the following state licensure requirements: This RULE: is not met as evidenced by: The facility staff was not in compliance with the Rules and Regulations for the Licensure of Nursing Facilities: COV32.1-126.01(A). Cross reference to F-602. 12VAC5-371-150 (B3). Resident Rights. Cross reference to F-585. 12VAC5-371-180. Infection Control. Cross reference to F-880. 12VAC5-371-220 (B. C. F. and H). Nursing Services. Cross reference to F-580, F-677, F-685, F-686, F-690, F-692, F-881. 12VAC5-371-250 (F). Resident Assessment & Care Planning. Cross reference to F-637, F-655 and F-656.	F 001		

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

State of Virginia

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	VA0179	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) COMPLETE DATE
F 001	Continued From page 1 12VAC5-371-300 (B). Pharmaceutical services. Cross reference to F-554 and F-761. 12 VAC 5-371-140 (E)(3)(b) and COV § 32.1-126.01 (A) Based on staff interview and facility documentation review, the facility staff failed to obtain a criminal background check with the Central Criminal Records Exchange within 30 days of hire for 1 employee, Dietary Employee #3, in a sample of 20 employee records. The facility staff failed to obtain a criminal background check within 30 days of hire for Dietary Employee #3. The findings included: On 1/11/22, a group interview was conducted with the Human Resources [HR] Director and the Facility Administrator who confirmed the hire date for Dietary Employee #3. The HR Director stated, "We conduct criminal background checks to be sure that we are not hiring any felons, sex offenders, or anyone with barrier crimes in order to protect our residents" and "We can obtain the criminal background check within 30 days of hire". On 1/12/22, a review of personnel records for Dietary Employee #3 was conducted. A criminal background check request 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. On 1/12/22, the findings for Dietary Employee #3 were shared with the HR Director and the Facility	F 001	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 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	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: VA0179	(X2) MULTIPLE CONSTRUCTION A. BUILDING: ___ B. WING ___	(X3) DATE SURVEY COMPLETED 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) COMPLETE DATE
F 001	Continued From page 2 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...". No further information was provided. Cross-reference to F-607 12 VAC 5-371-210 (E) Based on staff interview and facility documentation review, the facility staff failed to verify the professional license, prior to providing direct resident care, for 1 licensed professional nurse, LPN #2, in a sample of 20 employee records reviewed. 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. The findings included:	F 001	completed of Comprehensive care plans for 2 weeks 1/5/22 – 1/18/22 Care plans reviewed and revised as needed. 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 F657 1. Resident #47 is not receiving antibiotic therapy at this time. 2. All residents receiving antibiotic therapy have the potential to be affected. 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
	VA0179	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) COMPLETE DATE
F 001	Continued From page 3 On 1/12/22, a review of LPN #2's employee record was conducted. 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 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	F 001	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 F761 1. Resident #46's medications are stored in a secure location, accessible to designated staff.. 2. All residents have the potential to be affected. Facility wide observation of residents rooms completed, no other medications were found.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	VA0179	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) COMPLETE DATE
F 001	Continued From page 4	F 001		

abuse or neglect...".

The findings were discussed with the Facility Administrator and HR Director. No further information was provided.

Cross-reference to F-607
12 VAC 5-371-220 (F). Quality of Life. ADL Care Provided for Dependent Residents.

Under section (F). Each resident shall receive tub or shower baths as often as needed, but not less than twice weekly.

Based on resident interview, staff interviews and clinical record review the facility staff failed to provide personal care to include showers for 1 resident (Resident #6 and #177) who was unable to independently carry out activities of daily living (ADL) care.

The findings included:

1. The facility staff failed to ensure Resident #6 was offered and received a scheduled twice-weekly showers to maintain good personal hygiene. Resident #6 was originally admitted to the facility on 04/05/18. Diagnosis for Resident #6 included but not limited to muscle weakness.

Resident #6's Minimum Data Set (an assessment protocol) a quarterly assessment with an Assessment Reference Date (ARD) of 10/12/21 coded the resident's Brief Interview for Mental Status (BIMS) score 10 of a possible 15 with moderate cognitive impairment for daily decision-making. In section "G" (Physical functioning) the MDS coded Resident #6 requiring total dependence of one with bathing, extensive assistance of one two with bed mobility

3. Licensed nurses and department heads were educated on medication storage by the DON or designee. Newly hired licensed nurses and agency licensed nurses will be educated prior to providing direct resident care.
4. Unit manager or designee will visually audit 7 resident rooms per week for 12 weeks to validate medication storage (no meds at bedside). Results of audits will be reviewed in QAPI monthly for three months for review and revision as needed..
5. 2/17/2022

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: VA0179	(X2) MULTIPLE CONSTRUCTION A. BUILDING: ______ B. WING ______	(X3) DATE SURVEY COMPLETED 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) COMPLETE DATE
F 001	Continued From page 5 and extensive assistance of one with hygiene and toilet use. In section "H" (Bladder and Bowel) was coded for always incontinent of bladder and bowel. The comprehensive care plan with a created date of 05/01/19 and a revision date of 10/23/20 documented Resident #6 with ADL self-care performance deficit related to impaired mobility, cognitive deficit and often refuses ADL care. The goal set by the staff is that resident will maintain current level of function in ADL's through the next review date of 03/08/22. One of the intervention to manage goal include is to assist with bathing and dressing as needed. Review of the shower schedule evidenced Resident #6 was scheduled for showers twice weekly on Monday and Thursday (3-11 shift). Review of Resident 6's ADL Documentation Survey Report revealed the showers were not given on the following shower days: November 2021 (11/13, 11/17, 11/20, 11/24 and 11/27/21). December 2021 (12/01, 12/04, 12/11, 12/15, 12/18, 12/22, 12/25 and 12/29/21). January 2022 (01/05 and 01/08/22). An interview was conducted with Certified Nursing Assistant #1 (CNA) on 01/13/22 at approximately 3:45 p.m., who stated, "Resident #6 can't refuse his showers because they are not being offered or given." She said the residents are to be offered their showers at least twice a week and if they refuse, the nurse is to be made aware and we are to document their refusal as well as the nurse.	F 001	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 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.	

State of Virginia

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	VA0179	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) COMPLETE DATE
F 001	Continued From page 6	F 001		

A phone call was placed Certified Nursing Assistant (CNA) #2 on 01/14/22 at approximately 10:20 a.m. The CNA was assigned to provide care and services to Resident #6 on 02/01/21 (3p-11p shift). A message was left, the CNA never returned the call.

A debriefing was conducted with the Administrator, Director of Nursing (DON) and corporate on 01/17/22 at approximately 4:05 p.m. Corporate stated, "Residents are set up with scheduled shower days." She said Resident #6 should have the opportunity to receive a shower or tub bath twice a week. She said if the resident refuses his/her shower there should be a note in the CNA documentation and the nurse is to document the refusal in his/her clinical record.

2. The facility staff failed to ensure Resident #177 was offered and received a scheduled twice-weekly showers to maintain good personal hygiene. Resident #177 was admitted to the nursing facility on 01/29/21. Diagnosis for Resident #177 included but not limited to Osteomyelitis in the right ankle and foot.

The Minimum Data Set (MDS - an assessment protocol) a 14-day assessment with an Assessment Reference Date (ARD) of 09/29/21 coded Resident #177 with a 15 out of a possible score of 15 on the Brief Interview for Mental Status (BIMS), indicating no cognitive impairment. In section "G" (Physical functioning) the MDS coded Resident #177 requiring extensive assistance of one with hygiene, limited assistance of one with transfer, supervision with limited assistance of one with transfer, hygiene and bed mobility for Activities of Daily Living (ADL) care.

Provider's Plan of Correction (F 001):

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

State of Virginia

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	VA0179	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) COMPLETE DATE
F 001	Continued From page 7 The comprehensive care plan with a created date of 01/30/21 documented Resident #177 with self-care deficit. The goal set for the resident by the staff is to meet his needs by 05/18/21. One of the interventions to manage goal include to assist with activities of daily living with dressing, grooming, toileting, feeding and oral care. Review of the shower schedule evidenced Resident #177 was scheduled for showers twice weekly on Monday and Thursday (3-11 shift). Review of Resident 177's Activities of Daily Living (ADL) Documentation Survey Report revealed the showers were not given on the following shower days: February 2021 (02/01, 02/08, 02/11, 02/15 and 02/18/21). A phone call was placed Certified Nursing Assistant (CNA) #2 on 01/14/22 at approximately 10:20 a.m. The CNA was assigned to provide care and services to Resident #177 on 02/01/21 (3p-11p shift). A message was left, the CNA never returned the call. A debriefing was conducted with the Administrator, Director of Nursing and corporate on 01/17/22 at approximately 4:05 p.m. Corporate stated residents are set up with scheduled shower days. She said Resident #177 should have the opportunity to receive a shower or tub bath twice a week. She said if the resident refuses his/her shower there should be a note from the CNA documentation or the nurse is to document their refusal in his/her clinical record. The facility policy titled Resident Bath/Showering/Scheduling with a revision date: 02/02/21. -Policy: Residents will be bathed or showered	F 001		

State of Virginia

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	VA0179	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) COMPLETE DATE
F 001	Continued From page 8 according to their preferences in order to maintain healthy hygiene and skin conditions. Staff who have demonstrated competence may bathe the resident via shower, tub bath, whirlpool bath, or bed bath. (G) If the bath/shower cannot be given or the resident refuses, the nursing assistant will promptly report this to the Charge Nurse. (H) The Charge Nurse will speak with the resident who refuses to ascertain why they are refusing and to determine if alternative arrangements that suit the resident can be made. If the resident continues to refuse the Charge Nurse will inform the DON and document the resident's refusal in the Nurses Notes and on the 24-Hour Report. Further attempts and interventions will be documented in the Nurses Notes and on the 24-Hour Report. The facility policy titled Resident Bath/Showering/Scheduling with a revision date: 02/02/21. -Policy: Residents will be bathed or showered according to their preferences in order to maintain healthy hygiene and skin conditions. Staff who have demonstrated competence may bathe the resident via shower, tub bath, whirlpool bath, or bed bath. (G) If the bath/shower cannot be given or the resident refuses, the nursing assistant will promptly report this to the Charge Nurse. (H) The Charge Nurse will speak with the resident who refuses to ascertain why they are refusing and to determine if alternative arrangements that suit the resident can be made. If the resident continues to refuse the Charge Nurse will inform	F 001		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	VA0179	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) COMPLETE DATE
F 001	Continued From page 9 the DON and document the resident's refusal in the Nurses Notes and on the 24-Hour Report. Further attempts and interventions will be documented in the Nurses Notes and on the 24-Hour Report.	F 001		