#### DEPARTMENT OF FIEAL TRANS BUMAN SERVICES

PRINTED GRAPE TO FORM APPROVED OME NO. 0938-0391

| CENTERS FOR MEDICARE   | & MEDICAID SERVICES  |                     | Olv   | NO. 0938-039                 |
|--|--|---------------------|---|------------------------------|
| DIZTEMENT OF DEFICIENCIES<br>AND PLAN OF CONTECTION  | (X1) PROVIDLEASUPPLIESCHA<br>IDEN HEICATION NUMBER   |                     |   | X D DATE SURVEY<br>COMPLETED |
|  | 495283   | B WING              | br  | C<br>02/25/2022              |
| NAME OF PROVIDER OR SUPPLIER   |  |                     | STREET ADDRESS, CITY, STATE, ZIP CODE   | -                            |
| PROMEDICA SKILLED NURSI  | NG AND REHAB (IMPERIAL)  | J                   | 1719 BELLEVUE AVENUE  |                              |
|  |  |                     | RICHMOND, VA 23227  |                              |
| PREFIX (EACH DEFICIENCY  | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)  | ID<br>PREFII<br>TAG | PROVIDER'S PLAN OF CORRECTION  X (EACH CORRECTIVE ACTION SHOULD B  CROSS-REFERENCED TO THE APPROPRIA  DEFICIENCY)   |                              |
| F 000 INITIAL COMMENT  | S  | F 0                 | ,   |                              |
|  |  |                     |   |                              |
| and Focused Infection conducted 02/23/22 complaints (VA0005-deficiency, VA00054 deficiency, VA00052 deficiency), Ware investions are required for consultational control of the 107 currents of the 107 currents of the consultation of the 107 currents of the 107 curren | 20 certified bed facility was<br>ent residents, there were no<br>the COVID-19 virus, The<br>sted of twelve current<br>two closed record reviews.   | F 650               | 6<br>Tag F656 - Develop and Implement Ca<br>Plan  | nre                          |
| care plan for each restresident rights set fort §483.10(c)(3), that incobjectives and timefra medical, nursing, and needs that are identific assessment. The complete describe the following (i) The services that are or maintain the resider physical, mental, and prequired under §483.24   | ility must develop and ensive person-centered ident, consistent with the hat §483.10(c)(2) and ludes measurable mes to meet a resident's mental and psychosocial ed in the comprehensive prehensive care plan must e to be furnished to attain |                     | <ol> <li>Resident # 12, # 2, # 11, # 1, and # 5 a plans were reviewed on 3/16/22 by the MDS coordinator to validate accuracy Resident # 4 and Resident # 10 no lon reside at the facility.</li> <li>Resident care plans related to Medicat and Treatments were reviewed by the MDS coordinator.</li> <li>The DON or designee re-educated the licensed nurses on the development an implementation of care plans.</li> </ol> | e<br>ger<br>ions             |

Any deficiency statement ending with a sterisk (\*) 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.

#### DEPARTMENT OF THAT THAND HUMAN SERVICES

PAINTED: 03/08/202; FORM APPROVEL OMB NO. 0038-0391

| CENTERS FOI  | RMEDICARI  | . & MEDICAID SERVICES   |  |                                     |  |                                   | 0.8800                   |
|--|--|---|--|-------------------------------------|--|-----------------------------------|--------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   |  |   | (X2) MULTIPLE CONSTRUCTION  A BUILDING |                                     |  | EL SURVE, V<br>MPLETED            |                          |
|  |  | 495283  | 6                                      | WING                                |  | 0.2                               | C<br>/25/2022            |
| NAME OF PROVIDER OR SUPPLIER   |  |   | SI                                     | REET ADDRESS, CITY, STATE, ZIP CODE | 1 02.  | 12312022                          |                          |
| PROMEDICA SK   | ILLED NURSI  | NG AND REHAB (IMPERIAL  | )                                      | 17                                  | 19 BELLEVUE AVENUE<br>CHMOND, VA 23227   |                                   |                          |
|  | CH DEFICIENCY  | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)   | į                                      | ID<br>PREFIX<br>TAG                 | PROVIDER'S PLAN OF CORREC<br>(EACH CORRECTIVE ACTION SHOI<br>CROSS-REFERENCED TO THE APPR<br>DEFICIENCY)   | ULD BE                            | (X5)<br>COMPLETI<br>DATE |
| provide under § treatme (iii) Any rehabilit provide recomm findings rationale (iv)In concessident' (A) The redesired of (B) The reduced contentities, for (C) Dischellan, as a requirement section. This REQ by:  Based on clinical recomd in the was determed and in the was determed and in the corresponding to the corresponding and care plan for the corresponding to th | 483.24, §48; d due to the 483.10, incluing feath and the feath as a result of endations. If of the PASAI in the resident are representated as a secondaries. Facilitation with a representate exident's president's president's president's president's president's president's president's the resident's ty was assessed to the resident's purpose and propriate, in the set forth and the the feath and | 3.25 or §483.40 but are not resident's exercise of rights ding the right to refuse 3.10(c)(6). Services or specialized as the nursing facility will I PASARR a facility disagrees with the RR, it must indicate its ent's medical record. In the resident and the tive(s)-als for admission and afference and potential for lities must document a desire to return to the esed and any referrals to and/or other appropriate |  |                                     | The DON or designee will revie resident care plans weekly time. The Administrator will submit a findings to the QAPI committee and further recommendations. The facility's alleged date of conwill be April 4, 2022. | s 4 weeks.<br>audit<br>for review |                          |
|  |  |   |  | 6                                   |  | 1                                 |                          |
| The findings   | s include:   |   |  |                                     |  | 1                                 |                          |
| 93   |  |   | fi .                                   | 3.1                                 |  |                                   |                          |

1. For Resident #12, the facility staff failed to

#### PRINTED: 03/08/202 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVEL CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A BUILDING COMPLETED 495283 B. WING 02/25/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1719 BELLEVUE AVENUE PROMEDICA SKILLED NURSING AND REHAB (IMPERIAL) RICHMOND, VA 23227 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5)PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE **DEFICIENCY**) F 656 Continued From page 2 F 656 implement the comprehensive care plan regarding wound treatments. Resident #12 was admitted to the facility on 4/27/15 and had the diagnoses of, but not limited to, pressure injury. On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 12/17/21, the resident scored 7 out of 15 on the BIMS (brief interview for mental status, indicating the resident was severely cognitively impaired for making daily decisions. A review of the clinical record revealed the following: -A physician's order dated 12/2/21 for "Apply skin prep (1) to right heel daily and PRN (as needed) every night shift for preventive." A review of the December 2021 MAR and TAR (Medication Administration Record and Treatment

2/10/22 and 2/17/22.

Administration Record) revealed there was no documentation it was completed on 12/10/21,

- A physician's order dated 12/7/21 for "Cleanse wound to sacrum with wound cleanser, pat dry, apply skin prep to area. apply calcium alginate (2) and optifoam (3) dressing every 3 days and PRN every day shift every 3 day(s) for wound care." A review of the December 2021, January 2022 and February 2022 MAR and TAR revealed there was no documentation it was completed on 12/13/21, 12/22/21, 12/25/21, 1/3/22, 1/9/22, 1/18/22, 1/24/22, 1/27/22, 1/30/22, 2/5/22 and 2/20/22.

A review of the comprehensive care plan revealed the following: "4/28/15 ...At risk for alteration in skin integrity related to: impaired mobility, impaired cognition, incontinence

#### PRINTED: 03/08/2022 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER. COMPLETED A BUILDING C 495283 **B WING** 02/25/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1719 BELLEVUE AVENUE PROMEDICA SKILLED NURSING AND REHAB (IMPERIAL) RICHMOND, VA 23227 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION 7X41 ID (X5) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETION REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) F 656 Continued From page 3 F 656 ...Provide preventative skin care routinely and prn ...10/14/21 ... Resident has pressure ulcer to coccyx related to immobility ... Administer treatment per physician orders." On 2/24/22 at 10:35 AM an interview was conducted with LPN #1 (Licensed Practical Nurse). When asked what it means if areas were blank on the MAR or TAR, he stated, "That means it wasn't done. It wasn't clicked off in [name of electronic health record]." When asked if that means that the care wasn't provided, he stated, "Yes." When asked if the care plan documented to administer medications or treatments as ordered, and the MARs or TARs evidenced the medications or treatments was not done, if the care plan was followed, he stated, "It wasn't adhered to. It wasn't done. It wasn't carried out. It wasn't initiated. It wasn't started." The facility policy, "Interdisciplinary Care Planning" was reviewed. This care plan documented, "The patient's care plan is a communication tool that guides members of the interdisciplinary healthcare team in how to meet each individual patient's needs. It also identifies

the types and methods of care that the patient should receive....Once the care plan is developed, the staff must implement the interventions identified in the care plan."

On 2/24/22 at 4:45 PM, ASM #1, ASM #2, and ASM #3 (Administrative Staff Member) the Administrator, Director of Nursing, and Regional Quality Consultant, respectively, were made aware of the findings. No further information was

provided by the end of the survey.

|   | CENTEROT ON MEDICARE  | E & MEDICAID SERVICES   |                     |  | OMB NO: 0:            | 938-039                   |
|---|---|---|---------------------|--|-----------------------|---------------------------|
|   | STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER  | (X2) MUI<br>A BUILU | TIPLE CONSTRUCTION   | (X3) DATE S<br>COMPLI | SURVEY                    |
| ı |   | 495283  | B. WING             |  | C 02/25               | /2022                     |
| Į | NAME OF PROVIDER OR SUPPLIER  |   | 1.                  | STREET ADDRESS, CITY, STATE, ZIP CODE  | 1 02/23               | 12022                     |
| l |   |   | ĺ                   | 1719 BELLEVUE AVENUE   |                       |                           |
| l | PROMEDICA SKILLED NURSI   | NG AND REHAB (IMPERIAL)   | ľ                   | RICHMOND, VA 23227   |                       |                           |
|   | PREFIX (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)  | ID<br>PREFI)<br>TAG | PROVIDER'S PLAN OF CORRECTION  (EACH CORRECTIVE ACTION SHOULD  CROSS-REFERENCED TO THE APPROL  DEFICIENCY) | LD BE CO              | (X5)<br>OMPLETION<br>DATE |
|   | F 656 Continued From pag  | ge 4  | F 6                 | 56   |                       |                           |
|   | designed to form produring removal of tap<br>skin for drainage tub<br>surrounding ostomy<br>formulated to help sk<br>adheres better indicationly."        | kin breathe so tape and film ated for use on intact skin from com/jump/product/x/Z05-PF   |                     |  |                       |                           |
|   | 0 444 :   |   |                     |  |                       |                           |
|   | non-adhesive pads an natural polysaccharid from seaweed. On co dressings form a mois ion exchange. They are easy to pack, tuck or a wounds. Indicated for | ressings are non-woven, and ribbons composed of e fibers or xerogel derived intact with exudate, these st gel through a process of re soft and conformable, apply over irregular-shaped wounds with moderate to |                     | **   | 3                     |                           |
|   | heavy exudate, such a   | as pressure ulcers, infected  |                     |  |                       |                           |
|   | wounds and venous in  | sufficiency ulcers.   |                     |  |                       |                           |
|   | Alginates generally rec   | luire a secondary   |                     | i e  |                       | 1                         |
|   | dressing." Information obtained fr  | rom   |                     |  |                       | - 1                       |
|   |   | rce.com/product-category/   |                     |  |                       | ĺ                         |
|   | dressings/alginates   | rce.com/product-category/   |                     |  |                       | 1                         |
|   | Optifoam dressing -   | · "Optifoam® Adhesive is a  |                     |  |                       |                           |
|   | hydropolymer, adhesive  | e foam island dressing that   |                     |  |                       |                           |
|   | is waterproof and has a   |   |                     |  |                       |                           |
|   | capacity. Improved thin   | film backing for longer   |                     |  |                       | 1                         |
|   | wear time."   |   |                     |  |                       | 1                         |
|   | Information obtained fro  |   |                     |  |                       | - }                       |
|   |   | ce.com/product/optifoam-  |                     |  | 1                     |                           |
|   | adhesive  |   | - 1                 |  | 7                     |                           |

| CILITATION ON WILLIAM  | A MEDICAID SERVICES  |                           |   | OMB NO: 0938-03               |
|--|--|---------------------------|---|-------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  | (X2) MULTIP<br>A BUILDING | PLE CONSTRUCTION  | (X3) DATE SURVEY<br>COMPLETED |
|  | 495283   | B WING                    |   | C<br>02/25/2022               |
| NAME OF PROVIDER OR SUPPLIER PROMEDICA SKILLED NURSI   | NG AND REHAB (IMPERIAL)  | 1                         | STREEF ADDRESS, CITY, STATE, ZIP CODE<br>1719 BELLEVUE AVENUE<br>RICHMOND, VA 23227                     | 1 02/23/2022                  |
| PREFIX (EACH DEFICIENCY  | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG       | PROVIDER'S PLAN OF CORREC<br>(EACH CORRECTIVE ACTION SHO<br>CROSS-REFERENCED TO THE APPR<br>DEFICIENCY) | OULD BE COMPLETION            |
| implement the compregarding wound tree Resident #4 was added 6/19/14 and was discended with the diagnoses sclerosis, peripheral pressure injury. On the (Minimum Data Sot) an ARD (Assessment the resident scored at (brief interview for metresident was unable to cognitive status due to impaired for making discovered with the composition of the clinical following:  A review of the clinical following:  A physician's order discount was unable to cognitive status due to impaired for making discounts. | the facility staff failed to rehensive care plan atments.  nitted to the facility on charged on 8/8/21. Resident sof but not limited to multiple vascular disease, and he most recent MDS or quarterly assessment will. Reference Date) of 6/1/21, "99" out of 15 on the BIMS ental status), indicating the complete the interview for being severely cognitively aily decisions.          | F 656                     |   |                               |
| hydrogel (1) and purace area, cover with dry proversely shift and prn (as becomes soiled, wet, of skin alteration." A review and TAR (Medication A Treatment Administration was no documentation day shift on 6/17/21, da 6/18/21, evening shift or  | of (2) plus to any open plective dressing. Change needed) if dressing removed, as needed for ew of the June 2021 MAR dministration Record and on Record) revealed there that it was completed on y evening or night shift on 16/19/21, day or evening it on 6/24/21, day shift on 16/25/21.  ed 6/16/21 for "Clean with NS (normal saline) in (every) shift for wound the 2021 MAR and TAR |                           |   |                               |

|    |  | W MEDIO/NO CERVICES   |                     |                                       | OMR M   | Q 0938-039                 |
|----|--|---|---------------------|---------------------------------------|---|----------------------------|
|    | STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER                        |                     | (X7) MULTIPLE CONSTRUCTION A BUILDING |   | ATE SURVEY<br>OMPLETED     |
| l  |  | 495283  | B WING              |                                       |   | C                          |
| I  | NAME OF PROVIDER OR SUPPLIER                         |   | <del>'</del>        | STREET ADDRESS, CITY, ST              | TATE ZIP CODE   | 2/25/2022                  |
| ľ  |  |   |                     | 1719 BELLEVUE AVENUE                  |   |                            |
| ŀ  | PROMEDICA SKILLED NURSI                              | NG AND REHAB (IMPERIAL)   | - 1                 |                                       |   |                            |
| ١. |  |   |                     | RICHMOND, VA 23227                    |   |                            |
|    | PREFIX (EACH DEFICIENCY                              | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL CO IDENTIFYING INFORMATION) | ID<br>PREFIX<br>TAG | (EACH CORRECTIVE CROSS-REFERENCE      | AN OF CORRECTION VE ACTION SHOULD BE ED 10 THE APPROPRIATE ICIENCY) | (XS)<br>COMPLETION<br>DATE |
|    | F 656 Continued From pag                             | 1e 6  | C 05                |                                       |   |                            |
|    |  |   | F 65                | D                                     |   |                            |
|    | or pight shift on 6/49                               | hift on 6/17/21, day, evening   |                     |                                       |   |                            |
|    | day or evening shift.                                | /21, evening shift on 6/19/21,  |                     |                                       |   |                            |
|    | G/24/21 and day shift                                | on 6/20/21, day shift on  |                     |                                       |   |                            |
|    | 6/24/21, and day shift                               | t on 6/29/21,   |                     |                                       |   |                            |
|    | - A physician's order                                | dated 6/29/21 for "Right foot   |                     |                                       |   |                            |
|    | skin prep every shift                                | for wound treatment." A   |                     |                                       |   |                            |
|    | review of the July 201                               | 21 MAR and TAR revealed   |                     |                                       |   |                            |
|    | there was no docume                                  | entation it was completed on  |                     |                                       |   |                            |
|    | night shift on 7/4/21                                | day shift on 7/11/21, evening   |                     | \$11                                  |   |                            |
|    | shift on 7/18/21, and                                | day shift on 7/21/21  |                     |                                       |   |                            |
|    |  |   |                     |                                       |   | 20                         |
|    | - A physician's order of                             | ated 7/14/21 for "Santyl (4)  |                     |                                       |   |                            |
|    | Ointment 250 unit/gra                                | m (Collagenase). Apply to   |                     |                                       |   |                            |
|    | right foot topically eve                             | ry day shift every Mon  |                     |                                       | *   | •                          |
|    | (Monday), Wed (Wedi                                  | nesday), Fri (Friday) for   |                     |                                       |   |                            |
|    | wound, clean with NS,                                | apply Santyl and cover  |                     |                                       |   |                            |
|    | with foam dressing." /                               | A review of the July 2021   |                     |                                       |   |                            |
|    | MAR and TAR reveale                                  | d there was no  |                     |                                       |   | - 1                        |
|    | documentation it was                                 | completed on 7/16/21,   |                     |                                       |   |                            |
|    | 7/21/21, and 7/23/21.                                | ¥.)   |                     |                                       | 0   | 1                          |
|    | A mardan control                                     |   |                     | 6                                     |   |                            |
|    | A review of the compre                               | chensive care plan  |                     |                                       | ]   |                            |
|    | revealed the following:                              | 1"2/3/14At risk for   |                     |                                       |   |                            |
|    | alteration in skin integri                           | ty related to: impaired   | į.                  |                                       |   |                            |
|    | mobility, aftered cogniti                            | on, MS (multiple sclerosis)   |                     |                                       |   | 1                          |
|    | and incontinenceAdm                                  | ninister treatment per  |                     |                                       |   | 1                          |
|    | physician orders3/1/2                                | 21 Open area at the   | 37                  |                                       |   | 1                          |
|    | sacrum related to: impa<br>incontinence, nutritional | ureo mobility,  |                     |                                       |   | 1                          |
|    | treatment per physician                              | orders6/16/21Area   |                     |                                       |   |                            |
|    | to bottom of right foot                              | Administer treatment per  | 1                   |                                       |   | Į                          |
|    | physician orders."                                   | to thinister treatment per  | 1                   |                                       |   |                            |
|    |  |   | 4:                  |                                       |   | - 1                        |
|    | On 2/24/22 at 10:35 AM                               | an interview was  |                     |                                       |   | 1                          |
|    | conducted with LPN #1                                | (Licensed Practical   | 1                   |                                       | 187   |                            |
|    | Nurse). When asked wi                                | nat it means if areas were  | 3                   |                                       | į.  | 1                          |
|    | blank on the MAR or TA                               | R. he stated. "That   | ŀ                   |                                       | •   | 1                          |
|    | means it wasn't done. It                             | wasn't clicked off in   |                     |                                       |   | <b>[</b>                   |
|    |  |   |                     |                                       |   |                            |

|  |  |                     |   | VIND INO DROBO-03 |  |  |
|--|--|---------------------|---|-------------------|--|--|
| ATEMENT OF DEFICIENCIES<br>ID PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:                      | (X2) MULTIPLE       | (X3) DATE SURVEY<br>COMPLETED   |                   |  |  |
|  | ,  | A BUILDING _        |   | C                 |  |  |
|  | 495283   | B. WING             |   | 02/25/2022        |  |  |
| AME OF PROVIDER OR SUPPLIER                      |  | STE                 | REET ADDRESS, CITY, STATE, ZIP CODE   | 1 02/25/2022      |  |  |
| ROMEDICA SKILLED NURSI                           | NG AND BEHAR (MBEDIAL)   | 171                 | 19 BELLEVUE AVENUE  |                   |  |  |
| ———————————                                      |  | RIC                 | CHMOND, VA 23227  |                   |  |  |
| REFIX (EACH DEFICIENCY                           | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION) | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTIO<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROP<br>DEFICIENCY) | BE COMPLETION     |  |  |
| E SES CONTINUE LE                                | -  | 1                   |   |                   |  |  |
| F 656 Continued From pag                         |  | F 656               |   |                   |  |  |
| if that mappe that the                           | health record). When asked   |                     |   |                   |  |  |
| stated "Yes " When                               | e care wasn't provided, he asked if the care plan                          | 10                  |   |                   |  |  |
| , documented to admi                             | nister medications or  |                     |   |                   |  |  |
| treatments as ordere                             | d, and the MARs or TARs  |                     |   |                   |  |  |
| evidenced the medic                              | ations or treatments was not   |                     |   |                   |  |  |
| done, if the care plan                           | was followed, he stated, "It   |                     |   |                   |  |  |
| wash't adhered to. It                            | wasn't done. It wasn't   |                     |   |                   |  |  |
| carried out. It wash                             | initiated. It wasn't started."   |                     |   |                   |  |  |
| On 2/24/22 at 4:45 Pt                            | M, ASM #1, ASM #2, and   | :                   |   |                   |  |  |
| ASM #3 (Administrati                             | ve Staff Member) the   |                     |   | 1                 |  |  |
| Administrator, Directo                           | r of Nursing, and Regional 🧍   | 16                  |   |                   |  |  |
| Quality Consultant, re                           | spectively, were made  |                     |   |                   |  |  |
| aware of the findings.                           | No further information was :   |                     |   |                   |  |  |
| provided by the end o                            | rine survey.   | 70                  |   | -                 |  |  |
| COMPLAINT DEFICIE                                | ENCY   |                     |   |                   |  |  |
| References:                                      |  |                     |   | 14                |  |  |
| 34   |  | 53                  |   |                   |  |  |
| <ol> <li>"Hydrogel dressing:</li> </ol>          | s are in many respects   |                     |   | 8                 |  |  |
| ideal for wound dressing                         | ngs. When applied to dry   |                     |   | 1                 |  |  |
| they can make and kee                            | ughing or necrotic wounds,   | 9                   |   |                   |  |  |
| promoting the removal                            |  |                     |   | 1                 |  |  |
| tissue via autolysis. Hy                         | drogel dressings keep the  | 1                   |   | t t               |  |  |
| wound warm, moist, an                            | d close. Also, they do not   |                     |   | i i               |  |  |
| react with or irritate tiss                      | ue. When applied, they do  | 41                  |   |                   |  |  |
| not adhere to wound su                           |  | 11                  |   | ***               |  |  |
| metabolites to pass free                         | ely. These dressings help  | 1141                |   |                   |  |  |
| provide a cooling effect makes them very please  | on the wound, which  |                     |   | i                 |  |  |
| Information obtained fro                         |  |                     |   |                   |  |  |
|  | cal.net/health/Hydrogel-Dr   |                     |   |                   |  |  |
| essings.aspx                                     | ,  | 27.                 |   |                   |  |  |
|  |  | İ                   |   |                   |  |  |
| 2. "Puracol is a primary drainage types. Puracol | wound dressing for all   | 1                   |   |                   |  |  |
| т uramage types. Puracol.                        | is a nighty absorbent  | 4                   |   | 12                |  |  |

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 03/08/2022 FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER COMPLETED A BUILDING C 495283 B WING 02/25/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1719 BELLEVUE AVENUE PROMEDICA SKILLED NURSING AND REHAB (IMPERIAL) RICHMOND, VA 23227 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) F 656: Continued From page 8 F 656 material that converts to soft, gel sheet that stays in contact with wound bed as it absorbs exudate. Puracol features 100% pure native collagen, helps restore chemical balance in the wound bed, absorbent collagen sheets manage wound moisture, and gel sheet stays in contact with wound bed as it absorbs exudate." Information obtained from https://www.allegromedical.com/products/puracolcollagen-microscaffold-wound-dressing/ 3. Skin Prep - "A liquid protective barrier wipe designed to form protective film to reduce friction during removal of tapes and films as well as prep skin for drainage tubes, external catheters, surrounding ostomy sites and adhesives formulated to help skin breathe so tape and film adheres better indicated for use on intact skin only." Information obtained from https://www.medline.com/jump/product/x/Z05-PF 32716#mrkDocumentation 4. Santyl - "Collagenase SANTYL Ointment ("SANTYL") is indicated for debriding chronic

dermal ulcers and severely burned areas." Information obtained from https://santyl.com/hcp

Resident #2 was admitted to the facility with diagnoses that included but were not limited to chronic pain syndrome, hypertension and gastroesophageal reflux disease.

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 03/08/2022 /EC 391

| CENT                     | ERS FOR MEDICAR                        | E & MEDICAID SERVICES   |                     |  |          | 4APPROV<br><u>- 093</u> 8-03 |
|--------------------------|--|---|---------------------|--|----------|------------------------------|
| STATEME                  | ENT OF DEFICIENCIES<br>N OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER                          | (X2) MUL<br>A BUILD | LTIPLE CONSTRUCTION  | (X3) DAT | E SURVEY<br>APLETED          |
|                          |  | 495283  | B WING              |  | 1        | C<br>25/2022                 |
| NAME O                   | F PROVIDER OR SUPPLIER                 |   |                     | STREET ADDRESS, CITY, STATE, ZIP CODE  | 1 021    | ZJIZOZZ                      |
| 000                      | EDICA OVILLED MUDO                     | 110 110 551115  | - 1                 | 1719 BELLEVUE AVENUE   |          |                              |
| PROM                     | EDICA SKILLED NURSI                    | NG AND REHAB (IMPERIAL)   | - 1                 | RICHMOND, VA 23227   |          |                              |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)                       | TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION) | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION  (EACH CORRECTIVE ACTION SHOULD  CROSS-REFERENCED TO THE APPROP  DEFICIENCY) | ) BE     | (XS)<br>COMPLETIO<br>DATE    |
| F 656                    | Continued From page                    | ge 9  | F 65                | 56   |          |                              |
|                          | On the most                            | MDC (minimum 1 mm)  |                     |  |          |                              |
|                          | On the most recent                     | MDS (minimum data set), a nt with an ARD (assessment                          |                     |  |          |                              |
|                          | reference date) of 1:                  | /22/2022, the resident scored   |                     |  |          |                              |
|                          | 15 out of 15 on the F                  | BIMS (brief interview for   |                     | 93   |          |                              |
|                          | mental status), indic                  | ating the resident is   |                     |  |          |                              |
|                          | cognitively intact for                 | making daily decisions.   |                     |  |          |                              |
|                          | Section J documente                    | ed Resident #2 receiving  |                     |  |          |                              |
|                          | scheduled pain medi                    | cations. Section N  |                     |  |          |                              |
|                          |  | nt #2 receiving antianxiety,  |                     |  |          |                              |
|                          | antidepressant and c                   | piod medications,   |                     |  |          |                              |
|                          | On 2/23/2022 at app                    | roximately 12:05 p.m., an   |                     |  | Q)       |                              |
| 2                        | interview was conduc                   | cted of Resident #2 in her  |                     |  | 200      |                              |
| •                        | room. Resident #2 si                   | lated that there were   |                     |  | ,        |                              |
|                          | occasions where they                   |   |                     |  |          |                              |
|                          |  | is and times when the   |                     | 1  |          |                              |
|                          |  | given until the next shift.   |                     |  |          |                              |
|                          | Resident #2 stated the                 | at the evening nurse on   |                     |  |          |                              |
|                          | 2/13/2022 had walked                   | out, and they had not   |                     |  |          |                              |
| 16                       | received any medicati                  | ons for the evening shift   |                     |  |          |                              |
| 10                       | anu nau to wait for the                | e night shift to come in to ident #2 stated that was not                      |                     |  |          |                              |
| 1                        | the only time they had                 | not gotten their  |                     |  |          |                              |
| r                        | nedications and had r                  | eceived them on the next  |                     |  | - 7      |                              |
|                          | shift.                                 | 3   |                     |  | *        |                              |
|                          |  |   |                     |  |          |                              |
| 1 d                      | ne comprehensive ca                    | re plan for Resident #2   |                     |  |          |                              |
|                          | locumented in part, "P                 | ain related to<br>c pain syndrome. Date                                       |                     |  |          |                              |
|                          |  | t risk for changes in mood  |                     |  |          | }                            |
| · r/                     | t (related to) depressi                | on. Date Initiated:   |                     |  |          |                              |
| 7.10                     | 0/18/2021 and Sleep (                  | cycle issues. Date  |                     |  | - 1      |                              |
| i In                     | itiated: 10/18/2021A                   | dminister medications as  |                     |  |          |                              |
| or                       | dered. Date Initiated:                 | 10/18/2021Cardiac   |                     |  | - 9      |                              |
| di                       | sease related to Hype                  | rtension, Date Initiated:   | 1.5                 |  |          |                              |
| 10                       | 0/18/2021, GI (gastroir                | ntestinal) distress r/t   | -                   |  | TÍ.      | ľ                            |

GERD (gastroesophageal reflux disease), Date Initiated: 10/18/2021 and Has/At risk for

| OENTEROT ON WEDICAR                                 | E & MICDICAID SERVICES   |               |  | <u>OMB NO. 0938-03</u>        |
|---|--|---------------|--|-------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION | (X1) PROVIDENSUPPLIENCEIA<br>IDENTIFICATION NUMBER:                            | V BRITING V   | IPLE CONSTRUCTION  | (X3) DATE SURVEY<br>COMPLETED |
|   | 495283   | B WING        |  | C                             |
| NAME OF PROVIDER OR SUPPLIER                        |  | T G WING      | OVER COLUMN TO THE COLUMN TO T | 02/25/2022                    |
|   |  | - 1           | STREET ADDRESS, CITY, STATE, ZIP CO  | DC                            |
| PROMEDICA SKILLED NURS                              | ING AND REHAB (IMPERIAL)   | ĺ             | 1719 BELLEVUE AVENUE   |                               |
|   |  |               | RICHMOND, VA 23227   | _                             |
| PREFIX (EACH DEFICIENC)                             | ATFMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | PREFIX<br>TAG | PROVIDER'S PLAN OF CORE<br>(EACH CORRECTIVE ACTION S<br>CROSS-REFERENCED TO THE AL<br>DEFICIENCY)  | HOULD BE COMPLETIO            |
| E 656 Continued France                              | 40   |               | *  |                               |
| F 656 Continued From pa                             |  | F 656         | 3  |                               |
| respiratory impairm                                 | ent related to asthma. Date  |               |  |                               |
| Initiated: 10/18/202                                | 1 Administer medications as  |               |  |                               |
| ordered. Date Initia                                | ted: 10/18/2021Bowel   |               |  |                               |
| incontingnon of time                                | n; Constipation Bowel  |               |  |                               |
| Administer modies                                   | es. Date Initiated: 02/04/2022 ations per physician order &                    |               |  |                               |
| observe effectivenes                                | Se. Date Initiated:  |               |  |                               |
| 02/04/2022"   | 55. Date initiated.  |               |  |                               |
|   |  |               |  |                               |
| The eMAR (electron                                  | ic medication administration   |               |  |                               |
| record) for Resident                                | #2 dated 2/1/2022-2/28/2022  |               |  |                               |
| failed to evidence the                              | ofollowing medications   |               |  |                               |
| administered on the                                 | following dates and times:   |               |  |                               |
| - "Lactulose Solution                               | 10 gm/15 ml. Give 15 ml by   |               |  | :                             |
| mouth at bedtime for                                | bowel regimen." On   |               |  |                               |
| 2/4/2022 at 9:00 p.m.                               | and 2/13/2022 at 9:00 p.m.,  |               |  | 1                             |
| - Senna Laxative rai                                | olet 8.6 mg Give 2 tablet by   |               |  | £3                            |
| evperiencing loca et                                | constipation may hold if ools." On 2/4/2022 at 9:00                            |               |  | 4                             |
| p.m. and 2/13/2022 a                                | t 9:00 p.m.  |               |  |                               |
| - "Colace Capsule 10                                | 0 mg Give 100 mg by mouth  |               |  |                               |
| two times a day for co                              | onstipation." On 2/4/2022 at   |               |  |                               |
| 8:30 p.m. and 2/13/20                               | 22 at 8:30 p.m.,   |               |  |                               |
| <ul> <li>"Hydroxyzine HCL ta</li> </ul>             | blet 25 mg Give 1 tablet by  |               |  | 38                            |
| mouth two times a day                               | y for itch." On 2/4/2022 at 🖐  |               |  | i                             |
| 8:30 p.m. and 2/13/20                               | 22 at 8:30 p.m.,   |               |  | 185                           |
| - "Metoproloi tartrate ta                           | ablet 25 mg Give 1 tablet by   |               |  |                               |
| mouth two times a day                               | for HTN." On 2/4/2022 at   |               |  | 7.                            |
| 8:30 p.m. and 2/13/202                              | zz at 8:30 p.m.,<br>nded release 12 hour 600                                   |               |  | 2.0                           |
| ma Give 600 ma by ma                                | outh two times a day for   |               |  |                               |
| congestion." On 2/4/20                              | 022 at 8:30 n m and  |               |  |                               |
| 2/13/2022 at 8:30 p.m.                              |  |               |  | 1                             |
| - "Gabapentin Tablet 60                             | 00 mg 2 tablet by mouth  |               |  | £                             |
| three times a day for ne                            | europathic pain." On   |               |  | 0.00                          |
| 2/4/2022 at 8:30 p.m., 2                            | 2/10/2022 at 2:00 p.m. and   | - 1           |  | 2.3                           |
| 2/13/2022 at 8:30 p.m.                              | i  | 13            |  | H                             |
| - "Oxybutynin chloride ta                           | ablet 5 mg Give 1 tablet   |               |  | 4                             |
| by mouth three times a                              | day for overactive   | 3             |  |                               |

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:                          | 1                   | E CONSTRUCTION   | (X3) DATE SURVEY |
|---|--|---------------------|--|------------------|
|   |  | A BUILDING          |  | COMPLETED        |
|   | 495283   | B WING              |  | C                |
| NAME OF DROUBER OF CHIPMIES                         | <u> </u>   |                     |  | 02/25/2022       |
| NAME OF PROVIDER OR SUPPLIER                        |  | 1                   | TREET ADDRESS, CITY, STATE, ZIP CODE   |                  |
| PROMEDICA SKILLED NURS                              | ING AND REHAB (IMPERIAL)   | 1 _                 | 719 BELLEVUE AVENUE  |                  |
|   |  | R                   | ICHMOND, VA 23227  |                  |
| PRÉFIX (EACH DEFICIENC)                             | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPERTION OF THE APPROPERTIES OF THE A | DBE COMPLETION   |
| F 656 Continued From pa                             | ae 11  | E 050               |  |                  |
|   |  | F 656               |  |                  |
| 2:00 p.m. and 2/13/                                 | 022 at 8:30 p.m., 2/10/2022 at   |                     |  |                  |
|   | mg Give 1 tablet by mouth  |                     |  |                  |
|   | r Give with 4 mg for a total of  |                     |  |                  |
| 6 mg." On 2/4/2022                                  | e at 8:30 p.m., 2/10/2022 at   |                     |  |                  |
| 2:00 p.m., 2/11/2022                                | 2 at 6:00 a.m. and 2/13/2022   |                     |  |                  |
| at 6:00 p.m.  |  | ,                   |  |                  |
|   | mg Give 4 mg by mouth  | 1                   |  |                  |
| three times a day for                               | muscle spasm; give with 2  |                     |  |                  |
|   | g." On 2/4/2022 at 8:30 p.m., 🕾  | •                   |  |                  |
|   | m., 2/11/2022 at 6:00 a.m.   |                     |  |                  |
| and 2/13/2022 at 6:0                                |  |                     |  |                  |
| - bactolen tablet 10                                | mg Give 1 tablet by mouth  |                     |  |                  |
|   | ema give with 20 mg to =30<br>6:00 p.m., 2/10/2022 at                          | 1                   |  |                  |
|   | 2 at 6:00 a.m. and 2/13/2022 :   |                     |  |                  |
| at 6:00 p.m.  | - dt 0,00 b.m. dnd 2/70/2022   | •                   |  |                  |
|   | mg Give 1 tablet by mouth  | i                   |  |                  |
| ' every 6 hours for mus                             | scle spasms give with 10 mg  |                     |  | - 10             |
| to =30 mg" On 2/4/2(                                | 022 at 6:00 p.m., 2/10/2022  |                     |  |                  |
| at 12:00 p.m., 2/11/20                              | 22 at 6:00 a.m. and  | 1                   |  | 111              |
| 2/13/2022 at 6:00 p.m                               |  |                     |  |                  |
|   | et 50 mg Give 1 tablet by  | 8                   |  | 8                |
|   | or pain." On 2/4/2022 at   |                     |  |                  |
| 6:00 a.m. and 2/13/20                               | at 12:00 p.m., 2/11/2022 at  | 7                   |  |                  |
|   | 550 mg by mouth four times   |                     |  | j                |
| a day for pain.* On 2/4                             | 1/2022 at 6:00 n m   |                     |  | ŀ                |
|   | n., 2/11/2022 at 6:00 a.m.   |                     |  |                  |
| and 2/13/2022 at 6:00                               |  |                     |  | 1                |
| - "Famotidine Tablet 40                             |  |                     |  | 27               |
|   | for GERD." On 2/11/2022  | 61                  |  |                  |
| at 6:00 a.m.  | į  |                     |  |                  |
| - "Linzess Capsule (for                             | irritable bowel syndrome)  | 1                   |  |                  |
| 145 mcg Give 1 capsul                               | e by mouth one time a day  | 1                   |  | 9                |
| for constipation." On 2                             | /11/2022 at 6:30 a.m.  | 1                   |  | 4                |
| - "Bisacodyl Suppositor                             | y 10 mg insert 1   |                     |  | î                |
| constipation," On 2/13/                             | edtime every other day for 2022 at 9:00 p.m.                                   | į                   |  |                  |

| - (** |   | AL G INCOMED OF TANKE   |    |                         |  | ו סועוני  | <u>vo usas-us</u> ;        |
|-------|---|---|----|-------------------------|--|-----------|----------------------------|
|       | STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER                                    |    | (X2) MULT<br>A: BUILDIN | IPLE CONSTRUCTION  46  | (X3)      | DATE SURVEY<br>COMPLETED   |
|       |   | 495283  |    | B. WING_                |  | }         | C<br>02/25/2022            |
| Γ     | NAME OF PROVIDER OR SUPPLIE                         | R   |    |                         | STREET ADDRESS, CITY, STATE, ZIP   |           | OZIZJIZUZZ                 |
| 1     |   |   |    |                         | 1719 BELLEVUE AVENUE   |           |                            |
|       | PROMEDICA SKILLED NUR                               | SING AND REHAB (IMPERIAL)   |    | 1                       | RICHMOND, VA 23227   |           |                            |
|       | PREFIX (EACH DEFICIENT                              | TATEMENT OF DEFICIENCIES<br>CY MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION) |    | ID<br>PREFIX<br>TAG     | PROVIDER'S PLAN OF CO<br>(EACH CORRECTIVE ACTION<br>CROSS-REFERENCED TO THE<br>DEFICIENCY) | SHOULD BE | (X5)<br>COMPLETION<br>DATE |
|       | F 656 Continued From p                              | ago 12  | _  |                         |  |           |                            |
|       |   | _   |    | F 656                   | j  |           |                            |
|       | capsule by mouth days." On 2/13/20                  | le (antibiotic) 100 mg give 1<br>fwo times a day for UTI for 7<br>22 at 5:00 p.m.       |    |                         |  |           |                            |
|       | The physician and                                   | wie feu Carita 140  |    |                         |  |           |                            |
|       | The physician orde<br>documented the m              | edications as listed above.   |    |                         |  |           |                            |
|       | The progress notes                                  | for Resident #2 documented  | 1  |                         |  |           |                            |
|       | ' in part, "2/14/2022<br>doctor) and PE /rox        | 18:22 (6:22 p.m.) MD (medica  | əl |                         |  |           |                            |
|       | meds (medications)                                  | sponsible party) notified of  |    |                         |  |           |                            |
|       | (2/13/2022) evening                                 | shift. Resident monitored   |    |                         |  |           |                            |
|       | with no adverse effe                                | ects." The progress notes   | •  |                         |  |           |                            |
|       | failed to evidence d                                | ocumentation regarding the  | 7  |                         |  |           |                            |
|       | additional dates liste                              | ed above.   |    |                         |  |           |                            |
|       | 11  |   |    |                         |  |           |                            |
|       | On 2/24/2022 at 10:                                 | 35 a.m., an interview was   | 7  | 1                       |  |           |                            |
|       | conducted with LPN                                  | (licensed practical nurse) #1,  |    |                         |  |           | V.                         |
|       | LPN #1 stated that t                                | he care was not provided if it  |    | 1                       |  |           |                            |
|       | stated that multiple                                | d on the eMAR. LPN #1   |    |                         |  |           | ¥:                         |
|       | that they had not rec                               | esidents had reported to him eived their medications on                                 | 1  | 5                       |  |           |                            |
|       | 2/13/2022 when he r                                 | eturned to work the next  |    |                         |  |           |                            |
|       | week. LPN #1 state                                  | d that the residents told him   |    | - 1                     |  |           |                            |
|       | that they did not get i                             | their evening medications.  |    | - 4                     |  |           |                            |
|       | LPN #1 stated that the                              | ne staff were not   |    | 12                      |  |           | · ]                        |
|       | implementing the car                                | e plan for administering  | 5  |                         |  |           | - 1                        |
|       | medications as order                                |   | τ. |                         |  |           |                            |
|       | administering the me                                | dications.  |    |                         |  |           | 1                          |
|       | On 2/24/2022 at 1:45                                |   |    |                         |  |           | 1                          |
|       | conducted with LDN 4                                | p.m., an interview was<br>#5. LPN #5 stated that the                                    |    | -                       |  | •         |                            |
|       | purpose of the care of                              | lan was to keep the medical   |    | i.                      |  |           |                            |
|       | staff informed about the                            | he care the resident needed   |    |                         |  |           |                            |
|       |   | ated. LPN #5 stated that  |    |                         |  |           |                            |
|       | medications not signe                               | d off on the eMAR meant   |    |                         |  |           |                            |
|       | that they were not don                              | e. LPN #5 stated that the   |    |                         |  | 1         |                            |
|       | care plan was impleme                               | ented by administering the  |    | 1                       |  | 5         |                            |
|       | medications or docum                                | enting why they were not  |    | 19                      |  | 1         |                            |

| г | CENT                     | KS FOR MEDICARE   | & MEDICAID SERVICES  |                       |  | OMB NO               | <u>), 0938-03</u>         |
|---|--------------------------|---|--|-----------------------|--|----------------------|---------------------------|
|   |                          | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER  | (X2) MUL<br>A BUILD  | TIPLE CONSTRUCTION NG |  | TE SURVEY<br>MPLETED |                           |
| L |                          |   | 495283   | B WING                |  | 02                   | C<br>/25/2022             |
| l | NAME OF                  | PROVIDER OR SUPPLIER  |  |                       | STREET ADDRESS, CITY, STATE, ZIP CODE      |                      |                           |
|   | PROME                    | DICA SKILLED NURSI  | NG AND REHAB (IMPERIAL)  |                       | 1719 BELLEVUE AVENUE<br>RICHMOND, VA 23227 |                      |                           |
| - | (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY  | EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG   | PROVIDER'S PLAN OF CORRECTI                | LD BE                | (X5)<br>COMPLETIO<br>DATE |
|   | 1                        | conducted with ASM member) #2, the inte #2 stated that the car of the resident and er were in place to meet stated that if the eMA would assume that it was not signed as corthat the care plan was | ) p.m., an interview was (administrative staff rim director of nursing. ASM re plan identified the needs asured the interventions it their needs. ASM #2 R was not signed off they was not done because it impleted. ASM #2 stated is not being followed to its as ordered unless there is support why the | F 65                  | 66   |                      |                           |
|   | d<br>c<br>tl<br>T        | ocumented in part, ".<br>are plan is developed<br>ne interventions identi<br>hese may include, bu   | rdisciplinary care plan"Implementation: Once the , the staff must implement fied in the care plan. t is not limited to: and medications"   |                       |  |                      |                           |
|   | #*<br>di                 | I, the interim administ<br>rector of nursing and.   | ximately 4:30 p.m., ASM trator, ASM #2, the interim ASM #3, the regional notified of the findings.   |                       |  |                      |                           |
|   | No                       | further information v   | vas provided prior to exit.  |                       |  |                      |                           |
|   | Co                       | mplaint deficiency  |  |                       |  |                      | [                         |
|   | pla<br>ord<br>Re:        | n to administer medio<br>lered for Resident #1<br>sident #11 was admiti   | 1  |                       |  |                      |                           |

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 03/08/2022 391

| CENTERS FOR MEDICAR   | E & MEDICAID SERVICES  |                      |   | FORM APPROV<br>OMB NO: 0938-03 |
|---|--|----------------------|---|--------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  | V BAILDI<br>(XS) WAL | TIPLE CONSTRUCTION  | (X3) DATE SURVEY<br>COMPLETED  |
|   | 495283   | B WING               |   | C<br>02/25/2022                |
| NAME OF PROVIDER OR SUPPLIER  |  |                      | STREET ADDRESS, CITY, STATE, ZIP COL  | ) <u>02/23/2022</u><br>DE      |
|   |  | ŀ                    | 1719 BELLEVUE AVENUE  |                                |
| PROMEDICA SKILLED NURS  | ING AND REHAB (IMPERIAL)   | 1                    | RICHMOND, VA 23227  |                                |
| PREFIX (EACH DEFICIENC  | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG  | PROVIDER'S PLAN OF CORRI<br>(EACH CORRECTIVE ACTION SI<br>CROSS REFERENCED TO THE AP<br>DEFICIENCY) | HOULD BE COMPLETIC             |
| F 656 Continued From pa   | ge 14  | F 65                 | 6   |                                |
| quarterly assessme reference date) of 1 scored 15 out of 15 for mental status), in cognitively intact for Section J document scheduled pain med documented Reside antipsychotic, antian | MDS (minimum data set), a ant with an ARD (assessment 2/15/2021, the resident on the BIMS (brief interview adicating the resident is making daily decisions. ed Resident #11 receiving ications. Section N at #11 receiving insulin, xiety, antidepressant and |                      |   |                                |
| opiod medications.  |  |                      | (E))  |                                |
| 3   |  |                      | i e   |                                |
| interview was condu-<br>room. Resident #11  | roximately 2:00 p.m., an cted of Resident #11 in her stated that she had an open and that she put cream on ily brought in for her.   |                      |   |                                |
|   | hat the physician looked at  |                      |   |                                |
| the area when they c  | ame in and told the nurses   |                      |   |                                |
| how to treat the area.  | Resident #11 stated that   |                      |   |                                |
| some of the nurses c  | ame in to put a cream on   |                      |   |                                |
| the area but there we<br>anything on the area for<br>cream on the area an   | re times when no one put<br>for days so she put her own<br>d that it was healing   |                      |   |                                |
| Resident #11 proceed area on her cell phone   | ed to show pictures of the and stated she had asked  |                      |   |                                |
| Resident #11 stated the she did not receive he get them when the new Resident #11 stated the  | res of the area for her, at there were times when redications and would at shift came in to work, at on 2/13/2022 they did   |                      |   | W.                             |
| nurse had left and the  | g medications because the had to wait for the night  |                      |   | 1                              |
| nurse to come in to ge  |  | 1                    |   | 99                             |
| stated that this was not  | the only occasion that had   |                      |   |                                |
|   | and only opposition and made   |                      |   | 47                             |

happened to her.

The comprehensive care plan for Resident #2

### DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MED

| CENTERS FOR MIELICARE   | A MEDICAID SERVICES  |                     |                                       |   | OMB NO | <u>D_0938-03</u> 9         |
|---|--|---------------------|---------------------------------------|---|--------|----------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION   |  |                     | (X2) MULTIPLE CONSTRUCTION A BUILDING |   |        | TE SURVEY<br>MPLETED       |
|   | 495283   | B WING              | ***                                   |   | 0.2    | C<br>2/25/2022             |
| NAME OF PROVIDER OR SUPPLIER  |  |                     | STRE                                  | ET ADDRESS, CITY, STATE, ZIP CODE   | 1 02   | 72312022                   |
|   |  | 1                   | 1719                                  | BELLEVUE AVENUE   |        |                            |
| PROMEDICA SKILLED NURSI   | NG AND REHAB (IMPERIAL)  |                     |                                       | MOND, VA 23227  |        |                            |
| PREFIX (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | E.                                    | PROVIDER'S PLAN OF CORREC'<br>(EACH CORRECTIVE ACTION SHOU<br>CROSS-REFERENCED TO THE APPR<br>DEFICIENCY) | ULD BE | (XS)<br>COMPLETION<br>DATE |
| F 656 Continued From pag  | 30 15  | For                 |                                       |   |        |                            |
| documented in part, (related to) diabetesmeds (medications administration record 03/20/2020, monitor ordered by physician 09/12/2019At risk (anxiety, Date Initiated changes in mood r/t o 09/20/2019, and At risk bipolar, Date Initiated medication per physic 9/20/2019Open are Initiated: 01/31/2022 physician orders, Date | "The resident is on insulin r/t Date Initiated: 09/12/2019 s) as MARs (medication ds) Date Initiated: blood sugar, lab results as Dated Initiated: or changes in mood r/t d: 09/20/2019, At risk for depression, Date Initiated: sk for changes in mood r/t l: 09/20/2019Administer cian orders. Date Initiated: a left buttocks, DateAdminister treatment per e Initiated: 01/31/2022." | F 65                | 16                                    |   |        |                            |
| record) for Resident #<br>2/28/2022 failed to evi   | idence the following ered on the following dates   |                     |                                       |   | 1      |                            |
| scale: If 150-200=4 un  | its; 201-250=6 units;  |                     |                                       |   |        |                            |
| 251-300=8 units; 301-3  | 350=10; 351-400=12;<br>meals and at bedtime for  |                     | 0                                     |   |        |                            |
|   | 2." On 2/5/2022 at 6:30  |                     | B                                     |   |        | 1                          |
|   | a.m., 2/13/2022 at 4:30  |                     |                                       |   |        | - 1                        |
| p.m., and 2/16/2022 at  |  |                     |                                       |   |        | Í                          |
|   | et 500 mg Give 1000 mg by  |                     |                                       |   |        |                            |
| mouth every 8 hours re  |  |                     |                                       |   |        | - 1                        |
|   | d level of cervical spinal   |                     |                                       |   |        | -                          |
| cord, sequela." On 2/1:   | 3/2022 at 5:00 p.m.  |                     |                                       |   |        | 1                          |
| - "Seroquel tablet 25 mg  | g give 1 tablet by mouth   |                     |                                       |   | -1     | }                          |
|   | ression." On 2/13/2022 at  |                     |                                       |   |        |                            |
| 5:00 p.m.   | ma Give 25 ma by mouth   |                     |                                       |   | - 1    |                            |
| two times a day for seizi   | mg Give 25 mg by mouth   | 1                   |                                       |   | 34     |                            |
| 5:00 p.m.   | uica. Oil 2/13/2022 at   | 1                   |                                       |   | -      | 1                          |
|   | sintegrating 0.125 mg by   |                     |                                       |   | į      |                            |

|                              | STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION  | (X4) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER                          | J                   | (X2) MULTIPLE CONSTRUCTION A BUILDING |   |     | (X3) DATE SURVEY<br>COMPLETED |  |  |
|------------------------------|--|---|---------------------|---------------------------------------|---|-----|-------------------------------|--|--|
|                              |  | 495283  | B WING              |                                       |   | C   |                               |  |  |
| ŀ                            | NAME OF PROVIDER OR SUPPLIER   | 1   |                     | STD                                   | REET ADDRESS, CITY, STATE, ZIP CODE   |     | 02/25/2022                    |  |  |
| l                            |  |   |                     |                                       | 9 BELLEVUE AVENUE   |     |                               |  |  |
| l                            | PROMEDICA SKILLED NURSING AND REHAB (IMPERIAL)   |   | 1                   |                                       |   |     |                               |  |  |
| ŀ                            |  |   |                     | RIC                                   | HMOND, VA 23227   |     |                               |  |  |
|                              | PREFIX (EACH DEFICIENC   | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION) | ID<br>PREFIX<br>TAG | W                                     | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROPE<br>DEFICIENCY) | BE  | (X5)<br>COMPLETION<br>DATE    |  |  |
| F 656 Continued From page 16 |  |   | F 65                | 6                                     |   |     |                               |  |  |
|                              |  | day related to anxiety  | 1 00                | 0                                     |   |     |                               |  |  |
|                              | disorder." On 2/13/  | 2022 at 5:00 n m  |                     |                                       |   |     |                               |  |  |
|                              | - "Docusate sodium   | tablet 100 mg Give 1 tablet   |                     |                                       |   |     |                               |  |  |
|                              | by mouth two times   | a day for bowel regimen hold  |                     |                                       |   |     |                               |  |  |
|                              | for loose stools." O   | n 2/13/2022 at 5:00 p.m.  |                     |                                       |   |     |                               |  |  |
|                              | - "Gabapentin capsu  | le 100 mg give 2 capsule by   |                     |                                       |   |     |                               |  |  |
|                              | mouth two times a d  | lay for neuropathic pain." On   |                     |                                       |   |     |                               |  |  |
|                              | 2/13/2022 at 6:00 p.   |   |                     |                                       |   |     |                               |  |  |
|                              | <ul> <li>"Oxycontin Tablet ER 12 hour abuse-deterrent</li> <li>10 mg Give 10 mg by mouth every 12 hours</li> </ul> |   |                     |                                       |   |     |                               |  |  |
|                              |  |   |                     |                                       |   |     |                               |  |  |
|                              | related to encounter for orthopedic aftercare following surgical amputation." On 2/13/2022 at                      |   |                     |                                       |   |     |                               |  |  |
|                              |  | iputation," On 2/13/2022 at   |                     | 1                                     |   |     | *                             |  |  |
|                              | 9:00 p.m.  | uid nutritional supplements   |                     | 1                                     |   |     | vs                            |  |  |
|                              | give 30 ml by mouth  | two times a day for aid   |                     | 7                                     |   |     |                               |  |  |
|                              | wound healing." On   | 2/13/2022 at 5:00 p.m.  |                     |                                       |   |     | 27.                           |  |  |
|                              | - "Ascorbic Acid Table   | et Give 500 mg by mouth two   |                     |                                       |   |     |                               |  |  |
|                              | times a day for woun-  | d management." On   |                     | į.                                    |   |     | 7.1                           |  |  |
|                              | 2/13/2022 at 6:00 p.n  | 1,  |                     | 100                                   |   |     | J                             |  |  |
|                              | :: - "Metformin HCL tab  | let 500 mg Give 1000 mg by .  |                     |                                       |   |     | 2                             |  |  |
|                              |  | DM." On 2/13/2022 at 9:00 =   |                     | 0.00                                  |   |     |                               |  |  |
|                              | p.m. and 2/16/2022 a   |   |                     |                                       |   |     | 1                             |  |  |
|                              | - "Atorvastatin Calciur  | n Tablet 40 mg (milligram)  |                     |                                       |   |     | . 1                           |  |  |
|                              | Give 40 mg by mouth  |   | = :                 |                                       |   |     |                               |  |  |
|                              | hyperlipidemia." On 2  |   |                     |                                       |   |     | į .                           |  |  |
|                              | unit/ml Inject 70 unit e   | solution Pen injector 100 ubcutaneously at bedtime                            | N                   |                                       |   |     | 1                             |  |  |
|                              | for DM 2." On 2/13/20  | 122 at 9:00 p.m   | 1                   |                                       |   |     |                               |  |  |
|                              | 10.01.2. 01.27.10/20   | 22 at 5.00 p.m.   | 4                   |                                       |   |     | . }                           |  |  |
|                              | The eTAR (electronic   | reatment administration   |                     |                                       |   |     | 1                             |  |  |
|                              | , record) for Resident #   | 11 dated  |                     |                                       | -2:   |     | 1                             |  |  |
|                              | 1/1/2022-1/31/2022 fai   |   | 1                   |                                       |   |     | 1                             |  |  |
|                              | following treatments as  | dministered on the  | 1                   |                                       |   |     |                               |  |  |
|                              | following dates and tim  | es:   | į                   |                                       |   | 1   |                               |  |  |
|                              | - "Aquaphor Ointment   | (for dry skin) apply to leg-  | 1                   |                                       |   | 1 4 |                               |  |  |
|                              | both topically every day   | and evening shift for skin  |                     |                                       |   |     |                               |  |  |
|                              | alteration leave a bedsi   | de per MD." On 1/3/2022,  | 1                   |                                       |   | 1   |                               |  |  |
|                              | 1/4/2022, 1/5/2022, 1/1  | 5/2022, 1/16/2022,<br>[30/2022 and 1/31/2022 at                               | !                   |                                       |   | 14  | ĺ                             |  |  |
|                              | 112012022, 112312022,  | 30/2022 and 1/3 //2022 at   | 26                  |                                       |   |     |                               |  |  |

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION  |  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   |                     | (X2) MULTIPLE CONSTRUCTION A BUILDING |   |            | (X3) DATE SURVEY<br>COMPLETED |  |
|--|--|---|---------------------|---------------------------------------|---|------------|-------------------------------|--|
|  |  | 495283  | 8. WING             |                                       | W   |            | C                             |  |
| NAME OF PROVIDER   | OR SUPPLIER  |   |                     | STRI                                  | EET ADDRESS, CITY, STATE, ZIP CODE  | 1 0        | 2/25/2022                     |  |
| BBOWEDICASK  | ILLED MUDE   | ING AND REHAB (IMPERIAL)  |                     | 1719                                  | BELLEVUE AVENUE   |            |                               |  |
| PROMEDICASK  | ILLED NORS   | ING AND KEHAB (IMPERIAL)  |                     | RIC                                   | HMOND, VA 23227   |            |                               |  |
|  | CH DEFICIENCY  | NTEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFII<br>TAG | <                                     | PROVIDER'S PLAN OF CORRECT<br>(EACH CORRECTIVE ACTION SHOUL<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY) | .D BE      | (XS)<br>COMPLETION<br>DATE    |  |
| F 656 Continu  | ied From pa  | ge 17   | F 6                 | 56                                    |   |            |                               |  |
| 1/19/20<br>1/26/20<br>at 3:15<br>- "Balsa<br>medicin<br>and left<br>alteratio<br>1/3/2022<br>1/11/202<br>1/3/2022<br>1/3/2022<br>1/19/202  | 22, 1/20/202 22, 1/29/202 p.m. m Peru-Cas e to treat ski thigh topical n 1 applicati 2, 1/4/2022, 12, 1/17/2022 2 and 1/31/2 , 1/8/2022, 1 2, 1/20/2022 2, 1/29/2022 | 022, 1/11/2022, 1/17/2022, 1/21/2022, 1/23/2022, 1/23/2022, 1/23/2022, 1/23/2022, 1/23/2022 and 1/31/2022 tor Oil Ointment (combination ulcers) apply to buttocks ly two times a day for skin on to sites as ordered." On 1/5/2022, 1/8/2022, 2, 1/19/2022, 1/20/22, 2, 1/26/2022, 1/29/2022, 2022 at 9:00 a.m. On 1/11/2022, 1/17/2022, 2, 1/21/2022, 1/23/2022, 2, 1/30/2022, 1/30/2022 and |                     |                                       |   | <u>e</u> . |                               |  |
| 1/31/202<br>- "Dicolfe<br>shoulder<br>shift for p<br>1/4/2022,<br>1/20/2022<br>at 7:15 a.  | 2 at 5:00 p.n<br>nac Sodium<br>both topicall<br>ain apply 4 g<br>1/5/2022, 1,<br>2, 1/29/2022,<br>m. On 1/3/2<br>1, 1/20/2022,                                       |   |                     |                                       |   |            |                               |  |
| at 3:15 p.   |  |   |                     | t                                     |   | ·          |                               |  |
| 2/1/2022-2 following to following deferming de | reatments be<br>lates and time<br>or Ointment and evening<br>diside per MI<br>2/12/2022, 2<br>On 2/1/2022, 2/<br>2/17/2022, 2/                                       | iled to evidence the eing administered on the   |                     |                                       |   |            |                               |  |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  |  | (X2) MUL<br>A BUILDA   | TIPLE CONSTRUCTION ING | (X3) DATE SURVEY<br>COMPLETED   |                      |
|--|--|--|------------------------|---|----------------------|
| 1  |  | 495283   | B ,WING                |   | С                    |
| NAME OF PROVIDER   | OR SUPPLIER  | 433203   | Oviive, 6              | BIOUET ADDOCAG OUTV OTATE TO  | 02/25/2022           |
| 100 mm 10 |  |  | - 1                    | STREET ADDRESS, CITY, STATE, ZIP C  | CODE                 |
| PROMEDICA SKIL   | PROMEDICA SKILLED NURSING AND REHAB (IMPERIAL)   |  |                        | 1719 BELLEVUE AVENUE<br>RICHMOND, VA 23227  |                      |
| PREFIX (EAC  | H DEFICIENCY   | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG    | PROVIDER'S PLAN OF COI<br>(EACH CORRECTIVE ACTION<br>CROSS-REFERENCED TO THE<br>DEFICIENCY) | SHOULD BE COMPLETION |
| F 656 Continue   | d From pag   | ge 18  | F 65                   | 66  |                      |
| buttocks for skin a ordered." 2/17/202: 2/2/2022, 2/12/2022 - "Cleanse apply skin (antimicro island dre needed) u night shift 2/10/2022, 3:15 p.m.   | and left this left this left and left this left and left this left and left | gh topically two times a day application to sites as 22, 2/10/2022, 2/12/2022, 2 at 9:00 a.m. On 2/1/2022, 2/8/2022, 2/11/2022, 2/16/2022, 2/17/2022, 2 at 5:00 p.m.  In to left buttock, pat dry, ri wound, apply silva sorb gelogel) apply gauze affix with twice a day) and prn (as Every evening shift and care." On 2/4/2022, 2/17/2022, 2/21/2022, 2/2/2022, 2/13/2022, 2/13/2022, 2/13/2022, 2/20/2022, 2/22/2022, 2/22/2022, 2/22/2022, 2/22/2022, 2/22/2022, 2/22/2022, 2/22/2022, 2/22/2022, 2/22/2022, 2/22/2022, 2/2/2022, 2/22/2022, 2/2/2022, 2/22/2022, 2/2/2022, 2/22/2022, 2/2/2/2022, 2/2/2022, 2/2/2022, 2/2/2022, 2/2/2022, 2/2/2022, 2/2/2022, 2/2/2022, 2/2/2022, 2/2/2022, 2/2/2022, 2/2/2/2022, 2/2/2/2022, 2/2/2/2022, 2/2/2/2022, 2/2/2/2022, 2/2/2/2022, 2/2/2/2/2/2/2/2/2/2/2/2/2/2/2/2/2/2/ |                        |   |                      |
| The physic   | ian orders<br>d the medi   | or Resident #11<br>cations and treatments as   |                        |   | 15                   |
| in part, - "1/31/2022 with 3 x 1.5 wound has odor presen cleansed wi prep to peri to wound be island dress Resident is a aware." - "2/14/2022 doctor) and I meds (medic  | 2 00:40 (12 x 0.1 open maceration t. No drain th NS (norrwound, appl d covered fing. MD (nown RP (responsations) not   | Resident #11 documented area to left buttocks. Peri wound bed beef red. No age present. Area hal saline), patted dry, skin blied silva sorb wound gel with gauze covered with hedical doctor) informed. sponsible party) and is  p.m.) MD (medical sible party) notified of given on 2/13 ft. Resident monitored   |                        |   |                      |

|   | - OF MICESTON ME OF ICASOF  |                            |  | <u></u>                       |
|---|---|----------------------------|--|-------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER.  | (X2) MULTIP<br>A, BUILDING | LE CONSTRUCTION  | (X3) DATE SURVEY<br>COMPLETED |
|   |   | 1 "                        |  | С                             |
|   | 495283  | B WING                     |  | 02/25/2022                    |
| NAME OF PROVIDER OR SUPPLIER  | · ·   | S                          | TREET ADDRESS, CITY, STATE, ZIP CODE   |                               |
| PROMEDICA SKILLED NURS  | NG AND DEHAR (IMPEDIAL)   | 1                          | 719 BELLEVUE AVENUE  |                               |
| - TOMEDICA ONICEED NORS   |   | R                          | ICHMOND, VA 23227  |                               |
| PRÉFIX (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES  'MUST BE PRECEDED BY FULL  SCIDENTIFYING INFORMATION)   | 1D<br>PREFIX<br>TAG        | PROVIDER'S PLAN OF CORRECTI<br>(EACH CORRECTIVE ACTION SHOUL<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY) | LO BE COMPLETION              |
| failed to evidence de additional dates liste On 2/24/2022 at 10: conducted with LPN LPN #1 stated that the was not documented stated that multiple rethat they had not rece 2/13/2022 when he recessional descriptions. | ects." The progress notes ocumentation regarding the  | F 656                      |  |                               |
| LPN #1 stated that the  | e plan for administering<br>ed if they were not   |                            |  | 2                             |
| conducted with LPN # purpose of the care p staff informed about the and to keep them upd medications not signe that they were not don should be a progress of medications were not LPN #5 stated that the               | istering the medications or   | £                          |  |                               |
| #2 stated that the care of the resident and ens were in place to meet the   | dministrative staff in director of nursing. ASM plan identified the needs ured the interventions neir needs. ASM #2 or eTAR were not signed |                            |  |                               |

|   | STATEMENT OF DEF   |  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  | 1 0 | (X2) MULTIPLE CONSTRUCTION A BUILDING |  |       | (X3) DATE SURVEY<br>COMPLETED |  |  |
|---|--|--|--|-----|---------------------------------------|--|-------|-------------------------------|--|--|
| j |  |  | 405202   |     | B. WING                               |  |       | С                             |  |  |
| ı |  |  | 495283   | U   | . WING _                              |  | _!    | 02/25/2022                    |  |  |
|   | PROMEDICA SK   |  | ING AND REHAB (IMPERIAL)   |     |                                       | STREET ADDRESS, CITY, STATE, ZIP CODE<br>1719 BELLEVUE AVENUE<br>RICHMOND, VA 23227                        |       |                               |  |  |
|   |  | ACH DEFICIENCY   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   |     | ID<br>PREFIX<br>TAG                   | PROVIDER'S PLAN OF CORRECT<br>(EACH CORRECTIVE ACTION SHOU<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY) | LD BE | (X5)<br>COMPLETION<br>DATE    |  |  |
|   | #2 stat<br>followe<br>there w<br>were no<br>On 2/24<br>. #1, the<br>director | e it was not<br>ed that the ca<br>d to give men<br>as documen<br>of given.<br>W2022 at app<br>interim admi<br>of nursing a | ge 20 signed as completed. ASM are plan was not being dications as ordered unless tation to support why they proximately 4:30 p.m., ASM nistrator, ASM #2, the interiment ASM #3, the regional are notified of the findings.             | 8   | F 656                                 | 5  |       | 7                             |  |  |
|   | No furth   | er informatio  | on was provided prior to exit.   |     |                                       | ř  |       |                               |  |  |
|   | compreh  |  | ailed to implement the plan for medication sident #1.  | I.  |                                       |  |       |                               |  |  |
|   | not limite<br>diabetes<br>recent M<br>quarterly<br>reference<br>scoring a    | with diagnosed to: periphe<br>mellitus and<br>DS (minimur<br>assessment<br>date) of 1/2<br>15 out of 15                    | nitted to the facility on sis that included but were eral vascular disease, atrial fibrillation. The most m data set) assessment, a, with an ARD (assessment 0/22, coded the resident as on the BIMS (brief tatus) score, indicating the |     |                                       |  |       | © C                           |  |  |
|   | A review of 10/27/21 fibrillation thrombosic diabetes.                       | vas not cogn<br>of the compri<br>documented<br>hypertensics.<br>Endocrine  | ehensive care plan dated in part, "FOCUS: Atrial on and deep vein System related to TIONS: Administer  |     |                                       |  |       |                               |  |  |
|   | document<br>- For 5:00   | ed:<br>p.m. adminis  | stration: "Monitor blood<br>physician if fasting blood   |     |                                       |  |       |                               |  |  |

|   | CALL THE PROPERTY OF THE BROWN THE   | C MEDIOMB OCHTRICI   |                             |  | OIVID 14(), 0330-039          |
|---|--|--|-----------------------------|--|-------------------------------|
|   | STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER   | (X2) MULTIPLE<br>A BUILDING | CONSTRUCTION   | (X3) DATE SURVEY<br>COMPLETED |
| ĺ |  | 495283   | 8 WING                      |  | C<br>02/25/2022               |
|   | NAME OF PROVIDER OR SUPPLIER PROMEDICA SKILLED NURSI   | NG AND REHAB (IMPERIAL)  | 17                          | REET ADDRESS, CITY, STATE, ZIP CO<br>19 BELLEVUE AVENUE<br>CHMOND, VA 23227                      |                               |
|   | PREFIX (EACH DEFICIENCY  | FEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL BC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG         | PROVIDER'S PLAN OF CORI<br>(EACH CORRECTIVE ACTION S<br>CROSS-REFERENCED TO THE A<br>DEFICIENCY) | SHOULD BE COMPLETION          |
|   | hypertensionEliquidaily for blood thinned  - For 9:00 p.m. admid 100 UNIT/MILLILITE subcutaneously at Beyon Apply to chest topidand remove per scheet (antiepileptic) 100 mid neuropathy."  A review of the Februal administration record 100 on 2/13/22 at 6:30 PM, at 2/14/22 at 6:30 AM. The pressure of 103/64 on A review of the nursing 2/14/22 at 6:22 PM, with administrative staff midirector of nursing, review of the nursing 2/14/22 at 6:22 PM, with administrative staff midirector of nursing, review of the nursing 2/14/22 at 6:22 PM, with administrative staff midirector of nursing, review of the nursing 2/14/22 at 6:22 PM, with administrative staff midirector of nursing, review of the nursing 2/14/22 at 6:22 PM, with administrative staff midirector of nursing, review of the nursing 2/14/22 at 6:22 PM, with a review of the nursing 2/14/22 at 6:20 PM, with a review of the nursing 2/14/22 at 6:20 PM, with a review of the nursing 2/14/22 at 6:20 PM, with a review of the nursing 2/14/22 at 6:20 PM, with a review of the nursing 2/14/22 at 6:20 PM, with a review of the nursing 2/14/22 at 6:20 PM, with a review of the nursing 2/14/22 at 6:20 PM, with a review of the nursing 2/14/22 at 6:20 PM, with a review of the nursing 2/14/22 at 6:20 PM, with a review of the nursing 2/14/22 at 6:20 PM, with a review of the review o | Metoprolol 2.5 milligram twice daily for is (anticoagulant) 5 mg twice is (anticoagulant) 5 mg twice is."  nistration: "Lantus (insulin) R Inject 10 unit edtimeLidocaine Patch 4 cally every 12 hours for pain iduleGabapentin ligram at bedtime for  ary 2022 MAR (medication evidenced a blood sugar of 0 AM, no blood sugar on a blood sugar of 145 at the MAR evidenced a blood 2/8/22.  In progress note dated evitten by ASM ember) #2, the interim evaled, "Physician and RP iffied of meds (medications) ing shift. Resident erse effects."  Jucted on 2/23/22 at 12:56  When asked if he had doses, Resident #1 an evening where there the medications and I did day."  Jucted on 2/24/22 at 10:36 practical nurse) #1. When | F 656                       |  |                               |
|   | asked about the events missing medications, LF   |  |                             |  |                               |

|  | CATILITIES CALL MICHIGAN   | A MEDIONID OLIVIOLO   |                     |                         |  | ANIALISTA               | W 0330-033                 |
|--|--|---|---------------------|-------------------------|--|-------------------------|----------------------------|
|  | STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   | (X2) MU<br>A. BUILI | JETIPLE CONSTRI<br>DING |  | DATE SURVEY<br>OMPLLIED |                            |
| I  |  | 405202  | D MULLIC            |                         |  | 1                       | С                          |
| Į  |  | 495283  | 8 WINC              | ,                       |  | 0                       | 2/25/2022                  |
|  | PROMEDICA SKILLED NURSI  | NG AND REHAB (IMPERIAL)   |                     | 1719 BELLE              | RESS, CITY, STATE, ZIP CODE<br>EVUE AVENUE<br>D, VA 23227  |                         |                            |
|  | PREFIX (EACH DEFICIENCY  | FEMENT OF DEFICIENCIES MUST BE PRECEDED BY FUI L C IDENTIFYING INFORMATION)   | ID<br>PREF<br>TAG   | IX (EA                  | PROVIDER'S PLAN OF CORRECT<br>CH CORRECTIVE ACTION SHOU<br>SS-REFERENCED TO THE APPRO<br>DEFICIENCY) | JLD BE                  | (XS)<br>COMPLETION<br>DATE |
|  | handed off to the even what the nurse did. Tuesday 2/15/22, Refered his evening When asked the pure that the plan of care for givers." When asked MAR, was the care postated, "No, it was not an interview was con PM with ASM #2. Who for 2/13/22 and missing shift, ASM #2 stated, | shift medications and then ening nurse. I do not know When I came back on esident #1 told me he had not medicines on Sunday." pose of the care plan, LPN ose of the care plan is to lay or the resident and care if there were blanks on the lan implemented, LPN #1 it."  ducted on 2/24/22 at 1:58 nen asked about the events g medications on evening "I was told there was no |                     |                         |  |                         |                            |
| nurse to administer the meds on Wing 1 around 6:00 PM. When asked the purpose of the care plan, ASM #2 stated, "The purpose of the care plan is to identify the needs of the resident and to make sure you have interventions in place and to assist the CNA's and nurses with providing care for the resident." When asked if there were blanks on the MAR, was the care plan implemented, ASM #2 stated, "No, the care plan was not followed if there were blanks."  On 2/24/22 at 4:30 PM, ASM #1, the administrator, ASM #2, the director of nursing and ASM #3, the regional quality consultant and ASM #4, the regional director of risk management, quality and compliance, were made aware of the above concern. |  |   |                     |                         |  |                         |                            |
|  |  |   | 1                   |                         | ****   |                         |                            |
|  | No further information v   | was provided prior to exit.   |                     |                         |  |                         |                            |
|  |  | an for peritoneal dialysis  |                     | 1                       |  |                         |                            |

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

|  | CENTERS FOR MEDICAR  | E & MEDICAID SERVICES   | OMB NO. 0938        |  |                               |                          |  |
|--|--|---|---------------------|--|-------------------------------|--------------------------|--|
|  | STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:                       |   | (X2) MUL<br>A BUILD | TIPLE CONSTRUCTION ING                     | (X3) DATE SURVEY<br>COMPLETED |                          |  |
|  |  | 495283  | B WING              | and and h                                  | C<br>02/25/2                  | 2022                     |  |
| ŀ  | NAME OF PROVIDER OR SUPPLIER   | J   |                     | STREET ADDRESS, CITY, STATE, ZIP CODE      | 1 0112072                     |                          |  |
|  | PROMEDICA SKILLED NURS   | ING AND REHAB (IMPERIAL)  | ĺ                   | 1719 BELLEVUE AVENUE<br>RICHMOND, VA 23227 |                               |                          |  |
| -  | PREFIX (EACH DEFICIENC)  | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION              | DBE COM                       | (X5)<br>MPLETION<br>DATE |  |
| _  | F 656 Continued From pa  | ge 23   | F 6                 | 56   |                               |                          |  |
|  | 9/29/21 with diagno  |   |                     |  |                               |                          |  |
| The most recent MDS (minimum data set) assessment, a quarterly assessment, with an ARD (assessment reference date) of 11/19/21, coded the resident as scoring a 15 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was not cognitively impaired. A review of the MDS Section G-functional status coded the resident as requiring extensive assistance for bed mobility, |  |   |                     | 20<br>22                                   |                               |                          |  |
|  |  | giene and bathing; limited otion and supervision for  |                     |  | ţ                             |                          |  |
|  | 11/1/21 documented insufficiencies related   | A review of the comprehensive care plan dated 11/1/21 documented in part, "FOCUS: Renal insufficiencies related to end stage renal disease, INTERVENTIONS: Peritoneal dialysis catheter |                     |  | 2                             |                          |  |
|  | A review of the physic<br>revealed the following<br>care. Cleanse area w<br>dry. Apply dry dressin | ian orders dated 9/29/21,<br>i, "Peritoneal dialysis site<br>vith normal saline and pat   |                     | į.   |                               |                          |  |
|  | A review of Resident # administration record)  |   |                     |  |                               |                          |  |
|  | peritoneal dialysis site   | care, there was five of 31<br>1 and ten out of 23 missed  |                     |  | 240                           |                          |  |
|  | 00.0017 2021.  |   |                     |  | 5.1                           | - 1                      |  |

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   | (X2) MULTI  | PLE CONSTRUCTION  | (X3) DATE SURVEY<br>COMPLETED |
|--|---|-------------|---|-------------------------------|
| 1  |   | / GOICESITY |   | С                             |
| **   | 495283  | B. WING_    | *****   | 02/25/2022                    |
| NAME OF PROVIDER OR SUPPLIER   |   |             | STREET ADDRESS, CITY, STATE, ZIP CODE   |                               |
| PROMEDICA SKILLED NURS   | ING AND REHAB (IMPERIAL)  |             | 1719 BELLEVUE AVENUE<br>RICHMOND, VA 23227  |                               |
| PREFIX (EACH DEFICIENC)  | REFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL   |             | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPED DEFICIENCY) | D BE COMPLETION               |
| F 656 Continued From page 24   |   | F 656       | ·<br>6  |                               |
| An interview was co<br>AM with LPN (licens<br>asked if he had obs<br>peritoneal site care,<br>It is looks good." W<br>Resident #10's perit<br>what the blanks med<br>mean that the care of<br>not documented in the<br>asked the purpose of<br>stated, "The purpose                  | onducted on 2/24/22 at 10:36 sed practical nurse) #1. When erved Resident #10's LPN #1 stated, "Yes, I have. Then shown the TAR for oneal site care and asked an, "LPN #1 stated, "Blanks was not provided and it was the medical record." When of the care plan, LPN #1 to for the care plan is to lay out |             |   |                               |
| When asked if there  | the plan of care for the resident and care givers." When asked if there were blanks on the TAR, was the care plan implemented, LPN #1 stated, "No, it was not."   |             |   |                               |
| : An interview was con   | ducted on 2/24/22 at 1:58   | i           |   | 9,                            |
| PM with ASM (admin<br>the interim director of<br>the blanks on the TAI<br>means that the care of<br>the purpose of the can<br>"The purpose of the can<br>needs of the resident<br>interventions in place<br>nurses with providing<br>When asked if there of<br>was the care plan imp | istrative staff member) #2, If nursing. When asked what R mean, ASM #2 stated, "It was not given." When asked are plan, ASM #2 stated, eare plan is to identify the and to make sure you have and to assist the CNA's and   |             |   |                               |
| blanks."  On 2/24/22 at 4:30 PM, ASM #1, the administrator, ASM #2, the director of nursing and ASM #3, the regional quality consultant and ASM #4, the regional director of risk management, quality and compliance, were made aware of the above concern.                          |   |             |   |                               |
| No further information   | was provided prior to exit.   |             |   | 6                             |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER. |  | 1  | TIPLE CONSTRUCTION<br>ING | (X3) DATE SURVEY<br>COMPLETED   |    |                            |  |  |
|---|--|--|---------------------------|---|----|----------------------------|--|--|
| ĺ   |  | 405292   | B. WING                   |   |    | С                          |  |  |
| ŀ   | NAME OF PROVIDER OR SUPPLIER   | 495283   | B 44114G                  | STREET ADDRESS, CITY, STATE, ZIP CODE   |    | 02/25/2022                 |  |  |
|   | PROMEDICA SKILLED NURSI  | NG AND REHAB (IMPERIAL)  |                           | 1719 BELLEVUE AVENUE<br>RICHMOND, VA 23227  |    |                            |  |  |
|   | PREFIX (EACH DEFICIENCY  | EFIX (EACH DEFICIENCY MUST RE PRECEDED BY FULL   |                           | PROVIDER'S PLAN OF CORRECTIO<br>( (EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROP<br>DEFICIENCY) | BE | (XS)<br>COMPLETION<br>DATE |  |  |
|   | F 656 Continued From pag   | ne 25  | F 65                      | 56  |    |                            |  |  |
|   | comprehensive care administration for Re A review of the comp 9/29/21 documented Hyperlipidemia, cong  | sident #10<br>rehensive care plan dated<br>in part, "FOCUS:<br>estive heart failure and<br>rine System related to<br>NTIONS: Administer                                      |                           |   |    |                            |  |  |
|   | The physician orders   | dated 12/9/21 documented:  |                           | •   |    |                            |  |  |
|   | (antiemetic) 8 milligra<br>meals before nausea<br>(antihypotensive) 5 m<br>times a day for low blo<br>checks before meals<br>- For 9:00 p.m. admini<br>(antihyperlipidemic) 80 | stration time: "Atorvastatin<br>milligram daily for heart<br>lood sugar checks before  |                           |   |    |                            |  |  |
|   | blood sugar of 123 2/1<br>sugar at 2/13/22 at 4:3<br>9:00 PM and a blood s<br>6:00 AM. The MAR als<br>pressure of 130/62 on  | ry 2022 MAR evidenced a 3/22 at 11:30 AM, no blood 0 PM, no blood sugar at ugar of 91 at 2/14/22 at 0 evidenced a blood 2/13/22 at 12:20 PM and a 64 at 11:38 PM on 2/14/22. |                           |   |    |                            |  |  |
|   |  | mber) #2, the interim  | ;                         |   |    |                            |  |  |

|   | STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER      | (X2) MULTIPL<br>A BUILDING | E CONSTRUCTION   | (X3) DATE SURVEY.<br>COMPLETED |        |
|---|--|---|----------------------------|--|--------------------------------|--------|
|   |  | 1   | A DOLLOWO                  |  | C                              |        |
| ı |  | 495283  | B WING                     | B. WING  |                                |        |
| ı | NAME OF PROVIDER OR SUPPLIER   |   | 1 51                       | FREET ADDRESS, CITY, STATE, ZIP CODE   | 0212                           | 5/2022 |
| Į | 2 2  |   | I                          | 719 BELLEVUE AVENUE  |                                |        |
| Į | PROMEDICA SKILLED NURSI  | ING AND REHAB (IMPERIAL)                                  |                            | ICHMOND, VA 23227  |                                |        |
| ł | (X4) ID SUMMARY STA  | TEMENT OF DEFICIENCIES                                    |                            | PROVIDER'S PLAN OF CORRECT   | 1011                           |        |
|   | PREFIX (EACH DEFICIENCY  | Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION) | ID<br>PREFIX<br>TAG        | (EACH CORRECTIVE ACTION SHOU<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY) | SHOULD BE COMPLETIC            |        |
|   | F 656 Continued From page  | ge 26   | F 656                      |  |                                |        |
|   |  | with no adverse effects."                                 | 1 050                      |  |                                |        |
|   | NOSIGERI MONICICA  | with no adverse effects:                                  |                            |  |                                |        |
|   | An interview was co  | nducted on 2/23/22 at 2:06                                |                            |  |                                |        |
|   |  | 10. When asked if there had                               |                            |  |                                |        |
|   | been any missed medication doses, Resident #10 stated, "Yes, It was Superbowl Sunday, the agency nurse on evenings left and we did not get out medications that shift. I let the dialysis center know I had missed medications." |   |                            |  |                                |        |
|   |  |   |                            |  |                                |        |
|   |  |   |                            |  |                                |        |
|   |  |   |                            |  |                                |        |
|   |  |   | 13                         |  |                                |        |
|   | An interview was con   | nducted on 2/24/22 at 10:36                               |                            |  |                                |        |
|   |  | ed practical nurse) #1. When                              |                            |  |                                |        |
|   |  | nts of 2/13/22 including                                  |                            |  |                                |        |
|   |  | LPN #1 stated, "I gave                                    |                            |  |                                |        |
|   |  | / shift medications and then                              |                            |  |                                |        |
|   | handed off to the eve  | ning nurse. I do not know                                 |                            |  |                                |        |
|   | what the nurse did. V  | When I came back on                                       |                            |  |                                |        |
|   | not received her even  | sident #10 told me she had<br>ling medicines on Sunday."  |                            |  |                                | - 1    |
|   | When asked what the  | hlanks on the MAR   |                            |  | '                              |        |
|   |  | ration record) mean, LPN #1                               |                            |  | 1                              | 1      |
|   |  | the medication was not                                    |                            |  |                                |        |
|   | given."  |   |                            |  | -                              |        |
|   | 14   |   |                            |  |                                |        |
|   |  | ducted on 2/24/22 at 1:58                                 |                            |  |                                |        |
|   | of 2/12/22 and missing   | en asked about the events graduations on evening          |                            |  |                                |        |
|   |  | I was told there was no                                   |                            |  |                                | 1      |
|   |  | meds on Wing 1 around                                     |                            |  | -                              | 1      |
|   |  | d the purpose of the care                                 |                            |  |                                | 1      |
|   | plan, ASM #2 stated, "   | The purpose of the care                                   |                            |  |                                | - 1    |
|   | plan is to identify the no   | eeds of the resident and to                               | 1                          |  |                                |        |
|   |  | terventions in place and to                               |                            |  |                                |        |
|   |  | urses with providing care                                 | 43                         |  | 1                              |        |
|   | for the resident." When  |   |                            |  | 1                              |        |
|   | blanks on the MAR, wa  | •   |                            |  |                                |        |
|   | was not followed if there  | stated, "No, the care plan                                |                            |  |                                |        |
|   | was not followed it there  | e were blanks.  |                            |  | 13                             |        |

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  | 31                 |            | CONSTRUCTION   |      | DATE SURVEY<br>COMPLETED   |
|--|--|--------------------|------------|--|------|----------------------------|
|  | 495283   | B WING             |            |  |      | C<br>02/25/2022            |
| NAME OF PROVIDER OR SUPPLIER PROMEDICA SKILLED NURSI   |  |                    | STR<br>171 | REET ADDRESS, CITY, STAYE, ZIP CODE<br>9 BELLEVUE AVENUE<br>CHMOND, VA 23227                                 | _ !  | 0212312022                 |
| PREFIX (EACH DEFICIENCY  | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)  | ID<br>PREFI<br>TAG | х          | PROVIDER'S PLAN OF CORRECTI<br>(EACH CORRECTIVE ACTION SHOUL<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY) | D BE | (XS)<br>COMPLETION<br>DATE |
| ASM #3, the regional #4, the regional direct quality and compliant above concern.  No further information 7. The facility staff factor comprehensive care constipation for Resident #5 was adman 1/13/2022. On the medical part of | PM, ASM #1, the #2, the director of nursing and all quality consultant and ASM ctor of risk management, ice, were made aware of the in was provided prior to exit. illed to implement the plan for the treatment of dent #5.                                 | F 6                | 56         |  |      |                            |
| with an ARD (assessing 1/18/2022, the resident the BIMS (brief interview indicating the resident impaired for making distribution of the comprehensive conduction of the constipation of the constitution of t | i, an admission assessment, ment reference date) of int scored a 7 out of 15 on iew for mental status) score, it is severely cognitively ally decisions.  are plan dated, 1/14/2022 Focus: Bowel Elimination inAdminister medication observe effectiveness." |                    |            |  |      |                            |
| The physician order da documented, "Senna  | ated 1/14/2022<br>Fablet (used to treat<br>g; Give 1 tablet by mouth   |                    |            |  |      |                            |
|  |  |                    | i          |  |      |                            |
| Review of the nurse's n  | otes for 2/9/2022 failed to  |                    |            |  |      | 14                         |

|                          | NT OF DEFICIENCIES<br>NOF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  | (X2) MUI           |    | E CONSTRUCTION  | (X3) | DATE SURVEY<br>COMPLETED   |
|--------------------------|--|---|--------------------|----|---|------|----------------------------|
| Í                        |  | 495283  | B. WING            |    |   |      | C<br>02/25/2022            |
|                          | PROVIDER OR SUPPLIER   | NG AND REHAB (IMPERIAL)   |                    | 17 | TREET ADDRESS, CITY, STATE, ZIP CODE<br>719 BELLEVUE AVENUE<br>ICHMOND, VA 23227                                |      | 0212312022                 |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY   | FEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)   | ID<br>PREFI<br>TAG | ×  | PROVIDER'S PLAN OF CORRECTIO<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROP<br>DEFICIENCY) | 8E   | (X5)<br>COMPLETION<br>DATE |
| F 656                    | medication.  An interview was conpractical nurse) #1, of When asked if the castaff to administer medication, LPN #1 semedication, LPN #1 semedication. | ation related to the above adviced with LPN (licensed on 2/24/2022 at 10:34 a.m. are plan instructing the facility edications as ordered is there are blanks on a administration of a stated it wasn't adhered to | F6                 | 56 |   |      |                            |
|                          | director of nursing, or<br>When asked if the ca<br>staff to administer me  | ducted with ASM nember) #2, the interim n 2/24/2022 at 2:00 p.m. re plan instructing the facility dications as ordered is   |                    | 1  |   |      |                            |
| w                        |  | dministration of a tated ASM #2 stated no, ameters for not giving the   |                    |    |   |      | f                          |
| i<br>_ c<br>q            | nterim director of nurs<br>quality consultant, and<br>quality regulatory cons  | dministrator, ASM #2, the sing, ASM #3, regional ASM #4, the divisional ultant, were made aware of 2/24/2021 at 4:56 p.m.   |                    | 1  |   |      |                            |
| ٨                        | lo further information   | was obtained prior to exit.   |                    |    |   |      |                            |
| fo<br>ht<br>F 677 A      |  | s obtained from the<br>/druginfo/natural/652.html.<br>Dependent Residents   | F 677              |    |   |      |                            |

FORM APPROVED

OMB NO 1038 0304

| CENT                     | EKS LOK MEDICAK                      | E & MEDICAID SERVICES  | ·                  |      |  | OMP 1/1   | <u>0. 0938-03</u>      |
|--------------------------|--------------------------------------|--|--------------------|------|--|-----------|------------------------|
|                          | NT OF DEFICIENCIES<br>LOF CORRECTION | (C.I.) PROVIDER/SUPPLIER/CLIA<br>JOENTIFICATION NUMBER                           | 1                  |      | L CONSTRUCTION   |           | ATE SURVEY<br>IMPCETED |
|                          |                                      | 495283   | B WING             |      | The second secon | 0:        | C<br>2/25/2022         |
| NAME OF                  | PROVIDER OR SUPPLIER                 |  | <b>'</b> ——        | S1   | REET ADDRESS, CITY, STATE, ZIP CODE  | 1         |                        |
| BB OM                    | DIO 4 OLUL 1 ED 14400                |  | ł                  | 17   | 19 BELLEVUE AVENUE   |           |                        |
| PROME                    | EDICA SKILLED NURS                   | ING AND REHAB (IMPERIAL)   | ĺ                  | RI   | CHMOND, VA 23227   |           |                        |
| (X4) ID<br>PREFIX<br>FAG | (EACH DEFICIENC)                     | ATEMENT OF DEFICIENCIES  Y MUST BIE PRECEDED BY FULL  SCIDENTIFYING INFORMATION) | ID<br>PREFI<br>TAG | x    | PROVIDER'S PLAN OF CORRECTI<br>(FACH CORRECTIVE ACTION SHOUL<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY)   | D BE      | COMPLETION<br>DATE     |
| F 677                    | Continued From pa                    | ne 29  | E 6                | 77 Î | ag F677 – Failed to provide ADL  | Caro      |                        |
|                          |                                      | ident who is unable to carry   | 1 0                |      |  |           |                        |
|                          |                                      | / living receives the necessary  |                    | - 1  | . Resident # 2 was offered a shower  | er on     |                        |
|                          |                                      | good nutrition, grooming, and  |                    |      | 2/25/22 and Resident # 11 receive  | ed a      |                        |
|                          | personal and oral hy                 |  |                    |      | shower on 2/25/22.   |           |                        |
|                          | This REQUIREMEN                      | IT is not met as evidenced   |                    | 2.   | The DON has reviewed the facilit   | tv showe  | 217                    |
|                          | by:                                  |  |                    |      | schedule to validate accuracy.   | .,        |                        |
|                          |                                      | nterview, staff interview,   |                    | 3.   | The DON or designee has re-educ  | ated the  |                        |
|                          |                                      | view, clinical record review   |                    |      | licensed nurses and nurse aides or   | 1 Rathine | 0                      |
|                          |                                      | a complaint investigation, it the facility staff failed to                       |                    |      | procedure to include offering and  |           | 5                      |
|                          |                                      | es of daily living) care to 2 of   |                    |      | providing showers as scheduled.  |           |                        |
|                          | 14 residents in the si               | urvey sample, Residents #2   |                    | 4.   | The DON or designee will audit sl  | lower     |                        |
|                          | and #11.                             |  |                    |      | completion compliance weekly tin   |           |                        |
|                          |                                      | €  |                    |      | weeks. The Administrator will sul  | bmit      |                        |
|                          | The findings include:                |  |                    |      | findings to the QAPI committee fo  |           | ,                      |
|                          | 1. The facility staff fo             | illed to provide showers to  |                    |      | and further recommendations.   |           |                        |
|                          | Resident #2.                         | illed to provide showers to  |                    | 5.   | The facility's alleged date of comp  | liance    |                        |
|                          |                                      |  |                    |      | will be April 4, 2022.   |           | 4/4/2022               |
|                          |                                      | IDS (minimum data set), a  |                    |      |  |           |                        |
|                          |                                      | with an ARD (assessment  |                    |      |  |           |                        |
|                          |                                      | 2/2022, the resident scored  |                    |      |  |           |                        |
|                          | nental status), indicat              | MS (brief interview for  |                    | 1    |  |           |                        |
|                          |                                      | naking daily decisions.  |                    |      |  |           |                        |
|                          |                                      | d Resident #2 being totally  |                    |      |  |           |                        |
| d                        | ependent on staff for                | bathing, having functional   |                    |      |  |           |                        |
|                          |                                      | notion to both upper and   |                    |      |  |           |                        |
| lo                       | wer extremities and                  | requiring a wheelchair.  |                    |      |  |           |                        |
| 0                        | n 2/23/2022 at appro                 | ximately 12:05 p.m., an  |                    |      |  |           |                        |
|                          |                                      | ed of Resident #2 in her   |                    |      |  |           | 1                      |
|                          | om. Resident #2 sta                  |  |                    | ,    |  |           | ļ                      |
|                          |                                      | Resident #2 stated that she  |                    |      |  | 112       |                        |
|                          | d met with the staff a               |  |                    |      |  |           |                        |
|                          | cently and verbalized                |  | i                  |      |  | 3         | }                      |
|                          |                                      | ot getting them. Resident shad to use a mechanical                               |                    |      |  |           | j                      |
| 11/                      | Stated that the UNA                  | s nau to use a mechanical  |                    |      |  | 12.5      |                        |

lift to get her out of bed due to her paralysis, and

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA |  |   | (X2) MUL            | TIPLE CONSTRUCTION   | (X3) DATE SURVEY    |
|---|--|---|---------------------|--|---------------------|
| ^   | ND FEAR OF CORRECTION  | IDENTIFICATION NUMBER.  | A, BUILDI           | NG   | COMPLETED           |
|   |  | 495283  | B, WING             |  | C                   |
| -   | NAME OF PROVIDER OR SUPPLIER   |   | -                   | STREET ADDRESS, CITY, STATE, ZIP COD   | 02/25/2022<br>DE    |
| PROMEDICA SKILLED NURSING AND REHAB (IMPERIAL)        |  |   |                     | 1719 BELLEVUE AVENUE<br>RICHMOND, VA 23227   |                     |
|   | PREFIX (EACH DEFICIENCY  | TEMENT OF DEFICIENCIES<br>MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)                             | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRE<br>(EACH CORRECTIVE ACTION SH<br>CROSS-REFERENCED TO THE API<br>DEFICIENCY) | TOULD BE COMPLETION |
|   | her to the shower be<br>Resident #2 stated t   | not have enough time to take ecause they are understaffed, hat she did refuse bed baths became angry that the | F 67                | '7   |                     |
|   | The comprehensive care plan for Resident #2 documented in part, "ADL self care deficit related to paraplegia. Date Initiated: 10/18/2021 Assist to bathe/shower as needed. Date Initiated: 10/18/2021" |   |                     |  |                     |
|   |  | survey report dated I documented "NA" under 2/2021 and 11/25/2021.  |                     |  | *                   |
|   | The Documentation s<br>12/1/2021-12/31/2021<br>Shower/Bath on 12/13<br>12/20/2021 and 12/30  | f documented "NA" under 3/2021, 12/16/2021,   |                     |  | H                   |
|   |  | ocumented "NA" under 022, 1/13/2022, 1/17/2022,   |                     |  |                     |
|   | The Documentation su<br>2/1/2022-2/28/2022 do<br>Shower/Bath on 2/3/20   | cumented "NA" under   |                     |  |                     |
|   | The progress notes for evidence documentation received on the dates in   | on of a bed bath or shower 📗  |                     |  | e e                 |
|   | The "Care plan progres documented in part, " days. Monday and Thu p.m11:00 p.m.)ombi   | os note" dated 12/15/2021<br>Discussed about shower<br>Irsday 3-11 (3:00<br>Judsman present"                  |                     |  | =                   |

| CIETALE LOS LOIS INITIACIA   | VE 9. MEDICAID SEKVICES   |                              |   |                               |
|--|---|------------------------------|---|-------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER.   | (X2) MULTIPLE<br>A. BUILDING | CONSTRUCTION  | (X3) DATE SURVEY<br>COMPLETED |
|  | 495283  | B WING                       |   | C<br>02/25/2022               |
| NAME OF PROVIDER OR SUPPLIE PROMEDICA SKILLED NUR  | R<br>SING AND REHAB (IMPERIAL)  | 17                           | REET ADDRESS, CITY, STATE, ZIP CODE<br>19 BELLEVUE AVENUE<br>CHMOND, VA 23227                         |                               |
| PREFIX (EACH DEFICIEN  | TATEMENT OF DEFICIENCIES<br>CY MUST BE PRECEDED BY FULL<br>LISC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG          | PROVIDER'S PLAN OF CORRE<br>(EACH CORRECTIVE ACTION SHO<br>CROSS-REFERENCED TO THE APP<br>DEFICIENCY) | OULD BE COMPLÉTIO             |
| conducted with CI #3. CNA #3 state night shift as need documented under Documentation surplicable. CNA # were applicable. CNA # were applicable for been offered. CNA # were five or six CN were lucky, they had never worked on the unit. CNA # had enough help a liliey did not have extremely did not provide more help now than  | page 31 240 p.m., an interview was NA (certified nursing assistant) of that they worked day shift and led. CNA #3 stated that "NA" or shower/bath on the orvey report meant not of stated that shower/baths or all residents and should have of A #3 stated that the goal was to of the day shift but if they of four. CNA #3 stated they when there was only one CNA of stated that they felt like they of times and other times felt like onough to get things done, and of the shower/bath section of survey report meant that the of the past few months. CNA | F 677                        |   |                               |
| cna before, and hat end of the unit to the incontinence care. It they had two cnast weekends, and man show up to work. Clarot always someone if someone did not someone did no | d continuously gone from one other end providing CNA #2 stated that normally on the evening shift on the y times someone did not NA #2 stated that there was available to come in to cover  |                              |   |                               |
| "Purpose: To cleanse circulation"  |   |                              |   |                               |
| On 2/24/2022 at appr   | oximately 4:30 p.m., ASM  |                              | W.  | 20                            |

| 1   | TO TAILED TO LAID OF LAIDING                              |                            |   | OIMP IAO: 083R-03             |
|---|---|----------------------------|---|-------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                         | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER      | (X2) MULTIPE<br>A BUILDING | E CONSTRUCTION  | (X3) DATE SURVEY<br>COMPLETED |
|   | 495283  | B WING                     |   | C<br>02/25/2022               |
| NAME OF PROVIDER OR SUPPLIER  |   | SI                         | REET ADDRESS, CITY, STATE, ZIP CODE   | 1 02/23/2022                  |
|   |   |                            | 19 BELLEVUE AVENUE  |                               |
| PROMEDICA SKILLED NURS  | ING AND REHAB (IMPERIAL)                                  |                            | ICHMOND, VA 23227   |                               |
| (X4) ID SUMMARY STA   | ATEMENT OF DEFICIENCIES                                   |                            |   |                               |
| PREFIX (EACH DEFICIENC)   | Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION) | PREFIX<br>TAG              | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROIDEFICIENCY) | D BE COMPLETION               |
| F 677 Continued From pa   | 20.22   | E 0777                     |   |                               |
|   |   | F 677                      |   |                               |
| (administrative stati   | member) #1, the interim                                   |                            |   |                               |
|   | #2, the interim director of                               |                            |   |                               |
| consultant were not   | 3, the regional quality                                   |                            |   |                               |
| consultant were not   | med of the findings.                                      |                            | 22  |                               |
| No further information  | on was provided prior to exit                             |                            |   |                               |
| Complaint deficiency  | у   |                            |   | ,                             |
| <ol><li>The facility staff facility staff facility staff facility</li></ol> | ailed to provide showers to                               |                            |   |                               |
| On the most recent A  | MDS (minimum data set), a                                 |                            |   | •                             |
| quarterly assessmen   | it with an ARD (assessment                                | 6                          |   | 1                             |
| reference date) of 12   | 1/15/2021, the resident                                   | 81                         |   |                               |
| scored 15 out of 15 o   | on the BIMS (brief interview                              |                            |   |                               |
| for mental status), inc   | dicating the resident is                                  |                            |   |                               |
|   | naking daily decisions.                                   |                            |   |                               |
| Section G documente   | ed Resident #11 requiring                                 |                            |   |                               |
|   | person with portions of                                   | 4                          |   |                               |
| bathing and having fu   | inctional limitation in range                             |                            |   | 134                           |
| of motion to the lower  | extremities.  |                            |   |                               |
| . On 2/22/2022 -t   |   |                            |   | 1                             |
| interview was conduct   | oximately 2:00 p.m., an<br>ted of Resident #11 in her     |                            |   | 1                             |
|   | tated that they preferred to                              | . 1                        |   |                               |
| get showers and was   | scheduled to get them                                     | 7                          |   | ļ                             |
| every Wednesday and   | Saturday. Resident #11                                    |                            |   | 30                            |
| stated that they were r   | never able to get the                                     |                            |   |                               |
| shower on Saturdays t   | pecause the CNAs told                                     |                            |   | 40.                           |
| <ul> <li>them they were assign</li> </ul>                                   | ed too many residents and                                 |                            |   | 10                            |
| did not have time to do   | it. Resident #11 stated                                   |                            |   |                               |
| that the CNAs preferre  | d for her to take a bed bath                              | 65 350                     |   |                               |
|   | ave to get her out of the                                 |                            |   |                               |
| bed to go to the showe  | r room, and they told her it                              | 10                         |   | 1                             |
| took too long to get her  | up. Resident #11 stated                                   | 1                          |   |                               |
| that she did not mind th  | ne bed baths sometimes,                                   |                            |   |                               |
| but preferred going to the  |   |                            |   |                               |
| think it was fair that she  | could not get her   |                            |   | 4                             |

|    | OCITICION OF MICEDIONICE   | - O MILIDIONALID OPTIANO   |                        |  | OGGU .VVI CHNICE              | 135      |
|----|--|--|------------------------|--|-------------------------------|----------|
|    | STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   |  | (X2) MULT<br>A BUILDIN | IPLE CONSTRUCTION NG   | (X3) DATE SURVEY<br>COMPLETED | Y        |
|    |  | 495283   | B WING                 |  | С                             |          |
| J  | NI N   | 453263   | ] - ******             |  | 02/25/2022                    | <u> </u> |
| Į  | NAME OF PROVIDER OR SUPPLIER   |  |                        | STREET ADDRESS, CITY, STATE, ZIP CODE  |                               |          |
| l  | PROMEDICA SKILLED NURSI  | NO AND BEHAD (IMPEDIAL)  | ļ                      | 1719 BELLEVUE AVENUE   |                               |          |
| ĺ. | PROMEDIOA SRIECED NORSI  | NO AND KCHAB (IMPERIAL)  |                        | RICHMOND, VA 23227   |                               |          |
|    | PREFIX (EACH DEFICIENCY  | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)  | PREFIX<br>TAG          | PROVIDER'S PLAN OF CORRECTIVE ACTION SHO<br>(EACH CORRECTIVE ACTION SHO<br>CROSS-REFERENCED TO THE APPE<br>DEFICIENCY) | DULD BE COMPLET               |          |
|    | E 677 Continued France   | 00   | =                      | _  |                               |          |
|    | F 677 Continued From page  | _  | F 67                   | /  |                               |          |
|    | · showers because of   | the staffing,  |                        |  |                               |          |
|    | documented in part,<br>living) self care defic<br>perform basic needs  | care plan for Resident #11 "ADL (activities of daily it as evidenced by inability to related to paraplegia. DateAssist to bathe/shower as ed: 9/20/2019" |                        |  |                               |          |
|    | 12/1/2021 and 12/25  | 1 failed to evidence<br>hower or bed bath on<br>2021.  |                        |  |                               |          |
|    | Shower/Bath on 1/8/2   | survey report dated ocumented "NA" under 022 and failed to evidence nower or bath on 1/1/2022  |                        |  |                               |          |
|    | Shower/Bath on 2/19/3  | ocumented "NA" under<br>2022 and failed to evidence<br>ower or bath on 2/5/2022,   |                        |  | 1                             |          |
|    | The progress notes for evidence documentation received on the dates l  | on of a bed bath or shower 🙏   | ,                      |  |                               |          |
|    | #3. CNA #3 stated that night shift as needed. documented under sho Documentation survey applicable. CNA #3 statements of the control of the c | ertified nursing assistant) t they worked day shift and CNA #3 stated that "NA" wer/bath on the report meant not   |                        |  |                               |          |

| 2772                   | 7 MI 1 TO 1 O 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1      | C INTERPORTED DESTROY  |                     |   | -   |                            |
|------------------------|--|--|---------------------|---|-----|----------------------------|
|                        | MENT OF DEFICIENCIES                             | (X1) PROVIDER/SUPPLIER/CLIA  | (X2) MULTIPL        | E CONSTRUCTION  |     | E SURVEY                   |
| AND PE                 | AN OF CORRECTION                                 | IDENTIFICATION NUMBER:   | A BIJILDING         |   | CON | MELETED                    |
|                        |  | ,  |                     |   |     | С                          |
|                        |  | 495283   | B. WING             |   | 02/ | 25/2022                    |
| NAME                   | OF PROVIDER OR SUPPLIER                          |  | s                   | TREET ADDRESS, CITY, STATE, ZIP CODE  |     |                            |
| PPO                    | MEDICA SKILLED NURSI                             | NG AND REHAB (IMPERIAL)  | 10                  | 719 BELLEVUE AVENUE   |     |                            |
| I KOK                  | ILDION ORICLED HOROI                             | NO ARD RELIAD (IIIII ERIAE)  | R                   | ICHMOND, VA 23227   |     |                            |
| (X4) I<br>PREFI<br>TAG | X (EACH DEFICIENCY                               | TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SCIDENTIFYING INFORMATION) | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTIO<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROP<br>DEFICIENCY) | BE  | (XS)<br>COMPLETION<br>DATE |
| F 67                   | 77 Continued From pag                            | ge 34  | F 677               |   |     |                            |
|                        |  | As on the day shift, but if they   | . 0,,               |   |     |                            |
|                        |  | four. CNA#3 stated they  |                     |   |     |                            |
|                        |  | then there was only one CNA  |                     |   | 53  |                            |
|                        |  | stated that they felt like they  |                     |   |     |                            |
|                        |  | times, and other times felt  |                     |   |     |                            |
|                        |  | e enough to get things done,   |                     |   |     |                            |
|                        | and the pandemic ha                              | ad been hard on them all.  |                     |   |     |                            |
|                        | On 2/24/2022 at 2:11                             | 2 p.m., an interview was   |                     |   |     |                            |
|                        |  | #2. CNA#2 stated that they   |                     |   |     |                            |
|                        |  | shift CNA #2 stated that   |                     |   | 1   |                            |
|                        |  | on the shower/bath section of  |                     |   |     |                            |
|                        | the Documentation s                              | survey report meant that the   |                     |   |     |                            |
|                        |  | d. CNA #2 stated they had  |                     |   |     |                            |
|                        |  | in the past few months. CNA  |                     |   |     |                            |
|                        |  | ad worked a unit as the only   |                     |   |     | i i                        |
|                        |  | continuously gone from one   |                     |   |     |                            |
|                        | end of the unit to the                           | NA #2 stated that normally   |                     |   |     |                            |
|                        |  | n the evening shift on the   |                     |   |     | i I                        |
|                        |  | times someone did not  |                     |   |     |                            |
|                        |  | A #2 stated that there was   | 1.5                 |   |     |                            |
|                        |  | available to come in to cover  | 13                  |   |     | ĺ                          |
|                        | if someone did not sh                            | ow up.   |                     |   |     |                            |
|                        | On 2/24/2022 at appr                             | avimataly 4:20 nm ASM  |                     |   |     |                            |
|                        | (administrative staff m                          | oximately 4:30 p.m., ASM   |                     |   | - 1 | - 1                        |
|                        |  | 2, the interim director of   |                     |   | - 1 | ł                          |
|                        | nursing and ASM #3, t                            |  |                     |   |     | ľ                          |
|                        | consultant were notified                         |  |                     |   |     | ľ                          |
|                        |  | 4  |                     |   | 1   |                            |
|                        |  | was provided prior to exit.  |                     |   | 1   |                            |
| F 684                  | Quality of Care                                  |  | F 684               |   | 1   |                            |
| SS=E                   | CFR(s): 483.25                                   |  |                     |   |     |                            |
| į                      | 6 400 05 Ouelling -5                             |  | 1                   |   |     | -                          |
| 1                      | § 483.25 Quality of car Quality of care is a fun |  | i                   |   | 1   |                            |
|                        | applies to all treatment                         |  | i.                  |   | 1   | -                          |
| - 1                    | applies to all treatment                         | total date provided to   | 1                   |   |     |                            |
|                        |  |  |                     |   |     |                            |

PRINTED: 03/08/05/2 LORM APPROVED OMB NO. 0938-0391

| 121 1 1 7 3 11 1         | 10 1 011 1016 1231077 10 | CL. O. IVII 121(27 (IL) CIT I (VIC)) CI   |                                      |   | 421411,2 14 | (2, 1),2,30,30,0            |
|--------------------------|--------------------------|---|--------------------------------------|---|-------------|-----------------------------|
| STATEMENT OF CORRECTION  |                          | (2.1) PROVIDER/SUPPLIET/CHA<br>IDENTIFICATION NUMBER                              | (X2) MULTIPLE CONSTRUCTION A BURDING |   | COMPLETED   |                             |
|                          |                          | 495283  | B_WING                               |   | 0           | C<br>2/25/2022              |
| NAME OF P                | ROVIDER OR SUPPLIE       | R   |                                      | STREET ADDRESS, CITY, STATE, ZIP COO  | ρiΞ         |                             |
| PROMEDI                  | ICA SKILLED NUR          | SING AND REHAB (IMPERIAL)   |                                      | 1719 BELLEVUE AVENUE<br>RICHMOND, VA 23227  |             |                             |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIEN           | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID<br>PREFIX<br>TAG                  | PROVIDER'S PLAN OF CORRE<br>(EACH CORRECTIVE ACTION SH<br>CROSS-REFERENCED TO 1 HE APP<br>DEFICIENCY) | IOULD BE    | (XS)<br>COMPLETION<br>DATE: |
|                          |                          |   |                                      |   |             |                             |

#### F 684 Continued From page 35

facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices.

This REQUIREMENT is not met as evidenced by:

Based on resident interview, staff interview, facility document review, clinical record review and in the course of a complaint investigation, it was determined that the facility staff failed to follow professional standards of care for 6 of 14 residents in the survey sample, Residents #2, #11, #10, #1, #4 and #5

#### The findings include:

1. The facility staff failed to administer medications as ordered for Resident #2.

Resident #2 was admitted to the facility with diagnoses that included but were not limited to chronic pain syndrome, hypertension and gastroesophageal reflux disease.

On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 1/22/2022, the resident scored 15 out of 15 on the BIMS (brief interview for mental status), indicating the resident is cognitively intact for making daily decisions. Section J documented Resident #2 as receiving scheduled pain medications. Section N documented Resident #2 as receiving antianxiety, antidepressant and opioid medications.

On 2/23/2022 at approximately 12:05 p.m., an interview was conducted of Resident #2 in her

#### F 684 Tag F684 – Failed to follow Profession Standards of Care

- 1. The DON completed an incident report for resident # 2 regarding missing medication administration in December 2021, January 2022, and February 2022; resident # 11 for missing medication and treatments in December 2021, January 2022, and February 2022; resident # 1 for missing medication on 2/13/22; resident # 5 for missing medications on 2/9/22. Resident # 10 and resident # 4 no longer reside at the facility.
- The DON has reviewed the facilities Medication and Treatment Administration Guidelines.
- 3. The DON or designee has re-educated the licensed nurses on the Medication and Treatment Administration Guidelines to include the administration of medication and treatments as ordered by the physician and clarifying, transcribing and implementing physician orders.
- 4. The DON or designee will audit Medication and Treatment Administration Records for completion 5 times weekly times 4 weeks. The Administrator will submit audit findings to the QAPI committee for review and further recommendations.
- 5. The facility's alleged date of compliance will be April 4, 2022.

4/4/2022

|   | - WINDOWND OF LANCEO   |                            |   | OIME INC. 0930-0   | J-31 |
|---|--|----------------------------|---|--|------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER   | (X2) MULTIF<br>A. BUILDING | PLE CONSTRUCTION  | (X3) DATE SURVEY<br>COMPLETED  |      |
|   | 495283   | B WING                     |   | C<br>02/25/2022  | ,    |
| NAME OF PROVIDER OR SUPPLIER PROMEDICA SKILLED NURSI  | NG AND REHAB (IMPERIAL)  | .                          | STREET ADDRESS, CITY, STATE, ZIP CODI<br>1719 BELLEVUE AVENUE<br>RICHMOND, VA 23227                   |  |      |
| PREFIX (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG        | PROVIDER'S PLAN OF CORRE<br>(EACH CORRECTIVE ACTION SHI<br>CROSS-REFERENCED TO THE APP<br>DEFICIENCY) | OULD BE COMPLET  |      |
| occasions where the scheduled medication were not received any medications and had to wait for the only time they had                     | stated that there were by did not receive their but given until the next shift, that the evening nurse on but out, and they had not tions for the evening shift the night shift to come in to sident #2 stated that was not  | F 684                      |   | •  |      |
| record) for Resident:   |  |                            |   | #5<br>i<br>***   |      |
| following medications<br>following dates and ti<br>- "Famotidine Tablet (   | mes:<br>for acid reflux) 40 mg<br>let by mouth one time a day  | 2.1                        |   | ¥3   |      |
| <ul> <li>Bisacodyl Supposite<br/>Insert 1 suppository re</li> </ul>   | ory (for constipation) 10 mg ectaily at bedtime every lion." On 12/17/2021 at  |                            |   |  |      |
| <ul> <li>"Lactulose Solution (<br/>(gram)/15 ml (milliliter<br/>bedtime for bowel regi</li> </ul>   | for constipation) 10 gm<br>) Give 15 ml by mouth at<br>men." On 12/17/2021 at  | ď                          |   | 1  |      |
| mg Give 2 tablet by me constipation may hold stools." On 12/17/202 - "Cefuroxime Axetil Ta Give 500 mg by mouth (urinary tract infection) | if experiencing loose If at 9:00 p.m. If at 9:00 p.m. If an at 9:00 p.m. If at | ar I                       |   | The second secon |      |
| 12/17/2021 at 9:00 p.m<br>- "Colace Capsule (for<br>100 mg by mouth two ti  | constipation) 100 mg Give  |                            |   |  |      |

|   | STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:        | (X2) MUL<br>A BUILDI | TIPLE CONSTRUCTION   |      | OATE SURVEY        |
|---|---|---|----------------------|--|------|--------------------|
| I |   | 1 100   | A BUILD              |  |      | С                  |
| 1 |   | 495283  | B WING               |  | 1 0  | 2/25/2022          |
| ŀ | NAME OF PROVIDER OR SUPPLIER                        | -   | 1                    | STREET ADDRESS, CITY, STATE, ZIP CODE  | 1 0  | 2/20/2022          |
| l |   |   | ĺ                    | 1719 BELLEVUE AVENUE   |      |                    |
| ļ | PROMEDICA SKILLED NURSI                             | ING AND REHAB (IMPERIAL)                                  | ĺ                    | RICHMOND, VA 23227   |      |                    |
| ŀ | (X4) ID SUMMARY STA                                 | TEMENT OF DEFICIENCIES                                    | ID                   | PROVIDER'S PLAN OF CORRECTION  | N    | (X5)               |
|   | PREFIX (EACH DEFICIENCY                             | YMUST BE PRECEDED BY FULL<br>SCIDENTIFYING INFORMATION]   | PREFIX<br>TAG        | (EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROPI<br>DEFICIENCY) |      | COMPLÉTION<br>DATE |
|   | F 684 Continued From page                           | ge 37   | F 68                 | 34   |      |                    |
|   |   | 2/17/2021 at 8:30 p.m.                                    |                      |  |      |                    |
|   |   | (antihistamine) tablet 25 mg                              |                      |  |      |                    |
|   |   | uth two times a day for itch."                            |                      |  |      |                    |
|   | On 12/17/2021 at 8:                                 |   |                      |  |      |                    |
|   |   | tablet (for blood pressure)                               |                      |  |      |                    |
|   |   | by mouth two times a day for                              |                      |  |      |                    |
|   |   | " On 12/17/2021 at 8:30 p.m.                              |                      |  |      |                    |
|   |   | econgestant) extended<br>mg Give 600 mg by mouth          |                      |  |      |                    |
|   |   | congestion." On 12/17/2021                                |                      |  |      |                    |
|   | at 8:30 p.m.  |   |                      |  |      |                    |
|   |   | (for nerve pain) 600 mg 2                                 |                      |  |      |                    |
|   | tablet by mouth three                               | times a day for neuropathic                               |                      |  |      |                    |
|   | раін." Он 12/17/202                                 |   |                      |  |      | 1                  |
|   |   | e tablet (for overactive                                  |                      |  |      |                    |
|   |   | tablet by mouth three times                               |                      |  |      |                    |
|   | *   | oladder." On 12/17/2021 at                                |                      |  |      |                    |
|   | 8:30 p.m.   | uscle relaxer) 2 mg Give 1                                |                      |  |      | ea .               |
|   |   | times a day for give with 4                               |                      |  |      |                    |
|   |   | ." On 12/17/2021 at 8:30                                  |                      |  |      | -                  |
|   | p.m.  |   |                      |  |      | 1                  |
|   |   | g Give 4 mg by mouth                                      |                      |  |      | 1                  |
|   |   | muscle spasm; give with 2 🕌                               |                      |  |      |                    |
|   | _   | ." On 12/17/2021 at 8:30                                  |                      |  |      |                    |
|   | p.m.  |   |                      |  |      | 51                 |
|   |   | scle relaxer) 10 mg Give 1<br>6 hours for edema give with |                      |  |      |                    |
|   |   | n 12/17/2021 at 6:00 p.m.                                 |                      |  |      |                    |
|   |   | ng Give 1 tablet by mouth                                 |                      |  |      | 6                  |
|   |   | cle spasms give with 10 mg                                |                      |  |      |                    |
|   | to =30 mg." On 12/17/                               |   |                      |  |      |                    |
|   |   | olution (for dry eye) 0.6%                                |                      |  |      | 1                  |
|   |   | es four times a day for dry                               |                      |  |      |                    |
|   |   | unable to provide may use                                 |                      |  | 1    | - ]                |
|   | home med." On 12/17                                 | 12021 at 5:00 p.m. and                                    |                      |  |      |                    |
|   | 9:00 p.m.   | (for pain) 50 mg Give 1                                   |                      |  | 7.1  |                    |
|   | tablet by mouth every 6                             |   | 19                   |  | - 18 |                    |
|   |   |   | 1.0                  |  |      |                    |

|   |                                   | IT OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER.  | (X2) MULTIPLE CONSTRUCTION A BUILDING |   |         | (X3) DATE SURVEY<br>COMPLETED |  |  |
|---|-----------------------------------|---|--|---------------------------------------|---|---------|-------------------------------|--|--|
|   |                                   |   |  | I A BOILE                             | 7840  |         | С                             |  |  |
| 1 |                                   |   | 495283   | B. WING                               | ·   |         | 02/25/2022                    |  |  |
| ľ | NAME OF                           | PROVIDER OR SUPPLIER  |  |                                       | STREET ADDRESS, CITY, STATE, ZIP CODE<br>1719 BELLEVUE AVENUE |         | OZIZSIZUZZ                    |  |  |
|   | PROME                             | DICA SKILLED NURSI  | NG AND REHAB (IMPERIAL)  |                                       | RICHMOND, VA 23227  |         |                               |  |  |
|   | (X4) ID<br>PREFIX<br>TAG          | (EACH DEFICIENCY  | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)  | ID<br>PREFI)<br>TAG                   |   | OULD BE | (X5)<br>COMPLETION<br>DATE    |  |  |
|   | F 684                             | Continued From pag  | ge 38  | F 6                                   | 84  |         |                               |  |  |
|   |                                   |   | o.m.<br>pain) Give 650 mg by mouth<br>pain." On 12/17/2021 at 6:00   |                                       |   |         |                               |  |  |
|   | :                                 | record) for Resident failed to evidence the administered on the 1-"Gabapentin Tablet three times a day for 1/5/2022 at 2:00 p.m"Oxybutynin chloride | e tablet 5 mg Give 1 tablet  | ı                                     | N   |         |                               |  |  |
|   | t<br>t<br>-<br>ti<br>n            | hree times a day for a fame." On 1/5/2022 a "Tizanidine HCL 4 m hree times a day for a for a total of 6 mg. "Baclofen tablet 10 m                   | 2 at 2:00 p.m.  ng Give 1 tablet by mouth give with 4 mg for a total of at 2:00 p.m.  ng Give 4 mg by mouth muscle spasm; give with 2  " On 1/5/2022 at 2:00 p.m.  ng Give 1 tablet by mouth |                                       |   |         | ×                             |  |  |
|   | m<br>-<br>e<br>to<br>-<br>m<br>12 | ng." On 1/5/2022 at a Baclofen Tablet 20 r very 6 hours for muso = 30 mg" On 1/5/20. "Tramadol HCL table touth every 6 hours for 2:00 p.m.          | ng Give 1 tablet by mouth cle spasms give with 10 mg 22 at 12:00 p.m. t 50 mg Give 1 tablet by or pain." On 1/5/2022 at 50 mg by mouth four times  |                                       |   |         | 164<br>175<br>184             |  |  |
|   | re<br>fai<br>ad<br>- "l           | cord) for Resident #2<br>led to evidence the fo<br>ministered on the foll   | owing dates and times:<br>gm/15 ml, Give 15 ml by  |                                       |   |         | II.                           |  |  |

|                       | MENT OF DEFICIENCIES<br>AN OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER   | (X2) MULI<br>A BUILDII | FIPLE CONSTRUCTION<br>NG   | (X3) ( | DATÉ SURVEY<br>COMPLETED   |
|-----------------------|---|--|------------------------|--|--------|----------------------------|
|                       |   | 495283   | B WING_                |  |        | C<br>02/25/2022            |
| 1                     | OF PROVIDER OR SUPPLIER   | ING AND REHAB (IMPERIAL)   |                        | STREET ADDRESS, CITY, STATE, ZIP CODE:<br>1719 BELLEVUE AVENUE<br>RICHMOND, VA 23227                       |        |                            |
| (X4) I<br>PREF<br>TAG | X (EACH DEFICIENC)  | NTEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG    | PROVIDER'S PLAN OF CORRECT<br>(EACH CORRECTIVE ACTION SHOU<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY) | LD BE  | (XS)<br>COMPLETION<br>DATE |
|                       | - "Senna Laxative T mouth at bedtime for experiencing loose p.m. and 2/13/2022 - "Colace Capsule 1 two times a day for 8:30 p.m. and 2/13/2 - "Hydroxyzine HCL mouth two times a d8:30 p.m. and 2/13/2 - "Metoprolol tartrate mouth two times a d8:30 p.m. and 2/13/2 - "Metoprolol tartrate mouth two times a d8:30 p.m. and 2/13/2 - "Mucinex Tablet eximg Give 600 mg by rongestion." On 2/4/2 2/13/2022 at 8:30 p.m "Gabapentin Tablet three times a day for 2/4/2022 at 8:30 p.m. 2/13/2022 at 8:30 p.m "Oxybutynin chloride by mouth three times bladder." On 2/4/2022 - "Tizanidine HCL 2 m three times a day for 06 mg." On 2/4/2022 at 6:00 p.m "Tizanidine HCL 4 mg three times a day for much the times a day for much mouth the times a day for much manual manua | m. and 2/13/2022 at 9:00 p.m., ablet 8.6 mg Give 2 tablet by or constipation may hold if stools." On 2/4/2022 at 9:00 at 9:00 p.m. 00 mg Give 100 mg by mouth constipation." On 2/4/2022 at 2:022 at 8:30 p.m., tablet 25 mg Give 1 tablet by ay for itch." On 2/4/2022 at 2:022 at 8:30 p.m., tablet 25 mg Give 1 tablet by ay for HTN." On 2/4/2022 at 2:022 at 8:30 p.m., ended release 12 hour 600 mouth two times a day for 2:022 at 8:30 p.m. and n., 600 mg 2 tablet by mouth neuropathic pain." On 2/10/2022 at 2:00 p.m. and n. 2/10/2022 at 2:00 p.m. and n. Give at 8:30 p.m., 2/10/2022 at 2:00 p.m. and n. 2/10/2022 at 3:30 p.m., 2/10/2022 at 3:30 p.m. and n. 3/10/2022 at 3:30 p.m., 2/10/2022 at 3:30 p.m. | F 68                   |  |        |                            |
|                       | and 2/13/2022 at 6:00  <br>- "Baclofen tablet 10 m  | g Give 1 tablet by mouth a give with 20 mg to =30  | 1 111                  |  |        |                            |

|                          | ENT OF DEFICIENCIES<br>N OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:                             |                     |         | ISTRUCTION  | (XX                            | (X3) DATE SURVEY<br>COMPLETED |  |  |
|--------------------------|--|--|---------------------|---------|---|--------------------------------|-------------------------------|--|--|
|                          |  |  | I WORLD             | ,       |   |                                | C                             |  |  |
| 1                        |  | 495283   | B WING              |         |   | -                              | 02/25/2022                    |  |  |
| NAME O                   | F PROVIDER OR SUPPLIER                 |  | ,                   | STREET  | ADDRESS, CITY, STATE, ZIF   | CODE                           | ULIZUIZUZZ                    |  |  |
| PROM                     | EDICA SKILLED NURS                     | ING AND REHAB (IMPERIAL)   |                     | 1719 BE | ELLEVUE AVENUE  |                                |                               |  |  |
| I FROM                   | EDICA SKILLED MOKS                     | ING AND REHAB (IMPERIAL)   |                     | RICHM   | OND, VA 23227   |                                |                               |  |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)                       | ATEMENT OF DEFICIENCIES Y MUST BE PRÉCEDED BY FULL SC IDENTIFYING INFORMATION) | ID<br>PREFI)<br>TAG |         | PROVIDER'S PLAN OF C<br>(EACH CORRECTIVE ACTIV<br>(EACH CORRECTIVE ACTIV<br>(EACH CORRECTIVE ACTIVE AC | ON SHOULD BE<br>HE APPROPRIATI | (XS)<br>COMPLETION<br>DATE    |  |  |
| F 684                    | Continued From pa                      | ge 40  | F 68                | '<br>R4 |   |                                |                               |  |  |
|                          |  | 22 at 6:00 a.m. and 2/13/2022  |                     | , ,     |   |                                |                               |  |  |
|                          | at 6:00 p.m.                           |  |                     |         |   |                                |                               |  |  |
|                          | - "Baclofen Tablet 2                   | 0 mg Give 1 tablet by mouth  |                     |         |   |                                |                               |  |  |
|                          | every 6 hours for m                    | uscle spasms give with 10 mg   |                     |         |   |                                |                               |  |  |
|                          | to =30 mg" On 2/4/                     | 2022 at 6:00 p.m., 2/10/2022   |                     |         |   |                                |                               |  |  |
|                          | 2/13/2022 at 6:00 p.                   | 2022 at 6:00 a.m. and  |                     |         |   |                                |                               |  |  |
|                          |  | m.<br>plet 50 mg Give 1 tablet by  |                     |         |   |                                |                               |  |  |
|                          | mouth every 6 hours                    | of for pain." On 2/4/2022 at   |                     |         |   |                                |                               |  |  |
|                          | 6:00 p.m., 2/10/2022                   | 2 at 12:00 p.m., 2/11/2022 at  |                     |         |   |                                |                               |  |  |
|                          | 6:00 a.m. and 2/13/2                   |  |                     |         |   |                                |                               |  |  |
|                          |  | 650 mg by mouth four times   |                     | 15      |   |                                |                               |  |  |
|                          |  | 2/4/2022 at 6:00 p.m.,   |                     |         |   |                                |                               |  |  |
|                          | and 2/13/2022 at 6:0                   | .m., 2/11/2022 at 6:00 a.m.  |                     |         |   |                                |                               |  |  |
|                          |  | 40 mg Give 1 tablet by   |                     |         |   |                                |                               |  |  |
| :                        |  | y for GERD." On 2/11/2022  |                     |         |   |                                |                               |  |  |
| - 4                      | at 6:00 a.m.                           | .4   |                     |         |   |                                |                               |  |  |
| 4                        | - "Linzess Capsule (f                  | or irritable bowel syndrome)   |                     |         |   |                                |                               |  |  |
|                          |  | ule by mouth one time a day  |                     |         |   |                                |                               |  |  |
|                          | - "Bisacodyl Supposit                  | 2/11/2022 at 6:30 a.m.   |                     |         |   |                                |                               |  |  |
|                          |  | bedtime every other day for  |                     | ĺ       |   |                                |                               |  |  |
| T.                       | constipation." On 2/1                  | 3/2022 at 9:00 p.m.  |                     |         |   |                                |                               |  |  |
|                          |  | antibiotic) 100 mg give 1  |                     | ž.      |   |                                |                               |  |  |
|                          |  | times a day for UTI for 7  |                     | 1       |   |                                |                               |  |  |
|                          | days." On 2/13/2022                    | at 5:00 p.m.   |                     |         |   |                                | ĺ                             |  |  |
| 0                        | The physician order's                  | for Docidant #2  |                     |         |   |                                | - 1                           |  |  |
|                          |  | cations as listed above.   |                     |         |   |                                | 1                             |  |  |
| 8                        |  | 1  | 70                  | 0       |   |                                | ĺ                             |  |  |
|                          |  | r Resident #2 documented   |                     |         |   |                                |                               |  |  |
| ir ir                    | n part, "2/14/2022 18:                 | 22 (6:22 p.m.) MD (medical   |                     |         |   |                                | Si .                          |  |  |
|                          |  | nsible party) notified of  |                     |         |   |                                |                               |  |  |
| n                        | neds (medications) no                  | ot given on 2/13   |                     |         |   |                                | 9                             |  |  |
|                          |  | nift. Resident monitored s." The progress notes                                | ŧ                   |         |   |                                | i i                           |  |  |
|                          |  | mentation regarding the  | ĺ                   |         |   |                                | li l                          |  |  |
|                          | dditional dates listed a               |  | 1                   |         |   |                                | 140                           |  |  |

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED 03/05/2022 FORM APPROVED OMB NO. 0938-0391

| CENTERS   | FOR MEDICARE  | & MEDICAID SERVICES  |                     |  | OMB NO | . 0938-039                 |
|---|---|--|---------------------|--|--------|----------------------------|
| STATEMENT OF<br>AND PLAN OF CO  |   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  | (X2) MUL            | TIPLE CONSTRUCTION   |        | E SURVEY<br>APLEYED        |
|   |   | 495283   | B WING              |  |        | C<br>25/2022               |
| NAME OF PROV  | /IDER OR SUPPLIER   |  |                     | STREET ADDRESS, CITY, STATE, ZIP CODE  |        |                            |
|   |   |  | - 1                 | 1719 BELLEVUE AVENUE   |        |                            |
| PROMEDICA   | SKILLED NURSI   | NG AND REHAB (IMPERIAL)  |                     | RICHMOND, VA 23227   |        |                            |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIENCY  | TEMENT OF DEFICIENCIES<br>MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECT<br>(EACH CORRECTIVE ACTION SHOU<br>CROSS-REFERENCED TO THE APPRI<br>DEFICIENCY) | JLD BE | (XS)<br>COMPLETION<br>DATE |
| F 684 Cor   | ntinued From pag  | ge 41  | F 68                | 34   |        |                            |
| doct<br>poly<br>Initia<br>r/t (r<br>10/1<br>Initia<br>orde<br>10/14<br>GER<br>Initia<br>respi<br>Initiat<br>order<br>Elimin<br>incon        | umented in part, neuropathy, chrusted: 10/18/2021 elated to) depres 8/2021 and Sleet 10/18/2021 red. Date Initiates elated: 10/18/2021 ratory impairmented: 10/18/2021 red. Date Initiate nation Alteration timence at times  | onic pain syndrome. Date , At risk for changes in mood asion. Date Initiated: p cycle issues. DateAdminister medications as ed: 10/18/2021Cardiac //pertension, Date Initiated: rointestinal) distress r/t ageal reflux disease), Date and Has/At risk for at related to asthma. DateAdminister medications as ed: 10/18/2021Bowel Constipation Bowel Date Initiated: 02/04/2022 ons per physician order & |                     |  |        |                            |
| condu<br>LPN #<br>was no<br>stated<br>that the<br>2/13/20<br>week.<br>that the<br>LPN #<br>advers<br>their m<br>medica<br>hour be<br>docume | cted with LPN (I<br>I stated that the<br>of documented of<br>that multiple reset<br>ey had not recei<br>022 when he ret<br>LPN #1 stated the<br>ey did not get the<br>1 stated that he<br>e events from the<br>dications. LPN<br>tions should be<br>efore or after the<br>ented at the time | is a.m., an interview was icensed practical nurse) #1. In the eMAR. LPN #1 idents had reported to him wed their medications on urned to work the next hat the residents told him eir evening medications. Identify the intervention of any eresidents not getting the stated that administered within an scheduled time, and er of administration. LPN cian or nurse practitioner                          |                     |  |        |                            |

and the responsible party were notified if the

| A CONTRACTOR OF THE STATE OF TH | X WILLYNOT BE CITETATION   |                     |   | OMB 140, 0938-03              |
|--|--|---------------------|---|-------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  | (X2) MUETING        | CONSTRUCTION  | (X3) DATE SURVEY<br>COMPLETED |
|  | 495283   | B WING              |   | C                             |
| NAME OF PROVIDER OR SUPPLIER   | NG AND DELIAS MARGENIA   | ľ                   | REET ADDRESS, CITY, STATE, ZIP CODE   | 02/25/2022                    |
| PROMEDICA SKILLED NURSII   | NG AND REHAB (IMPERIAL)  | RI                  | CHMOND, VA 23227  |                               |
| PREFIX (EACH DEFICIENCY  | FEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTIVE ACTION SHO<br>(EACH CORRECTIVE ACTION SHO<br>CROSS-REFERENCED TO THE APP<br>DEFICIENCY) | DULD BE COMPLETION            |
| F 684 Continued From pag   | je 42  | F 684               |   |                               |
| medication was give  | n late, refused or not given   |                     |   |                               |
| for any reason. LPN  | #1 stated that Resident #2   |                     |   |                               |
| had reported getting   | their medications up to six  |                     |   |                               |
| hours after the sched  | tated time from staff<br>tated that Resident #2  |                     |   |                               |
|  | re and refused to have   |                     |   |                               |
|  | medications, but there   |                     |   |                               |
| should be documenta  | ation in the medical record  |                     |   |                               |
| why they were not ad   | ministered.  |                     |   |                               |
| On 2/24/2022 at 1:15   | p.m., an interview was   |                     |   |                               |
| conducted with LPN #   | #5. LPN #5 stated that   |                     |   |                               |
| medications not signe  | ed off on the eMAR meant   | 1                   |   |                               |
|  | en. LPN #5 stated that   |                     |   |                               |
|  | gress note documenting   |                     |   |                               |
|  | vere not administered in the distance of the d |                     |   |                               |
|  | medications on 2/13/2022   |                     |   |                               |
| around 8:45 p.m. and   | was only able to administer  |                     |   |                               |
| medications to some of   | of the residents. LPN #5   |                     |   |                               |
| stated that they did no  |  |                     |   |                               |
| medications to Reside  | nt #2.   |                     |   |                               |
| On 2/24/2022 at 2:00 p   | o.m., an interview was   |                     |   | £ .                           |
| conducted with ASM (a  | dministrative staff  |                     |   | -2071<br>-2071                |
| member) #2, the interir  | n director of nursing. ASM   |                     |   |                               |
|  | AR was not signed off they   |                     |   |                               |
| would assume that it was not signed as com   |  | 194                 |   | 1                             |
| that they were notified of   | of the purse leaving on  | 01                  |   | 1                             |
|  | mpted to contact agencies  |                     |   |                               |
| and off-duty staff to fill in  | n the shift but were   | 15.                 |   | N .                           |
| unsuccessful, ASM #2   |  |                     |   | 16                            |
|  | to Unit 1 when they were   |                     |   |                               |
|  | n Unit 2. ASM #2 stated other nurse on Unit 2 to   | ,                   |   | .,                            |
|  | Iminister medications on   |                     |   | Ÿ                             |
| Unit 1, but she did not he   |  | Ė                   |   | 7                             |
| she was not aware that i   |  |                     |   |                               |

| CILITILITIES                     | OU MINISTORIAL                       | - OF MICHIGATE SELVICES   |                       |  | UNB N  | O. 0938-03                 |
|----------------------------------|--------------------------------------|---|-----------------------|--|--|----------------------------|
| STATEMENT OF E<br>AND PLAN OF CO |                                      | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER.                             | (X2) MUL<br>A. BUILDI | TIPLE CONSTRUCTION                     |  | ATE SURVEY<br>DMPLETED     |
|                                  |                                      | 495283  | B WING                |  | _   0  | C<br>2/25/2022             |
| NAME OF PROV                     | IDER OR SUPPLIER                     |   |                       | STREET ADDRESS, CITY, STA              |  |                            |
|                                  |                                      |   | - 1                   | 1719 BELLEVUE AVENUE                   |  |                            |
| PROMEDICA                        | SKILLED NURSI                        | NG AND REHAB (IMPERIAL)   | )                     | RICHMOND, VA 23227                     |  |                            |
| (X4) ID<br>PREFIX<br>TAG         | (EACH DEFICIENCY                     | TEMENT OF DEFICIENCIES<br>MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION) | ID<br>PREFIX<br>TAG   | ( (EACH CORRECTIVE<br>CROSS-REFERENCED | N OF CORRECTION<br>E ACTION SHOULD BE<br>O TO THE APPROPRIATE<br>CIENCY) | (X5)<br>COMPLETION<br>DATE |
| E 604 0                          |                                      | 40  |                       | *                                      |  |                            |
|                                  | tinued From pag                      |   | F 68                  | 34                                     |  |                            |
| med                              | lications until the                  | e next day. ASM #2 stated   |                       |  |  |                            |
| that                             | she had contact                      | ted the physician and   |                       |  |  |                            |
|                                  |                                      | of the residents who had  |                       |  |  |                            |
|                                  |                                      | medications on 2/13/22 to   | )                     |  |  |                            |
|                                  |                                      | no one had suffered any   |                       |  |  |                            |
|                                  |                                      | M #2 stated that she had  |                       |  |  |                            |
|                                  | en airectly with l<br>ed medications | Resident #2 regarding the on 2/13/2022.   |                       |  |  |                            |
| Th - 4                           | 5195a87                              | - I' at I mm  |                       |  |  |                            |
|                                  |                                      | edication and Treatment   |                       |  |  |                            |
|                                  |                                      | lines" documented in part,<br>dministered in accordance                           |                       |  |  |                            |
|                                  |                                      |   |                       |  |  | 7                          |
|                                  |                                      | ctice and state specific and<br>edications and treatments                         |                       |  |  |                            |
|                                  |                                      | umented immediately   | 1                     |  |  |                            |
|                                  |                                      | on or per state specific  |                       |  |  |                            |
|                                  |                                      | ns not administered   | ř.                    |  |  | 1                          |
|                                  |                                      | practitioner's orders are   | •                     |  |  |                            |
|                                  |                                      | ing medical practitioner and  | 4                     |  |  |                            |
|                                  |                                      | linical record including the  | -                     |  |  |                            |
|                                  |                                      | medication and reason the   |                       |  |  |                            |
| medica                           | ation was not ac                     | IministeredThe licensed   |                       | 01                                     |  |                            |
| nurse i                          | is responsible fo                    | or validating documentation   | 14                    | 7.0                                    |  |                            |
|                                  |                                      | redication administered   |                       |  |  |                            |
| during                           | the shift"                           |   |                       |  |  |                            |
| 58                               |                                      |   | 7                     | į                                      |  |                            |
|                                  |                                      | ximately 4:30 p.m., ASM   |                       |  |  | - 1                        |
|                                  |                                      | trator, ASM #2, the interim   |                       |  |  |                            |
|                                  |                                      | ASM #3, the regional  |                       |  |  |                            |
| quality                          | consultant, were                     | notified of the findings.   |                       |  |  |                            |
| No Sundle                        | an infares state : :                 |   | 7                     |  |  |                            |
| NO TURT                          | ier information \                    | was provided prior to exit.   | 1                     |  | 1  |                            |
| Comple                           | int deficiency                       |   | . 1                   |  |  |                            |
| Compla                           | пи оенстепсу                         |   | 1                     |  |  |                            |
| 2 The                            | facility staff faile                 | d to administer   |                       |  |  | 1                          |
|                                  |                                      | ents as ordered for   |                       |  |  |                            |
| Residen                          |                                      | Cinta da Ordered IOI  |                       |  |  |                            |

|   | CENTERO FOR MILISTORIA   | - G MEDICAUD SEKAICES   |                     |  | OMB     | NO: 0938-039               | J |
|---|--|---|---------------------|--|---------|----------------------------|---|
|   | STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   | (X2) MUL            | HPLE CONSTRUCTION<br>NC  |         | DATE SURVEY<br>COMPLETED   | - |
|   |  | 495283  | B WING              |  |         | C                          |   |
| l | NAME OF PROVIDER OR SUPPLIER   |   |                     | STREET ADDRESS, CHY, STATE, ZIP COD  | E .     | 02/25/2022                 | _ |
| ļ | DDOMEDICA CIVILLED MUDO  |   |                     | 1719 BELLEVUE AVENUE   |         |                            |   |
| l | PROMEDICA SKILLED NURSI  | NG AND REHAB (IMPERIAL)   |                     | RICHMOND, VA 23227   |         |                            |   |
|   | PREFIX (EACH DEFICIENCY  | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRE<br>(EACH CORRECTIVE ACTION SH<br>CROSS-REFERENCED TO THE APP<br>DEFICIENCY) | OULD BE | (×5)<br>COMPLETION<br>DATE | J |
|   | F 684 Continued From pag<br>Resident #11 was at<br>diagnoses that inclu-<br>type 2 diabetes.   | ge 44<br>dmitted to the facility with<br>ded but were not limited to  | F 68                | 4  |         |                            |   |
|   | quarterly assessment reference date) of 12 scored 15 out of 15 of for mental status), independent of the cognitively intact for rescheduled pain medical documented Resident   | MDS (minimum data set), a It with an ARD (assessment l/15/2021, the resident on the BIMS (brief interview dicating the resident is making daily decisions. If Resident #11 receiving cations. Section N traceiving insulin, iety, antidepressant and  |                     |  |         |                            |   |
|   | interview was conduct room. Resident #11 s area on her buttock ar the area that her famil Resident #11 stated the the area when they can how to treat the area. some of the nurses can the area but there were anything on the area and Resident #11 proceede area on her cell phone the nurse to take picture. Resident #11 stated that she did not receive her get them when the next Resident #11 stated that not receive any evening nurse had left and they the state of the state o | at the physician looked at me in and told the nurses Resident #11 stated that me in to put a cream on a times when no one put r days so she put her own that it was healing. It was healing, do show pictures of the and stated she had asked as of the area for her. If there were times when medications and would shift came in to work, ton 2/13/2022 they did medications because the had to wait for the night. |                     |  |         |                            |   |
|   | nurse to come in to get t  | hem. Resident #11 he only occasion that had   |                     |  |         | 0                          |   |

| _ | OFNIE  | WALL OF CHALLES  | A MEDICAID GERVICES   |                     |  | CIVID                                | 140 1/3/30-03:             |
|---|--|--|---|---------------------|--|--------------------------------------|----------------------------|
|   |  | OF DEFICIENCIES<br>F CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER.  | (X2) MUL<br>A BUILD | TIPLE CONSTRUCTION   |                                      | DATE SURVEY<br>COMPLETED   |
|   |  |  | 495283  | B. WING             |  |                                      | C                          |
| H | NAME OF P  | ROVIDER OR SUPPLIER  | 1.00200   |                     | STREET ADDRESS, CITY, STATE                                      |                                      | 02/25/2022                 |
| İ | INFINE OF THE  | NOVIDEN ON SUITEIEN  |   | 1                   |  | , zir cobe                           |                            |
|   | PROMEDI  | CA SKILLED NURSI   | NG AND REHAB (IMPERIAL)   | ĺ                   | 1719 BELLEVUE AVENUE   |                                      |                            |
| L |  |  |   |                     | RICHMOND, VA 23227   |                                      |                            |
|   | (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)   | ID<br>PREEIX<br>TAG | PROVIDER'S PLAN ( (EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIÉ | CTION SHOULD BE<br>O THE APPROPRIATE | (X5)<br>COMPLETION<br>DATE |
|   | E 684 (  | Continued From pag   | 20.45   | Г.60                | ·<br>·   |                                      |                            |
|   |  |  | je 45   | F 68                | 34   |                                      |                            |
|   | 1  | nappened to her.   |   |                     |  |                                      |                            |
|   | n<br>for<br>for<br>in<br>su<br>ty<br>at<br>- '<br>pe<br>ur<br>su<br>Di | ecord) for Resident 2/1/2021-12/31/202 pllowing medications ollowing dates and to "Basaglar KwikPen piector 100 unit/ml (ubcutaneously at be pe 2)." On 12/2/20. 9:00 p.m. "Insulin Lispro Soluter sliding scale: If 15 pits; 251-300=8 unit becutaneously befor abetes mellitus typem, and 12/10/2021: Atorvastatin Calciur | 21 failed to evidence the s administered on the imes: solution (for diabetes) Pen milfiliter) Inject 70 unit edtime for DM 2 (diabetes 21 9:00 p.m. and 12/10/2021 ion (for diabetes) Inject as 50-200=4 units; 201-250=6 s; 301-350=10; 351-400-12; e meals and at bedtime for e 2." On 12/2/2021 9:00 p.m" m Tablet (for high | #:                  |  |                                      |                            |
|   |  |  | illigram) Give 40 mg by<br>nyperlipidemia." On  | *                   |  |                                      |                            |
|   |  | /10/2021 at 9:00 p.r   |   |                     | *  |                                      |                            |
|   |  |  | et (for diabetes) 500 mg  |                     |  |                                      |                            |
|   |  |  | th at bedtime for DM." On   |                     | Ģ.   |                                      |                            |
|   |  | 10/2021 2100   |   |                     |  |                                      |                            |
|   |  |  | nin C) Tablet Give 500 mg   | 5                   | 16   |                                      |                            |
|   |  | mouth two times a  |   |                     |  |                                      | ſ                          |
|   |  | •  | 10/2021 at 6:00 p.m.  |                     |  |                                      |                            |
|   |  |  | for anxiety) disintegrating   |                     |  |                                      | 3                          |
|   |  |  | times a day related to  |                     |  |                                      | ĺ                          |
|   |  |  | 12/10/2021 at 5:00 p.m.   |                     |  |                                      | 1                          |
|   |  |  | olet (for constipation) 100 uth two times a day for   |                     |  |                                      | ¥ I                        |
|   |  | el regimen hold for  |   |                     |  |                                      |                            |
|   |  | 0/2021 at 5:00 p.m   |   |                     |  |                                      | 1.                         |
|   |  |  | for nerve pain) 100 mg  |                     |  |                                      | , I                        |
|   |  |  | h two times a day for   | 1.5                 |  |                                      |                            |
|   |  |  | 12/10/2021 at 6:00 p.m.   | 1                   |  |                                      | ž.                         |
|   |  |  | (extended release) 12   | 1                   |  |                                      | 10<br>0                    |

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:                             | 1 ' '               | IPLE CONSTRUCTION   | (X3) DATE SURVEY<br>COMPLETED |
|---|--|---------------------|---|-------------------------------|
|   |  | A BUILDI            | NG  |                               |
|   | 495283   | B WING              |   | C                             |
| NAME OF PROVIDER OR SUPPLIER                        |  | 1                   | STREET ADDRESS, CITY, STATE, ZIP CODE   | 02/25/2022                    |
| THINE OF THE TOTAL CITY DOT   ELECT                 |  |                     | 1719 BELLEVUE AVENUE  |                               |
| PROMEDICA SKILLED NURSI                             | NG AND REHAB (IMPERIAL)  |                     | RICHMOND, VA 23227  |                               |
|   |  |                     |   |                               |
| PREFIX (FACH DEFICIENCY                             | TEMENT OF DEFICIENCIES  'MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION) | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTI  (EACH CORRECTIVE ACTION SHOULD  CROSS-REFERENCED TO THE APPRODEFICIENCY) | LD BE COMPLETION              |
| F 684 Continued From page                           | ge 46  | F 68                | 4   |                               |
|   | nt (for pain) 10 mg. Give 10   |                     |   |                               |
|   | 12 hours related to encounter  |                     |   |                               |
|   | are following surgical   |                     |   |                               |
| amputation." On 12                                  | /10/2021 at 9:00 p.m.  |                     |   |                               |
|   | uid nutritional supplements  |                     |   |                               |
|   | give 30 ml by mouth two  |                     |   |                               |
| times a day for aid w                               |  |                     |   |                               |
| 12/10/2021 at 5:00 p                                |  |                     |   |                               |
|   | r depression) 25 mg give 1 imes a day for depression."                         |                     |   |                               |
| On 12/10/2021 at 5:0                                |  |                     |   | 25                            |
|   | for seizures) 25 mg Give 25  |                     |   | 4                             |
|   | es a day for seizures." On   |                     |   |                               |
| 12/10/2021 at 5:00 p.                               |  |                     |   |                               |
| <ul> <li>"Methocarbamol tab</li> </ul>              | ilet (muscle relaxer) 500 mg   |                     |   |                               |
|   | uth every 8 hours related to   |                     |   |                               |
|   | e at unspecified level of  |                     |   |                               |
|   | equela." On 12/10/2021 at  |                     |   |                               |
| 5:00 p.m.   |  |                     |   | 9                             |
| The eMAR (electronic                                | medication administration  |                     | [   | Ģ.                            |
| record) for Resident #                              |  |                     |   |                               |
| 1/1/2022-1/31/2022 fa                               |  |                     |   | Ñ.                            |
| following medications                               | administered on the  |                     |   |                               |
| following dates and tin                             |  |                     |   | 10                            |
| - "Insulin Lispro Solution                          |  |                     |   | 10                            |
| scale: If 150-200=4 un                              |  |                     |   | P i                           |
| 251-300=8 units; 301-3                              |  |                     |   | 6311                          |
|   | meals and at bedtime for 2." On 1/2/2022 at 6:30                               |                     |   | ĺ                             |
| a.m., 1/2/2022 at 11:30                             |  |                     |   |                               |
|   | a.m., 1/19/2022 at 11:30   |                     |   |                               |
|   | a.m., 1/27/2022 at 4:30  |                     |   | 11                            |
|   | p.m., 1/28/2022 at 11:30   |                     |   |                               |
|   | 0 a.m., and 1/30/2022 at   |                     |   |                               |
| 9:00 p.m.   |  | ı                   |   | 1                             |
|   | amin supplement) 1000  | 1                   |   |                               |
| unit Give 1000 unit by n                            |  | 1                   |   |                               |
| supplement for 14 days                              | ." On 1/2/2022 at 7:15   |                     |   | 1                             |

| STATEMENT OF DEFICIENCIES             | (X1) PROVIDER/SUPPLIER/CLIA                               | TOWN MULTIPLE | CONSTRUCTION  | (X3) DATE SU |       |
|---------------------------------------|---|---------------|---|--------------|-------|
| AND PLAN OF CORRECTION                | IDENT FICATION NUMBER                                     | A BUILDING    | CONSTITUTION  | COMPLE       |       |
| }                                     |   |               |   | C            |       |
| 1                                     | 495283  | B. WING       |   | 02/25/2      | 2022  |
| NAME OF PROVIDER OR SUPPLIER          | <u> </u>  | ST            | REET ADDRESS, CITY, STATE, ZIP CODE.  | 02/40/1      | LVEL  |
|                                       |   | 17            | 19 BELLEVUE AVENUE  |              |       |
| PROMEDICA SKILLED NURS                | ING AND REHAB (IMPERIAL)                                  |               | CHMOND, VA 23227  |              |       |
| (X4) ID SUMMARY STA                   | ATEMPNT OF DEFICIENCIES                                   | 10            | PROVIDER'S PLAN OF CORRECT  | ON           | (X5)  |
| PREFIX (EACH DEFICIENC)               | Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION) | PREFIX<br>TAG | (EACH CORRECTIVE ACTION SHOUL<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY) |              | DATE. |
| F 684 Continued From pa               | ge 47   | F 684         |   |              |       |
| a.m. and 1/12/2022                    | at 11:15 a.m.   |               |   |              |       |
| <ul> <li>"Methocarbamol ta</li> </ul> | ablet 500 mg Give 1000 mg by                              |               |   |              |       |
| -                                     | s related to central cord                                 |               |   |              |       |
|                                       | cified level of cervical spinal                           |               |   |              |       |
|                                       | 1/27/2022 at 5:00 p.m., and                               |               |   |              |       |
| 1/29/2022 at 9:00 p.                  |   |               |   |              |       |
|                                       | mg give 1 tablet by mouth                                 |               |   |              |       |
|                                       | depression." On 1/27/2022 at                              |               |   |              |       |
| 5:00 p.m. and 1/29/2                  |   |               |   |              |       |
|                                       | 25 mg Give 25 mg by mouth ; seizures." On 1/27/2022 at    |               |   |              |       |
| 5:00 p.m. and 1/29/2                  |   |               |   |              |       |
|                                       | r urinary pain) 100 mg give 1                             |               |   |              |       |
|                                       | times a day for genitourinary                             |               |   |              |       |
|                                       | On 1/27/2022 at 5:00 p.m.                                 |               |   | *            |       |
| and 1/29/2022 at 9:0                  |   |               |   |              |       |
|                                       | ablet 100 mg Give 1 tablet                                |               |   |              |       |
|                                       | a day for bowel regimen hold                              |               |   |              |       |
| for loose stools." On                 | 1/27/2022 at 5:00 p.m. and                                |               |   |              |       |
| = 1/29/2022 at 9:00 a.n               | 181   |               |   |              |       |
|                                       | e 100 mg give 2 capsule by 🖐                              |               |   | 50           |       |
|                                       | y for neuropathic pain." On 📙                             |               |   |              |       |
| •                                     | n. and 1/29/2022 at 10:00                                 | 77            |   | 19           |       |
| a.m.                                  |   | 22            |   |              |       |
|                                       | R 12 hour abuse-deterrent                                 |               |   |              |       |
|                                       | mouth every 12 hours                                      |               |   |              |       |
|                                       | or orthopedic aftercare outation." On 1/27/2022 at        | 69            |   | 54           |       |
| 9:00 p.m. and 1/29/20                 |   |               |   |              |       |
|                                       | d nutritional supplements                                 |               |   |              | j     |
| give 30 ml by mouth to                |   |               |   |              |       |
|                                       | /27/2022 at 5:00 p.m. and                                 | 1             |   |              | ļ     |
| 1/29/2022 at 9:00 a.m.                |   | 1             |   |              |       |
| - "Ascorbic Acid Tablet               | Give 500 mg by mouth two                                  | 4             |   | i            |       |
| times a day for wound                 |   | į             |   | 3            |       |
| 1/27/2022 at 6:00 p.m.                |   |               |   | !            | - 1   |
|                                       | lisintegrating 0.125 mg by                                |               |   | 1            | - 1   |
| mouth two times a day                 |   | 1             |   | 1            |       |
| disorder." On 1/27/202                | ?2 at 5:00 p.m.   | 1             |   | -            |       |

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   | (X2) MULT IPL<br>A BUILDING | E CONSTRUCTION   | (X3) DATE SURVEY<br>COMPLETED |
|---|---|-----------------------------|--|-------------------------------|
|   |   | 200                         |  | С                             |
|   | 495283  | B WING                      |  | 02/25/2022                    |
| PROMEDICA SKILLED NURS  | GING AND REHAB (IMPERIAL)   | 17                          | REET ADDRESS, CITY, STATE, ZIP CODE<br>19 BELLEVUE AVENUE<br>CHMOND, VA 23227                              |                               |
| PREFIX (EACH DEFICIENC  | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG         | PROVIDER'S PLAN OF CORRECT<br>(EACH CORRECTIVE ACTION SHOU<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY) | JLD BE COMPLETION             |
| Give 40 mg by more hyperlipidemia." O - "Basaglar KwikPe unit/ml Inject 70 un for DM 2." On 1/27 - "Aspirin Tablet che mouth one time a decident) prophylax a.m "Ferrous Sulfate (img give 325 mg by anemia." On 1/29/2 - "Icy Hot Patch (meshould blade topical remove per schedul 8:59 a.m. Apply 9:00 - "Loratadine tablet (mouth one time a da 1/29/2022 at 9:00 a.u - "Medroxyprogreste replacement) 10 mg | cium Tablet 40 mg (milligram)  oth at bedtime for n 1/27/2022 at 9:00 p.m. on solution Pen injector 100 it subcutaneously at bedtime /2022 at 9:00 p.m. ewable 81 mg give 81 mg by ay for CVA (cerebrovascular is. "On 1/29/2022 at 10:00  ron supplement) tablet 325 mouth one time a day for 1022 at 9:00 a.m. onthol) (for pain) apply to right ly one time a day for pain and le. On 1/29/2022 Remove 0 a.m." for allergies) Give 10 mg by by for allergy symptoms." On m. one acetate tablet (hormone give 2 tablet by mouth one | F 684                       |  |                               |
| 9:00 a.m "Metformin HCL tab mouth one time a day 9:00 a.m "Multivitamin-mineral mouth one time a day On 1/29/2022 at 9:00 - "Paxil tablet (for dep by mouth one time a day 1/29/2022 at 9:00 a.m "Tradjenta tablet (for mouth one time a day 2." On 1/29/2022 at 1 - "Trospium chloride E bladder) extended rele  | ression) 20 mg Give 40 mg day for depression." On diabetes) Give 5 mg by for diabetes mellitus type   |                             |  |                               |

|               | 11 10 1 01 1 III B 10 1 II III   | CONTROL CONTROL   | _,                         |                                  |                |                    |
|---------------|--|---|----------------------------|----------------------------------|----------------|--------------------|
|               | STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER |   | (X2) MULTIPLE CONSTRUCTION |                                  |                | ATE SURVEY         |
|               |  |   | A BUILD                    | JING                             |                | С                  |
|               |  | 495283  | B WING                     | s                                |                | 2/25/2022          |
| NAME OF       | PROVIDER OR SUPPLIER   |   | 1                          | STREET ADDRESS, CITY, STATE, ZIF |                | 2/23/2022          |
|               |  |   |                            | 1719 BELLEVUE AVENUE             |                |                    |
| PROME         | DICA SKILLED NURSI   | NG AND REHAB (IMPERIAL)                                 | -                          | RICHMOND, VA 23227               |                |                    |
| (X4) ID       | SUMMARY STA  | TEMENT OF DEFICIENCIES                                  | ID                         | PROVIDER'S PLAN OF C             | ORRECTION      | (X5)               |
| PREFIX<br>TAG |  | MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)    | PREFI<br>TAG               | and a concept of the Tr          | 1E APPROPRIATE | COMPLÉTION<br>DATE |
| F 684         | Continued From pag   | PA 49   | F 6                        | 1884                             |                |                    |
| 1 00 1        | On 1/29/2022 at 9:0  | =   | 1 0                        | 104                              |                |                    |
|               |  | al replacement) Give 220 mg                             |                            |                                  |                |                    |
|               | •  | day for supplement." On                                 |                            |                                  |                |                    |
|               | 1/29/2022 at 9:00 a.i  |   |                            |                                  |                |                    |
|               | The eMAR (electronic   | ic medication administration                            |                            |                                  |                |                    |
|               | record) for Resident   | ic medication administration #11 dated 2/1/2022-        |                            |                                  |                |                    |
|               | •  | vidence the following                                   |                            |                                  |                |                    |
|               | medications adminis  | tered on the following dates                            |                            |                                  |                |                    |
|               | and times:   |   |                            |                                  |                |                    |
|               |  | tion Inject as per sliding                              |                            |                                  |                |                    |
|               |  | inits; 201-250=6 units;<br>-350=10; 351-400=12;         |                            | 22                               |                |                    |
|               |  | re meals and at bedtime for                             |                            |                                  |                |                    |
|               |  | e 2." On 2/5/2022 at 6:30                               |                            | 75                               |                |                    |
|               |  | 30 a.m., 2/13/2022 at 4:30                              |                            |                                  |                |                    |
|               | o.m., and 2/16/2022 a  |   |                            |                                  |                | -0                 |
|               |  | let 500 mg Give 1000 mg by                              |                            | T.                               |                | 1                  |
|               | -  | related to central cord<br>ied level of cervical spinal |                            | V.                               |                | ,                  |
|               |  | /13/2022 at 5:00 p.m.                                   |                            |                                  |                | 1                  |
|               |  | ng give 1 tablet by mouth                               |                            | 400                              |                |                    |
|               |  | pression." On 2/13/2022 at                              |                            |                                  |                | 1                  |
|               | :00 p.m.   | 5 0: 05 1 4   |                            | 10                               |                | 1                  |
|               |  | 5 mg Give 25 mg by mouth is izures." On 2/13/2022 at    |                            |                                  |                | - 1                |
|               | :00 p.m.   | izules. On 2/13/2022 at                                 |                            |                                  |                |                    |
|               |  | disintegrating 0.125 mg by                              |                            |                                  |                | - 1                |
| ± m           | outh two times a day   | related to anxiety                                      |                            | 9                                |                |                    |
|               | sorder." On 2/13/202   |   |                            |                                  |                | 1                  |
|               |  | blet 100 mg Give 1 tablet                               |                            |                                  |                | 1                  |
|               |  | day for bowel regimen hold # //13/2022 at 5:00 p.m.     |                            | 1                                |                |                    |
|               |  | 100 mg give 2 capsule by                                |                            | İ                                |                |                    |
|               |  | for neuropathic pain." On                               |                            | 1                                |                | -                  |
|               | 13/2022 at 6:00 p.m.   |   |                            | i i                              |                |                    |
| ) - e         | Oxycontin Tablet ER  | 12 hour abuse-deterrent                                 |                            |                                  | 2              | 3                  |
|               |  | nouth every 12 hours                                    |                            |                                  | Ŷ              |                    |
| rei           | ated to encounter for  | orthopedic aftercare                                    |                            |                                  |                |                    |

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:                                | (X2) MULTIPLE<br>A BUILDING | CONSTRUCTION  | (X3) DATE SURVEY  COMPLETED |  |
|---|--|-----------------------------|---|-----------------------------|--|
|   |  |                             |   |                             |  |
|   | 495283   | B WING                      |   | 02/25/2022                  |  |
| NAME OF PROVIDER OR SUPPLIER                        |  | ST                          | REET ADDRESS, CITY, STATE, ZIP CODE   |                             |  |
| PROMEDICA SKILLED NURS                              | ING AND REHAR (IMPERIAL)   | 17                          | 19 BELLEVUE AVENUE  |                             |  |
| TROMEDION SHIELED HORSE                             | MO AND REHAB (IMPERIAL)  | RI                          | CHMOND, VA 23227  |                             |  |
| PREFIX (EACH DEFICIENC)                             | NTEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION) | ID<br>PREFIX<br>TAG         | PROVIDER'S PLAN OF CORRECTH<br>(EACH CORRECTIVE ACTION SHOUL<br>CROSS-REFERENCED TO THE APPROI<br>DEFICIENCY) | D BE COMPLETION             |  |
| F 684 Continued From pa                             | ne 50  | F 684                       |   |                             |  |
|   |  | 1 004                       |   |                             |  |
| 9:00 p.m.   | mputation." On 2/13/2022 at  |                             |   |                             |  |
|   | uid nutritional supplements  |                             |   |                             |  |
| give 30 ml by mouth                                 | two times a day for aid  |                             |   |                             |  |
|   | 2/13/2022 at 5:00 p.m.   |                             |   |                             |  |
|   | let Give 500 mg by mouth two   |                             |   |                             |  |
|   | nd management." On   |                             |   |                             |  |
| 2/13/2022 at 6:00 p.                                |  | 40                          |   |                             |  |
|   | blet 500 mg Give 1000 mg by  |                             |   |                             |  |
| mouth at bedtime for                                | DM." On 2/13/2022 at 9:00  |                             |   |                             |  |
| p.m. and 2/16/2022 a                                | at 9:00 p.m.   |                             |   |                             |  |
| : - "Atorvastatin Calciu                            | ım Tablet 40 mg (milligram)  | 8                           |   |                             |  |
| Give 40 mg by mouth                                 | at bedtime for   |                             |   |                             |  |
| hyperlipidemia." On                                 | 2/13/2022 at 9:00 p.m.   |                             |   |                             |  |
|   | solution Pen injector 100  |                             |   |                             |  |
|   | subcutaneously at bedtime  |                             |   |                             |  |
| for DM 2." On 2/13/2                                | :022 at 9:00 p.m.  |                             |   | 12                          |  |
| The eTAD /-lt                                       | Annulus and a dark fed and   |                             |   | 4                           |  |
| record) for Resident #                              | treatment administration   |                             |   |                             |  |
| 1/1/2022-1/31/2022 fa                               |  | 2                           |   |                             |  |
| following treatments a                              |  |                             |   | 8                           |  |
| following dates and tir                             |  |                             |   | ~                           |  |
|   | (for dry skin) apply to leg-   | î                           |   |                             |  |
| both topically every da                             | ay and evening shift for skin  |                             |   | _                           |  |
|   | side per MD," On 1/3/2022,   |                             |   |                             |  |
| 1/4/2022, 1/5/2022, 1/                              |  | A11                         |   | j                           |  |
|   | 130/2022 and 1/31/2022 at  | 80                          |   |                             |  |
|   | 2, 1/11/2022, 1/17/2022,   |                             |   | - N                         |  |
| 1/19/2022, 1/20/2022,                               |  |                             |   |                             |  |
|   | 1/30/2022 and 1/31/2022  |                             |   | 18                          |  |
| at 3:15 p.m.  |  |                             |   | 1                           |  |
|   | Oil Ointment (combination  | ii                          |   |                             |  |
|   | licers) apply to buttocks  | 9                           |   | 1                           |  |
|   | wo times a day for skin  | 4                           |   | 1                           |  |
|   | to sites as ordered." On   | 1                           |   | 36                          |  |
| 1/3/2022, 1/4/2022, 1/5                             |  | 1                           |   |                             |  |
| 1/11/2022, 1/17/2022, 1<br>1/21/2022, 1/23/2022, 1  |  | 7.                          |   |                             |  |
| 112112022, 112312022,                               | 112012022, 112312022,  | - 1                         |   | 90                          |  |

| 100                      |  | & WEDICARD GETTVICES  |                     |   |                 |  |
|--------------------------|--|---|---------------------|---|-----------------|--|
|                          | STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER |   | (X2) MULTIC         | (X3) DATE SURVEY<br>COMPLETED   |                 |  |
| 7,1001 67,110            |  |   | A BUILDING          | <u> </u>  |                 |  |
|                          |  | 405303  | B WING              |   | C               |  |
|                          |  | 495283  | B WING_             |   | 02/25/2022      |  |
| NAME OF F                | ROVIDER OR SUPPLIER  |   |                     | STREET ADDRESS, CITY, STATE, ZIP CODE   |                 |  |
| PROMED                   | ICA SKILLED NURSI  | NG AND REHAB (IMPERIAL)   |                     | 1719 BELLEVUE AVENUE  |                 |  |
| ]                        |  |   |                     | RICHMOND, VA 23227  |                 |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTIC<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROF<br>DEFICIENCY) | DIBE COMPLETION |  |
|                          |  |   |                     | ,   |                 |  |
|                          | Continued From page  |   | F 684               |   |                 |  |
|                          |  | 2022 at 9:00 a.m. On  |                     |   |                 |  |
|                          |  | 1/11/2022, 1/17/2022,   |                     |   |                 |  |
|                          |  | 2, 1/21/2022, 1/23/2022,  |                     |   |                 |  |
|                          |  | 2, 1/30/2022, 1/30/2022 and   |                     |   |                 |  |
|                          | 1/31/2022 at 5:00 p.   |   |                     |   |                 |  |
|                          |  | n Gel 1% (for pain) Apply to<br>Ily every day and evening                   |                     |   |                 |  |
|                          |  | g (gram)." On 1/3/2022,   |                     |   |                 |  |
|                          |  | 1/15/2022, 1/16/2022,   |                     |   |                 |  |
|                          |  | 2, 1/30/2022 and 1/31/2022  |                     |   |                 |  |
|                          |  | 2022, 1/11/2022, 1/17/2022,   |                     |   |                 |  |
|                          |  | 2, 1/21/2022, 1/23/2022,  |                     |   |                 |  |
|                          |  | 2, 1/30/2022 and 1/31/2022  | 1                   |   |                 |  |
|                          | t 3:15 p.m.  |   |                     |   |                 |  |
| _                        |  |   |                     |   |                 |  |
|                          | he eTAR for Reside   |   |                     |   |                 |  |
|                          |  | ailed to evidence the   |                     |   |                 |  |
|                          | ollowing dates and ti  | peing administered on the   |                     |   |                 |  |
|                          | <b>~</b>   | t apply to leg- both topically  |                     |   |                 |  |
|                          |  | g shift for skin alteration   |                     |   | i i             |  |
|                          | ave a bedside per N  |   |                     |   |                 |  |
|                          |  | 2/17/2022, 2/21/2022 at   |                     |   | W)              |  |
|                          |  | 2, 2/2/2022, 2/6/2022,  |                     |   | 10              |  |
|                          |  | 2/12/2022, 2/13/2022,   |                     |   | 0               |  |
| 21                       | 16/2022, 2/17/2022,  | 2/20/2022, 2/22/2022 at   |                     |   | 8               |  |
|                          | 15 p.m.  | i   |                     |   | ľ               |  |
|                          |  | r Oil Ointment apply to   |                     | *   | i               |  |
|                          |  | topically two times a day   |                     |   |                 |  |
|                          | skin alteration 1 ap   |   |                     |   | 74              |  |
|                          |  | 2, 2/10/2022, 2/12/2022,<br>at 9:00 a.m. On 2/1/2022,                       |                     |   | 72"             |  |
|                          | ?/2022, 2/6/2022, 2/8  |   |                     |   | 11              |  |
|                          |  | 2/16/2022, 2/17/2022,   |                     |   | II.             |  |
|                          | 2/2022, 2/10/2022,<br>20/2022, 2/22/2022 a   |   | 1                   |   | 1               |  |
| 1                        |  |   |                     |   |                 |  |
| - "C                     | Cleanse open area to   | o left buttock, pat dry,  |                     |   | 1               |  |
| арр                      | oly skin prep to peri  | wound, apply silva sorb gel   | 1                   |   | 1               |  |
| (an                      | timicrobial wound ge   | el) apply gauze affix with  | 4                   |   | i               |  |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER   |  | (X2) MULTIPLE CONSTRUCTION A BUILDING  |                                       |      |  | X3) DATE<br>COMPL            |     |                            |
|--|--|--|---------------------------------------|------|--|------------------------------|-----|----------------------------|
|  |  |  | , , , , , , , , , , , , , , , , , , , |      |  | С                            |     |                            |
|  |  | 495283   | B WING                                |      |  |                              |     | 5/2022                     |
| NAME OF PROVIDER   | R OR SUPPLIER  |  |                                       | STRE | EET ADDRESS, CITY, STATE, Z  | IP CODE                      |     |                            |
| DDOMEDICASK  | U LED NUDE   | NC AND DELIAR (MADEDIAL)   |                                       | 1719 | BELLEVUE AVENUE  | i.                           |     |                            |
| PROMEDICASK  | ILLED NORSI  | NG AND REHAB (IMPERIAL)  |                                       | RIC  | HMOND, VA 23227  |                              |     |                            |
|  | ACH DEFICIENCY   | TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)  | ID<br>PREF<br>TAG                     |      | PROVIDER'S PLAN OF (<br>(EACH CORRECTIVE ACT)<br>CROSS-REFERENCED TO T<br>DEFICIENCY | ION SHOULD B<br>HE APPROPRIA |     | (X5)<br>COMPLETION<br>DATE |
| island of needed night shift purchased shift p | d) until healed of the control of th | (twice a day) and prn (as d. Every evening shift and d care." On 2/4/2022, 2, 2/17/2022, 2/21/2022 at 022, 2/2/2022, 2/13/2022, 2/20/2022, 2/20/2022, 2/20/2022, 2/20/2022 at s for Resident #11 dications and treatments as for Resident #11 documented | F                                     | 84   |  |                              |     |                            |
|  |  | (2:40 a.m.) Resident noted en area to left buttocks. Peri  |                                       | 1    |  |                              | 35  |                            |
|  |  | on wound bed beef red. No  |                                       |      |  |                              |     | -                          |
|  |  | ninage present. Area<br>ormal saline), patted dry, skin  |                                       |      |  |                              | 10  | j                          |
|  |  | pplied silva sorb wound gel  |                                       |      |  |                              | 16. |                            |
|  |  | d with gauze covered with  |                                       |      |  |                              |     | 1                          |
|  |  | (medical doctor) informed.   |                                       |      |  |                              |     |                            |
|  | is own RP (  | responsible party) and is  |                                       |      |  |                              |     |                            |
| aware."  | 722 18:24 (6:  | :24 p.m.) MD (medical  |                                       |      |  |                              |     |                            |
|  |  | onsible party) notified of   |                                       |      |  |                              |     |                            |
| meds (m  | edications) n  | ot given on 2/13   |                                       |      |  |                              |     | 1                          |
|  |  | hift. Resident monitored   |                                       | 23   |  |                              | 0   |                            |
| with no a  | dverse effect  | ts." The progress notes  |                                       |      |  |                              |     | - 1                        |
|  | evidence doc<br>I dates listed   | umentation regarding the   |                                       |      |  |                              |     | ł                          |
| auditional   | านแธง แอเซน  | 20040.   |                                       |      |  |                              |     |                            |
| The comp   | orehensive ca  | are plan for Resident #2   |                                       | ŭ.   |  |                              |     |                            |
| documen  | ted in part, "T  | The resident is on insulin r/t   |                                       | Ť.   |  |                              |     |                            |
|  |  | ate Initiated: 09/12/2019  |                                       | 1    |  |                              | 1   |                            |
|  |  | as MARs (medication  |                                       | i    |  |                              | 1   |                            |
|  |  | ) Date Initiated:  |                                       |      |  |                              | i   |                            |
| 03/20/202  | <ul> <li>u. monitor bl</li> </ul>  | ood sugar, lab results as  |                                       | 0    |  |                              | - 6 | - 1                        |

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

| LAND DEAN OF CORRECTION ADSIDE FOR TON NUMBERS   | ATE SURVEY         |
|--|--------------------|
| A BUILDING   | OMPLETED C         |
| 495283 B WING  | C<br>2/25/2022     |
| NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE   | LIZGIZUZZ          |
| 1719 BELLEVUE AVENUE   |                    |
| PROMEDICA SKILLED NURSING AND REHAB (IMPERIAL) RICHMOND, VA 23227  |                    |
| CONTROL OF A PERSON NAME OF A PERSON NAM |                    |
| (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  | COMPLETION<br>DATE |
| 5 694 Continued From many 52   |                    |
| F 684 Continued From page 53 F 684   |                    |
| ordered by physician. Dated Initiated:   |                    |
| 09/12/2019At risk for changes in mood r/t  |                    |
| anxiety, Date Initiated: 09/20/2019, At risk for   |                    |
| changes in mood r/t depression, Date Initiated:  |                    |
| 09/20/2019, and At risk for changes in mood r/t  |                    |
| bipolar, Date Initiated: 09/20/2019Administer  |                    |
| medication per physician orders. Date Initiated: 9/20/2019Open area left buttocks, Date  |                    |
| Initiated: 01/31/2022Administer trealment per  |                    |
| physician orders, Date Initiated: 01/31/2022."   |                    |
| physician orders, bate initiated. 01/31/2022.  |                    |
| On 2/24/2022 at 10:35 a.m., an interview was   |                    |
| conducted with LPN (licensed practical nurse) #1.  |                    |
| LPN #1 stated that the care was not provided if it   |                    |
| was not documented on the eMAR. LPN #1   |                    |
| stated that multiple residents had reported to him   |                    |
| that they had not received their medications on  |                    |
| 2/13/2022 when he returned to work the next  |                    |
| week. LPN #1 stated that the residents told him  |                    |
| that they did not get their evening medications.   |                    |
| LPN #1 stated that he did not know of any  | TIS.               |
| adverse events from the residents not getting  |                    |
| their medications. LPN #1 stated that  |                    |
| medications should be administered within an   | 2                  |
| hour before or after the scheduled time and documented at the time of administration. LPN  | -                  |
| #1 stated that the physician or nurse practitioner   | 1                  |
| and the responsible party were notified if the   |                    |
| medication was given late, refused or not given  | [                  |
| for any reason.  | [                  |
| 101 0.17 1.000011  | ļ                  |
| On 2/24/2022 at 1:15 p.m., an interview was  | 1                  |
| conducted with LPN #5. LPN #5 stated that  | Į                  |
| medications not signed off on the eMAR meant   | J                  |
| that they were not given. LPN #5 stated that   | İ                  |
| there should be a progress note documenting  |                    |
| why the medications were not administered in the   | 1                  |
| record. LPN #5 stated that they were pulled over   |                    |
| to Unit 1 to administer medications on 2/13/2022   |                    |

| OLIVICIO I OR MILITIONIVE  | TO MITTOLOGICA COLLARON   |                             |  | OIVID 140 09:30-03:3            |
|--|---|-----------------------------|--|---------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER  | (X2) MULTIPL<br>A. BUILDING | E CONSTRUCTION   | (X3) DATE SURVEY -<br>COMPLETED |
|  | 495283  | B WING                      |  | C                               |
| NAME OF PROVIDER OR SUPPLIER   | 433203  |                             | TREET ADDRESS, CITY, STATE, ZIP CO   | 02/25/2022                      |
| MAME OF ROVIDER ON SOFFEIER  |   | J                           |  | JOE .                           |
| PROMEDICA SKILLED NURSI  | NG AND REHAB (IMPERIAL)   |                             | 719 BELLEVUE AVENUE  |                                 |
|  |   | R                           | ICHMOND, VA 23227  |                                 |
| PREFIX (FACH DEFICIENCY  | TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG         | PROVIDER'S PLAN OF CORI<br>(EACH CORRECTIVE ACTION S<br>CROSS-REFERENCED TO THE A<br>DEFICIENCY) | SHOULD BE COMPLETION            |
|  |   |                             |  |                                 |
| F 684 Continued From page  | <del>-</del>  | F 684                       |  |                                 |
|  |   |                             |  |                                 |
| conducted with ASM member) #2, the into #2 stated that if the esigned off they would because it was not s #2 stated that they we leaving on 2/13/2022 contact agencies and shift but were unsucce, they had asked LPN they were finished with #2 stated that they had unit 2 to come to help medications on Unit 1 | erim director of nursing. ASM eMAR or eTAR were not diassume that it was not done igned as completed. ASM were notified of the nurse and had attempted to difficulty staff to fill in the essful. ASM #2 stated that #5 to move to Unit 1 when the their hall on Unit 2. ASM and asked the other nurse on |                             |  |                                 |
|  | SM #2 stated that she had   |                             |  |                                 |
|  | an and responsible parties  |                             |  |                                 |
|  | and missed their evening  |                             |  | **                              |
|  | 2 to notify them, and that  |                             |  | W                               |
|  | ny adverse effects. ASM   |                             |  |                                 |
|  | re working to get a wound   |                             |  | 8                               |
|  | ng and was setting up a   |                             |  | V.                              |
|  | ork with her to oversee the   |                             |  |                                 |
| wound program, along   |   |                             |  |                                 |
|  | be coming in April of 2022.   |                             |  |                                 |
| ASM #2 stated that the   |   | 9                           |  |                                 |
| modify their wound do  | sumentation,  | 3                           |  |                                 |
| On 2/24/2022 at appro  | ximately 4:30 p.m., ASM   | 1                           |  |                                 |
|  | trator, ASM #2, the interim   |                             |  | 9                               |
| director of nursing and  |   | 4                           |  | 127                             |
| quality consultant were  |   |                             |  |                                 |

| STATEMENT OF DEFICIENCE           |                                  | ROVIDER/SUPPLIER/CLIA  | (X2) MULT           | IPLE CONSTRUCTION                  |   | (X3) DATE SURVEY |
|-----------------------------------|----------------------------------|--|---------------------|------------------------------------|---|------------------|
| AND PLAN OF CORRECTIO             | N ID                             | ENTIFICATION NUMBER  | A BUILDING          |                                    |   | COMPLETED        |
|                                   | 1                                | 10000  |                     |                                    |   | С                |
|                                   |                                  | 495283   | B WING_             |                                    |   | 02/25/2022       |
| NAME OF PROVIDER OR               | SUPPLIER                         |  | ĺ                   |                                    | ITY, STATE, ZIP CODE  |                  |
| PROMEDICA SKILLE                  | D NURSING AN                     | D REHAB (IMPERIAL)   | 1                   | 1719 BELLEVUE AV<br>RICHMOND, VA 2 |   |                  |
| 5111                              | ALABY CTATCA (CAL                | OF DEFICK MOVES  |                     |                                    | 2,5   |                  |
| PREFIX (EACH D                    | EFICIENCY MUST B                 | OF DEFICIENCIES IE PRECEDED BY FULL FIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | (EACH COR                          | R'S PLAN OF CORRECTION<br>RECTIVE ACTION SHOULD<br>RENCED TO THE APPROPF<br>DEFICIENCY) | BE COMPLETION    |
| F 684 Continued F                 |                                  |  | F 68                | 4                                  |   |                  |
| No lumher in                      | normation was                    | provided prior to exit.  |                     |                                    |   |                  |
|                                   |                                  |  |                     |                                    |   |                  |
|                                   |                                  | to follow physician  |                     |                                    |   |                  |
| orders for pe<br>Resident #1      | eritoneal dialys<br>o            | s site care for  |                     |                                    |   |                  |
|                                   |                                  | to the facility on   |                     |                                    |   |                  |
|                                   |                                  | included but were not  |                     |                                    |   |                  |
|                                   | nd stage renal<br>ease, diabetes | disease, peripheral  |                     |                                    |   |                  |
|                                   |                                  | e most recent MDS  |                     |                                    |   |                  |
| (minimum da                       | ita set) assess                  | ment, a quarterly  |                     |                                    |   |                  |
|                                   |                                  | assessment reference   |                     |                                    |   | i.               |
|                                   |                                  | e resident as scoring a in<br>rief interview for   |                     |                                    |   | :                |
| mental status                     | s) score, indica                 | ting the resident was  |                     |                                    |   |                  |
| not cognitivel                    | y impaired.                      |  |                     |                                    |   | 1                |
| A review of th                    | e comprehens                     | ive care plan dated  |                     |                                    |   |                  |
| 11/1/21 docur                     | mented in part,                  | "FOCUS: Renal  |                     |                                    |   | 15-              |
|                                   |                                  | stage renal disease  |                     |                                    |   |                  |
| physician orde                    |                                  | r and site care per  |                     |                                    |   | 18               |
|                                   |                                  | ers dated 9/29/21  |                     |                                    |   |                  |
|                                   |                                  | oneal dialysis site  |                     |                                    |   | 1                |
| dry. Apply dry                    |                                  | mat saline and pat   |                     |                                    |   |                  |
|                                   |                                  | e peritoneal dialysis  |                     |                                    |   | 1                |
| insertion site."                  |                                  | ¥  |                     |                                    |   | 3                |
| A                                 | -1.1. 1.31401 71                 | 15.4   |                     |                                    |   |                  |
| A review of Re<br>administration  |                                  |  |                     |                                    |   |                  |
|                                   |                                  | ion of treatments for  |                     |                                    |   | 100              |
| peritoneal dialy                  | ⁄sīs site care, o                | n five of 31   |                     |                                    |   | 0                |
| opportunities ir opportunities in |                                  | , and ten out of 23  | 7                   |                                    |   |                  |
| opportunites in                   | i i cordary 202                  | 1a 27 and 10 and | - 1                 |                                    |   |                  |
|                                   |                                  | n 2/23/22 at 2:06  |                     |                                    |   | i                |
| PM with Reside                    | ent #10. Wher                    | asked if she was 📑   | 1                   |                                    |   |                  |

| Contractor of the Million of the Mil | AL G IVIL DIGITIO OLIVIOLO   |                             |  | OIMP 140 030-038              |
|--|--|-----------------------------|--|-------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER   | (X2) MULTIPLE<br>A BUILDING | CONSTRUCTION   | (X3) DATE SURVEY<br>COMPLETED |
|  | 405202   | B. WING                     |  | С                             |
|  | 495283   | B WING                      |  | 02/25/2022                    |
| NAME OF PROVIDER OR SUPPLIER   | 2  | 1                           | REET ADDRESS, CITY, STATE, ZIP CODE  |                               |
| PROMEDICA SKILLED NURS   | SING AND REHAB (IMPERIAL)  | ,                           | P BELLEVUE AVENUE<br>CHMOND, VA 23227  |                               |
| PREFIX (EACH DEFICIENC   | ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION)  | PREFIX<br>TAG               | PROVIDER'S PLAN OF CORRECT<br>(EACH CORRECTIVE ACTION SHOU<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY) | LD BE COMPLETION              |
| stated, "No, I am nabout getting an infection can be bather peritoneal catheter hemodialysis."  An interview was concerned and with LPN #1. When the concerned resident LPN #1 stated, "Yes is no sign of infection be dressed daily."  Resident #10's peritonial infection is no sign of infection is no sign of infection be dressed daily."   | of site care, Resident #10 of receiving it daily. I worry fection. I understand that the d. I have not used the for dialysis since I started onducted on 2/24/22 at 10:36 When asked if he had #10's peritoneal catheter site, s. I have. It looks okay, there on, redness/swelling. It is to When shown the TAR for oneal site care and asked | F 684                       |  |                               |
| mean that the care was not physician orders followed.  An interview was con  | owed, LPN #1 stated, "No,  |                             |  |                               |
| the wound care docu<br>stated, "if there are b<br>off, then it was not do<br>An interview was con<br>PM with ASM #2, the<br>When asked what the<br>ASM #2 stated, "It me<br>given." When asked   | mentation means, LPN #5 clanks and it was not signed one." iducted on 2/24/22 at 1:58 interim director of nursing. e blanks on the TAR mean, eans that the care was not if the care was not given, ders followed, ASM #2   |                             | DC   |                               |
| ASM #3, the regional #4, the regional direct   | M, ASM #1, the P, the director of nursing and quality consultant and ASM for of risk management, e, were made aware of the   |                             |  |                               |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X  |   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | (X2) MUL            | TIPLE CONSTRUCTION  |          | (X3) DATE SURVEY<br>COMPLETED<br>C<br>02/25/2022 |  |
|--|---|--|---------------------|---|----------|--|--|
|  |   | 495283   | B. WING             |   | 02       |  |  |
| NAME OF PROVIDER OF  |   | NG AND REHAB (IMPERIAL)  |                     | STREET ADDRESS, CITY, STATE, ZIP COE<br>1719 BELLEVUE AVENUE<br>RICHMOND, VA 23227                  |          | 12312022   |  |
| PREFIX (EACH   | DEFICIENCY  | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRE<br>(EACH CORRECTIVE ACTION SH<br>CROSS REFERENCED TO THE AP<br>DEFICIENCY) | HOULD BE | (X5)<br>COMPLETION<br>DATE                       |  |
| quality con practice for procedures  No further if a.b. The factorders for in #10.  A review of 9/29/21 door Hyperlipider hypertension diabetes. If medication in The physicial forms a day if the checks before (antihypotentimes a day if the checks before and blood premeals and at the A review of the blood sugar at 2/13/9:00 PM and significant in the checks before the che | 2 at 8:30 A sultant star the facility staff in nedication the comprisumented mia, congress of the modern of the complete man administration of the modern of the complete man orders of the modern of | M, ASM #3, the regional ated, "The standard of y is our policies and and was provided prior to exit."  Failed to follow physician administration for Resident rehensive care plan dated in part, "FOCUS: estive heart failure and ine System related to NTIONS: Administer ian orders."  Idated 12/9/21 documented: Itration time: "Ondansetron m, given by mouth before and vomitingMidodrine ligram by mouth three od pressureBlood sugar and at bedtime." | F 68                |   |          |  |  |
| blood pressure   | e of 128/6  | 1/13/22 at 12:20 PM and a 4 at 11:38 PM on 2/14/22.  |                     |   | 1        |  |  |

| CENT  | EUS LOU MEDICAL  | E & MEDICAID SEKVICES  |                     |   | OMID NO. 0930-039             |
|---|--|--|---------------------|---|-------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION   |  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER   | (X2) MULT           | TIPLE CONSTRUCTION NG   | (X3) DATE SURVEY<br>COMPLETED |
|   |  | 495283   | B WING              |   | C<br>02/25/2022               |
| NAME OF PROVIDER OR SUPPLIER PROMEDICA SKILLED NURSING AND REHAB (IMPERIAL)   |  |  | 1                   | STREET ADDRESS, CITY, STATE, ZIP CO<br>1719 BELLEVUE AVENUE<br>RICHMOND, VA 23227               |                               |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIENC)   | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF COR<br>(EACH CORRECTIVE ACTION S<br>CROSS-REFERENCED TO THE A<br>DEFICIENCY) | SHOULD BE COMPLETION          |
| F 684   | (administrative staff<br>director of nursing,<br>revealed, "Physician<br>notified of meds not  | ige 58<br>f member) #2, the interim<br>dated 2/14/22 at 6:21 PM,<br>n and RP (responsible party)<br>t given on 2/13 evening shift,<br>with no adverse effects."  | F 68                | 4   |                               |
|   | PM with Resident #<br>been any missed me<br>stated, "Yes, It was a<br>gency nurse on eve   | Inducted on 2/23/22 at 2:06 10. When asked if there had edication doses, Resident #10 Superbowl Sunday, the enings left and we did not get a shift. I let the dialysis center nedications."  |                     |   |                               |
|   | AM with LPN (license asked about the ever missing medications Resident #10 her day handed off to the ever what the blanks on the dministration record means that the medicasked if blanks on the | nducted on 2/24/22 at 10:36 ed practical nurse) #1. When ints of 2/13/22 including , LPN #1 stated, "I gave y shift medications and then ening nurse." When asked he MAR (medication I) mean, LPN #1 stated, "It cation was not given." When he MAR indicate the physician of LPN #1 stated, "No, they |                     |   |                               |
| Foods stands of the stands of | M with ASM #2. When the state of 2/13/22 and missing the hift, ASM #2 stated, we stated, which was the medical atted, "No, the medical ere were blanks."   | ducted on 2/24/22 at 1:58 nen asked about the events g medications on evening "I was told there was no ne meds on Wing 1 around ed if there were blanks on dication given, ASM #2 rations were not given if When asked if blanks on the sician orders were followed, he orders were not                |                     |   |                               |

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

| PERMIT                   | EKS FOR MEDICARE   | & MEDICAID SERVICES  |                        |  | OME NO. 0936-039              |
|--------------------------|--|--|------------------------|--|-------------------------------|
|                          | NT OF DEFICIENCIES<br>FOR CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  | (X2) MULT<br>A BUILDII | TIPLE CONSTRUCTION NG  | (X3) DATE SURVEY<br>COMPLETED |
|                          |  | 40.500   | 0 141140               |  | С                             |
|                          |  | 495283   | B WING                 |  | 02/25/2022                    |
| NAME OF                  | PROVIDER OR SUPPLIER   |  |                        | STREET ADDRESS, CITY, STATE, ZIP CO  | DE                            |
| DDOME                    | DICA CIVILLED MILIDON  | NO AND DELLAR (MOEDIAL)  | J                      | 1719 BELLEVUE AVENUE   |                               |
| PROME                    | DICA SKILLED NORSI   | NG AND REHAB (IMPERIAL)  |                        | RICHMOND, VA 23227   |                               |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY   | FEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL IC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG    | PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY) | HOULD BE COMPLETION           |
| F 684                    | Continued From page  | ge 59  | F 68                   | 34   |                               |
|                          | ASM #3, the regional #4, the regional direct quality and complian above concern. | PM, ASM #1, the #2, the director of nursing and I quality consultant and ASM ctor of risk management, ce, were made aware of the n was provided prior to exit. |                        |  |                               |
|                          | orders for medication #1   | iled to follow physician administration for Resident   |                        |  |                               |
| 4                        | not limited to: periphe<br>diabetes mellitus and<br>recent MDS (minimur          | sis that included but were   |                        |  |                               |
| i<br>1                   | reference date) of 1/2<br>scoring a 15 out of 15<br>interview for mental st      | 0/22, coded the resident as on the BIMS (brief atus) score, indicating the   |                        |  | *1                            |
|                          | resident was not cogn  |  |                        |  |                               |
|                          | The physician orders   | Dated 11/19/21   |                        |  | ((0))                         |
|                          | documented:  | stration: "Monitor blood   |                        |  |                               |
|                          |  | y physician if fasting blood   |                        |  |                               |
|                          | ugar less than 100   |  |                        |  |                               |
|                          |  | milligram twice daily for  |                        |  |                               |
|                          |  | (anticoagulant) 5 mg twice   |                        |  |                               |
|                          | aily for blood thinner.  |  | 9                      |  |                               |
| 3                        | - ,  |  |                        |  | 4                             |
| 1-                       | For 9:00 p.m. adminis  | stration: "Lantus (insulin)  |                        |  | 4                             |
| 11                       | 00 UNIT/MILLILITER   | Inject 10 unit   | 1                      |  |                               |
| S                        | ubcutan <mark>eously at Bed</mark>   | timeLidocaine Patch 4  |                        |  | 4                             |
| 1 %                      | Apply to chest topical   | Illy every 12 hours for pain   | -                      |  | 1                             |
|                          | nd remove per schede   |  |                        |  |                               |
| (a                       | ntiepileptic) 100 millig   | ram at bedtime for   |                        |  | 0                             |

| OLIVILIO I OILIME, DIGITIA                          | - O MELNONID OF LANGED  |                             |   | 21VID 140. 0300-00            |
|---|---|-----------------------------|---|-------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   | (X2) MULTIPLE<br>A BUILDING | CONSTRUCTION  | (X3) DATE SURVEY<br>COMPLETED |
|   | 1   |                             |   | С                             |
|   | 495283  | B WING                      |   | 02/25/2022                    |
| NAME OF PROVIDER OR SUPPLIER                        |   |                             | REET ADDRESS, CITY, STATE, ZIP CODE   |                               |
| PROMEDICA SKILLED NURSI                             | ING AND REHAB (IMPERIAL)  | - 1                         | 19 BELLEVUE AVENUE  |                               |
|   |   | RIC                         | CHMOND, VA 23227  |                               |
| PREFIX (EACH DEFICIENCY                             | TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SCIDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG         | PROVIDER'S PLAN OF CORRECTIC<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROF<br>DEFICIENCY) | D BE COMPLETION               |
|   | ruary 2022 MAR (medication  | F 684                       |   |                               |
| 100 on 2/13/22 at 6:<br>2/13/22 at 4:30 PM,         | d) evidenced a blood sugar of 30 AM, no blood sugar on and a blood sugar of 145 at The MAR evidenced a blood on 2/8/22. | 15                          |   |                               |
| A review of the nursi<br>2/14/22 at 6:22 PM,        | ng progress note dated<br>written by ASM  |                             |   |                               |
|   | member) #2, the interim   | .31                         |   |                               |
|   | evealed, "Physician and RP  | - 29                        |   |                               |
|   | otified of meds (medications)   |                             |   |                               |
| not given on 2/13 even monitored with no ad         |   |                             |   |                               |
| a monitored with no so                              | verse effects.  |                             |   |                               |
| A review of the comp                                | rehensive care plan dated   |                             |   |                               |
| 10/27/21 documented                                 |   |                             |   |                               |
|   | lisease, atrial fibrillation,   |                             |   | i.                            |
| hypertension and dee<br>Endocrine System rel        |   |                             |   |                               |
|   | Administer medication per   |                             |   |                               |
| physician orders."                                  | ·   |                             |   |                               |
|   | ducted with Resident #1 on 🦈  |                             |   | 1                             |
|   | When asked if he had  |                             |   |                               |
| missed any medicatio                                | n doses, Resident #1 s an evening where there   |                             |   |                               |
|   | e the medications and I did   |                             |   |                               |
|   | t day." When asked if there   |                             |   |                               |
| were staff to give the r                            | medications that evening,   |                             |   | 0.7                           |
|   | lo there was not a nurse.   | 01                          |   |                               |
|   | ed nursing assistant) to  |                             |   | 3                             |
| care for us, but no nur                             | se.   |                             |   |                               |
| An interview was cond                               | ucted on 2/24/22 at 10:36   | 1                           |   |                               |
|   | practical nurse) #1. When   | 1                           |   |                               |
| asked about the events                              | s of 2/13/22 including  | 1                           |   |                               |
| missing medications, L                              | PN #1 stated, "When I   |                             |   |                               |

| <u> </u>   | OF THE ENTENT OF THE PROPERTY  |                        |   | O141D 140. 0000-000           |
|--|--|------------------------|---|-------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  | (X2) MULT<br>A BUILDIN | TIPLE CONSTRUCTION NG   | (X3) DATE SURVEY<br>COMPLETED |
|  | 495283   | B WING                 |   | C                             |
| NAME OF PROVIDER OR SUPPLIER PROMEDICA SKILLED NURSIN  |  |                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br>1719 BELLEVUE AVENUE<br>RICHMOND, VA 23227                     | 02/25/2022                    |
| PREFIX (EACH DEFICIENCY  | EMENT OF DEFICIENCIES<br>MUST BE PRECEDED BY FULI,<br>C IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG    | PROVIDER'S PLAN OF CORREC<br>(EACH CORRECTIVE ACTION SHO<br>CROSS-REFERENCED TO THE APPI<br>DEFICIENCY) | OULD BE COMPLETION            |
| me he had not receiv<br>Sunday." When aske<br>MAR (medication add<br>LPN #1 stated, "It me<br>not given." When asl<br>medications have not   | ay 2/15/22, Resident #1 told yed his evening medicines on ed what the blanks on the ministration record) mean, eans that the medication was ked if there are blanks and been given, then have the n followed, LPN #1 stated, | F 684                  | 4   |                               |
| PM with ASM #2. When of 2/13/22 and missing shift, ASM #2 stated, nurse to administer the 6:00 PM. I called for some staff around so their medications and the blanks on the TAR "It means the care was holes in documentation orders being followed, does not indicate that the contract of t | the director of nursing and  |                        |   |                               |
| ASM #3, the regional q   | uality consultant and ASM 🦠  |                        |   |                               |
| No further information v   | vas provided prior to exit.  |                        |   |                               |
| 5. For Resident #4, the clarify, transcribe and for the treatment of a unit  | llow a physician's order 💨 🥛   |                        |   |                               |

|    | - OLIVIER OF WAR                                    | A MESTORIB BERTHOLD   |                    |      |   | (5,111111111111111111111111111111111111 | 10,0000 000  |
|----|---|---|--------------------|------|---|---|--|
| l  | STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER                        | (X2) MUI           |      | CONSTRUCTION  |   | DATE SURVEY  |
| ı  |   | A-707-004 4-5-0   | I N GOLL           |      |   |   | С  |
| I  | _   | 495283  | B WING             |      |   |   | 02/25/2022   |
| ľ  | NAME OF PROVIDER OR SUPPLIER                        | <u> </u>  | -                  | STR  | ELI ADDRESS, CITY, STATE, ZIP CODI  |   |  |
| I  | PROMEDICA SKILLED NURSI                             | NG AND REHAB (IMPERIAL)   |                    | 1719 | BELLEVUE AVENUE   |   |  |
| ļ. |   | ( )   |                    | RICI | HMOND, VA 23227   |   |  |
|    | PREFIX (EACH DEFICIENCY                             | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID<br>PREFI<br>TAG | ×    | PROVIDER'S PLAN OF CORRE<br>(EACH CORRECTIVE ACTION SHI<br>CROSS-REFERENCED TO THE APP<br>DEFICIENCY) | OULD BE                                 | (X5)<br>COMPLETION<br>DATE   |
|    | E 694 Continued From 100                            | 62  | F 0                | 0.4  |   |   |  |
|    | F 684 Continued From pag                            |   | F 6                | 84   |   |   |  |
|    |   | mitted to the facility on charged on 8/8/21. Resident                       |                    |      |   |   |  |
|    |   | s of but not limited to multiple  |                    |      |   |   |  |
|    |   | vascular disease, and   |                    |      |   |   |  |
|    |   | the most recent MDS   |                    |      |   |   |  |
|    |   | a quarterly assessment with   |                    |      |   |   |  |
|    |   | at Reference Date) of 6/1/21, in 199" out of 15 on the BIMS                 |                    |      |   |   |  |
|    |   | ental status), indicating the   |                    |      |   |   |  |
|    |   | to complete the interview for   |                    |      |   |   |  |
|    |   | cognitive status due to being severely cognitively                          |                    | 1    |   |   |  |
|    | impaired for making                                 | daily decisions.  |                    |      |   |   |  |
|    | A review of the clinical                            | al record sounded o   |                    |      |   |   |  |
|    | physician's order date                              |   |                    | 1    |   |   |  |
|    |   | ulture and Sensitivity (2)  |                    |      |   |   |  |
|    | :per family request.                                |   |                    |      |   |   |  |
|    |   |   |                    |      |   |   |  |
|    |   | 7/16/21 documented, "UA   |                    | 1    |   |   |  |
|    | was obtained."                                      |   |                    |      |   |   |  |
|    | Review of the clinical                              | record revealed a UA result   |                    |      |   |   | 1  |
|    |   | cumented, "Aerococcus   |                    | 1    |   |   |  |
|    |   | nism identified in the lab  |                    | 3    |   |   | 11   |
|    |   | t, the physician had hand   |                    | -    |   |   |  |
|    |   | ract infection) Amoxicillin   |                    |      |   |   |  |
|    | (4) 675 mg blu x 5 day                              | s and signed underneam.   |                    | 20   |   |   |  |
|    | Further review of the o                             | linical record failed to  |                    |      |   |   | 1  |
|    | reveal any evidence th                              |   |                    |      |   |   |  |
|    |   | lab form for the Amoxicillin  |                    |      |   |   | 1  |
|    | was ever transcribed to                             |   |                    | 10   |   |   | 40   |
|    |   | ntered into the electronic stem, and administered.                          |                    | 1    |   |   |  |
|    | Ticality lecold order sys                           | and administered.   |                    | 5    |   |   |  |
|    | On 2/24/22 at 10:35 AM                              | d an interview was  |                    | 1    |   |   | 1  |
|    | conducted with LPN #1                               | (Licensed Practical   |                    |      |   |   | 1  |
|    |   | a physician writes at the   |                    |      |   |   |  |
|    | hottom of a lab result a                            | diagnosis medication  |                    | į.   |   |   | A STATE OF THE STA |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER  | 1 ' '               | E CONSTRUCTION  |         | DATE SURVEY<br>COMPLETED   |
|---|--|---------------------|---|---------|----------------------------|
|   | 495283   | B WING              |   |         | C<br>02/25/2022            |
| NAME OF PROVIDER OR SUPPLIER PROMEDICA SKILLED NURSI  |  | S1<br>17            | REET ADDRESS, CITY, STATE, ZIP CODI<br>19 BELLEVUE AVENUE<br>CHMOND, VA 23227                         |         | JZ12312022                 |
| PREFIX (EACH DEFICIENCY   | FEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRE<br>(EACH CORRECTIVE ACTION SHI<br>CROSS-REFERÊNCEO TO THE APP<br>DEFICIÊNCY) | OULD BE | (XS)<br>COMPLÉTION<br>DATE |
| constitute an order, clarify it, I would not would call to clarify." components of an or "If it was on a T.O. (twould have more stuneeds to be clarified, T.O. order form, and health record]."  On 2/24/22 at 2:35 P. #2 (Administrative St. | ge 63 and frequency, did that the stated, "My guess, before consider it to be an order. I When asked if all the der was present, he stated, elephone order sheet) it if on it like a date, etc. It I would clarify it, put it on a put it in (name of electronic  M in an interview with ASM aff Member) the Director of hat the order should have | F 684               |   |         |                            |
| Guidelines was review documented, "Orders electronically entered  | are transcribed or<br>then noted by the licensed<br>urse noting an order is  |                     |   |         |                            |
| the end of the shift dur<br>received. Will indicate<br>of the licensed nurse c  | documented, "Lab test<br>an external labWill be  |                     |   |         |                            |
| On 2/24/22 at 4:45 PM,<br>ASM #3, the Administra<br>and Regional Quality C<br>were made aware of the  | ontor, Director of Nursing, onsultant, respectively,   |                     |   |         |                            |

|   | STATEMEN                 | NT OF DEFICIENCIES OF CORRECTION                | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER                           | 1 ' '             |        | CONSTRUCTION   |      | DATE SURVEY                |
|---|--------------------------|---|---|-------------------|--------|--|------|----------------------------|
| ł | MILD I LAN               | OF CONTRECTION                                  | DENTI TOX TOX TOWNSER   | A BUIL            | ING    |  |      |                            |
| l |                          |   | 405202  | B. WING           | :      |  |      | C                          |
| ŀ |                          | 200011252 02 011001150                          | 495283  | O. WINC           |        | EET ADDRESS, CITY, STATE, ZIP CODE   | 1 0  | 2/25/2022                  |
| l | NAME OF                  | PROVIDER OR SUPPLIER                            |   |                   |        | BELLEVUE AVENUE  |      |                            |
| l | PROME                    | DICA SKILLED NURSI                              | NG AND REHAB (IMPERIAL)   |                   |        | HMOND, VA 23227  |      |                            |
| L |                          |   |   |                   | - KICI |  |      |                            |
|   | (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY                                | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID<br>PREF<br>TAG | x      | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY) | D BE | (XS)<br>COMPLETION<br>DATE |
|   | F 684                    | Continued From page                             | ze 64   | F6                | RA     |  |      |                            |
|   |                          | , -   | vided by the end of the   |                   | 04     |  |      |                            |
|   |                          | survey.   | vided by the end of the   |                   |        |  |      |                            |
|   |                          | Salvey.   |   |                   |        |  |      |                            |
|   |                          | COMPLAINT DEFIC                                 | IENCY   |                   |        |  |      |                            |
|   |                          | References:                                     |   |                   |        |  |      |                            |
|   |                          | Urinalysis - A urin     It is often done to che | alysis is a test of your urine.   |                   |        |  |      |                            |
|   |                          | infections, kidney pro                          | blems, or diabetes. You may   |                   |        |  |      |                            |
|   |                          | also have one during                            |   |                   |        |  |      |                            |
|   |                          |   | tal, before you have surgery,   |                   |        |  |      |                            |
|   |                          | or if you are pregnant<br>medical conditions ar | t. It can also monitor some   |                   |        |  |      |                            |
|   |                          | Information obtained                            |   |                   |        |  |      |                            |
|   |                          | https://medlineplus.go                          |   |                   |        |  |      |                            |
|   |                          |   | 51  |                   |        |  |      |                            |
|   |                          |   | tivity - If bacteria grow in the  |                   |        |  |      |                            |
|   |                          |   | you have symptoms of an itation, it means you have a                        |                   |        |  |      | 7.6                        |
|   |                          |   | ositive urine culture test or   |                   |        |  |      |                            |
|   |                          | abnormal test result.                           |   |                   |        |  |      |                            |
|   |                          |   | st on the bacteria in the   |                   | N.     |  |      | -                          |
|   |                          | cultured sample. Also                           |   |                   | 1      |  |      |                            |
|   |                          |   | test identifies the type of   |                   | 4      |  |      | _                          |
|   |                          | pacteria causing the in                         |   |                   |        |  |      |                            |
|   |                          | which antibiotics will ki                       | i is sensitive to, meaning  |                   |        |  |      | 12.                        |
|   |                          |   | healthcare provider select  |                   |        |  |      |                            |
|   |                          |   | biotic medicine. Certain  |                   |        |  |      |                            |
|   | a                        | ntibiotics only work ag                         | gainst certain bacteria.And 🎏   |                   |        |  |      | 50                         |
|   |                          |   | ntibiotic resistance. This  |                   | 8      |  |      |                            |
|   |                          |   | longer can stop that type   |                   |        |  |      |                            |
|   |                          |   | ng. Antibiotic-resistant  |                   | i .    |  |      | £3                         |
|   |                          | fections are harder to                          |   |                   | ř.     |  |      | ii)                        |
|   |                          | formation obtained fre                          | om<br>nic.org/health/diagnostics/2  |                   |        |  |      |                            |
|   |                          | tps://my.clevelanochr<br>126-urine-culture#resi |   |                   |        |  |      | <i>[</i> 2                 |
|   | ; 2                      | , 20-di il 16-00 (di eni esi                    | and onononomap  |                   |        |  |      | (**)                       |

|                                | ENT OF DEFICIENCIES<br>IN OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER   |  | HPLE CONSTRUCTION   |         | OATE SURVEY                |
|--------------------------------|--|--|--|---|---------|----------------------------|
| 1                              |  | }  | 1 501251   |   |         | С                          |
| 1                              |  | 495283   | B. WING  |   | 0       | 2/25/2022                  |
|                                | PROVIDER OR SUPPLIER   | ING AND REHAB (IMPERIAL)   |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br>1719 BELLEVUE AVENUE<br>RICHMOND, VA 23227                     |         |                            |
| (X4) ID<br>PREFIX<br>TAG       | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG  | PROVIDER'S PLAN OF CORREC<br>(EACH CORRECTIVE ACTION SHO<br>CROSS-REFERENCED TO THE APPS<br>DEFICIENCY) | DULD BE | (X5)<br>COMPLETION<br>DATE |
|                                | increasingly recogni-<br>urinary tract bacteric<br>isolated from urine of<br>females with a wide<br>including urinary trac-<br>urinary incontinence<br>bladder (OAB). A. ur<br>concern because it is<br>antibiotics and, when<br>invasive and life-three<br>or soft tissue infection<br>Information obtained | ae - "Aerococcus urinae is ized as a potentially significant um. A. urinae has been collected from both males and range of clinical conditions, ct infection (UTI), urgency (UUI), and overactive rinae is of particular clinical is highly resistant to many in undiagnosed, can cause catening bacteremia, sepsis, ins."  from org/doi/10.1128/JB.00170-20 | F 68   | 4   |         |                            |
|                                | tml 6. The facility staff fail antidepressant and a orders for Resident #5 Resident #5 was admi  | laxative per the physician 5.  |  |   |         |                            |
| t<br>ii<br>lii<br>tl<br>a<br>b | data set) assessment, with an ARD (assessment, with an ARD (assessment/18/2022, the resident blood by the resident mpaired for making dather resident was coded  | an admission assessment, inent reference date) of it scored a 7 out of 15 on ew for mental status) score, is severely cognitively ally decisions. In Section N, if as receiving five doses of lication during the look   | The state of the s |   |         |                            |

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

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| CENTERS FOR MEDICAR   | E & MEDICAID SERVICES  |                      | <del></del> _   | OMB NO    | 0938-03                    |
|---|--|----------------------|---|-----------|----------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                       | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  | (X2) MUL<br>A. BUILD | TIPLE CONSTRUCTION  | (X3) DAT  | TE SURVEY<br>MPLETED       |
|   | 495283   | B WING               |   | I .       | C<br>/25/2022              |
| NAME OF PROVIDER OR SUPPLIER  |  |                      | STREET ADDRESS, CITY, STATE, ZIP C  |           |                            |
| PROMEDICA SKILLED NUBS  | INC AND DELLAD MADERIALS   | 1                    | 1719 BELLEVUE AVENUE  |           |                            |
| PROMEDICA SKILLED NURS  | ING AND REHAB (IMPERIAL)   |                      | RICHMOND, VA 23227  |           |                            |
| PREFIX (EACH DEFICIENC  | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG  | PROVIDER'S PLAN OF COR<br>(EACH CORRECTIVE ACTION<br>CROSS-REFERENCED TO THE A<br>DEFICIENCY) | SHOULD BE | (XS)<br>COMPLETION<br>DATE |
| depression) (1) 7.5<br>by mouth at bedtime<br>physician order date<br>"Senna Tablet (used | ige 66 izapine Tablet (used to treat mg (milligrams); give 7.5 mg e for depression." The ed, 1/14/2022 documented, if to treat constipation) (2) 8.6 if mouth at bedtime for | F 68                 | 34  |           |                            |
| physician orders. Th  | d) documented the above ere was nothing documented ses of Mirtazapine and Senna  |                      |   |           |                            |
| Review of the nurse's evidence documental medications.                                    | s notes for 2/9/2022 failed to tion related to the above   |                      |   | i<br>I    |                            |
| documented in part, '<br>Alteration: Constipation'<br>per physician order al              | Focus: Bowel Elimination onAdminister medication and observe effectiveness diverse effects related to use dication."   |                      |   |           |                            |
| practical nurse) #1, or When asked what a b   | ducted with LPN (licensed of 2/24/2022 at 10:34 a.m. lank on the MAR indicated, 't done, or not clicked off in ogram].   |                      |   |           |                            |
|   | When asked what a blank LPN #5 stated if it isn't  |                      |   | I         |                            |
| ASM #1, the interim ad<br>interim director of nursi<br>quality consultant, and            |  | 1                    |   |           |                            |

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MED

FORM APPROVED
OME NO. 0938-0391

| CEMI   | ERS F <u>OR MEDICARE</u>   | & MEDICAID SERVICES   |                     |   | OMB NO. 0938-039  |
|--|--|---|---------------------|---|---|
|  | NY OF DEFICIENCIES<br>FOE CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER  | 1 ' '               | FIPEC CONSTRUCTION<br>NG  | COMPILICD COMPILICD   |
|  |  | 495283  | B WING              | 8 c   | 02/25/2022  |
| NAME OF  | PROVIDER OR SUPPLIER   |   | -                   | STREET ADDRESS, CITY, STATE, ZIP CO   |   |
| DD OAAC  | DICA CIVIL LED NILIDO  | NO AND DELLAS (MASSOLAL)  | 1                   | 1719 BELLEVUE AVENUE  |   |
| PROME  | DICA SKILLED NURSI   | NG AND REHAB (IMPERIAL)   |                     | RICHMOND, VA 23227  |   |
| (X4) ID<br>PRECIX<br>TAG                           | (EACH DEFICIENCY   | ELMENT OF DEFICIENCIES MUST BE PRECEDED BY LULL BC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORI<br>(EACH CORRECTIVE ACTION S<br>CROSS-REFERENCED TO THE A<br>DEFICIENCY)  | SHOULD BE COMPLETION  |
| F 684  |  | ge 67<br>nsultant, were made aware of<br>on 2/24/2021 at 4:56 p.m.  | F 68                | 34  |   |
|  |  | on was obtained prior to exit.  |                     |   |   |
| F 686 SS=E  () () () () () () () () () () () () () | following website: https://medlineplus.g tml (2) This information of following website: https://medlineplus.g Treatment/Svcs to Pr CFR(s): 483.25(b)(1) §483.25(b) Skin Integ §483.25(b)(1) Pressu Based on the compressional tender (i) A resident receives professional standard pressure ulcers and dulcers unless the individemonstrates that the individemonstrates that the ecessary treatment and the professional standard promote healing, previous ulcers from development of the professional standard promote healing, previous ulcers from development in the course we ulcers from development in the course with professional standard promote healing, previous ulcers from development in the course we ulcers from development in the course we ulcers from development in the course we ulcers from the cou | rity re ulcers. hensive assessment of a ust ensure that- care, consistent with s of practice, to prevent oes not develop pressure idual's clinical condition y were unavoidable, and ssure ulcers receives nd services, consistent dards of practice, to ent infection and prevent oping. is not met as evidenced  staff interview, resident d review, facility document se of a complaint termined that the facility | F 686               | Tag F686 – Failed to provide S Prevent/Heal Pressure Ulcers.  1. Resident # 12 wound was ass nursing on 2/28/22. Resident was assessed by nursing on 2 Resident # 4 no longer reside facility.  2. The DON or designee review the center with wounds to valuentation.  3. The DON or designee re-education include wound documentate documenting treatments on the administration record.  4. The DON or designee will review residents with wounds weekly weeks to validate appropriate tation is in place. The Administration is in place. The Administration is in place. The Administration for review and further recommendations.  5. The facility's alleged date of control will be April 4, 2022. | sessed by t # 11 wound /25/22. ss at the red patients in fidate docu- cated licensed int guidelines ion and the treatment // iew / times 4 documen- istrator will API her |

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER  | (X2) MUL  |    | NSTRUCTION  |    | DATE SURVEY                |
|---|---|---|----|---|----|----------------------------|
|   | 495283  | B. WING   | 15 |   |    | C                          |
| NAME OF PROVIDER OR SUPPLIER PROMEDICA SKILLED NURSI  |   | STREET ADDRESS, CITY, STATE, ZIP CODE  1719 BELLEVUE AVENUE  RICHMOND, VA 23227 |    |   |    | 02/25/2022                 |
| PREFIX (EACH DEFICIENCY   | FEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL BC IDENTIFYING INFORMATION)   | IU<br>PREFIX<br>TAG   |    | PROVIDER'S PLAN OF CORRECTIO<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROP<br>DEFICIENCY) | BE | (XS)<br>COMPLETION<br>DATE |
| and/or treat pressure   | ge 68<br>e and services to prevent<br>e injuries for 3 of 14 residents<br>e, Residents #12, #4, and   | F 68  | 6  |   |    |                            |
| evidence that wound<br>treatment evaluation   | the facility staff failed to<br>tracking, monitoring, and<br>was provided, and that<br>atments were completed.  |   |    |   |    |                            |
| 4/27/15 and had the of to, pressure injury (1) (minimum data set), a an ARD (assessment the resident scored 7 | mitted to the facility on<br>diagnoses of, but not limited<br>. On the most recent MDS<br>a quarterly assessment with<br>reference date) of 12/17/21,<br>out of 15 on the BIMS (brief<br>tatus, indicating the resident |   |    |   |    | 1                          |
| was severely cognitive decisions. The resider stage 2 pressure injured A review of the clinical               | ely impaired for making daily int was coded as having a y.  record revealed the   |   |    |   |    | ži                         |
| a stage 2 (2) at this time present to wound bed. defined. Peri-wound in to Santyl daily and PRI               | 12/2/21 documented, acral wound presenting as i.e. 100% granulation tissue 5.4x3.6x0.1. edges well fact. Will change treatment is (as needed). Noted her blanchable red area. Skin                                      |   |    | 47  |    |                            |
|   | oressure wound to sacrum ed. Area is macerated and  | i   |    |   |    |                            |

|   | STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER.  | (X2) MUI TIF   | PLF CONSTRUCTION  |      | DATE SURVEY                |
|---|---|---|--|---|------|----------------------------|
|   |   | 405202  | B. WING  |   |      | C                          |
| I | NAME OF PROVIDER OR SUPPLIER  | 495283  |  | STREET ADDRESS, CITY, STATE, ZIP CODE   | 1 0  | 2/25/2022                  |
|   | PROMEDICA SKILLED NURSI   | NG AND REHAB (IMPERIAL)   |  | 1719 BELLEVUE AVENUE<br>RICHMOND, VA 23227  |      |                            |
| ľ | PREFIX (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG  | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPED DEFICIENCY) | D BE | (XS)<br>COMPLETION<br>DATE |
|   | F 686 Continued From pag  | ge 69   | F 686  | 7   |      |                            |
|   | "weekly wound note:<br>area 3.0x2,5x0.1 with  | ed 12/14/21 documented,<br>s: pressure wound to sacral<br>h maceration noted to<br>al tissue to wound bed.<br>atment change."   |  |   |      |                            |
|   | "weekly wound notes   | d 12/22/21 documented,<br>: pressure wound to sacrum<br>issue present to wound bed.<br>nd peri-wound intact.  | :  |   |      | ι                          |
|   | This assessment was   | ent dated 2/23/22<br>1.5 x 1.6 no drainage."<br>approximately 2 months<br>ove) wound assessment.  |  |   |      | el el                      |
|   | A review of the clinica following orders and to   | I record revealed the reatment administration:  |  |   |      | £6                         |
|   | prep to right heel daily<br>every night shift for pre<br>December 2021 MAR<br>Administration Record<br>Administration Record            |   | i  |   |      | 45<br>a                    |
|   | wound to sacrum with apply skin prep to area and optifoam (5) dressi every day shift every 3 review of the Decembe February 2022 MAR an | ated 12/7/21 for "Cleanse wound cleanser, pat dry, apply calcium alginate (4) ng every 3 days and PRN day(s) for wound care." A r 2021, January 2022 and d TAR revealed there was s completed on 12/13/21, 1/22, 1/9/22, 1/18/22, | 1101 to 1101 t |   |      |                            |

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

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| CENTE                    | KS FOR MEDICARE                             | & MEDICAID SERVICES  |                    |      |   | OMB M     | <u>O. 0938-</u> 0391       |
|--------------------------|---|--|--------------------|------|---|-----------|----------------------------|
|                          | OF DEFICIENCIES<br>OF CORRECTION            | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  | (X2) MU<br>A BUILI |      | CONSTRUCTION  |           | ATE SURVEY<br>DMPLETED     |
|                          | 10  | 495283   | B: WING            | 3    |   | 0:        | C<br>2/25/2022             |
| 5020                     | ROVIDER OR SUPPLIER                         | NG AND REHAB (IMPERIAL)  |                    | 1719 | EET ADDRESS, CITY, STATE, ZIP (<br>9 BELLEVUE AVENUE<br>HMOND, VA 23227                     |           |                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY                            | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL IC IDENT IFYING INFORMATION)   | ID<br>PREFI<br>TAG |      | PROVIDER'S PLAN OF COI<br>(EACH CORRECTIVE ACTION<br>CROSS-REFERENCED TO THE<br>DEFICIENCY) | SHOULD BE | (X5)<br>COMPLETION<br>DATE |
| E 686                    | 0   | 70   |                    | - 19 |   |           |                            |
|                          | Continued From pag                          | ge 70<br>30/22, 2/5/22 and 2/20/22.  | F6                 | 86   |   |           |                            |
|                          | 1127122, 1121122, 110                       | OUZZ, ZISIZZ AND ZIZUIZZ.  |                    |      |   |           |                            |
|                          |   | 2/23/22 for "Cleanse wound   |                    |      |   |           |                            |
|                          |   | d cleanser, pat dry, apply uply Venelex (6) ointment and   |                    |      |   |           |                            |
| (                        | optifoam dressing ev                        | ery other days and PRN as  |                    |      |   |           |                            |
|                          |   | ne first treatment change in this since the previous   |                    |      |   |           |                            |
|                          | above) wound care                           |  |                    |      |   |           |                            |
|                          | On 2/24/22 at approx                        | imately 1:00 PM an   |                    |      |   |           | 1                          |
| . 0                      | bservation was mad                          | e with LPN #3 performing   |                    |      |   |           | Te.                        |
|                          |   | ent #12. The wound was   |                    |      |   |           | r.                         |
|                          |   | with the wound care  |                    |      |   |           |                            |
| p                        | rocess.                                     |  |                    |      |   |           | 2                          |
|                          | n 2/24/22 at 10:35 A                        |  |                    |      |   |           |                            |
|                          |   | 1 (Licensed Practical what it means if areas were  |                    | 1    |   |           | 25                         |
|                          |   | AR, he stated, "That   |                    |      |   |           |                            |
|                          |   | It wasn't clicked off in alth record).' When asked   |                    |      |   |           |                            |
|                          |   | care wasn't provided, he   |                    | 1    |   |           |                            |
| sta                      | ated, "Yes."                                |  |                    |      |   |           |                            |
| Th                       | ere was no docume                           | ntation regarding any  |                    |      |   |           |                            |
|                          | aluation of the woun                        |  |                    | E.   |   | 13        |                            |
|                          |   | 2/21 and 2/23/22, a period https://doi.org/<br>https://doi.org/<br>https://doi.org/<br>https://doi.org/<br>https://doi.org/<br>https://doi.org/<br>https://doi.org/<br>https://doi.org/<br>https://doi.org/<br>https://doi.org/<br>https://doi.org/<br>https://doi.org/<br>https://doi.org/<br>https://doi.org/<br>https://doi.org/<br>https://doi.org/<br>https://doi.org/<br>https://doi.org/<br>https://doi.org/<br>https://doi.org/<br>https://doi.org/<br>https://doi.org/<br>https://doi.org/<br>https://doi.org/<br>https://doi.org/<br>https://doi.org/<br>https://doi.org/<br>https://doi.org/<br>https://doi.org/<br>https://doi.org/<br>https://doi.org/<br>https://doi.org/<br>https://doi.org/<br>https://doi.org/<br>https://doi.org/<br>https://doi.org/<br>https://doi.org/<br>https://doi.org/<br>https://doi.org/<br>https://doi.org/<br>https://doi.org/<br>https://doi.org/<br>https://doi.org/<br>https://doi.org/<br>https://doi.org/<br>https://doi.org/<br>https://doi.org/<br>https://doi.org/<br>https://doi.org/<br>https://doi.org/<br>https://doi.org/<br>https://doi.org/<br>https://doi.org/<br>https://doi.org/<br>https://doi.org/<br>https://doi.org/<br>https://doi.org/<br>https://doi.org/<br>https://doi.org/<br>https://doi.org/<br>https://doi.org/<br>https://doi.org/<br>https://doi.org/<br>https://doi.org/<br>https://doi.org/<br>https://doi.org/<br>https://doi.org/<br>https://doi.org/<br>https://doi.org/<br>https://doi.org/<br>https://doi.org/<br>https://doi.org/<br>https://doi.org/<br>https://doi.org/<br>https://doi.org/<br>https://doi.org/<br>https://doi.org/<br>https://doi.org/<br>https://doi.org/<br>https://doi.org/<br>https://doi.org/<br>https://doi.org/<br>https://doi.org/<br>https://doi.org/<br>https://doi.org/<br>https://doi.org/<br>https://doi.org/<br>https://doi.org/<br>https://doi.org/<br>https://doi.org/<br>https://doi.org/<br>https://doi.org/<br>https://doi.org/<br>https://doi.org/<br>https://doi.org/<br>https://doi.org/<br>https://doi.org/<br>https://doi.org/<br>https://doi.org/<br>https://doi.org/<br>https://doi.org/<br>https://doi.org/<br>https://doi.org/<br>https://doi.org/<br>https://doi.org/<br>https://doi.org/<br>https://doi.org/<br>https://doi.org/<br>https://doi.org/<br>https://doi.org/<br>https://doi.org/<br>https://doi.org/<br>https://doi.org/<br>https://doi.org/<br>https://doi.org/<br>https://doi.org/<br>https://doi.org/<br>https://doi.org/<br>https://doi.o |                    |      |   |           |                            |
| wh                       | at, if any, impact the                      | missed treatments had on   |                    | 8    |   | 7         |                            |
|                          |   | is no documentation<br>ging, and progress of this  |                    | 1    |   | -         |                            |
| wo                       | und between 12/22/2                         | 21 and 2/23/22, a period of  |                    |      |   | -         |                            |
| app                      | proximately 2 months                        | S.   |                    | İ    |   | i         |                            |
|                          | 2/23/22 at approxim                         |  |                    | 1    |   |           | ļ                          |
|                          | rview was conducte<br>ministrative Staff Me | d with ASM #2<br>ember) the Director of  |                    | E.   |   |           |                            |
| 1. 1.                    |   | 17 112 112121 21   |                    | 411  |   | i         |                            |

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER  | (X2) MULTIPL<br>A BUILDING | E CONSTRUCTION   | (X3) DATE SURVEY<br>COMPLETED |
|---|---|----------------------------|--|-------------------------------|
|   | 495283  | B WING                     |  | C<br>02/25/2022               |
| NAME OF PROVIDER OR SUPPLIER PROMEDICA SKILLED NURS   | ING AND REHAB (IMPERIAL)  | t'                         | TREET ADDRESS, CITY, STATE, ZIP CODE<br>719 BELLEVUE AVENUE<br>ICHMOND, VA 23227                       |                               |
| PREFIX (EACH DEFICIENC  | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY I'ULL SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG        | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY) | D BE COMPLET                  |
| measurements and stated that there we wound nurse. She the facility since 1/2 here, I asked them stuff?" She stated, I had a wound prog back, there was not She stated, "I know treatments. I have a around with them ye stated that she "just first time yesterday (A review of the comprevealed the following a care plan included the 4/17/17, for "Provide routinely and prn."  - A care plan dated 1 pressure ulcer to cool This care plan included the cool of the cool | ked about the lack of I tracking of the wound, she as no wound program and no stated that she had been at 14/22. She stated, "When I got "where is all your wound "When I was here a year ago ram running. When I came one, and no unit managers." the nurses are doing the not had a chance to go et." For Resident #12 she looked at the wound for the 12/22/22)."  The prehensive care plants:  1/28/15 for "At risk for grity related to: impaired gnition, incontinence." This | F 686                      |  |                               |
| The facility policy, "Sk<br>Guidelines," documer  |   |                            |  | #<br>#                        |
| development of skin a prevention techniques   | ion of patients at risk for the   |                            |  |                               |

|  |  | T OF DEFICIENCIES<br>OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER  | (X2) MULTIPLE CONSTRUCTION A BUILDING |   |         | TE SURVEY<br>MPLETFO       |  |
|--|--|---|---|---------------------------------------|---|---------|----------------------------|--|
|  |  |   | 495283  | B WING                                |   | 02      | C<br>!/25/202 <b>2</b>     |  |
|  |  | PROVIDER OR SUPPLIER<br>DICA SKILLED NURS   | ING AND REHAB (IMPERIAL)  |                                       | STREET ADDRESS, CITY, STATE, ZIP CODE<br>1719 BELLEVUE AVENUE<br>RICHMOND, VA 23227               |         | ZOTZUZZ                    |  |
|  | (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIENC   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | PREFI<br>PAG                          | PROVIDER'S PLAN OF CORREC  X (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPL DEFICIENCY) | OULD BE | (X5)<br>COMPLETION<br>DATE |  |
|  | f<br>f<br>a  | and underlying soft prominence or related device.  - Can present as interpretable and processor of the control | ocalized damage to the skin tissue, usually over a bony sed to a medical or other lact skin or an open ulcer and use of intense and, or or pressure in combination erations and pressure injuries ocumented by the licensed on/Readmission Evaluation a head-to-toe skin oletion of the Braden Scale ure Sore Risk Scale, weekly X 3 after of 4 weekly evaluations  | F 6                                   | 86  |         |                            |  |
|  | alide - 'Composition of the composition of the comp | Using the Skin Alter pplication in PCC (if pplication in PCC (if pensed nurse for no Whenever there is a production or clinically Quarterly, in coordinates addy audits are comply the licensed nurse essure injuries and the with the pressure injuries and the pressure injuries are gress note by the nursing assist   | a significant change in indicated nation with the MDS/RAI pleted: the daily for patients with documented on the eTAR; imented in a progress note the weekly for patients and documented on the income the sand documented on the indicate weekly for patients and documented on the indicate weekly for patients and documented on the indicate weekly for patients and documented on the indicated in indicated in indicated in indicated in indicated in indicated in indicated |                                       |   |         |                            |  |

|   | CENTERO FOR MEDICARE                                | E & MEDICARD BELLARGES   |                     |  | CHAIR MAC | . 0920.038                 |
|---|---|--|---------------------|--|-----------|----------------------------|
|   | STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER                            | 1                   | IPLE CONSTRUCTION  |           | E SURVEY<br>MPLETED        |
| I |   | 105000   |                     |  |           | С                          |
| l |   | 495283   | B. WING             |  | 02/       | 25/2022                    |
| ľ | NAME OF PROVIDER OR SUPPLIER                        |  | 1                   | STREET ADDRESS, CHY, STATE, ZIP CODE   |           |                            |
| ľ | PROMEDICA SKILLED NURSI                             | NG AND PEHAR (IMPERIAL)  | ł                   | 1719 BELLEVUE AVENUE   |           |                            |
| Į | FROMEDION GRIELED HONG                              | NO AND NEITAB (IIM ENIAC)  | -                   | RICHMOND, VA 23227   |           |                            |
|   | PREFIX (EACH DEFICIENCY                             | TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SCIDENTIFYING INFORMATION) | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECT<br>(EACH CORRECTIVE ACTION SHOU<br>CROSS-REFERENCED TO THE APPRI<br>DEFICIENCY) | JLD BF    | (XS)<br>COMPLETION<br>DATE |
|   | F 686 Continued From page                           | ne 73  | F 68                | ·<br>6   |           |                            |
|   |   | T  | 1 00                |  |           |                            |
|   | daily care and docui                                |  |                     |  |           |                            |
|   |   | raden Scale is the clinically  |                     |  |           |                            |
|   |   | o identify potential levels of   |                     |  |           |                            |
|   |   | ry development. The scale scales scales for determining skin                 |                     |  |           |                            |
|   |   | cale is completed at the time  |                     |  |           |                            |
|   | of admission and is                                 |  |                     |  |           |                            |
|   |   | ment under the Assessment  |                     |  |           |                            |
|   | (ab in PCC. The PCC                                 |  |                     |  |           |                            |
|   |   | d, also includes the Braden  |                     |  |           |                            |
|   |   | entered within the application   |                     |  |           |                            |
|   |   | r Scale for Healing (PUSH  |                     |  |           |                            |
|   |   | ment the healing status of   |                     |  |           |                            |
|   | pressure injuries. It is                            | s initiated upon identification 🤺  |                     | ,  |           |                            |
|   | of a pressure injury a                              | nd is updated weekly by the  |                     |  |           |                            |
|   |   | ound rounds until the wound  |                     |  |           |                            |
|   |   | ration Record is used to   |                     |  |           |                            |
|   |   | tus of non-pressure injuries.  |                     |  |           |                            |
|   |   | ound application, if enabled,  |                     |  |           |                            |
|   |   | entry of non-pressure injury   |                     |  |           |                            |
|   | healing status                                      |  |                     |  |           |                            |
|   | The Skin Worksheet i                                |  |                     |  | 500       |                            |
|   |   | t skin observations. The ed at least twice/week with                         |                     |  |           | - 1                        |
|   |   | wer. Completed worksheets  |                     |  | - 4       | - 1                        |
|   |   | ed nurse for validation and  |                     |  |           | - 1                        |
|   | action planning as indi                             |  |                     |  |           | - 1                        |
|   |   | selected based upon the  |                     |  |           | - 1                        |
|   |   | type, exudate, condition of  |                     |  |           | J                          |
|   |   | he need for protection of  |                     |  |           |                            |
|   | the wound bed, the go                               |  |                     |  |           | 1                          |
|   | manufacturer's recomr                               | mendations for product   |                     |  |           |                            |
|   | utilizationWound rou                                | inds are completed weekly  | i i                 |  |           |                            |
|   |   | d complex woundsThe  |                     |  |           |                            |
|   | wound team consists o                               |  |                     |  |           |                            |
|   | licensed nurse, and nur                             |  | 1                   |  |           |                            |
|   | director of nursing, med                            |  |                     |  |           |                            |
|   | rehabilitation team men                             | Ü  | 1                   |  |           | ſ                          |
|   | dietitian may participate                           | e in wound rounds if   | 100                 |  | 10        |                            |

PRINTED: 03/08/2022 FORM APPROVED

| CENT                     | CK3 LOV MEDICAKI                       | E & MIEDICVID SEKAICES  |                     |        |   | OMB N  | O 0938 039                 |
|--------------------------|--|---|---------------------|--------|---|--------|----------------------------|
|                          | INT OF DEFICIENCIES<br>N OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:                            | (X2) MUL<br>A BUILD |        | CONSTRUCTION  |        | OMPLETED                   |
|                          |  | 495283  | B WING              |        | 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0   | 1      | C<br>2/25/2022             |
| NAME O                   | F PROVIDER OR SUPPLIER                 |   |                     | STI    | REET ADDRESS, CITY, STATE, ZIP CODE   | 1 0    | LILOILOLL                  |
|                          |  |   |                     |        | 19 BELLEVUE AVENUE  |        |                            |
| PROME                    | EDICA SKILLED NURS                     | NG AND REHAB (IMPERIAL)   | - 1                 |        |   |        |                            |
|                          |  |   |                     | RIC    | CHMOND, VA 23227  |        |                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)                       | TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION) | ID<br>PREFIX<br>TAG | (      | PROVIDER'S PLAN OF CORREC<br>(EACH CORRECTIVE ACTION SHO<br>CROSS-REFERENCED TO THE APPR<br>DEFICIENCY) | ULD BE | (XS)<br>COMPLETION<br>DATE |
| F 686                    | Continued From page                    |   | F 68                | ne.    |   |        |                            |
| , 000                    |  | _   | F 00                | 30     |   |        |                            |
|                          |  | ounds should be held on a   |                     |        |   |        |                            |
|                          |  | e week and time of day to   |                     |        |   |        |                            |
|                          |  | evaluated no less often than  |                     |        |   |        |                            |
|                          |  | he wound team is to provide   |                     |        |   |        |                            |
|                          |  | oing management and   |                     |        |   |        |                            |
|                          |  | re injuries and complex   |                     |        |   |        |                            |
|                          |  | wound etiology, selecting   |                     |        |   |        |                            |
|                          |  | atment strategies and   |                     |        |   |        |                            |
|                          | evaluation and revisi                  | on of the patient specific plan   |                     |        |   |        |                            |
|                          | of care. One member                    |   |                     |        |   |        |                            |
|                          |  | valuations in a Pressure  |                     | 1      |   |        |                            |
| ,                        | Ulcer Weekly Note in                   |   |                     | 110.00 |   |        |                            |
| ī                        | Skin/wound application                 | on of PCC (if enabled).   |                     |        |   |        |                            |
|                          |  | ld include wound location,  |                     |        |   |        |                            |
|                          | etiology, presence of                  | exudate/odor, tissue type,  |                     |        |   |        |                            |
| +                        | measurements, pres-                    | ence of undermining or  |                     | 1      |   |        |                            |
|                          | tunneling, description                 | of peri-wound, PUSH   |                     |        |   |        |                            |
| 1                        | score, indications of p                | pain or infection, notifications  |                     |        |   |        |                            |
|                          |  | r and patient/responsible   |                     |        |   |        |                            |
|                          | party, education provi                 | ded and any changes in  |                     |        |   |        |                            |
| , 1                      | treatment or care plar                 | interventionsThe  |                     |        |   |        |                            |
|                          | individualized compre                  |   |                     |        |   |        | 200                        |
|                          |  | anagement program, the  |                     | i.     |   |        | **                         |
|                          |  | d treatment, individualized   |                     |        |   |        | 5-1                        |
|                          |  | ss the patient's specific risk  |                     |        |   |        |                            |
| f                        | actors and the plan fo                 | or reduction of risk"   |                     |        |   |        |                            |
|                          | •                                      |   |                     |        |   |        |                            |
| 1 1                      | 00 0104100 -t 4:45 Day                 | L ACA444 ACA440   |                     |        |   |        | J                          |
|                          |  | I, ASM #1, ASM #2, and  |                     |        |   |        |                            |
|                          | SM #3 (Administrativ                   |   |                     |        |   |        |                            |
| A                        | aministrator, Director                 | of Nursing, and Regional  |                     | i.     |   | 3.9    | 1                          |
|                          |  | pectively, were made  |                     |        |   |        | }                          |
|                          |  | No further information was  |                     |        |   | -      |                            |
| p                        | rovided by the end of                  | the survey.   |                     |        |   |        |                            |
| - 1                      |  | -   |                     |        |   | 1      | 1                          |
| R                        | eferences:                             |   | 1                   |        |   | - 1    | -                          |
| - 5                      |  |   | 1                   |        |   | F      |                            |
|                          |  | Department of Health and 🗼  | 1                   |        |   | 1      |                            |
| Hz                       | uman Services Public                   | Health Service Agency   | - 1                 |        |   |        |                            |

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER   | (X2) MULTIPLE<br>A BUILDING                       | CONSTRUCTION   | (X3) DATE SURVEY<br>COMPLETED | × |
|--|--|---|--|-------------------------------|---|
|  | 495283   | B WING  |  | C<br>02/25/2022               |   |
| NAME OF PROVIDER OR SUPPLIED PROMEDICA SKILLED NURS  | SING AND REHAB (IMPERIAL)  | 171   | REET ADDRESS, CITY, STATE, ZIP CODE<br>19 BELLEVUE AVENUE<br>CHMOND, VA 23227                                |                               |   |
| PREFIX (EACH DEFICIENCE  | ATEMENT OF DEFICIENCIES<br>OF MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)   | ID<br>PRĒFIX<br>TAG                               | PROVIDER'S PLAN OF CORRECTI<br>(EACH CORRECTIVE ACTION SHOUL<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY) | DBE COMPLETION                | Z |
| Practice Guidelines<br>Ulcers, Number 15   | age 75 licy and Research, Clinical s, Treatment of Pressure an AHCPR Publication No. The Clinical Practice   | F 686   |  |                               |   |
| revealed in part the<br>regarding pressure<br>Assessment of pres<br>toward healing sho             | ssure sore healing. Progress<br>ald be evaluated weekly. If  | E)  |  |                               |   |
| (e.g. during daily dreases them should Reassessment of Tof Adherence. If the                       | oration are observed sooner essing changes), steps to d be taken immediately. 9, reatment Plan and evaluation e ulcer is not healing, the ess the treatment plan and | \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ - |  |                               |   |
| determine whether in particular the clinician tissue load manager evaluate the extent of           | t is being followed. In<br>in should assess whether<br>ment is adequate and should<br>of adherence to cleansing  | •   |  | \$                            |   |
| uniformly described  | ssure ulcers should be to facilitate communication ensure adequate monitoring rd healing."   |   |  | n<br>E                        |   |
| damage to the skin a usually over a bony p   | A pressure injury is localized nd underlying soft tissue rominence or related to a ce. The injury can present  | į.  |  | :                             |   |
| painful. The injury occ<br>and/or prolonged pre-<br>combination with she<br>tissue for pressure an | curs as a result of intense ssure or pressure in ar. The tolerance of soft d shear may also be   | 2   |  |                               |   |
| affected by microclims<br>co-morbidities and co<br>Information obtained f<br>https://cdn.ymaws.cor | ate, nutrition, perfusion,<br>notition of the soft tissue.<br>from<br>n/npiap.com/resource/resm  |   |  |                               |   |
| gr/online_store/npiap_   | pressure_injury_stages.pdf   | į.  |  |                               |   |

| CLATEMENT OF DESIGNATIO  | 1   |               |  | OMB NO. 0938-03  |
|--|---|---------------|--|------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:                             | F             | E CONSTRUCTION   | (X3) DATE SURVEY |
|  |   | A BUILDING    |  | COMPLETED        |
|  | 495283  | B WING        |  | C                |
| NAME OF PROVIDER OR SUPPLIE  |   |               | TOSSY ADDRESS OF A DESCRIPTION OF THE PROPERTY ADDRESS | 02/25/2022       |
|  |   | 1             | TREET ADDRESS, CITY, STATE, ZIP CODE   |                  |
| PROMEDICA SKILLED NUR  | SING AND REHAB (IMPERIAL)   | l _           | 719 BELLEVUE AVENUE  |                  |
| (VALID STRAMADY S  | TATEMENT OF BEGINSTON   |               | ICHMOND, VA 23227  |                  |
| PREFIX (EACH DEFICIENT   | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROVIDENCY)  | D BE COMPLETION  |
| E 686 Continued From   | 7.0   |               |  |                  |
| F 686 Continued From p   |   | F 686         |  |                  |
| 2. Stage 2 Pressu  | ire Injury: Stage 2 Pressure  |               |  |                  |
| Injury: Partial-thick  | ness skin loss with exposed   |               |  |                  |
| dermis The wound   | kness loss of skin with expose<br>I bed is viable, pink or red,                   | ed            |  |                  |
| minist and may ale   | o present as an intact or   |               |  |                  |
| ruptured serum-fille   | ed blister. Adipose (fat) is not  |               |  |                  |
| visible and deeper   | tissues are not visible.  |               |  |                  |
| Granulation tissue,  | slough and eschar are not   |               |  |                  |
| present. These inju  | ries commonly result from   |               |  |                  |
| adverse microclima   | ite and shear in the skin over  |               |  |                  |
| the pelvis and shea  | r in the heel. This stage   |               |  |                  |
| should not be used   | to describe moisture  | 1             |  |                  |
| associated skin dan  | nage (MASD) including   |               |  |                  |
| interfricipous derma   | ated dermatitis (IAD),  |               |  |                  |
| related skin injury /N   | litis (ITD), medical adhesive MARSI), or traumatic wounds                         |               |  |                  |
| (skin tears, burns, al   | brasions)   |               |  |                  |
| Information obtained   | f from  | 1             |  |                  |
|  | om/npiap.com/resource/resm  |               |  |                  |
| gr/online_store/npiap  | pressure injury stages pdf  |               |  | (4)              |
| 9  |   |               |  |                  |
| 3 Skin Prep - "A liq   | uid protective barrier wipe   |               |  | ſ                |
| designed to form pro   | tective film to reduce friction   | 1             |  | ļ                |
| skin for drainens tube   | es and films as well as prep  |               |  | 1                |
| surrounding ostomy s   | es, external catheters,   |               |  | 50               |
| formulated to help ski   | in breathe so tape and film   |               |  |                  |
| adheres better indicat   | ted for use on intact skin  | 72.           |  | · ·              |
| only."   | 131 doo on anact skin   | -11           |  | 83               |
| Information obtained f   | from  |               |  |                  |
| https://www.medline.c  | om/jump/product/x/Z05-PF  |               |  |                  |
| 32716#mrkDocument  | ation   | 7             |  |                  |
| 1  |   | 7             |  | 4                |
| 4. "Alginate wound dro   | essings are non-woven,  | i i           |  | 37               |
| non-adnesive pads and  | d ribbons composed of   | 1             |  |                  |
| from seawood Op can  | fibers or xerogel derived   | i.            |  | 11               |
| dressings form a project   | tact with exudate, these gel through a process of                                 | 1             |  |                  |
| ion exchange. They are   | soft and conformable  | 1             |  |                  |
| and the same of th | TITLE TO CONTOURNABLE,  | 10            |  |                  |

#### PRINTED: 03/08/2021 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A BUILDING COMPLETED С 495283 B. WING 02/25/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1719 BELLEVUE AVENUE PROMEDICA SKILLED NURSING AND REHAB (IMPERIAL) RICHMOND, VA 23227 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREEIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) F 686 Continued From page 77 F 686 easy to pack, tuck or apply over irregular-shaped wounds. Indicated for wounds with moderate to heavy exudate, such as pressure ulcers, infected wounds and venous insufficiency ulcers. Alginates generally require a secondary dressing." Information obtained from https://www.woundsource.com/product-category/ dressings/alginates 5. Optifoam dressing - "Optifoam® Adhesive is a hydropolymer, adhesive foam island dressing that is waterproof and has a high fluid-handling capacity. Improved thin film backing for longer wear time." Information obtained from https://www.woundsource.com/product/optifoamadhesive 6. Venelex ointment - is used to promote wound healing and the treatment of decubitus ulcers, varicose ulcers and dehiscent wounds. Information obtained from https://www.drugs.com/pro/venelex-ointment.html 2. For Resident #4, the facility staff failed to

FORM CMS-2567(02-99) Previous Versions Obsolete

completed.

evidence that physician ordered treatments were

Resident #4 was admitted to the facility on 6/19/14 and was discharged on 8/8/21. Resident #4 had the diagnoses of but not limited to multiple sclerosis, peripheral vascular disease, and pressure injury. On the most recent MDS (Minimum Data Set) a quarterly assessment with an ARD (Assessment Reference Date) of 6/1/21, the resident scored a "99" out of 15 on the BIMS

Event ID:9GY111

Facility ID: VA0154

If continuation sheet Page 78 of 158

| DEPAI<br>CENTI                                    | RTMENT OF HEALTH   | AND HUMAN SERVICES  & MEDICAID SERVICES   |                     |   | FORM    | )_ 03/08/202;<br>AAPPROVE(          |
|---|--|---|---------------------|---|---------|-------------------------------------|
| STATEME   | NT OF DEFICIENCIES<br>FOR CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER  | (X2) MULTIF         | PLE CONSTRUCTION  | (X3) DA | 0_0938-0391<br>TE SURVEY<br>MPLETED |
|   |  | 495283  | B WING              | - State of the st | 02      | C<br>/25/2022                       |
| NAME OF   | PROVIDER OR SUPPLIER   |   |                     | STREET ADDRESS, CITY, STATE, ZIP CODE   | 1 02    | IZGIZUZZ                            |
| PROME   | PROMEDICA SKILLED NURSING AND REHAB (IMPERIAL)   |   |                     | 1719 BELLEVUE AVENUE<br>RICHMOND, VA 23227  |         |                                     |
| (X4) ID<br>PREFIX<br>TAG                          | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL. C IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORREC<br>(EACH CORRECTIVE ACTION SHOI<br>CROSS-REFERENCED TO THE APPR<br>DEFICIENCY)  | ULD BE  | (X5)<br>COMPLETION<br>DATE          |
| F 686   | Continued From page  | ge 78   | F 686               |   |         | 6                                   |
|   |  | ental status), indicating the   | 1 000               |   | •       |                                     |
|   | resident was unable<br>cognitive status due<br>impaired for making   | to complete the interview for<br>to being severely cognitively<br>daily decisions. The resident<br>a Stage 3 pressure injury.   |                     |   |         |                                     |
| ,<br>,  | "MASD (moisture ass<br>sacrum, coccyx, bilate<br>scar tissue noted. Re<br>Inferior sacrum 0.2cm                                | d 6/14/21 documented, sociated dermatitis) noted to eral buttocks, with 100% exident is a healing Stage 3. (centimeters) x0.2cm erior sacrum 2.0cm x 1.5cm enoted to inferior and anulation."   | 4                   |   |         |                                     |
| s<br>i ti<br>i ir                                 | Wound rounds perfor<br>acrum, coccyx, bilate<br>ssue noted, Resident<br>oferior sacrum 0.2cm<br>0.1cm, Superior inferi         | ral buttocks with 100% scar<br>is a healing Stage 3.<br>(centimeter) x (by) 0.2cm<br>or sacrum 2.0 cm x 1.5cm   | 4                   |   |         |                                     |
| sa<br>no<br>rig                                   | oted the same. DTI (d<br>ght foot. Area measur   | noted to inferior and<br>hulation. Measurements<br>leep tissue injury) noted to<br>es 2cm x 3cm. Area is<br>e new order for skin prep."   |                     |   |         |                                     |
| "W<br>da<br>res<br>pre<br>the<br>Me<br>are<br>sur | ughters [name] and [redents wounds (sacrue) wentative measures as sacrum being a heal asurements were gives. Resident has a fo | er spoke with residents name] concerning the um and right foot), are in place. The status of ing stage 3 as well as en to daughters for both allow-up with the vascular am [address]. Daughters |                     | <b>∵</b>  |         |                                     |

resident with cushion for bony predominance of

|   | STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  | 201                 | PLE CONSTRUCTION  | (X3) DATE SURVE<br>COMPLETED |      |  |
|---|--|--|---------------------|---|------------------------------|------|--|
| ĺ |  |  | A BUILDING          | ,   | С                            |      |  |
| I |  | 495283   | B. WING             | 02/25/2022  | 2                            |      |  |
|   | NAME OF PROVIDER OR SUPPLIER PROMEDICA SKILLED NURSI   | NG AND REHAB (IMPERIAL)  |                     | STREET ADDRESS, CITY, STATE, ZIP CODE<br>1719 BELLEVUE AVENUE<br>RICHMOND, VA 23227                     |                              |      |  |
|   | PRÉFIX (EACH DEFICIENCY  | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORREC<br>(EACH CORRECTIVE ACTION SHO<br>CROSS-REFERENCED TO THE APPR<br>DEFICIENCY) | ULD BE COMPLE                | TION |  |
|   | to prevent bruising. Meeting be held nea Manager to follow-up These notes evidence wound in addition to was being treated, a (addressed separate  A review of the clinical following order: "6/14 normal saline, apply and puracol (2) plus to dry protective dressing   | gs meet her w/c (wheel chair) Requesting that a Care Plan ir the end of July. Unit in with the Social Worker."  The the presence of a Stage 3 MASD for which the resident is well as the foot wound ity).  The the presence of a Stage 3 MASD for which the resident is well as the foot wound ity).  The the presence of a Stage 3 MASD for which the resident is well as the foot wound ity).  The the the presence of a Stage 3 MASD for which the resident is well as the foot wound ity). | F 686               |   |                              |      |  |
|   | A review of the June 2 (Medication Administration Record documentation that the day shift on 6/17/21, of 6/18/21, evening shift shift on 6/20/21, day sfo/24/21, and night shift on 2/24/22 at 10:35 A conducted with LPN # Nurse). When asked blank on the MAR or T means it wasn't done. [name of electronic hears and conducted with the cond | 2021 MAR and TAR ation Record and Treatment d) revealed there was no is order was completed on lay evening or night shift on on 6/19/21, day or evening hift on 6/24/21, day shift on it on 6/25/21.  M an interview was 1 (Licensed Practical what it means if areas were AR, he stated, "That  |                     |   |                              |      |  |
|   |  | e MAR and TAR and LPN<br>it, sporadically, the wound   |                     |   |                              |      |  |

| <br>······································  |   |                    |  | OND IV                            | O. 0000"008                   |  |
|---|---|--------------------|--|-----------------------------------|-------------------------------|--|
| TATEMENT OF DEFICIENCIES<br>ND PLAN OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   | (X2) MU<br>A BUILI | ULTIPLE CONSTRUCTION<br>DING   | (X3) D                            | (X3) DATE SURVEY<br>COMPLETED |  |
|   | 495283  | B. WING            | 3  |                                   | C                             |  |
| NAME OF PROVIDER OR SUPPLIER PROMEDICA SKILLED NURSI  | NG AND REHAB (IMPERIAL)   | -1,                | STREET ADDRESS, CITY, STATE, Z<br>1719 BELLEVUE AVENUE<br>RICHMOND, VA 23227 |                                   | 2/25/2022                     |  |
| PREFIX (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION]   | ID<br>PREFI<br>TAG |  | TION SHOULD BE<br>THE APPROPRIATE | (X5)<br>COMPLETION<br>DATE    |  |
| F 686 Continued From page   | ge 80   | F 6                | 586  |                                   |                               |  |
| Foot wound:   |   |                    |  |                                   |                               |  |
| A review of the clinic following:   | cal record revealed the   |                    |  |                                   | i                             |  |
| "Writer in to do dress CNA (Certified Nursi resident had an area assessment noted th is spongy in center to toe area cleanse with prep applied RP (res (nurse practitioner) n evaluate and treat."  - Another nurses' not documented, "RP not right leg and that mai wheelchair and will fix ultrasound of right leg [name of X-ray Comp  - Another nurses' note documented, "NP (nur | nat there was a dark area that oright foot just below great wound cleanse and skin ponsible party) and NP otified wound nurse to e dated 6/16/21 dified of arterial ultrasound of intenance looked at at it. Claim number for its [number] and called to any]." |                    |  |                                   |                               |  |
| yesterday and Dr (door<br>recommendation for a<br>Daughters are in agree<br>appointment. Facility to<br>Dr [name] office for firs   | h Resident's daughters terial Doppler performed tor) [name] vascular consult. ement with the p set up appointment with  |                    |  |                                   |                               |  |

### DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 03/08/2022 FORM APPROVED OMB NO: 0938-0391

|   | CENTERS FOR MEDICAR   | <u>E &amp; MEDICAID SERVICES</u>  |                      |      |  | OMB     | NO.0938-039                |
|---|---|---|----------------------|------|--|---------|----------------------------|
| ĺ | STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   | (X2) MUL<br>A BUILDI |      | CONSTRUCTION   |         | DATE SURVEY<br>COMPLETED   |
|   |   | 495283  | B WING               |      |  |         | C<br>02/25/2022            |
| ĺ | NAME OF PROVIDER OR SUPPLIER  |   |                      | STR  | REET ADDRESS, CITY, STATE, ZIP CODE  | 87      |                            |
| ı |   |   |                      | 171  | 9 BELLEVUE AVENUE  |         |                            |
| ľ | PROMEDICA SKILLED NURS  | ING AND REHAB (IMPERIAL)  |                      | RIC  | :HMOND, VA 23227   |         |                            |
|   | PREFIX (EACH DEFICIENC)   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG  |      | PROVIDER'S PLAN OF CORREC<br>(EACH CORRECTIVE ACTION SHO<br>CROSS-REFERENCED TO THE APP<br>DEFICIENCY) | DULD BE | (XS)<br>COMPLETION<br>DATE |
|   | little blood flow. Per is related to periphe Prevalon boot for prevalon boot for prevalon boot for prevalon boot for prevalon boot for prevalon boot for prevalon boot for prevalon boot for prevalon between that was noted yested open blister measur with no drainage. Confiscomfort and exact discomfort for the clinic ultrasound result data "DUPLEX LOWER EUNILATERAL, RIGH Extremity Arterial Ducomplex plaquing. All obtained. No flow was from the proximal fer lower extremity. Mild within distal femoral apedis artery. Visualize waveforms. Pieces stas follows: common from the proximal fer safellows: common from the prevalence of the | ote dated 6/17/21 ial study to right leg showed NP (nurse practitioner) area iral vascular disease. Pt has revention."  ress note dated 6/17/21 being seen today per nursing wound to ball of right foot erday. Wound is a purple ing 2cm (centimeter) by 3cm ordition associated with mild erbated by peripheral artery  al record revealed an ed 6/16/21 that documented: EXTREMITY ARTERIAL T: FINDINGS: Right Lower plex Ultrasound: there is nkle brachial index was not s generally demonstrated moral artery through the flow was demonstrated artery and within dorsalis ed arteries had monophasic colid velocities in cm/sec are emoral 147, profunda foral 6, dorsalis pedis 30. | F 68                 | . 66 |  |         |                            |
|   | demonstrates little blo<br>flow at the dorsalis pe<br>collaterals."   | ood flow. There was some dis artery, likely from results evidenced presence   |                      |      |  |         |                            |
|   |   |   | ,                    |      |  |         |                            |

Wound care of foot:

|   |  | WINEDID/NO OCITYTOLO   |                    |          |  |         | VID IVO, U                    | 1220-039                   |  |
|---|--|--|--------------------|----------|--|---------|-------------------------------|----------------------------|--|
|   | STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER   | (X2) MU<br>A: BUIL |          | CONSTRUCTION   |         | (X3) DATE SURVEY<br>COMPLETED |                            |  |
|   |  | 495283   | B. WING            | 3        |  |         | C                             |                            |  |
| l   |  | 455205   | D. ***             | <u> </u> |  |         | 02/25                         | /2022                      |  |
|   | NAME OF PROVIDER OR SUPPLIER PROMEDICA SKILLED NURSI   | NG AND REHAB (IMPERIAL)  |                    | 1719     | EET ADDRESS, CITY, STATE, ZIP CODE<br>9 BELLEVUE AVENUE<br>CHMOND, VA 23227                          | E       |                               |                            |  |
| (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) |  |  | ID<br>PREF<br>TAG  |          | PROVIDER'S PLAN OF CORRE<br>(EACH CORRECTIVE ACTION SH<br>CROSS-REFERENCED TO THE APP<br>DEFICIENCY) | IOULD E | BE (                          | (X5)<br>COMPLETION<br>DATE |  |
|   | following:  - A physician's order area to bottom right and apply skin prepicare." A review of the revealed there was recompleted on day shor night shift on 6/18, day or evening shift of 6/24/21, and day shift in A physician's order skin prepievery shift review of the July 202 there was no docume         | dated 6/16/21 for "Clean foot with NS (normal saline) (3) q (every) shift for wound e June 2021 MAR and TAR to documentation that it was ift on 6/17/21, day, evening /21, evening shift on 6/20/21, day shift on  | F                  | 686      |  |         |                               |                            |  |
|   | Ointment 250 unit/graright foot topically ever (Monday), Wed (Wed wound, clean with NS with foam dressing."  MAR and TAR revealed documentation it was 7/21/21, and 7/23/21.  On 2/24/22 at 10:35 Arconducted with LPN # Nurse). When asked blank on the MAR or The means it wasn't done. [name of electronic he | dated 7/14/21 for "Santyl (4) m (Collagenase). Apply to my day shift every Mon nesday), Fri (Friday) for apply Santyl and cover A review of the July 2021 and there was no completed on 7/16/21,  M an interview was 1 (Licensed Practical what it means if areas were TAR, he stated, "That |                    |          |  |         |                               |                            |  |

|                          | IT OF DEFICIENCIES<br>OF CORRECTION                                       | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | (X2) MUL<br>A. BUILD |         | CONSTRUCTION   |      | DATE SURVEY                |
|--------------------------|---|--|----------------------|---------|--|------|----------------------------|
|                          |   | 495283   | B WING               |         |  | 1.   | C<br>02/25/2022            |
|                          | PROVIDER OR SUPPLIER  | ING AND REHAB (IMPERIAL)   |                      | 1719    | EET ADDRESS, CITY, STATE, ZIP CODE<br>9 BELLEVUE AVENUE<br>HMOND, VA 23227                                     |      | TETESTEORE                 |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFII<br>TAG  | (       | PROVIDER'S PLAN OF CORRECTIC<br>(EACH CORRECTIVE ACTION SHOUL<br>CROSS-REFERENCED TO THE APPROF<br>DEFICIENCY) | D BE | (XS)<br>COMPLETION<br>DATE |
| F 686                    | Continued From pa   |  | F 6                  | 86      |  |      |                            |
|                          |   | of the MAR and TAR and LPN I that, sporadically, the wound   |                      |         |  |      |                            |
|                          | A review of the comrevealed the following                                 | prehensive care plan<br>ng:  |                      |         |  |      |                            |
|                          | alteration in skin into<br>mobility, altered cog                          | 12/3/14 for "At risk for egrity related to: impaired nition, MS (multiple sclerosis) This care plan included the                         |                      |         |  |      |                            |
|                          | intervention, dated 3 treatment per physic                                | 2/20/20, for "Administer<br>dian orders."  |                      | Į.      |  |      | ž                          |
| 1                        | sacrum related to: in<br>incontinence, nutrition<br>included the interver | 3/1/21 for "Open area at the npaired mobility, and deficit." This care plan stion, dated 3/1/21, for at per physician orders."           |                      | is<br>1 |  |      | 8                          |
| r                        | ight foot." This care   | 16/21, for "Administer   |                      |         |  |      |                            |
| A<br>A<br>C<br>a         | ASM #3 (Administrati<br>Administrator, Directo<br>Quality Consultant, re  | M, ASM #1, ASM #2, and ve Staff Member) the or of Nursing, and Regional espectively, were made No further information was of the survey. |                      |         |  |      |                            |
| С                        | OMPLAINT DEFICI   | ENCY   |                      |         |  |      |                            |
| R                        | eferences:  |  |                      |         |  |      | 1                          |
| id                       | eal for wound dressi  | s are in many respects<br>ngs. When applied to dry<br>oughing or necrotic wounds,  |                      |         |  |      |                            |

|                          | NT OF DEFICIENCIES<br>FOR CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  | (X2) MUL            | TIPLE CONSTRUCTION   | (X3) DATE SUI<br>COMPLET | RVEY<br>ED               |
|--------------------------|--|---|---------------------|--|--------------------------|--------------------------|
|                          |  | 495283  | B WING              |  | C                        | ທາງ                      |
|                          | PROVIDER OR SUPPLIER   | NG AND REHAB (IMPERIAL)   |                     | STREET ADDRESS, CITY, STATE, ZIP<br>1719 BELLEVUE AVENUE<br>RICHMOND, VA 23227               | 02/25/2<br>CODE          | .022                     |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)  | ID<br>PREFI)<br>TAG | PROVIDER'S PLAN OF CO<br>X (EACH CORRECTIVE ACTION<br>CROSS-REFERENCED TO THE<br>DEFICIENCY) | NI SHOULD BE CON         | (X5)<br>IPLETION<br>DATE |
| f a collinh 3            | tissue via autolysis. wound warm, moist, react with or irritate to not adhere to wound metabolites to pass provide a cooling effi- makes them very plo Information obtained https://www.news-me essings.aspx  2. "Puracol is a prim drainage types. Pura- material that converts in contact with wound Puracol features 100 helps restore chemica absorbent collagen sl moisture, and gel she wound bed as it abso Information obtained https://www.allegrome collagen-microscaffol 3. Skin Prep - "A liquid designed to form prote during removal of tape skin for drainage tube surrounding ostomy si formulated to help skin adheres better indicate only." Information obtained formation obtained for | keep them clean by val of infected or necrotic Hydrogel dressings keep the and close. Also, they do not issue. When applied, they do surfaces and allow freely. These dressings help ect on the wound, which issant for patients." from edical net/health/Hydrogel-Dressing for all col is highly absorbent is to soft, gel sheet that stays labed as it absorbs exudate. We pure native collagen, at balance in the wound bed, neets manage wound et stays in contact with rise exudate. "From edical.com/products/puracold-wound-dressing/"  d protective barrier wipe ective film to reduce friction is and films as well as prepose, external catheters, tes and adhesives in breathe so tape and film end for use on intact skin tom orm/jump/product/x/Z05-PF etion | F 68                | 86   |                          |                          |

| OLIVICIO I OIL MEDIONIA  | E & MEDIONID SERVICES  |                     |     |   | CINID IA | <u>O. 0938-03</u>          |
|--|--|---------------------|-----|---|----------|----------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION            | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  | (X2) MUL<br>A BUILD |     | CONSTRUCTION  |          | ATE SURVEY<br>DMPLETED     |
|  | 495283   | B_WING              |     |   | 1 0      | C<br>2/25/2022             |
| NAME OF PROVIDER OR SUPPLIER                                   |  |                     | STR | REET ADDRESS, CITY, STATE, ZIP CODE   |          | EILDIZUZZ                  |
| 127  |  | - 1                 |     | 9 BELLEVUE AVENUE   |          |                            |
| PROMEDICA SKILLED NURS   | ING AND REHAB (IMPERIAL)   | - 1                 | RIC | CHMOND, VA 23227  |          |                            |
| PRÉFIX (EACH DEFICIENC)  | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG |     | PROVIDER'S PLAN OF CORRECTIV<br>(EACH CORRECTIVE ACTION SHOUL<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY) | D BE     | (X5)<br>COMPLETION<br>DATE |
| F.000 0 44   |  |                     | •   |   |          |                            |
| F 686 Continued From pa  |  | F 68                | 36  |   |          |                            |
| dermal ulcers and s  | ated for debriding chronic<br>severely burned areas."<br>d from https://santyl.com/hcp   |                     |     |   |          |                            |
|  | o promote healing of a   | 7                   |     |   |          |                            |
| pressure ulcer for R   | esident #11.   |                     |     |   |          |                            |
| quarterly assessment reference date) of 13 scored 15 out of 15 | MDS (minimum data set), a not with an ARD (assessment 2/15/2021, the resident on the BIMS (brief interview adicating the resident is |                     |     |   |          |                            |
| cognitively intact for<br>Section M document                   | making daily decisions.<br>led Resident #11 being at risk  |                     | ١   |   |          | •                          |
| of developing pressu   | re ulcers but not having any   |                     |     |   |          |                            |
| pressure ulcers durir  | ng the assessment period.  |                     | 13  |   |          |                            |
| On 2/23/2022 at app  | roximately 2:00 p.m., an   |                     |     |   |          |                            |
|  | cled of Resident #11 in her  |                     |     |   |          |                            |
| room. Resident #11   | stated that she had an open  |                     | 1   |   |          | į.                         |
| area on her buttock a  | and that she put cream on  |                     |     |   |          |                            |
| the area that her fam  |  |                     |     |   |          |                            |
| Resident #11 stated t  | hat the physician looked at  |                     | 1   |   |          |                            |
| the area when they ca  | ame in and told the nurses   |                     | 1   |   |          |                            |
|  | Resident #11 stated that   |                     | 1   |   |          |                            |
| some of the nurses of  | ame in to put a cream on   |                     |     |   |          |                            |
|  | re times when no one put   |                     |     |   |          |                            |
| cream on the area an   | or days so she put her own   |                     |     |   |          |                            |
| Resident #11 proceed   | led to show pictures of the  |                     |     |   |          |                            |
| area on her cell phone   | and stated she had asked   |                     |     |   |          | a l                        |
| the nurse to take pictu  | res of the area for her.   |                     |     |   | 5.0      |                            |
|  | nat the nurse had come in to   |                     |     |   |          | ĺ                          |
|  | morning and she had to   |                     |     |   |          |                            |
| show them where it wa  |  |                     |     |   |          |                            |
|  | 511  |                     |     |   |          |                            |
| Resident #11 refused   |  | 54                  |     |   | - 1      |                            |
| wound care to the left.  | buttack wound by survey  | - 1                 |     |   |          |                            |

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| CLITT  | TYO I OIL ME INOVINE   | & MEDICAID SERVICES   |                      |  | OMB NO. 0938-039              |
|--|--|---|----------------------|--|-------------------------------|
|  | OF DEFICIENCIES OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   | (X2) MUL<br>A BUILDI | TIPLE CONSTRUCTION   | (X3) DATE SURVEY<br>COMPLETED |
|  |  | 495283  | B. WING              |  | C<br>02/25/2022               |
|  | PROVIDER OR SUPPLIER   | NG AND REHAB (IMPERIAL)   |                      | STREET ADDRESS, CITY, STATE, ZIP (<br>1719 BELLEVUE AVENUE<br>RICHMOND, VA 23227             |                               |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES<br>'MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG  | PROVIDER'S PLAN OF CO<br>( (EACH CORRECTIVE ACTION<br>CROSS-REFERENCED TO THE<br>DEFICIENCY) | SHOULD BE COMPLETION          |
| F 686  | Continued From pastaff.  | ge 86   | F 68                 | 36   |                               |
|  | (Thursday) for skin of 5/11/2021."  - "Cleanse open are apply skin prep to pegel apply gauze affix (twice a day) and PR Order Date: 1/31/202 for part: "1/31/2022 of noted with 3 x 1.5 x 0 Peri wound has mace No odor present. No cleansed with NS (no orep to peri wound, a to wound bed coveresland dressing. MD   | evening shift every Thu observation. Order Date: a to left buttock, pat dry, ari wound, apply Silva sorb with island dressing BID   |                      |  |                               |
| a<br>  T<br>  2<br>  fo<br>  fo<br>  le<br>  w<br>  is<br>  no<br>  ni<br>  2/<br>  3:<br>  2/<br>  2/ | The eTAR for Resident 1/1/2022-2/28/2022 facillowing treatments by the street buttock, pat dry, a round, apply Silva so stand dressing BID (the dedd) until healed. If the shift for wound cound the shift for wound cound the shift for wound cound to 1/10/2022, 2/11/ | nt #11 dated hiled to evidence the heing administered on the heing administered on the hees: "Cleanse open area to opply skin prep to perior gel apply gauze affix with his wice a day) and prn (as Every evening shift and are." On 2/4/2022, 2/17/2022 at 2, 2/2/2022, 2/6/2022, 2/13/2022, 2/20/2022, 2/20/2022 at 2/20/2022, 2/2/2022 at 2/20/2022, 2/2/2022 at |                      |  |                               |

PRINTED: 03/08/2022 FORM APPROVED

| OEITI EITO I OIT MEDI  | CHILL & MEDICHIO SEN  | ·VICEO  |                    |  | OIMR M                        | <i>).</i> 0938-039         |
|--|---|---|--------------------|--|-------------------------------|----------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION  | (X1) PROVIDER/SUPPL<br>IDENTIFICATION N   | LIMBER ' '                                    | ) MULTIPLE (       | CONSTRUCTION   | (X3) DA                       | TE SURVEY                  |
|  | 495283  | ви  | VING               |  | 0.3                           | C<br>2/25/2022             |
| NAME OF PROVIDER OR SUF  | PLIER<br>IURSING AND REHAB (IMI   | PERIAL)                                       | 1719               | EET ADDRESS, CITY, STATE, ZIP<br>BELLEVUE AVENUE<br>HMOND, VA 23227                        |                               | 12312022                   |
| PREFIX (EACH DEFI  | RY STATEMENT OF DEFICIENCIE<br>CIENCY MUST BE PRECEDED BY<br>Y OR LSC IDENTIFYING INFORM  | Y FULL PF                                     | ID<br>REFIX<br>TAG | PROVIDER'S PLAN OF CO<br>(EACH CORRECTIVE ACTION<br>CROSS-REFERENCED TO THE<br>DEFICIENCY) | ON SHOULD BE<br>E APPROPRIATE | (X5)<br>COMPLETION<br>DATE |
| F 686 Continued Fro  | m page 87   |   | F 686              |  |                               |                            |
| additional wou   | cord failed to evidence and assessments other the dated 1/31/2022.  | an the  |                    |  |                               |                            |
| documented in<br>Date Initiated: (<br>per physician o<br>"Noncompliant   | nsive care plan for Reside<br>part, "Open area left butt<br>01/31/2022Administer<br>rders, Date Initiated: 01/3<br>with smoking, removes deveral times throughout the<br>15/28/2020."                           | tocks,<br>treatment<br>31/2022<br>fressing    |                    |  |                               |                            |
| request was ma<br>member) #2, the  | t approximately 1:00 p.m<br>de to ASM (administrative<br>interim director of nursination<br>of the left buttock   | e staff<br>ng for all                         | C                  |  |                               |                            |
| quality consultar<br>dated 1/31/2022   | 3:45 p.m., ASM #3, the of the provided the progress of the left buttool vas everything that they be   | note<br>k wound                               | :                  |  |                               |                            |
| interview was co<br>director of nursin<br>no wound progra<br>facility. ASM #2<br>facility since 1/24<br>running when she<br>ASM #2 stated th | approximately 3:00 p.m., nducted with ASM #2, the g. ASM #2 stated that the m and no wound nurse a stated that she had been /22 and had a wound program at the nurses were doing the had not had a chance tyet. | e interim nere was at the at the ogram r ago. |                    |  |                               | 1-7                        |
| On 2/24/2022 at conducted with Lf  | 0:35 a.m., an interview v   | vas<br>rse) #1.                               |                    |  |                               |                            |

LPN #1 stated that the care was not provided if it

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CHA<br>IDENTIFICATION NUMBER   | (X2) MULTIPL<br>A, BUILDING | L CONSTRUCTION  | (X3) DATE SURVEY<br>COMPLETED |
|--|---|-----------------------------|---|-------------------------------|
|  | 495283  | B WING                      |   | C                             |
| NAME OF PROVIDER OR SUPPLIER PROMEDICA SKILLED NURSI   | NG AND REHAB (IMPERIAL)   | 17                          | TREET ADDRESS, CITY, STATE, ZIP COU<br>19 BELLEVUE AVENUE<br>CHMOND, VA 23227                       |                               |
| PREFIX (EACH DEFICIENCY  | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)  | PREFIX<br>TAG               | PROVIDER'S PLAN OF CORRI<br>(EACH CORRECTIVE ACTION SE<br>CROSS-REFERENCED TO THE AP<br>DEFICIENCY) | HOULD BE COMPLETION           |
| stated that the physical the responsible part was not completed not aware of Reside treatment to the area stated that at times I them do the treatment do it herself. LPI healing.  On 2/24/2022 at 1:15 conducted with LPN treatments not signed they were not done, should be a progress treatments were not LPN #5 stated that the to administer medical 8:45 p.m. and was or medications to some stated that they did not to Resident #11. | d on the eTAR, LPN #1 dician or nurse practitioner and y were notified if a treatment LPN #1 stated that he was int #11 applying their own a on the left buttock. LPN #1 Resident #11 would have int later in the shift but she did N #1 stated that the area was  5 p.m., an interview was #5. LPN #5 stated that d off on the eTAR meant that LPN #5 stated that there is note documenting why the administered in the record. Itely were pulled over to Unit 1 tions on 2/13/2022 around ally able to administer of the residents. LPN #5 of administer any treatments  p.m., an interview was | F 686                       |   |                               |
| member) #2, the inter<br>#2 stated that if the e <sup>2</sup><br>would assume that it to<br>was not signed as cor<br>that they were working<br>up and running, and we<br>manager to work with  | im director of nursing. ASM ITAR was not signed off they was not done because it impleted. ASM #2 stated g to get a wound program was setting up a new unit her to oversee the wound wound nurse practitioner   |                             |   |                               |
| who would be coming<br>stated that they were a   | in April of 2022. ASM #2 also working to get their the way it needed to be  |                             |   |                               |

|                          | T OF DEFICIENCIES   | (X1) PROVIDER/SUPPLIER/CLIA   | (X2) MUL      | TIPLE CONSTRUCTION  | (X3) DATE SURVEY |
|--------------------------|---|---|---------------|---|------------------|
|                          | OF CORRECTION   | IDENTIFICATION NUMBER   | 1             | NG  | COMPLETED        |
| ļ                        |   |   |               |   | C                |
|                          |   | 495283  | B WING        | 70,000  | 02/25/2022       |
| NAME OF                  | PROVIDER OR SUPPLIER  |   |               | STREET ADDRESS, CITY, STATE, ZIP CODE<br>1719 BELLEVUE AVENUE |                  |
| PROME                    | DICA SKILLED NURSI  | NG AND REHAB (IMPERIAL)   |               | RICHMOND, VA 23227  | 3                |
|                          | C. MALLON OXA   | TENERS OF DESIGIENCIES  |               | PROVIDER'S PLAN OF CORRECTION                                 | N (X5)           |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY  | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | PREFIX<br>TAG | THE PROPERTY OF A CTION CHOOK O                               | BE COMPLETION    |
| F 686                    | Continued From pa   | ae 89   | F 68          | 86  |                  |
| 1 000                    |   | ikin management guidelines"   |               |   |                  |
|                          | documented in part  | "Skin alterations and   |               |   |                  |
|                          |   | e evaluated and documented  |               |   |                  |
|                          |   | se:Using the PUSH<br>ale for Healing) Tool and                              |               |   |                  |
|                          | Skin/wound applical   | tion in PCC (if enabled)  |               |   |                  |
|                          |   | record) weekly by the wound injuries or complex wounds.                     |               |   |                  |
|                          |   | ation record or Skin/wound  |               |   |                  |
|                          | application in PCC (  | if enabled) weekly by the   |               |   |                  |
|                          | licensed nurse for n  | on-pressure injuries"   |               |   |                  |
|                          | On 2/24/2022 at app   | proximately 4:30 p.m., ASM  |               |   |                  |
| ,                        |   | nistrator, ASM #2, the interim  |               | ä   |                  |
|                          | quality consultant we   | nd ASM #3, the regional<br>ere notified of the findings.                    |               |   |                  |
|                          | 165   | on was provided prior to exit.  |               |   | 1                |
|                          | Sufficient Nursing St   |   | F 72          | 25 Tag F725 – Failed to provide Suffic                        | viant            |
|                          | CFR(s): 483,35(a)(1   |   |               | Staffing  | .ieit            |
|                          | §483.35(a) Sufficien  |   |               | 1. Resident # 2 was offered a shower                          | on               |
|                          |   | e sufficient nursing staff with   |               | 2/25/22 and Resident # 11 receive                             |                  |
|                          |   | petencies and skills sets to related services to assure                     |               | shower on 2/25/22. Resident # 1 b                             |                  |
|                          | provide nursing and related services to assure resident safety and attain or maintain the highest |   |               | sugars were reviewed by provider                              | on               |
|                          |   | mental, and psychosocial  |               | 2/25/22. Resident # 10 discharged                             | from             |
|                          |   | sident, as determined by as and individual plans of care                    |               | the center on 2/24/22. 2. The Director of Nursing or designed |                  |
|                          | and considering the   | number, acuity and  |               | reviewed resident's that receive blo                          | e has            |
|                          |   | lity's resident population in   |               | sugars to validate completion and s                           | chower           |
|                          | at §483.70(e).  | facility assessment required  |               | schedules for residents in the center                         | r.,              |
| •                        |   |   |               | 3. The Administrator re-educated the                          | DON              |
|                          |   | cility must provide services  |               | and Scheduler on the facility sched                           |                  |
|                          |   | s of each of the following<br>n a 24-hour basis to provide                  |               | process to meet sufficient staffing l                         | evels            |
| 1                        | nursing care to all re  | sidents in accordance with  |               | each day.   |                  |

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED 03/08/2022 FORM APPROVED

|  | RE & MEDICAID SERVICES   |               |   | CHAILLIA  | <u>. 0938-039</u>          |
|--|--|---------------|---|---|----------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA IDENT/FICATION NUMBER:   | A BUILDING    | CONSTRUCTION  | COV   | E SURVEY<br>MPLE (ED       |
|  | 495283   | B WING        |   |   | C<br>/25/2022              |
| NAME OF PROVIDER OR SUPPLIES   | ₹  | STR           | EET ADDRESS, CITY, STATE, ZIP COR   |   | 2312022                    |
|  |  | - 1           | 9 BELLEVUE AVENUE   |   |                            |
| PROMEDICA SKILLED NUR:   | SING AND REHAB (IMPERIAL)  | í             | HMOND, VA 23227   |   |                            |
| PREFIX (EACH DEFICIENC   | FATEMENT OF DEFICIENCIES  CY MUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION)  | PRÉFIX<br>TAG | PROVIDER'S PLAN OF CORRI<br>(EACH CORRECTIVE ACTION SI<br>CROSS-REFERENCED TO THE AP<br>DEFICIENCY)   | HOULD BE  | (X5)<br>COMPLETION<br>DATE |
| this section, licens (ii) Other nursing p limited to nurse aid §483.35(a)(2) Exce paragraph (e) of th designate a license nurse on each tour This REQUIREME by: Based on resident facility document re and in the course of was determined that provide sufficient st the survey sample, | s:  aived under paragraph (e) of ed nurses; and ersonnel, including but not des.  ept when waived under is section, the facility must ed nurse to serve as a charge  | 1,            | The Administrator or designed nursing staffing 5 times week weeks to validate appropriate staffing are in place. The Addesignee will randomly intervesidents weekly times 4 weekstaff availability. The Admin submit audit findings for revieturther recommendations. The facility's alleged date of will be April 4, 2022. | cly for 4<br>elevels of<br>ministrator of<br>view 5<br>ks regarding<br>distrator will<br>ew and |                            |
| The findings include   | e:   |               |   |   |                            |
|  | failed to provide sufficient<br>ng assistant) staffing to<br>Resident #2.  |               |   |   |                            |
| quarterly assessment reference date) of 1/2 out of 15 on the Emental status), indiction of the cognitively intact for Section G document dependent on staff for limitation in range of lower extremities and On 2/23/2022 at app   | MDS (minimum data set), a ant with an ARD (assessment /22/2022, the resident scored BIMS (brief interview for ating the resident is making daily decisions. Led Resident #2 being totally or bathing, having functional motion to both upper and direquiring a wheelchair. |               |   |   |                            |

| STATEMENT OF DEFICI<br>AND PLAN OF CORRECT  |   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   | (X2) MUL           |      | CONSTRUCTION  |     | DATE SURVEY                |
|---|---|---|--------------------|------|---|-----|----------------------------|
|   |   |   | N BOILE            |      | <del>.</del>  |     | С                          |
|   |   | 495283  | B WING             |      |   | 1 ( | 02/25/2022                 |
| PROMEDICA SKIL  |   | ING AND REHAB (IMPERIAL)  |                    | 1719 | EET ADDRESS, CITY, STATE, ZIP CODE<br>9 BELLEVUE AVENUE<br>HMOND, VA 23227                                      |     |                            |
| PREFIX (EAC   | H DEFICIENCY  | NTEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFI<br>TAG | (    | PROVIDER'S PLAN OF CORRECTIO<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROP<br>DEFICIENCY) | BE  | (X5)<br>COMPLETION<br>DATE |
| receive a had met recently a showers, #2 stated lift to get told her to the Resident at times be staff would to paraple | esident #2 any shower with the sta and verbali, but was st I that the C her out of I hat they do e shower be #2 stated t because the d not take brehensive ted in part, egia. Date hower as r | ge 91 stated that they did not s. Resident #2 stated that she aff and the ombudsman zed wishes to receive ill not getting them. Resident NAs had to use a mechanical bed due to her paralysis, and not have enough time to take ecause they are understaffed, hat she did refuse bed baths bey became angry that the her to the shower.  care plan for Resident #2 "ADL self care deficit related Initiated: 10/18/2021Assist needed. Date Initiated: | F 7                | 25   |   |     |                            |
| 11/1/2021   | -11/30/202°   | survey report dated<br>1 documented "NA" under<br>2/2021 and 11/25/2021.  |                    |      |   |     |                            |
| 12/1/2021-  | -12/31/202<br>ath on 12/1   | survey report dated<br>1 documented "NA" under<br>3/2021, 12/16/2021,<br>0/2021.  |                    |      |   |     |                            |
| 1/1/2022-1<br>Shower/Ba   | /31/2022 dith on 1/9/2  | urvey report dated ocumented "NA" under 022, 1/13/2022, 1/17/2022, and 1/31/2022.   |                    | 1    |   |     |                            |
| 2/1/2022-2/   | /28/2022 do   | urvey report dated<br>ocumented "NA" under<br>022 and 2/7/2022.   |                    |      |   |     |                            |
|   |   | r Resident #2 failed to<br>on of a bed bath or shower   |                    |      |   |     |                            |

|                                       | THO I OIL MEDIOMICE  | O MEDIOMID OFFIAIORO   |                            |   | OIVID 140. 0930-039           |
|---------------------------------------|--|--|----------------------------|---|-------------------------------|
|                                       | T OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER   | (X2) MULTIPL<br>A BUILDING | E CONSTRUCTION  | (X3) DATÉ SURVEY<br>COMPLETED |
|                                       |  | 495283   | B WING                     |   | C                             |
|                                       | PROVIDER OR SUPPLIER   | NG AND REHAB (IMPERIAL)  | S 1                        | TREET ADDRESS, CITY, STATE, ZIP CODE<br>719 BELLEVUE AVENUE<br>RICHMOND, VA 23227                                     | 02/25/2022                    |
| (X4) ID<br>PREFIX<br>TAG              | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG        | PROVIDER'S PLAN OF CORRECTIVE ACTION SHO<br>(EACH CORRECTIVE ACTION SHO<br>CROSS-REFERENCED TO THE APP<br>DEFICIENCY) | OULD BE COMPLETION            |
| F 725                                 | Continued From pa  | -  | F 725                      |   |                               |
|                                       | received on the date   | es listed above.   |                            |   |                               |
| 81                                    | 2022 revealed one (  | orked schedules for January<br>CNA scheduled for Unit 1 on<br>2, 1/2/2022, 1/10/2022,  |                            |   |                               |
| 2                                     | two CNAs schedule  | 2022. It further documented d for day shift on 1/17/2022, 2, 1/24/2022 and 1/29/2022.  |                            |   |                               |
|                                       | 2022 at the facility re  | rked schedules for February<br>evealed one CNA scheduled<br>ft for 2/5/2022 and 2/6/2022.  |                            |   |                               |
| 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 | conducted with CNA CNA #1 stated that the condition of th | D p.m., an interview was #1, staffing coordinator. hey had been in the position ill learning the scheduling. hey used a combination of acy staff to staff the building, hey worked with the director te the schedule. CNA#1 not had any shortages and a staff walking out. CNA#1 |                            |   |                               |
| e<br>v<br>a<br>n<br>#                 | CNAs on each unit or<br>each unit on evening<br>unit on night shift. Ch<br>vorked on the unit pro<br>and had never had ar<br>not complete their sho<br>to stated that they ha  | or staffing was to have five in day shift, five CNAs on shift, and 3 aides on each NA #1 stated that they it ior to entering this position may instance where they could lowers due to staffing. CNA in ot heard any other CNAs hey could not provide care                       |                            |   |                               |
| Li<br>al                              | onducted with LPN (I<br>PN #1 stated that he<br>bout three weeks, an   | 5 a.m., an interview was licensed practical nurse) #1. had been at the facility for d Resident #2 did not go to stated that as far as he   |                            |   |                               |

| CITIAI                   | ELLO LOLLIMEDICAL  | E & MEDICAID SERVICES  | ,                   |           |  | OIND IN  | <i>.).</i> 0938-038        |
|--------------------------|--|--|---------------------|-----------|--|--|----------------------------|
|                          | ENT OF DEFICIENCIES<br>N OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  | (X2) MUL'           |           | CONSTRUCTION   |  | TE SURVEY<br>MPLETED       |
|                          |  | 495283   | B. WING             |           |  | 02   | C<br>2/25/2022             |
|                          | F PROVIDER OR SUPPLIER<br>EDICA SKILLED NURS   | ING AND REHAB (IMPERIAL)   |                     | 1719      | EET ADDRESS, CITY, STATE, ZIP CODE<br>9 BELLEVUE AVENUE<br>HMOND, VA 23227                                     |  |                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC  | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG |           | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOUL<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY) | D BC   | (X5)<br>COMPLETION<br>DATE |
| F 725                    | they worked the ever facility. LPN #1 states when they had one shift. LPN #1 states CNA for the night shad never worked witmes, the schedule they were never the   | eference. LPN #1 stated that tening and day shift at the ted that they were lucky to in Unit 1, and there were shifts or two CNAs for the entire day do that they normally had one offt. LPN #1 stated that they with six CNAs on a unit, and at said they had that many but | F 72                | 25        |  |  |                            |
|                          | conducted with CNA worked day shift and #3 stated that "NA" of shower/bath on the limeant not applicable shower/baths were a and should have been that the goal was to liday shift but if they we CNA #3 stated they have only one CNA of that they felt like they and other times felt li | 4.43. CNA #3 stated that they in ight shift as needed. CNA   |                     |           |  |  |                            |
|                          | conducted with ASM member) #2, the inter #2 stated that the goaday shift, 10 on eveni ASM #2 stated that thon the weekends but  On 2/24/2022 at 3:12 conducted with CNA #  | p.m., an interview was (administrative staff rim director of nursing. ASM al was to have 11 CNAs on ng shift and 6 on night shift. ley were still having trouble staffing was getting better. p.m., an interview was f2. CNA #2 stated that they nift. CNA #2 stated that    |                     | - AND AND |  | The second secon |                            |

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| AND PLAN OF CORRECTION   IDENTIFICATION NUMBER:   A BUILDING   CO.  495283   B. WING   O:  NAME OF PROVIDER OR SUPPLIER   STREET ADDRESS, CITY, STATE, ZIP CODE    1719 BELLEVUE AVENUE   | ATE SURVEY DMPLETED  C 2/25/2022  (XS) COMPLETION DATE |
|---|--|
| NAME OF PROVIDER OR SUPPLIER  PROMEDICA SKILLED NURSING AND REHAB (IMPERIAL)  STREET ADDRESS, CITY, STATE, ZIP CODE  1719 BELLEVUE AVENUE   | 2/25/2022<br>(XS)<br>COMPLETION                        |
| NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  1719 BELLEVUE AVENUE   | (X5)<br>COMPLETION                                     |
| RICHMOND, VA 23227  | COMPLETION   |
| (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) |  |
| F 725 Continued From page 94 F 725  |  |
| blank areas or "NA" on the shower/bath section of   |  |
|   |  |
| the Documentation survey report meant that the  |  |
| care was not provided. CNA #2 stated they had   |  |
| more help now than in the past few months. CNA  |  |
| #2 stated that they had worked a unit as the only   |  |
| CNA before, and had continuously gone from one  |  |
| end of the unit to the other end providing  |  |
| incontinence care. CNA #2 stated that normally  |  |
| they had two CNAs on the evening shift on the   |  |
| weekends, and many times someone did not  |  |
| show up to work. CNA #2 stated that there was   |  |
| not always someone available to come in to cover  |  |
| if someone did not show up.   |  |
|   |  |
| The facility policy, "Pandemic plan, Staffing"  |  |
| documented in part, "During the pandemic the  | 50   |
| staffing plan is implemented based on current   |  |
| needs"  |  |
|   |  |
| The facility policy "Focus on F725" documented in   |  |
| part, "The facility must provide services by  |  |
| sufficient numbers of each of the following types   |  |
| on personnel on a 24-hour basis to provide  | į.   |
| nursing care to all residents in accordance with  |  |
| resident care plans: Except when waived under   |  |
| paragraph (e) of this section, licensed nurses;   | i.   |
| and other nursing personnel, including but not  |  |
| limited to nurse aides"   |  |
|   |  |
| On 2/24/2022 at approximately 4:30 p.m., ASM  | i  |
| #1, the interim administrator, ASM #2, the interim  |  |
| director of nursing and ASM #3, the regional  | 2  |
| quality consultant were notified of the findings.   |  |
|   |  |
| No further information was provided prior to exit.  |  |
|   |  |
| Complaint deficiency  |  |
|   |  |
| 2. The facility staff failed to provide sufficient  |  |

|   | CENTERS FOR MEDICAN                                 | - & MEDICAID GELANCES  |                     |  | OINID INO. 0830-038                            |
|---|---|--|---------------------|--|--|
|   | STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:                            | (X2) MUL<br>A BUILD | TIPLE CONSTRUCTION   | (X3) DATE SURVEY<br>COMPLETED                  |
|   |   | 1  | <b>.</b>            |  | C  |
| l |   | 495283   | B WING              |  | 02/25/2022                                     |
| ı | NAME OF PROVIDER OR SUPPLIER                        |  |                     | STREET ADDRESS, CITY, STATE, Z   | IP CODE  |
| ı |   |  |                     | 1719 BELLEVUE AVENUE   |  |
| İ | PROMEDICA SKILLED NURSI                             | ING AND REHAB (IMPERIAL)   | ĺ                   | RICHMOND, VA 23227   |  |
| l | OLLO DE CHARAGO CTA                                 | TEMENT OF DEFICIENCIES   |                     | ·  | CODDECTION                                     |
|   | PREFIX (CACH DEFICIENCY                             | ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION) | ID<br>PREFI)<br>TAG | PROVIDER'S PLAN OF  ( (EACH CORRECTIVE ACT  CROSS-REFERENCED TO T  DEFICIENC | TION SHOULD BE COMPLETION THE APPROPRIATE DATE |
|   | F 725 Continued From pa                             | ae 95  | F 7:                | 25   |  |
|   | •   | <del>-</del>   | 1 /                 | 23   |  |
|   | CIVA statting to prov                               | vide showers to Resident #11.  |                     |  |  |
|   | On the most recent                                  | MDS (minimum data set), a  |                     |  |  |
|   |   | nt with an ARD (assessment   |                     |  |  |
|   | reference date) of 1                                | 2/15/2021, the resident  |                     |  |  |
|   | scored 15 out of 15                                 | on the BIMS (brief interview   |                     |  |  |
|   |   | ndicating the resident is  |                     |  |  |
|   |   | making daily decisions.  |                     |  |  |
|   |   | ted Resident #11 requiring   |                     |  |  |
|   |   | person with portions of  |                     |  |  |
|   |   | unctional limitation in range  |                     |  |  |
|   | of motion to the lowe                               | er extremities.  |                     | i  |  |
|   | 0 - 0/00/0000 -1                                    |  |                     |  |  |
|   |   | roximately 2:00 p.m., an   |                     |  |  |
|   |   | cted of Resident #11 in her  |                     |  |  |
|   |   | stated that they preferred to scheduled to get them                              |                     |  |  |
|   |   | nd Saturday. Resident #11  |                     |  |  |
|   |   | never able to get the  |                     |  |  |
|   |   | because the CNAs told  |                     |  |  |
|   |   | ned too many residents and   |                     |  |  |
|   |   | do it. Resident #11 stated   |                     |  |  |
|   |   | red for her to take a bed bath   |                     |  |  |
|   |   | have to get her out of the   |                     |  | £  |
|   |   | er room, and they told her it  |                     |  |  |
|   |   | er up. Resident #11 stated   |                     |  | , ,  |
|   |   | the bed baths sometimes,   |                     |  | 1  |
|   |   | the shower, and did not  |                     |  | 2.7  |
|   | think it was fair that sl                           | he could not get her   |                     |  | 18   |
|   | showers because of t                                | he staffing.   |                     | 1  |  |
|   | 9   |  |                     |  | 10, 12   |
|   |   | are plan for Resident #11  |                     | 1  | , ,  |
|   |   | ADL (activities of daily   |                     | 10   | 19   |
|   |   | as evidenced by inability to   |                     | 1  | 11   |
|   |   | elated to paraplegia. Date   |                     | E  |  |
|   |   | Assist to bathe/shower as  |                     | 1/4  |  |
|   | needed. Date Initiated                              | D: 9/20/2019"  |                     | l.   | 4  |
|   | The Desumentation                                   | injuly report detail   |                     |  | i P  |
|   | The Documentation su                                | nvey report dated  |                     | \$ CO  |  |

| OLIVIE                   | -1101 01(1110010)1110              | A MEDIO ME OLIVIOLO  |                              |  | O1110 110. 0000 000           |
|--------------------------|------------------------------------|--|------------------------------|--|-------------------------------|
|                          | T OF DEFICIENCIES<br>OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:                              | (X2) MULTIPLE<br>A. BUILDING | CONSTRUCTION   | (X3) DATE SURVEY<br>COMPLETED |
|                          |                                    |  |                              |  | С                             |
|                          |                                    | 495283   | B. WING                      |  | 02/25/2022                    |
| NAME OF                  | PROVIDER OR SUPPLIER               |  | STF                          | REET ADDRESS, CITY, STATE, ZIP CODE  | 02/20/2022                    |
|                          |                                    |  | 171                          | 19 BELLEVUE AVENUE   |                               |
| PROME                    | DICA SKILLED NURSI                 | NG AND REHAB (IMPERIAL)  | RIC                          | CHMOND, VA 23227   |                               |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY                   | TEMENT OF DEFICIENCIES<br>'MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION) | ID<br>PREFIX<br>TAG          | PROVIDER'S PLAN OF CORRECT<br>(EACH CORRECTIVE ACTION SHOU<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY) | LD BE COMPLETION              |
| E 725                    | Continued From up                  | 00   | F 705                        |  |                               |
| F 720                    | Continued From pa                  | · .  | F 725                        |  |                               |
|                          |                                    | 21 failed to evidence  |                              |  |                               |
|                          | 12/1/2021 and 12/2                 | shower or bed bath on  |                              |  |                               |
|                          | 12/1/2021 and 12/2                 | 0/2021.  |                              |  |                               |
|                          | The Documentation                  | survey report dated  |                              |  |                               |
|                          |                                    | documented "NA" under  |                              |  |                               |
|                          | Shower/Bath on 1/8                 | /2022 and failed to evidence   |                              |  |                               |
|                          | documentation of a                 | shower or bath on 1/1/2022   |                              |  |                               |
|                          | and 1/29/2022.                     |  |                              |  |                               |
|                          |                                    |  | 1                            |  |                               |
|                          | The Documentation                  |  |                              |  |                               |
|                          |                                    | documented "NA" under<br>9/2022 and failed to evidence                             |                              |  |                               |
|                          |                                    | shower or bath on 2/5/2022,  |                              |  |                               |
| - d                      | 2/12/2022 and 2/16/2               |  |                              |  |                               |
|                          |                                    |  |                              |  |                               |
| 9                        |                                    | for Resident #11 failed to   |                              |  | 27                            |
|                          |                                    | tion of a bed bath or shower   |                              |  |                               |
|                          | received on the date               | s listed above.  |                              |  |                               |
| - 1                      | D                                  | dead askedulas Kan Januara   |                              |  |                               |
|                          | 2022 at the facility do            | ked schedules for January  |                              |  |                               |
|                          |                                    | on day shift 1/1/2022,   |                              |  |                               |
|                          |                                    | 1/15/2022 and 1/16/2022. It  |                              |  |                               |
|                          |                                    | wo CNAs scheduled for day  |                              |  |                               |
|                          | shift on 1/17/2022, 1/             |  |                              |  | W.                            |
| 27.5                     |                                    | 022. Review of the as  | 10                           |  |                               |
|                          |                                    | February 2022 at the facility  |                              |  |                               |
|                          | day shift for 2/5/2022             | A scheduled for Unit 1 on  | 1127                         |  |                               |
| 1                        | uay Still 101 21312022             | allo ZIVIZUZZ,   |                              |  | 1                             |
|                          | On 2/23/2022 at 3:30               | p.m., an interview was   |                              |  | 3                             |
|                          |                                    | certified nursing assistant)   |                              |  | i i                           |
| #                        | #1, staffing coordinate            | or. CNA#1 stated that they   |                              |  |                               |
| ł                        | nad been in the positi             | on for two weeks and still   |                              |  |                               |
|                          |                                    | g. CNA #1 stated that they   |                              |  |                               |
|                          |                                    | f facility staff and agency  |                              |  |                               |
|                          |                                    | ng. CNA#1 stated that they   |                              |  | 1                             |
| V                        | vorked with the direct             | or of nursing to complete  | 12                           |  | 1                             |

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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   | 1 ' '               | CONSTRUCTION  | (X3) DATE SURVEY<br>COMPLETED |
|---|---|---------------------|---|-------------------------------|
|   | -   | A BUILDING_         |   | С                             |
| į   | 495283  | B WING              |   | 02/25/2022                    |
| NAME OF PROVIDER OR SUPPLIER  |   | ST                  | REET ADDRESS, CITY, STATE, ZIP CODE   | 00.20.20.2                    |
| DOMEDICA CIVILI ED MILIDO   | INC AND DEHAD (MADEDIAL)  | 17                  | 19 BELLEVUE AVENUE  |                               |
| PROMEDICA SKILLED NURS  | ING AND REMAB (IMPERIAL)  | RI                  | CHMOND, VA 23227  |                               |
| PREFIX (EACH DEFICIENC  | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOUL<br>CROSS-REFERENCED TO THE APPROP<br>DEFICIENCY) | D BE COMPLETION               |
| had any shortages walking out. CNA staffing was to have day shift, five CNAs and 3 aides on each stated that they worken the showers due to staffing.  On 2/24/2022 at 10: conducted with LPN LPN #1 stated that it about three weeks. worked the evening LPN #1 stated that it CNAs on Unit 1 and had one or two CNA LPN #1 stated that it for the night shift. Li | age 97  #1 stated that they had not and was not aware of any staff that the goal for a five CNAs on each unit on an each unit on each unit on each unit on each unit on each unit on in each unit on right shift. CNA #1 ked on the unit prior to an and had never had any could not complete their fing. CNA #1 stated that they other CNAs telling residents provide care because of as a.m., an interview was (licensed practical nurse) #1. The had been at the facility for LPN #1 stated that they and day shift at the facility. They were lucky to have three there were shifts when they are for the entire day shift.  They normally had one CNA PN #1 stated that they had a CNAs on a unit and at | F 725               |   |                               |
| times the schedule s<br>they were never ther  | aid they had that many but<br>e. LPN #1 stated that they<br>he facility and had decided to  |                     |   |                               |
| On 2/24/2022 at 1:40 conducted with CNA #3. CNA #3 stated the night shift as needed documented under state of Documentation surves applicable. CNA #3 swere applicable for all  | p.m., an interview was<br>(certified nursing assistant)<br>(at they worked day shift and<br>CNA #3 stated that "NA"<br>(nower/bath on the   |                     |   |                               |

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#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

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| CEN                     | LERS FOR MEDICARE                       | & MEDICAID SERVICES   |                     |          |  | <u> </u> | O: 0938-0391               |
|-------------------------|---|---|---------------------|----------|--|----------|----------------------------|
| STATEM                  | ENT OF DEFICIENCIES<br>AN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:                       | (X2) MUL<br>A BUILD |          | CONSTRUCTION   | (X3) D.  | ATE SURVEY<br>OMPLETED     |
|                         |   | 495283  | B WING              |          |  | 0        | C<br>2/25/2022             |
| NAME (                  | OF PROVIDER OR SUPPLIER                 |   |                     | STF      | REET ADDRESS, CITY, STATE, ZIP CODE  |          |                            |
|                         |   |   | ł                   |          | 19 BELLEVUE AVENUE   |          |                            |
| PROM                    | EDICA SKILLED NURSI                     | NG AND REHAB (IMPERIAL)   |                     |          | CHMOND, VA 23227   |          |                            |
| (X4) IC<br>PREHI<br>TAG | X (EACH DEFICIENCY                      | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID<br>PREFIX<br>TAG | <b>ζ</b> | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROFIDENCY) | .D 8E    | (X5)<br>COMPLETION<br>DATE |
| F 72                    | 5 Continued From page                   | ne 98   | F:7                 | 25       |  |          |                            |
|                         | ·                                       | As on the day shift, but if they  | 120.1               | 20       |  |          |                            |
|                         |   | d four. CNA #3 stated they  |                     | 40       |  |          |                            |
|                         |   | then there was only one CNA   |                     |          |  |          |                            |
|                         | on the unit. CNA#3                      | stated that they felt like they times, and other times felt                 |                     | Ē.       |  |          |                            |
|                         |   | e enough to get things done,  |                     |          |  |          |                            |
|                         |   | ad been hard on them all.   |                     |          |  |          |                            |
|                         |   | 0 p.m., an interview was  |                     |          |  |          |                            |
|                         |   | I (administrative staff erim director of nursing. ASM                       |                     |          |  |          |                            |
|                         |   | pal was to have 11 CNAs on  |                     | 31       |  |          |                            |
|                         |   | ning shift and 6 on night shift.  |                     |          |  |          |                            |
|                         |   | hey were still having trouble   |                     | 4        |  |          |                            |
|                         | on the weekends but                     | t staffing was getting better.  |                     | 3        |  |          |                            |
|                         | On 2/24/2022 at 3:12                    | 2 p.m., an interview was  |                     | 12       |  |          |                            |
|                         |   | #2. CNA #2 stated that they   |                     | 1        |  |          | Į,                         |
|                         |   | shift. CNA #2 stated that   |                     |          |  |          |                            |
|                         |   | on the shower/bath section of   |                     |          |  |          | II.                        |
|                         |   | urvey report meant that the   |                     |          |  |          | 52                         |
|                         |   | d. CNA #2 stated they had   |                     |          |  |          | 0                          |
|                         |   | in the past few months. CNA   |                     | 1        |  |          | į.                         |
|                         |   | ad worked a unit as the only continuously gone from one                     |                     | 1.       |  |          | J                          |
|                         | end of the unit to the                  |   |                     | ř        |  |          |                            |
|                         |   | NA #2 stated that normally  |                     | i        |  |          | ā                          |
|                         |   | n the evening shift on the  |                     |          |  |          | - 1                        |
|                         |   | times someone did not   |                     | E        |  |          | 1                          |
|                         |   | A #2 stated that there was  |                     | 1        |  |          | [                          |
|                         |   | available to come in to cover   |                     |          |  |          |                            |
|                         | if someone did not sh                   | ow up.  |                     |          |  |          |                            |
|                         | On 2/24/2022 at appr                    | oximately 4:30 p.m., ASM  |                     | 1        |  |          | 1                          |
|                         |   | strator, ASM #2, the interim  |                     | 1        |  |          | 1                          |
|                         | director of nursing and                 | d ASM #3, the regional  |                     | 1        |  |          | 1                          |
|                         | quality consultant wer                  | e notified of the findings.   |                     | 1        |  |          | 1                          |
|                         |   | 4   |                     | 1        |  |          |                            |
|                         | No turther information                  | was provided prior to exit.   |                     | 1        |  |          |                            |
|                         |   |   |                     |          |  |          |                            |

|                          | NT OF DEFICIENCIES<br>N OF CORRECTION                                      | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER  | (X2) MUI           |     | CONSTRUCTION  |    | DATE SURVEY                |
|--------------------------|--|---|--------------------|-----|---|----|----------------------------|
|                          |  | 405000  |                    |     |   |    | С                          |
| N/41/5 O                 | £ 000//050 00 6/100/160  | 495283  | B WING             |     | DEST ADDRESS OF STATE 310 CODE  | 0  | 02/25/2022                 |
|                          | F PROVIDER OR SUPPLIER EDICA SKILLED NURSI                                 | NG AND REHAB (IMPERIAL)   |                    | 171 | REET ADDRESS, CITY, STATE, ZIP CODE<br>19 BELLEVUE AVENUE<br>CHMOND, VA 23227                                     |    |                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)   | ID<br>PREFI<br>TAG | x   | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROPI<br>DEFICIENCY) | BE | (X5)<br>COMPLETION<br>DATE |
| F 725                    | 5 Continued From pa  | ge 99   | F7                 | 25  | ,   |    | -                          |
|                          |  | ailed to provide sufficient<br>t #1 on Wing 1 to meet his   |                    |     |   |    |                            |
|                          | 10/27/21 documento<br>fibrillation, hypertens<br>thrombosis. Endocri       | ne System related to<br>ENTIONS: Administer   |                    |     |   |    |                            |
|                          | The physician orders   | s dated 11/19/21  | 0                  | 1   |   |    |                            |
|                          | sugar twice daily, not<br>sugar less than 100<br>(antihypertensive) 12     | .5 milligram twice daily for  | <u>0</u>           |     |   |    |                            |
|                          | daily for blood thinne   | s (anticoagulant) 5 mg twice<br>r."   |                    | 3   |   |    |                            |
|                          | 100 UNIT/MILLILITE subcutaneously at Be                                    | edtimeLidocaine Patch 4 cally every 12 hours for pain duleGabapentin  |                    |     |   |    |                            |
|                          | administration record)<br>100 on 2/13/22 at 6:30<br>2/13/22 at 4:30 PM, at | ary 2022 MAR (medication<br>evidenced a blood sugar of<br>0 AM, no blood sugar on<br>nd a blood sugar of 145 at<br>the MAR evidenced a blood<br>2/8/22. |                    |     |   |    |                            |
|                          | A review of the nursing<br>2/14/22 at 6:22 PM, w                           |   |                    |     |   |    | Î                          |

|   | STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   | 1                 | JLTIPLE CONSTRUCTION DING                  | (X3) DATE SURVEY<br>COMPLETED |
|---|--|---|-------------------|--|-------------------------------|
| I |  | 495283  | B WING            | 3  | C                             |
| I | NAME OF PROVIDER OR SUPPLIER   | 400200  |                   | STREET ADDRESS, CITY, STATE, ZIP C         | 02/25/2022                    |
|   | PROMEDICA SKILLED NURSII   | NG AND REHAB (IMPERIAL)   |                   | 1719 BELLEVUE AVENUE<br>RICHMOND, VA 23227 |                               |
|   | PREFIX (EACH DEFICIENCY  | EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)   | ID<br>PREF<br>TAG |  | SHOULD BE COMPLETION          |
|   | director of nursing, r<br>(responsible party) n  | member) #2, the interim<br>evealed, "Physician and RP<br>otified of meds (medications)<br>ening shift. Resident   | F 7               | 725  |                               |
|   | When asked to desc 2/13/22, LPN #5 state scheduled for Wing 1 Wing 2 and signed up Wing 2. Approximate Wing 1 because there I had already worked 1st unit to be pulled at number and left the number and left the number walked out and come back. The Adm Nursing told me I had call person didn't answnurse who had the phe back and did not. I losection of Wing 1 that the residents. I was to and the other nurse from and give a section of residents. | (licensed practical nurse) #5. ribe the staffing events of ed, "There was no nurse it. I had worked day shift on p to work evening shift on ely 8:45 PM, I was pulled to ewere no other nurses there, a full day shift, I had to go to all day shift, I had to go to all called the on call nessage. There was to be 4 alked out. The agency the on call nurse did not anistrator and Director of to go over there. The on wer the phone. The on call one was supposed to come cked the keys up for the I could not give meds to a cover a majority of Wing 1 om Wing 2 was to come up esidents their evening know until the next day the |                   |  |                               |
|   | AM with LPN (licensed asked about the event missing medications, L Resident #1 his day sh handed off to the event what she did. When I was the missing what she did.   |   |                   |  |                               |

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  | 1 ' '               | CONSTRUCTION   | (X3) DATE SURVEY<br>COMPLETED |
|--|--|---------------------|--|-------------------------------|
|  |  | A BUILDING_         |  | С                             |
|  | 495283   | B WING              |  | 02/25/2022                    |
| NAME OF PROVIDER OR SUPE<br>PROMEDICA SKILLED N  | URSING AND REHAB (IMPERIAL)  | 171                 | REET ADDRESS, CITY, STATE, ZIP CODE<br>19 BELLEVUE AVENUE<br>CHMOND, VA 23227  |                               |
| PREFIX (EACH DEFIC   | Y STATEMENT OF DEFICIENCIES JENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROPRIED TO THE | D BE COMPLETION               |
| what the blanks<br>administration r<br>means that the  | dicines on Sunday." When asked<br>s on the MAR (medication<br>record) mean, LPN #1 stated, "It<br>medication was not given."   | F 725               |  |                               |
| PM with ASM #. of 2/13/22 and r shift, ASM #2 st nurse to adminis 6:00 PM, I called move staff aroun their medication the following monurse did not co 1." When asked on 2/14/22 regar notified of Resid stated, "I wrote to | as conducted on 2/24/22 at 1:58 2. When asked about the events missing medications on evening tated, "I was told there was no ster the meds on Wing 1 around of for staff and we had a plan to and so the residents would receive and care. I did not know until brining on 2/14/22, that the one me to give medications on Wing I about the progress note written reding the physician and RP being ent's meds not given, ASM #2 the note after I found out |                     |  |                               |
| On 2/24/22 at 4:3<br>administrator, AS<br>ASM #3, the regi   | on a part of Wing 1."  30 PM, ASM #1, the  SM #2, the director of nursing and onal quality consultant and ASM director of risk management, liance, were made aware of the  |                     |  |                               |
| No further inform  | ation was provided prior to exit.  |                     |  | = :                           |
|  | f failed to provide sufficient<br>ent #10 on Wing 1 to meet her  |                     |  |                               |
| 9/29/21 with diagn   | admitted to the facility on nosis that included but were not age renal disease, peripheral   |                     |  |                               |

|    | TEMENT OF DEFICIENCIES PLAN OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER   |                     | TIPLE CONSTRUCTION NG   | (X3) DATE SURVEY<br>COMPLETED |
|----|--|--|---------------------|---|-------------------------------|
|    |  | 495283   | B WING              |   | C<br>02/25/2022               |
|    | ME OF PROVIDER OR SUPPLIER  OMEDICA SKILLED NURSI  | NG AND REHAB (IMPERIAL)  |                     | STREET ADDRESS, CITY, STATE, ZIP CODE<br>1719 BELLEVUE AVENUE<br>RICHMOND, VA 23227                               | 0212312822                    |
| PF | REFIX (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROPE<br>DEFICIENCY) | BE COMPLETION                 |
| F  | (minimum data set) assessment, with ar date) of 11/19/21, co 15 out of 15 on the b mental status) score not cognitively impai  A review of the comp 9/29/21 documented Hyperlipidemia, cong hypertension. Endoc diabetes. INTERVE medication per physi  A review of the comp 10/27/21 documented fibrillation, hypertensi thrombosis. Endocrin diabetes. INTERVE medication per physic  The physician orders documented: - For 5:00 p.m. admin sugar twice daily, noti sugar less than 100 (antihypertensive) 12. hypertensionEliquis daily for blood thinner  For 9:00 p.m. adminis 100 UNIT/MILLILITER subcutaneously at Ber | abetes mellitus and ure. The most recent MDS assessment, a quarterly ARD (assessment reference oded the resident as scoring a BIMS (brief interview for indicating the resident was red.  orehensive care plan dated in part, "FOCUS: gestive heart failure and rine System related to NTIONS: Administer cian orders."  rehensive care plan dated d in part, "FOCUS: Atrial ion and deep vein the System related to NTIONS: Administer cian orders."  dated 11/19/21 distration: "Monitor blood fy physician if fasting blood .Metoprolol 5 milligram twice daily for a (anticoagulant) 5 mg twice " tration: "Lantus (insulin) 8 Inject 10 unit dtimeLidocaine Patch 4 ally every 12 hours for pain luleGabapentin | F 72                | 25  |                               |

| CLIVIL                   | TO TOR WILDIOARI  | A MILDIONID BEITAIDED  |                             |  | OND 110, 0000-002             |
|--------------------------|---|--|-----------------------------|--|-------------------------------|
| _ ,                      | IT OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER.   | (X2) MULTIPLE<br>A BUILDING | E CONSTRUCTION =   | (X3) DATE SURVEY<br>COMPLETED |
|                          |   | 405000   | B IMBNC                     |  | C                             |
|                          |   | 495283   | B WING                      |  | 02/25/2022                    |
|                          | PROVIDER OR SUPPLIER DICA SKILLED NURSI   | NG AND REHAB (IMPERIAL)  | 17                          | TREET ADDRESS, CITY, STATE, ZIP CO<br>19 BELLEVUE AVENUE<br>ICHMOND, VA 23227              | DDE                           |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY  | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG         | PROVIDER'S PLAN OF COR<br>(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A<br>DEFICIENCY) | SHOULD BE COMPLÉTION          |
| F <b>7</b> 25            | Continued From pa   | ge 103   | F 725                       |  |                               |
|                          | administration recor<br>100 on 2/13/22 at 6<br>2/13/22 at 4:30 PM,  | ruary 2022 MAR (medication d) evidenced a blood sugar of 30 AM, no blood sugar on and a blood sugar of 145 at The MAR evidenced a blood on 2/8/22.   |                             |  |                               |
|                          | 2/14/22 at 6:22 PM,<br>(administrative staff<br>director of nursing, r<br>(responsible party) r   | member) #2, the interim<br>evealed, "Physician and RP<br>lotified of meds (medications)<br>ening shift. Resident   |                             |  |                               |
|                          | PM with Resident #1<br>been any missed me<br>stated, "Yes, It was S   | nducted on 2/23/22 at 2:06  0. When asked if there had edication doses, Resident #10 superbowl Sunday, the mings left and we did not get shift."   | 11                          |  |                               |
|                          | AM with LPN (license asked about the ever missing medications, Resident #10 her day handed off to the ever what the nurse did. Variesday 2/15/22, Resot received her ever When asked what the medication administrations. | iducted on 2/24/22 at 10:36 and practical nurse) #1. When this of 2/13/22 including LPN #1 stated, "I gave a shift medications and then ning nurse. I do not know When I came back on sident #10 told me she had ning medicines on Sunday." at blanks on the MAR reation record) mean, LPN #1 the medication was not |                             |  |                               |
| 5.7                      |   | ducted on 2/24/22 at 1:58 en asked about the events  | 1                           |  |                               |

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 03/08/2022 FORM APPROVED

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  | (X2) MULT<br>A; BUILDI | TIPLE CONSTRUCTION  | (X3) DATE SURVEY                                |
|---|--|------------------------|---|---|
|   | J  | A BOILDII              | VG  | COMPLETED                                       |
|   | 495283   | B. WING                |   | 02/25/2022                                      |
| NAME OF PROVIDER OR SUPPLIER PROMEDICA SKILLED NURS   | NG AND REHAB (IMPERIAL)  |                        | STREET ADDRESS, CITY, STATE, ZI<br>1719 BELLEVUE AVENUE<br>RICHMOND, VA 23227         |   |
| PREFIX (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES  'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG    | PROVIDER'S PLAN OF (<br>(EACH CORRECTIVE ACT)<br>CROSS-REFERENCED TO TI<br>DEFICIENCY | ION SHOULD BE COMPLETION<br>HE APPROPRIATE DATE |
| shift, ASM #2 stated nurse to administer 6:00 PM." On 2/24/22 at 4:30 F administrator, ASM ASM #3, the regional direquality and complian above concern. | ing medications on evening if, "I was told there was no the meds on Wing 1 around PM, ASM #1, the #2, the director of nursing and al quality consultant and ASM ctor of risk management, ace, were made aware of the | F 72                   | 5   |   |
| 5. The facility staff fa  | ailed to provide nursing on unit one during the p.m. to 11:00 p.m. shift on  |                        | 1<br>1  |   |
| 02/13/2022 failed to on nurse assigned to un 11:00 p.m. shift. Furt revealed a hand writt   | reployment Sheet" dated evidence documentation of a it one for the 3:00 p.m. to the review of the sheet en note that documented, sed practical nurse) # 2].  |                        |   |   |
| 2/12/2022 through 02  | et for LPN # 2 dated 0<br>/15/2022 documented in<br>/13. IN 3:14PM (3:14 p.m.).  |                        |   | 1   |
| admission assessmer reference date) of 12/.   | the BIMS (brief interview icating the resident is  |                        |   |   |

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

| CENTERS FOR MEDICARE  | & MEDICAID SERVICES   |                     |   | OMB NO. 0938-039              |
|---|---|---------------------|---|-------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER  | (X2) MUL<br>A BUILD | TIPLE CONSTRUCTION  | (X3) DATE SURVEY<br>COMPLETED |
| Living of Orion was   | 495283  | B WING              |   | C<br>02/25/2022               |
| PROMEDICA SKILLED NURSI   | NG AND REHAB (IMPERIAL)   |                     | STREET ADDRESS, CITY, STATE, ZIP CODE<br>1719 BELLEVUE AVENUE<br>RICHMOND, VA 23227                 |                               |
| PRECIX (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)   | ID<br>PREFI)<br>TAG | PROVIDER'S PLAN OF CORRECT ( (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY) | ILD BE COMPLETION             |
| interview was condu When asked if they walking out on their the resident's medice "The nurse came in else was coming in one else was coming at the agency to find opening, then she ga and just left. She (nu working on all three h asked how they knew above Resident # 6 s nurse's station when if they knew what shif Resident # 6 stated, " (3:00 p.m. to 11:00 p. received their medica # 6 stated, "Yes, three nurse on Unit 2." Whe | ge 105 proximately 2:00 p.m., an octed with Resident # 6, were aware of a nurse shift and not administering ations, Resident # 6 stated, and waited to see if anyone. When she realized that no in she called her supervisor out if they had another over her keys to another nurse urse) said that she was not halls by herself." When we the information stated tated, "I was sitting up at the it happened." When asked it the incident occurred The overnight shift, 3-11 m.)." When asked if they tions that evening Resident or four hours later from the en asked if they recalled the ir medications Resident # 6 | 9                   | 25  |                               |
| Review of Resident # medication administration administration 22/13/2022 revealed Rescheduled evening me  | tion record) dated<br>lesident # 6 received their   |                     |   | E                             |
| quarterly assessment value reference date) of 12/1  | the BIMS (brief interview ating the resident is   |                     |   |                               |
| On 02/23/2022 at approinterview was conducte When asked if they wer   | d with Resident # 7.  |                     |   |                               |

|   | A MEDICARD SERVICES  |                             |   | OIMR MO: 03/38-038.           |
|---|--|-----------------------------|---|-------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER   | (X2) MULTIPL<br>A. BUILDING | E CONSTRUCTION  | (X3) DATE SURVEY<br>COMPLETED |
|   | 495283   | B WING                      |   | C<br>02/25/2022               |
| NAME OF PROVIDER OR SUPPLIER PROMEDICA SKILLED NURSI  | NG AND REHAB (IMPERIAL)  | 17                          | TREET ADDRESS, CITY, STATE, ZIP CO<br>219 BELLEVUE AVENUE<br>ICHMOND, VA 23227                    |                               |
| PREFIX (EACH DEFICIENCY   | TEMENT OF DEFICIENCIFS MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG         | PROVIDER'S PLAN OF CORE<br>(EACH CORRECTIVE ACTION S<br>CROSS-REFERENCED TO THE AI<br>DEFICIENCY) | HOULD BE COMPLETION           |
| resident's medication heard about it." Who their medications the stated, "Yes."  Review of Resident #   | shift and not administering his Resident # 7 stated, "I en asked if they received hit evening Resident # 7  # 7's eMAR dated 02/13/2022  | F 725                       |   | <b>3</b> 0                    |
| evening medications  On 02/23/2022 at apprinterview was conduct nursing assistant) # 1 asked how long they a staff coordinator CN at the beginning of the describe the minimal requirements to province sident care, CNA # four nurses, two on each unit for the 7: the 3:00 p.m. to 11:00 two on each unit and sunit for the 11:00 p.m. staffing is five nurses, floating and eleven CN (Unit 1) and six on the the 7:00 a.m. to 3:00 p. 11:00 p.m. shifts and funit, one floating and sunit for the 11:00 p.m. asked if they were away on their shift on 02/13/2 resident's medications  On 02/24/2022 at appreciated and surviview was conducted practical nurse) # 1. W | proximately 3:30 p.m., an exted with CNA (certified , staffing coordinator. When had been in the position as IA# 1 stated, "I just started is week." When asked to and full staffing de adequate and consistent 1 stated, "The minimal is each unit and ten CNAs, five 00 a.m. to 3:00 p.m. and p.m. shifts and four nurses, six CNAs, three on each to 7:00 a.m. shift. Full two on each unit, one IAs, five on the front unit back (Unit 2) each unit for e.m. and the 3:00 p.m. to exe nurses, two on each ix CNAs, three on each ix CNAs, th |                             |   |                               |

| - | CENT                     | TION ON MEDICARE                    | A MEDICAID SERVICES   |                       |   | ONB M                             | O. 0938-039                |
|---|--------------------------|-------------------------------------|---|-----------------------|---|-----------------------------------|----------------------------|
|   |                          | NT OF DEFICIENCIES<br>OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:                       | (X2) MULT<br>A BUILDI | TIPLE CONSTRUCTION NG   | (X3) D/                           | ATE SURVEY<br>OMPLETED     |
|   |                          |                                     | 495283  | B. WING               |   | 0.                                | C<br>2/25/2022             |
| Г | NAME OF                  | PROVIDER OR SUPPLIER                |   | ,                     | STREET ADDRESS, CITY, STATE, 2  |                                   |                            |
| ľ |                          |                                     |   |                       | 1719 BELLEVUE AVENUE  |                                   |                            |
|   | PROME                    | DICA SKILLED NURSI                  | NG AND REHAB (IMPERIAL)   | - 1                   | RICHMOND, VA 23227  |                                   |                            |
| _ |                          |                                     |   |                       | RICHMOND, VA 23227  |                                   |                            |
|   | (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY                    | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID<br>PREFIX<br>TAG   | PROVIDER'S PLAN OF<br>(EACH CORRECTIVE ACT<br>CROSS-REFERENCED TO 1<br>DEFICIENCE | TION SHOULD BE<br>THE APPROPRIATE | (XS)<br>COMPLETION<br>DATE |
|   | E 725                    | Continued From an                   | ~ 407   | 5.70                  | ,   |                                   |                            |
|   | 1 725                    | Continued From pag                  |   | F 72                  | .5  |                                   |                            |
|   |                          | 11:00 p.m. shift, LPI               | N# 1 stated that they worked  |                       |   |                                   |                            |
|   |                          |                                     | 3:00 p.m. shift and there was   |                       |   |                                   |                            |
|   |                          | one nurse for the 3:t               | 00 p.m. to 11:00 p.m. shift for   |                       |   |                                   |                            |
|   |                          | Unit 1. LPN # 1 furti               | ner stated, "[Name of   |                       |   |                                   |                            |
|   |                          | Administrator) and [f               | Name of Director of Nursing]  |                       |   |                                   |                            |
|   |                          | were calling around                 | to find help for the 3-11 shift.  |                       |   |                                   |                            |
|   |                          |                                     | iurse on Unit 1 for the 3-11  |                       |   |                                   |                            |
|   |                          | shift, and gave them                | the medication cart keys.   |                       |   |                                   |                            |
|   | 1                        | When asked if they r                | ecalled the name of the   |                       |   |                                   |                            |
|   |                          | nurse they gave repo                | ort to LPN # 1 stated, "I can't   |                       |   |                                   |                            |
|   |                          | remember."                          |   |                       |   |                                   |                            |
|   | 1                        |                                     |   |                       |   |                                   | 1                          |
|   |                          |                                     | proximately 11:39 a.m., a   |                       | Ÿ.  |                                   | 13                         |
|   |                          |                                     | vas conducted with LPN # 2.   |                       |   |                                   | Į.                         |
|   |                          |                                     | ribe the circumstances that   |                       |   |                                   |                            |
|   |                          |                                     | 22, LPN # 2 stated, "There 🖐  |                       |   |                                   |                            |
|   |                          |                                     | es on the 3-11 shift and I was  |                       | 1   |                                   |                            |
|   |                          |                                     | ne. I called the DON  |                       |   |                                   |                            |
|   |                          |                                     | he on-call called the DON   |                       |   |                                   |                            |
|   |                          |                                     | e 7-3 shift called the DON.   |                       | 10  |                                   |                            |
|   |                          |                                     | N that it was unsafe for one  |                       |   |                                   |                            |
|   |                          |                                     | skilled unit (unit one). I told   |                       |   |                                   |                            |
|   |                          |                                     | ot going to work in an unsafe   |                       |   |                                   | <u> </u>                   |
|   |                          |                                     | asked about the DON's   |                       | 1   |                                   |                            |
|   |                          |                                     | N # 2 stated, "She didn't say   |                       |   |                                   | 1                          |
|   |                          |                                     | e and hung up the phone,  |                       |   |                                   | 4                          |
|   |                          |                                     | because they would not  |                       |   |                                   | 1                          |
|   |                          |                                     | shift. The on-call left at  |                       |   |                                   | 1                          |
|   |                          |                                     | was scheduled to be back  |                       |   |                                   | ė l                        |
|   | а                        | co (b.uu p.m.) but ca               | lled and said they were not   |                       |   |                                   | i                          |
|   |                          |                                     | my agency and told them   |                       |   |                                   |                            |
|   |                          |                                     | unsafe it was and they said   |                       |   | ž.                                |                            |
|   |                          |                                     | y to get someone to come  |                       |   |                                   | . [                        |
|   | 10                       | nano intey iolo inte lo l           | eave. I did a medication PN # 1], handed off the                            | -                     |   | 5                                 | ă.                         |
|   | L.                       | ove to a nuree on with              | two and left at about 6   |                       |   |                                   | 4                          |
|   |                          |                                     | ked if they administered  | i                     |   | (1)                               | N.                         |
|   |                          |                                     | of the residents on unit  | 1                     |   |                                   | 1                          |
|   |                          |                                     |   | 1                     |   |                                   | 1                          |
|   | Or                       | re writte triey were in             | the facility LPN # 2 stated, 📜  |                       |   |                                   |                            |

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

| , CCI   | VIERS FOR MEDICARE  | & MEDICAID SERVICES  |   |   | <u> </u>                      |
|---|---|--|---|---|-------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION |   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER   | (X2) MUL<br>A, BUILD                    | TIPLE CONSTRUCTION  | (X3) DATE SURVEY<br>COMPLETED |
|   |   | 495283   | B. WING                                 |   | С                             |
| ALAB III  | OF PROVIDED OF SUSSILIES  | +53203   | 0. ************************************ |   | 02/25/2022                    |
| NAMI  | OF PROVIDER OR SUPPLIER   |  |   | STREET ADDRESS, CITY, STATE, ZIP CODE   | Ē                             |
| PRO   | MEDICA SKILLED NURSI  | NG AND REHAB (IMPERIAL)  |   | 1719 BELLEVUE AVENUE  |                               |
|   |   | TO AND REITAD (IMIT ERIAL)   |   | RICHMOND, VA 23227  |                               |
| (X4)<br>PREI<br>TAG                                 | FIX (EACH DEFICIENCY  | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)  | PREFIX<br>TAG                           | PROVIDER'S PLAN OF CORRECTIVE ACTION SHE<br>(EACH CORRECTIVE ACTION SHE<br>CROSS-REFERENCED TO THE APP<br>DEFICIENCY) | OULD BE COMPLETION            |
| F 7   | interview was condu   | pproximately 1:58 p.m., an cted with ASM (administrative   | F 72                                    | 25  | 8                             |
|   | When asked to desc<br>occurred on 02/13/20<br>the nurses called me<br>p.m., called agencies<br>with the agency nurs<br>not credentialed. I as<br>come in early and co<br>the nurses on the 3 to<br>cover and pass meds<br>and they said they we<br>they never went over | nterim director of nursing. cribe the circumstances that 022, ASM # 2 stated, "One of and I came in at about 6:00 and nurses. The problem es that were available were sked people to stay over, ver the units. I asked one of 11 shift from unit two to (medications) on unit one, ould, but I found out later that to unit one." When asked I # 2 stated, "I can't recall |   | A   |                               |
|   | which nurse." ASM # from residents the ne their meds. I notified resident's families and residents for adverse describe the process "I call available nurses I have six that I can potent them every hour." Whadequately staffed on                                     | 2 further stated, "I heard xt day that they did not get the physician and the d told nursing to monitor the effects." When asked to to fill shifts ASM # 2 stated, and nursing agencies that from, and follow up with the nesked if the facility was 02/13/2022 during the 3 needs of the residents ASM  |   |   |                               |
|   | # 1, interim administra<br>director of nursing, AS<br>consultant, and ASM #<br>regulatory consultant,<br>above findings.  | M # 3, regional quality 4, division quality were made aware of the   |   |   |                               |
|   | No further information  | was provided prior to exit.  | j                                       |   | H42                           |

### DEPARTMENT OF HEALTH AND HUMAN SERVICES

| CENTERS FOR MEDICARI  | & MEDICAID SERVICES  |                           |   | OMB NO   | D. 0938-039           |
|---|--|---------------------------|---|--|-----------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION   | (X1) PROVIDER/SUPPLIER/GLIA IDENTIFICATION NUMBER:   | (X2) MULTIF<br>A BUILDING | EL CONSTRUCTION   |  | ME SURVEY<br>IMPLETED |
|   | 495283   | B. WING                   |   | n:   | C<br>2/25/2022        |
| NAME OF PROVIDER OR SUPPLIER  |  |                           | STREET ADDRESS, CITY, STATE, ZIP COL  |  | 12312022              |
| PROMEDICA SKILLED NURS  | NG AND REHAB (IMPERIAL)  | 1                         | 719 BELLEVUE AVENUE<br>RICHMOND, VA 23227   |  |                       |
| PREFIX (EACH DEFICIENCY   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SCIDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG       | PROVIDER'S PLAN OF CORRI<br>(EACH CORRECTIVE ACTION SI<br>CROSS-REFERENCED TO THE AP<br>DEFICIENCY)   | HOULD BE   | COMPLETION<br>DATE    |
| F 725 Continued From pa<br>Complaint deficienc<br>F 727 RN 8 Hrs/7 days/W   | ry<br>k, Full Time DON   |                           | Tag F727 – Failed to provide 8  | hours of R   | N                     |
| paragraph (e) or (f) must use the service least 8 consecutive service least 8 consecutive service service least 8 consecutive service | red nurse of when waived under of this section, the facility es of a registered nurse for at hours a day, 7 days a week. It when waived under of this section, the facility gistered nurse to serve as the na full time basis.  The rector of nursing may serve ally when the facility has an ancy of 60 or fewer residents. It is not met as evidenced and, staff interview, facility dictinical record review, it acility staff failed to provide a coverage 8 hours per 24 deek. Martha, I do not see the life record reviews in this are to provide RN (registered persistered                         | 1. The Administrator validated of employee schedules for RN of 3/9/22.  2. The Administrator has review facility nurse master schedule RN staffing levels for the cent scheduler and DON on the starequirement to schedule an RN per 24 hours per 7 days a week center.  3. The Administrator will audit stimes weekly times 4 weeks to that RN minimum staffing requare met. The Administrator will audit findings to the QAPI con review and further recommend. The facility's alleged date of cowill be April 4, 2022. | current overage on red the to validate ter, cated the ffing N for 8 hours k in the chedules 5 o validate uirements ill submit nmittee for lations. |                       |

| CLIVIC                   | TIO LOIS MEDICARI   | = & IVICUICAID SERVICES   |                     |      |   | OMPIN     | <u>U. 0938-039</u> 1       |
|--------------------------|---|---|---------------------|------|---|-----------|----------------------------|
|                          | OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER   | (X2) MUL<br>A BUILD |      | CONSTRUCTION  |           | ATE SURVEY<br>DMPLETED     |
| ĺ                        |   | 495283  | B WING              |      |   | 0.        | C<br>2/25/2022             |
|                          | PROVIDER OR SUPPLIER  | ING AND REHAB (IMPERIAL)  |                     | 1719 | EET ADDRESS, CITY, STATE, ZIP C<br>BELLEVUE AVENUE<br>HMOND, VA 23227                         |           | LILUIZUZZ                  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)  | ITEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | (    | PROVIDER'S PLAN OF COR<br>(EACH CORRECTIVE ACTION<br>CROSS-REFERENCED TO THE A<br>DEFICIENCY) | SHOULD BE | (X5)<br>COMPLETION<br>DATE |
| F 727                    | Continued From pa   | ne 110  | F 72                | 27   |   |           |                            |
|                          | 12/1/21-2/25/22. Wentrance conference   | /hen asked during the<br>e if there were any staffing<br>ated, "No, there are no  | F 7.                | 21   |   |           |                            |
|                          | As-worked staffing : 2/23/22 at 5:15 PM   | sheets were provided on by ASM #1.  |                     |      |   |           |                            |
| ·<br>:                   | evidenced no RN horequested (12/1/21-12/12, 12/15, 12/25, 1/12, 1/17, 1/22, 1/2             | orked staffing sheets<br>burs worked on 27 of 87 dates<br>2/25/22): 12/1/21, 12/6, 12/11,<br>12/26, 12/27, 12/29, 1/4/22,<br>3, 1/26, 1/27, 1/28, 1/29,<br>6, 2/6, 2/9, 2/14, 2/19, 2/22. |                     |      |   |           | i.                         |
| 7.2                      | ASM #1 to provide the   | M, a request was made of<br>ne name of the RN who<br>on the above 27 dates.   |                     | į    |   |           |                            |
|                          | consultant, provided<br>21 dates, with six da   | ASM #3, the regional quality evidence of RN coverage for les (12/25/21, 12/26/21, 9/22 and 2/5/22) still missing  |                     |      |   |           | <br>                       |
| F<br>  \<br>  C<br>  C   | PM, with ASM #2, the<br>When asked the num<br>coverage required pe<br>coverage should be in | ducted on 2/24/22 at 1:58 interim director of nursing, iber of hours of RN r day, ASM #2 stated, "RN in the building 8 hours a 3 hours a day, the standard                                |                     |      |   | 8         |                            |
| a<br>A<br>#<br>q         | ASM #3, the regional<br>4, the regional direct  | M, ASM #1, the 2, the director of nursing and quality consultant and ASM or of risk management, e, were made aware of the   |                     |      |   |           |                            |

PRINTEO. 03/08/2022 VED 391

| CENTERS FOR MEDICARI  | # AND HUMAN SERVICES   |                     |  | FORM APPRO<br>OMB NO, 0938-0   |
|---|--|---------------------|--|--|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION   | (XI) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER   | i                   | PLE CONSTRUCTION<br>IG   | (X3) DATE SURVE<br>COMPLETED   |
|   | 495283   | B WING_             |  | 02/25/2022   |
| NAME OF PROVIDER OR SUPPLIER PROMEDICA SKILLED NURSI  | NG AND REHAB (IMPERIAL)  |                     | STREET ADDRESS, CITY, STATE, ZIP C<br>1719 BELLEVUE AVENUE<br>RICHMOND, VA 23227   |  |
| PREFIX (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SCIDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF COM<br>(EACH CORRECTIVE ACTION<br>CROSS-REFERENCED TO THE A<br>DEFICIENCY)  | SHOULD DE COMPLET  |
| "Except when waive services of a registe consecutive hours a  | week" policy, which reveals, d, the facility must use the red nurse for at least 8 day, 7 days a week."  | F 760               | Tag F760 – Failed to prevent<br>Medication Error   | Significant  |
| medication errors. This REQUIREMENT by: Based on observation document review, and in the course of compute determined the facility medication in a safe of medication errors for survey sample, Resident #11. The findings include:  1. The facility staff fails in a safe manner to precore on 2/13/22 for FResident #1 was admit 10/15/21 with diagnosition of limited to: peripher | It is not met as evidenced in, staff interview, facility diclinical record review, and plaint investigation, it was a staff failed to administer manner to prevent significant four of 14 residents in the tents #1, #10, #2 and intervent significant medication in the event significant |                     | <ol> <li>An incident report for sign cation error for Resident # 11 was created on 3/17/22 RP notification. Resident resides at the facility.</li> <li>The DON or designee revie medication administration</li> <li>The DON or designee re-edinurses on the Medication Acquidelines to include admin medications as ordered by the Attention administration records for times weekly times 4 week Administrator will submit author QAPI committee for revirecommendations.</li> <li>The facility's alleged date of will be April 4, 2022.</li> </ol> | 1, # 2 and # with MD and # 4 no longer  ewed residents records. ucated licensed diministration istering patient ne physician. udit medica- for completion as. The adit findings to lew and further |

recent MDS (minimum data set) assessment, a quarterly assessment, with an ARD (assessment reference date) of 1/20/22, coded the resident as

|                         | ENT OF DEFICIENCIES<br>IN OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  |                     | IPLE CONSTRUCTION   | (X3) DATE SURVEY<br>COMPLETED |
|-------------------------|---|--|---------------------|---|-------------------------------|
|                         |   | 20. 60075  | A BUILDI            | 10  | С                             |
|                         |   | 495283   | B. WING             |   | 02/25/2022                    |
| 200.10.000              | DE PROVIDER OR SUPPLIER<br>SEDICA SKILLED NURSI   | NG AND REHAB (IMPERIAL)  |                     | STREET ADDRESS, CITY, STATE, ZIP CODE<br>1719 BELLEVUE AVENUE<br>RICHMOND, VA 23227                     | 1 3212312022                  |
| (X4) IE<br>PREFI<br>TAG | X (EACH DEFICIENCY  | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORREC<br>(EACH CORRECTIVE ACTION SHO<br>CROSS-REFERENCED TO THE APPR<br>DEFICIENCY) | ULD BE COMPLETION             |
| F 76                    | 0 Continued From page   | ne 112   | F 76                | 0   |                               |
|                         | scoring a 15 out of 1   | 15 on the BIMS (brief status) score, indicating the  | 1 70                | U   |                               |
|                         | 10/27/21 documente fibrillation, hypertens  |  |                     |   |                               |
|                         | thrombosis. Endocri<br>diabetes. INTERVE<br>medication per phys                                 | NTIONS: Administer   |                     |   |                               |
|                         | The physician orders  | s dated 11/19/21   |                     | 1   |                               |
|                         | - For 5:00 p.m. admi  | nistration: "Monitor blood<br>lify physician if fasting blood  |                     |   |                               |
|                         | (antihypertensive) 12   | 1.5 milligram twice daily for s (anticoagulant) 5 mg twice   |                     | ľ.  |                               |
|                         | 100 UNIT/MILLILITE  |  |                     |   |                               |
|                         | % Apply to chest topi<br>and remove per sche  |  |                     |   |                               |
|                         | (antiepileptic) 100 mil<br>neuropathy."   | ligram at bedtime for  |                     |   | 4:                            |
| 100                     | administration record)<br>100 on 2/13/22 at 6:30<br>2/13/22 at 4:30 PM, at                      | ary 2022 MAR (medication evidenced a blood sugar of DAM, no blood sugar on a blood sugar of 145 at the MAR evidenced a blood 2/8/22. |                     |   |                               |
|                         | A review of the nursing 2/14/22 at 6:22 PM, wi (administrative staff m director of nursing, rev | ritten by ASM  |                     |   |                               |

| CENT                     | ENG FOR MEDICAR                      | - CIMEDICKID SERVICES  |                     |  | OMB NO. 0938-039                               | , |
|--------------------------|--------------------------------------|--|---------------------|--|--|---|
|                          | NT OF DEFICIENCIES<br>FOR CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:                               | 1 ' '               | TIPLE CONSTRUCTION   | (X3) DATE SURVEY<br>COMPLETED                  |   |
|                          |                                      | 405202   | B WING              |  | С  |   |
|                          |                                      | 495283   | I WING              |  | 02/25/2022                                     |   |
| NAME OF                  | PROVIDER OR SUPPLIER                 |  | İ                   | STREET ADDRESS, CITY, STATE, ZIP   | CODE   |   |
| PROME                    | DICA SKILLED NITDSI                  | NG AND REHAB (IMPERIAL)  |                     | 1719 BELLEVUE AVENUE   |  |   |
| , KOME                   |                                      | (IMPERIAL)   |                     | RICHMOND, VA 23227   |  |   |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY                     | TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SCIDENTIFYING INFORMATION)     | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CO<br>( (FACH CORRECTIVE ACTIO<br>CROSS-REFERENCED TO TH<br>DEFICIENCY) | ON SHOULD BE COMPLETION<br>IE APPROPRIATE DATE | 1 |
| F 760                    | Continued From pa                    | ge 113   | F 76                | 30   |  |   |
|                          | *                                    | notified of meds (medications)   |                     |  |  |   |
|                          |                                      | vening shift. Resident   |                     |  |  |   |
|                          | PM with Resident #                   | nducted on 2/23/22 at 12:56<br>1. When asked if he had<br>ion doses, Resident #1 |                     |  |  |   |
|                          |                                      | vas an evening where there   |                     |  |  |   |
|                          |                                      | ive the medications and I did  |                     |  |  |   |
|                          | not get any till the ne              | ext day."  |                     |  |  |   |
|                          | An interview was co                  | nducted on 2/24/22 at 10:36  |                     |  |  |   |
|                          |                                      | ed practical nurse) #1. When   |                     | ij.  |  | i |
|                          |                                      | nts of 2/13/22 including   |                     |  |  |   |
|                          |                                      | , LPN #1 stated, "I gave   |                     |  | i  | ı |
|                          |                                      | shift medications and then   |                     |  |  | ľ |
|                          |                                      | ening nurse. I do not know   |                     | •  |  | ı |
|                          | what the nurse did. 1                | When I came back on  |                     |  |  | J |
|                          |                                      | sident #1 told me he had not   |                     | \$3  |  | l |
|                          |                                      | medicines on Sunday."  |                     | Y-1  |  | ł |
|                          | When asked what the                  |  |                     | 47   |  | l |
|                          |                                      | ration record) mean, LPN #1  |                     |  |  | ľ |
|                          |                                      | the medication was not   |                     |  |  | l |
|                          | given."                              |  |                     | t .  |  | l |
|                          | Δn interview was con                 | ducted on 2/24/22 at 1:58  |                     |  | 1  | l |
|                          |                                      | nen asked about the events   |                     | •  | i .  | l |
|                          |                                      | g medications on evening   |                     |  |  |   |
|                          |                                      | "I was told there was no   |                     |  | -  |   |
|                          |                                      | e meds on Wing 1 around  |                     |  | \$   |   |
|                          |                                      | taff and we had a plan to  |                     | r e  | į į  |   |
| r                        | nove staff around so                 | the residents would receive  |                     |  |  |   |
|                          |                                      | care. I did not know until   |                     | ÷  |  |   |
|                          |                                      | on 2/14/22 that the one  |                     |  |  |   |
|                          |                                      | give medications on Wing   |                     | ,  |  |   |
| ୁ 1                      | •                                    |  |                     |  | Į,   |   |
| 1                        | n 0/04/00 -4 4:00 DE                 | 1 ACM #1 +-  |                     |  |  |   |
|                          | on 2/24/22 at 4:30 PM                |  |                     |  |  |   |
| а                        | ummistrator, ASM #2                  | , the director of nursing and  |                     |  |  |   |

| OCITICITO I OIT MEDICALLI  | - OLIVICALD SELVICES   |                     |           | (  | DOEU TAO. DASO | <u>1-039</u>         |
|--|--|---------------------|-----------|--|----------------|----------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                    | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  | V BRIFDI            | TIPLE CON | (X3) DATE SURV<br>COMPLETED  |                |                      |
|  | 495283   | B. WING             |           |  | C              |                      |
|  | 455205   | 0. 11110            |           |  | 02/25/202      | 22                   |
| NAME OF PROVIDER OR SUPPLIER PROMEDICA SKILLED NURS                    | ING AND REHAB (IMPERIAL)   |                     | 1719 BE   | ADDRESS, CITY, STATE, ZIP CODE<br>ELLEVUE AVENUE<br>OND, VA 23227  |                |                      |
| PREFIX (EACH DEFICIENCY  | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)                             | ID<br>PREFIX<br>TAG |           | PROVIDER'S PLAN OF CORRECTIO<br>(EACH CORRECTIVE ACTION SHOULD<br>ROSS-REFERENCED TO THE APPROP<br>DEFICIENCY) | DBE COMPL      | K5)<br>LETION<br>NTE |
|  |  |                     | 1/2       |  |                |                      |
| F 760 Continued From pa  | ge 114   | F 76                | 0         |  |                |                      |
| #4, the regional dire  | al quality consultant and ASM ector of risk management, nce, were made aware of the                              |                     |           |  |                |                      |
| According to the fac   | ility's "Medication and  |                     |           |  |                |                      |
| and treatments adm   | ration" policy, "Medications<br>inistered are documented   |                     | 8         |  | ¥              |                      |
| specific standards. \  | g administration or per state<br>/ital signs are taken and   |                     |           |  |                |                      |
| <ul> <li>dependent medication</li> </ul>                               | administration of vital sign<br>ons in accordance with<br>s orders. Medications not                              |                     | 9         |  | ř              |                      |
| administered accord<br>orders are reported to<br>practitioner and docu | ing to medical practitioner's to the attending medical amented in the clinical record and dose of the medication |                     | 1         |  |                |                      |
| No further informatio  | n was provided prior to exit.  |                     |           |  | -19            | - 1                  |
|  | ÷  |                     | \$0.      |  |                | - 1                  |
| 10   |  |                     |           |  |                | - 1                  |
| 2. The facility staff fai  | led to administer medication !   |                     | 1         |  | - 1            |                      |
| in a safe manner to p<br>errors on 2/13/22for f                        | revent significant medication<br>Resident #10.   |                     | i.        |  | V              |                      |
| Resident #10 was ad  | mitted to the facility on  |                     |           |  | Į.             |                      |
| 9/29/21 with diagnosi  | s that included but were not   |                     | d         |  | 1              |                      |
|  | renal disease, peripheral  |                     |           |  |                | - 1                  |
| vascular disease, dial   |  |                     |           |  |                |                      |
|  | re. The most recent MDS  |                     |           |  | 4              |                      |
|  | ssessment, a quarterly   |                     |           |  | 7              |                      |
|  | ARD (assessment reference  |                     | (         |  | 1              |                      |
|  | ed the resident as scoring a   |                     | 1         |  |                |                      |
| 15 out of 15 on the Bl   |  |                     |           |  |                |                      |
|  | indicating the resident was  |                     |           |  | 1              | 1                    |
| not cognitively impaire  | u.   |                     |           |  |                |                      |
|  |  |                     |           |  |                |                      |

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   | (X2) MULTIPLE<br>A BUILDING           | E CONSTRUCTION   | (X3) DATE SURVEY<br>COMPLETED |
|--|---|---------------------------------------|--|-------------------------------|
|  | 1   | A BOILDING_                           |  | С                             |
|  | 495283  | B WING                                |  | 02/25/2022                    |
| NAME OF PROVIDER OR SUPPLIEF PROMEDICA SKILLED NURS  | GING AND REHAB (IMPERIAL)   | 17                                    | REET ADDRESS, CITY, STATE, 7IP CODE<br>19 BELLEVUE AVENUE<br>CHMOND, VA 23227                                |                               |
| PREFIX (EACH DEFICIENC   | ATEMENT OF DEFICIENCIES<br>BY MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG                   | PROVIDER'S PLAN OF CORRECTI<br>(EACH CORRECTIVE ACTION SHOUL<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY) | D BE COMPLETION               |
| 9/29/21 documente<br>Hyperlipidemia, co<br>hypertension. Endo<br>diabetes. INTERV<br>medication per phy  | nprehensive care plan dated<br>ed in part, "FOCUS:<br>ngestive heart failure and<br>ocrine System related to<br>(ENTIONS: Administer  | F 760                                 |  |                               |
| (antiemetic) 8 millig<br>meals before nause<br>(antihypotensive) 5   | nistration time: "Ondansetron<br>fram, given by mouth before<br>ea and vomitingMidodrine<br>milligram by mouth three<br>blood pressureBlood sugar<br>is and at bedtime."                        | II Y                                  |  | 4                             |
| (antihyperlipidemic)   | nistration time: "Atorvastatin<br>80 milligram daily for heart<br>Blood sugar checks before<br>ne."   |                                       |  |                               |
| blood sugar of 123 2<br>sugar at 2/13/22 at 4<br>9:00 PM and a blood<br>6:00 AM. The MAR a<br>pressure of 130/62 of  | uary 2022 MAR evidenced a 2/13/22 at 11:30 AM, no blood 1:30 PM, no blood sugar at 1 sugar of 91 at 2/14/22 at also evidenced a blood on 2/13/22 at 12:20 PM and a 8/64 at 11:38 PM on 2/14/22. | 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 |  |                               |
| (administrative staff in director of nursing, director of nursing, director of nursing, director of nursing, director of nursing nursi | ng progress note by ASM member) #2, the interim ated 2/14/22 at 6:21 PM, and RP (responsible party) given on 2/13 evening shift. with no adverse effects."                                      |                                       |  |                               |
| PM with Resident #10   | ducted on 2/23/22 at 2:06  D. When asked if there had dication doses, Resident #10  | 1                                     |  |                               |

PRINTED: 03/08/2022 FORM APPROVED

| CENTENS I ON MEDICA  | ALLE & MEDICAID SERVICES   |                         |  | OMB NO. 0938-039              |
|--|--|-------------------------|--|-------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | (X2) MULT<br>A. BUILDII | IPLE CONSTRUCTION  | (X3) DATE SURVEY<br>COMPLETED |
|  | 495283   | B. WING _               |  | 02/25/2022                    |
| PROMEDICA SKILLED NU   | ER RSING AND REHAB (IMPERIAL)  |                         | STREET ADDRESS, CITY, STATE, ZIP CON<br>1719 BELLEVUE AVENUE<br>RICHMOND, VA 23227                 |                               |
| PREFIX (EACH DEFICIE   | STATEMENT OF DEFICIENCIES<br>NCY MUST BE PRECEDED BY FULL<br>R LSC IDENTIFYING INFORMATION)  | PREFIX<br>TAG           | PROVIDER'S PLAN OF CORR<br>(EACH CORRECTIVE ACTION SI<br>CROSS-REFERENCED TO THE AP<br>DEFICIENCY) | HOULD BE COMPLETION           |
| agency nurse on  | as Superbowl Sunday, the<br>evenings left and we did not get<br>that shift. Het the dialysis center  | F 76                    | 0  |                               |
| AM with LPN (lice asked about the emissing medication Resident #10 here handed off to the what the nurse did Tuesday 2/15/22, not received here when asked what (medication admirals). | conducted on 2/24/22 at 10:30 ensed practical nurse) #1. When events of 2/13/22 including ons, LPN #1 stated, "I gave day shift medications and then evening nurse. I do not know d. When I came back on Resident #10 told me she had evening medicines on Sunday." It the blanks on the MAR histration record) mean, LPN #1 that the medication was not |                         |  |                               |
| PM with ASM #2, of 2/13/22 and mis shift, ASM #2 state nurse to administe 6:00 PM, I called for move staff around their medications at the following morning                           | when asked about the events when asked about the events sing medications on evening ed, "I was told there was no or the meds on Wing 1 around for staff and we had a plan to so the residents would receive and care. I did not know until ing on 2/14/22, that the one e to give medications on Wing  |                         |  |                               |
| administrator, ASM ASM #3, the region #4, the regional dire quality and complia above concern.   | #2, the director of nursing and all quality consultant and ASM ector of risk management, nce, were made aware of the   |                         |  |                               |
| ino turther informati  | on was provided prior to exit.   | 1                       |  |                               |

| CLIVILLIA   | T ON MEDICAN  | O MICDICALLY SELANCES   |                       |   | OMB NO. 0938-039                               |
|---|---|---|-----------------------|---|--|
| STATEMENT OF<br>AND PLAN OF C   |   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER  | (X2) MUL'<br>A BUILDI | TIPLE CONSTRUCTION  | (X3) DATE SURVEY<br>COMPLETED                  |
|   |   | 495283  | B WING                |   | 02/25/2022                                     |
|   | VIDER OR SUPPLIER  A SKILLED NURSI  | NG AND REHAB (IMPERIAL)   |                       | STREET ADDRESS, CITY, STATE, 21<br>1719 BELLEVUE AVENUE<br>RICHMOND, VA 23227           |  |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIENCY  | TEMENT OF DEFICIENCIES<br>MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG   | PROVIDER'S PLAN OF C<br>(EACH CORRECTIVE ACTIVE<br>CROSS-REFERENCED TO TH<br>DEFICIENCY | ON SHOULD BE COMPLETION<br>HE APPROPRIATE DATE |
| F 760 Co  | ntinued From pa   | ge 117  | F 76                  | 50  |  |
| Res<br>for the<br>Res<br>diag<br>hype<br>data<br>(ass<br>resid<br>inter | s free of significa sident #2 did not blood pressure o sident #2 was add gnoses that includertension. On the a set), a quarterly sessment referendent scored 15 orview for mental s   | failed to ensure Resident #2 nt medication errors. receive medications ordered in multiple dates as ordered. mitted to the facility with ded but were not limited to a most recent MDS (minimum assessment with an ARD ce date) of 1/22/2022, the ut of 15 on the BIMS (brief status), indicating the vintact for making daily              |                       |   |  |
| interroom occa sche medi Resid 2/13/ receiv and h get m was r           | view was conduct. Resident #2 sitions where they duled medication were not dent #2 stated the 2022 had walked yed any medicational to wait for the nedications. Respect the only time | roximately 12:05 p.m., an atted of Resident #2 in her lated that there were add not receive their is and times when the given until the next shift, at the evening nurse on a lout and they had not ons for the evening shift, a night shift to come in to ident #2 stated that that they had not gotten their waited for the next shift to |                       |   |  |
| record<br>12/1/2<br>following<br>following<br>following                 | d) for Resident #3<br>2021-12/31/2021<br>ing medications :<br>ing dates and tirr<br>oprolol tartrate ta   | failed to evidence the administered on the  | I<br>F                |   |  |

|                          | · to r ort meditorin   | E & MICETONIE OF ICATORO   |                       |      |   | OIVID INC | <u>, 0936-</u> 039         |
|--------------------------|--|--|-----------------------|------|---|-----------|----------------------------|
|                          | IT OF DEFICIENCIES<br>OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER  | (X2) MULT<br>A BUILDI |      | CONSTRUCTION  | (X3) DAT  | TE SURVEY<br>MPLETED       |
|                          |  | 495283   | B WING                |      |   | 0.0       | C                          |
| NAME OF                  | PROVIDER OR SUPPLIER   |  | <u> </u>              | STR  | EET ADDRESS, CITY, STATE, ZIP CO  |           | /25/2022                   |
|                          |  | ING AND REHAB (IMPERIAL)   |                       | 1719 | 9 BELLEVUE AVENUE<br>HMOND, VA 23227  |           |                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)   | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG   |      | PROVIDER'S PLAN OF CORF<br>(EACH CORRECTIVE ACTION S<br>CROSS-REFERENCED TO THE AI<br>DEFICIENCY) | HOULD BE  | (X5)<br>COMPLETION<br>DATE |
| F 760                    | Continued From pa  | ge 118   | F 76                  | 0    |   |           | 2)                         |
|                          | HTN (hypertension)   | )." On 12/17/2021 at 8:30 p.m.   |                       |      |   |           |                            |
|                          | The eMAR (electror record) for Resident failed to evidence the administered on the - "Metoprolol tartrate"   | nic medication administration<br>t #2 dated 2/1/2022-2/28/2022<br>ne following medications<br>following dates and times:<br>e tablet 25 mg Give 1 tablet by<br>day for HTN." On 2/4/2022 at  |                       |      |   |           |                            |
| 3                        |  | dications as listed above.   |                       | 8    |   |           |                            |
| 1                        | in part, "2/14/2022 1<br>doctor) and RP (resp<br>meds (medications)<br>(2/13/2022) evening<br>with no adverse effec  | shift. Resident monitored cts." The progress notes cumentation regarding the   |                       |      |   |           |                            |
| C<br>  H<br>  1          | documented in part, '<br>Hypertension, Date Ir   | ter medications as ordered.  |                       |      |   | ,         |                            |
| C<br>L<br>W<br>S<br>th   | conducted with LPN (<br>PN #1 stated that the<br>vas not documented<br>tated that multiple re<br>nat they had not rece<br>/13/2022 when he re<br>reek. LPN #1 stated | 5 a.m., an interview was licensed practical nurse) #1. e care was not provided if it on the eMAR. LPN #1 sidents had reported to him ived their medications on turned to work the next that the residents told him leir evening medications. |                       |      |   |           |                            |
| - ∳Li                    | PN #1 stated that he   |  | 1                     |      |   |           |                            |

| CENT                     | ERS FOR MEDICARE                                | S & MEDICAID SERVICES  |                     |     |   | <u> </u> | <u>vo. 0</u> 938-039       |
|--------------------------|---|--|---------------------|-----|---|----------|----------------------------|
|                          | NT OF DEFICIENCIES<br>OF CORRECTION             | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:                        | (X2) MUL<br>A BUILD |     | CONSTRUCTION  |          | DATE SURVEY<br>COMPLETED   |
|                          |   | 495283   | B WING              |     |   | ,        | C<br>02/25/2022            |
| NAME OF                  | PROVIDER OR SUPPLIER                            |  |                     | ST  | REET ADDRESS, CITY, STATE, ZIP CODE   |          |                            |
|                          |   |  |                     | 171 | 19 BELLEVUE AVENUE  |          |                            |
| PROME                    | DICA SKILLED NURSI                              | ING AND REHAB (IMPERIAL)   | ļ                   |     | CHMOND, VA 23227  |          |                            |
| *****                    | CI II IA IA DIVI CITA                           | JEWENT OF DEFINITIONS  |                     |     | ·   |          | ·                          |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY                                | TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SCIDENTIFYING INFORMATION) | PREFI)<br>TAG       | (   | PROVIDER'S PLAN OF CORRECTIO<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROP<br>DEFICIENCY) | DBC      | (X5)<br>COMPLETION<br>DATE |
| F 760                    | Continued From page                             | ne 119   | F 76                | 80  |   |          |                            |
|                          | *   | .PN #1 stated that Resident  | 1. 10               | JU  |   |          |                            |
|                          |   |  |                     |     |   |          |                            |
|                          | eiv hours after the s                           | ting their medications up to<br>cheduled time from staff                     |                     |     |   |          |                            |
|                          |   | stated that Resident #2  |                     |     |   |          |                            |
|                          |   | are and refused to have  |                     |     |   |          |                            |
|                          |   | medications but there should   |                     |     |   |          |                            |
|                          |   | the medical record why they  |                     |     |   |          |                            |
|                          | were not administere                            |  |                     |     |   |          |                            |
|                          | On 2/24/2022 at 1:1                             | 5 p.m., an interview was   |                     |     |   |          |                            |
| 1                        |   | #5. LPN #5 stated that   |                     |     |   |          |                            |
|                          | medications not sign                            | ed off on the eMAR meant   |                     |     |   |          |                            |
|                          |   | one. LPN #5 stated that there  |                     | 1   |   |          |                            |
|                          |   | s note documenting why the   |                     | 1.  |   |          |                            |
|                          |   | t administered in the record.  |                     |     |   |          |                            |
|                          |   | ney were pulled over to Unit 1   |                     | £:  |   |          |                            |
|                          |   | tions on 2/13/2022 around  |                     | 1.5 |   |          |                            |
|                          | 8:45 p.m. and was or                            |  |                     | 10  |   |          |                            |
|                          |   | of the residents. LPN #5   |                     |     |   |          |                            |
|                          | stated that they did no<br>medications to Resid |  |                     |     |   |          | 3                          |
| 3.                       | medicalions to Resid                            | em #2.   |                     |     |   |          | 1                          |
| 1                        | On 2/24/2022 at 2:00                            | p.m., an interview was   |                     | *   |   |          |                            |
|                          | conducted with ASM                              |  |                     |     |   |          |                            |
|                          |   | im director of nursing. ASM  |                     |     |   |          |                            |
|                          |   | MAR was not signed off they  |                     |     |   |          | Ė                          |
|                          |   | was not done because it  |                     |     |   |          | F.                         |
| V                        | vas not signed as cor                           | npleted. ASM #2 stated   |                     |     |   |          |                            |
| tl                       | hat they were notified                          | of the nurse leaving on  |                     | J.  |   |          |                            |
|                          |   | empted to contact agencies   |                     |     |   |          |                            |
|                          |   | in the shift, but were   |                     | į.  |   |          | 200                        |
|                          |   | 2 stated that they had   |                     |     |   |          | i                          |
|                          |   | e to Unit 1 when they were   |                     |     |   |          |                            |
|                          |   | on Unit 2. ASM #2 stated   |                     |     |   |          |                            |
|                          |   | e other nurse on Unit 2 to   |                     |     |   |          | j l                        |
|                          |   | administer medications on  |                     |     |   |          |                            |
|                          |   | I done this. ASM #2 stated   |                     |     |   |          |                            |
|                          | SM #2 stated that she                           | e of this until the next day.  |                     |     |   |          |                            |
| : ^                      | OIN HE SIGIOU HIGH SHE                          | e nau contacteu ine  |                     |     |   |          |                            |

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

| CENTE                    | RS FOR MEDICARI  | & MEDICAID SERVICES  |                     |     | (  | A BMC  | O 0938-039                 |
|--------------------------|--|--|---------------------|-----|--|--------|----------------------------|
|                          | NT OF DEFICIENCIES<br>OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER   | (X2) MULT           |     | CONSTRUCTION   | (X3) £ | OATE SURVEY<br>OMPLETED    |
|                          |  | 495283   | B WING              |     |  |        | C<br>)2/25/2022            |
| NAME OF                  | PROVIDER OR SUPPLIER   |  |                     | STR | REET ADDRESS, CITY, STATE, ZIP CODE  |        |                            |
| PROME                    | DICA SKILLED NURSI   | NG AND REHAB (IMPERIAL)  |                     |     | 9 BELLEVUE AVENUE  |        |                            |
|                          | 57   |  |                     | RIC | CHMOND, VA 23227   |        |                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)   | TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG |     | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROVIDENCY) | D BE   | (X5)<br>COMPLETION<br>DATE |
| F 760                    | Continued From pa  | 20 120   | C 70                | ,   |  |        |                            |
| F 760                    | physician and responsible who had missed the 2/13/22 to notify the suffered any advers she had spoken directions.  | ge 120 consible parties of the residents consible parties of the residents considerations on considerations on considerations on 2/13/2022.  | F 76                | 0   |  |        |                            |
|                          | Administration Guide "Medications are a with standards of pra federal guidelines" administered are do following administrat standardsMedication according to medical reported to the attenda documented din the name and dose of the medication was not a nurse is responsible | practitioner's orders are<br>ding medical practitioner and<br>clinical record including the<br>e medication and reason the<br>idministeredThe licensed<br>for validating documentation |                     |     |  |        |                            |
|                          | during the shift"  | medication administered  |                     |     |  |        |                            |
| #<br>C                   | #1, the interim admini<br>director of nursing an   | oximately 4:30 p.m., ASM istrator, ASM #2, the interim d ASM #3, the regional re notified of the findings.   |                     | S   |  |        |                            |
| 11                       | No further information   | was provided prior to exit.  |                     |     |  |        | 0.0                        |
| C                        | Complaint deficiency   |  |                     |     |  |        | ii<br>Ii                   |
| w<br>R<br>fo             | as free of significant<br>esident #11 did not r  | led to ensure Resident #11 medication errors. eceive medications ordered res on multiple dates as  |                     |     |  |        |                            |

| OCITICINO I ON MILDIOMINI                           | - OF INITIONID SERVICES  |                     |      |  | _OIVIB I | NO. 0938-1138              |
|---|--|---------------------|------|--|----------|----------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:                            | (X2) MUL<br>A BUILD |      | CONSTRUCTION   |          | DATE SURVEY<br>COMPLETED   |
|   | 495283   | B. WING             |      |  |          | C<br>02/25/2022            |
| NAME OF PROVIDER OR SUPPLIER                        |  | <del>'</del>        | STR  | EET ADDRESS, CITY, STATE, ZIP CODE   |          | 02/23/2022                 |
| 2201152104 000 1 55 10120                           |  | - 1                 | 1719 | 9 BELLEVUE AVENUE  |          |                            |
| PROMEDICA SKILLED NURSI                             | ING AND REHAB (IMPERIAL)   | - 1                 |      | HMOND, VA 23227  |          |                            |
| PREFIX (EACH DEFICIENCY                             | NTEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION) | ID<br>PREFIX<br>TAG | K    | PROVIDER'S PLAN OF CORRECT<br>(EACH CORRECTIVE ACTION SHOU<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY) | JLD BE   | (X5)<br>COMPLETION<br>DATE |
| E 760 Continued From the                            | 404  |                     | ś    |  |          |                            |
| F 760 Continued From pa                             | •  | F 76                | 50   |  |          |                            |
|   | dmitted to the facility with   |                     |      |  |          |                            |
|   | ided but were not limited to the most recent MDS                                 |                     |      |  |          |                            |
|   | , a quarterly assessment with  |                     |      |  |          |                            |
| an ARD (assessmer                                   | nt reference date) of  |                     | ٠    |  |          |                            |
|   | dent scored 15 out of 15 on  |                     |      |  |          |                            |
|   | view for mental status),   |                     |      |  |          |                            |
|   | nt is cognitively intact for   |                     |      |  |          |                            |
|   | ns. Section N documented   |                     |      |  |          |                            |
| antianxiety, antidepre                              | eiving insulin, antipsychotic,   |                     |      |  |          |                            |
| medications.  | essant and opioio  |                     |      |  |          |                            |
| modicalions.  |  |                     |      |  |          |                            |
| On 2/23/2022 at app                                 | roximately 2:00 p.m., an   |                     |      |  |          |                            |
| interview was conduc                                | cted of Resident #11 in her  |                     | 1    |  |          |                            |
|   | stated that there were times   |                     |      |  |          |                            |
|   | eive her medications and   |                     | 1    |  |          | 7                          |
| work Resident #11 s                                 | the next shift came in to stated that on 2/13/2022 they                          |                     |      |  |          |                            |
|   | vening medications because   |                     |      |  |          |                            |
| the nurse had left and                              | they had to wait for the   |                     | 4    |  |          |                            |
|   | n to get them. Resident #11  |                     | î    |  |          |                            |
|   | ot the only occasion that had 🔭  |                     |      |  |          | į.                         |
| happened to her.                                    |  |                     |      |  |          | k:                         |
| The eMAR (electronic                                | madiantian administration  |                     | ,    |  |          |                            |
| record) for Resident #                              | medication administration  |                     |      |  |          | to the                     |
|   | failed to evidence the   |                     | 9    |  |          |                            |
| following medications                               |  |                     |      |  |          |                            |
| following dates and tin                             | nes:   |                     |      |  |          |                            |
|   | solution Pen injector (for   |                     |      |  |          | - 1                        |
| diabetes) 100 unit/ml (                             |  |                     |      |  |          |                            |
|   | Itime for DM 2 (diabetes<br>1 9:00 p.m. and 12/10/2021                           |                     |      |  |          | 3                          |
| at 9:00 p.m.  | 1 9.00 p.m. and 12/10/2021   | 19                  |      |  |          |                            |
|   | on (for diabetes) Inject as  |                     |      |  |          | 1                          |
| per sliding scale: If 150                           | 0-200=4 units; 201-250=6   |                     |      |  |          | 1                          |
|   | 301-350=10; 351-400=12;  | j                   |      |  |          | 4                          |
|   | meals and at bedtime for   |                     |      |  |          |                            |

|                       |  | CAMILLETON ALL CLINATOLO   |                     |             |   |           | 140. 0830   | -บระม               |
|-----------------------|--|--|---------------------|-------------|---|-----------|-------------|---------------------|
|                       | MENT OF DEFICIENCIES<br>AN OF CORRECTION     | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER.   | (X2) MU<br>A. BUILI |             | CONSTRUCTION  |           | ) DATE SURV | /EY                 |
|                       |  | !  | 1 100               |             |   | - 1       | С           |                     |
|                       |  | 495283   | BIWING              | ·           |   | - 1       | 02/25/202   | 22                  |
| NAME                  | OF PROVIDER OR SUPPLIER                      |  |                     | STR         | REET ADDRESS, CITY, STATE, ZIP C  | ODE       | 02.201201   |                     |
| PRO                   | MEDICA SKILLED NURSI                         | NG AND REHAB (IMPERIAL)  |                     | 171         | 9 BELLEVUE AVENUE   |           |             |                     |
|                       |  | TO AND KEIND (IMI EKIAL)   |                     | RIC         | CHMOND, VA 23227  |           |             |                     |
| (X4) I<br>PREF<br>TAG | IX (EACH DEFICIENCY                          | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL BC IDENT IFYING INFORMATION)   | ID<br>PREF<br>TAG   |             | PROVIDER'S PLAN OF COF<br>(EACH CORRECTIVE ACTION<br>CROSS-REFERENCED TO THE A<br>DEFICIENCY) | SHOULD BE | COMPL       | (5)<br>LETION<br>ME |
| F 7/                  | 50 0 " 15                                    |  |                     | 22          |   |           |             |                     |
| - 70                  | 60 Continued From pag                        |  | F7                  | <b>'</b> 60 |   |           |             |                     |
|                       | Diabetes mellitus ty                         | pe 2." On 12/2/2021 9:00   |                     |             |   |           |             |                     |
|                       | p.m. and 12/10/202                           |  |                     |             |   |           |             |                     |
|                       | - "Metrormin HCL tal                         | blet (for diabetes) 500 mg   |                     |             |   |           |             |                     |
|                       | 12/10/2021 2100.                             | outh at bedtime for DM." On  |                     |             |   |           |             |                     |
|                       |  | (for seizures) 25 mg Give 25   |                     |             |   |           |             |                     |
|                       | ma by mouth two tim                          | es a day for seizures." On   |                     |             |   |           |             |                     |
|                       | 12/10/2021 at 5:00 p                         |  |                     |             |   |           |             |                     |
|                       |  |  |                     |             |   |           |             |                     |
|                       | The eMAR (electroni                          | c medication administration  |                     |             |   |           |             |                     |
|                       | record) for Resident<br>1/1/2022-1/31/2022 f | #11 dated  |                     |             |   |           |             |                     |
|                       | following medications                        |  |                     |             |   |           | - 6         |                     |
|                       | following dates and ti                       | mes.   |                     | 41          |   |           | 100         | - 1                 |
|                       |  | ion Inject as per sliding  |                     | 1           |   |           |             | Į                   |
|                       | scale: If 150-200=4 u                        | nits; 201-250=6 units;   |                     |             |   |           |             |                     |
|                       | 251-300=8 units; 301                         | -350=10; 351-400=12;   |                     |             |   |           |             | - 1                 |
|                       | <ul> <li>subcutaneously before</li> </ul>    | e meals and at bedtime for   |                     |             |   |           |             |                     |
|                       | Diabetes mellitus type                       | 2." On 1/2/2022 at 6:30  |                     |             |   |           |             |                     |
|                       |  | 00 a.m., 1/8/2022 at 9:00  |                     |             |   |           | 9           | - 1                 |
|                       |  | 80 a.m., 1/19/2022 at 11:30  |                     |             |   |           | 1           | 1                   |
|                       |  | 30 a.m., 1/27/2022 at 4:30 0 p.m., 1/28/2022 at 11:30  |                     |             |   |           | 1           |                     |
|                       | a.m., 1/29/2022 at 11:                       | 30 a.m., and 1/30/2022 at  |                     |             |   |           |             |                     |
|                       | 9.00 p.m.                                    | and the state of   |                     | 1           |   |           |             |                     |
|                       | - "Topiramate tablet 2:                      | 5 mg Give 25 mg by mouth   |                     |             |   |           | -           |                     |
|                       |  | izures." On 1/27/2022 at   |                     |             |   |           |             |                     |
|                       | 5:00 p.m. and 1/29/20                        |  |                     |             |   |           |             |                     |
|                       | - "Basagiar KwikPen s                        | olution Pen injector 100   |                     |             |   |           |             | ŀ                   |
|                       | for DM 2." On 1/27/20                        | ubcutaneously at bedtime   |                     |             |   |           | 1           | - 1                 |
|                       |  | et 500 mg give 500 mg by   |                     |             |   |           | B           | -                   |
|                       |  | for DM." On 1/29/2022 at   |                     | 7           |   |           | 1           |                     |
| 9                     | 9:00 a.m.                                    | The state of the s |                     |             |   |           |             | J                   |
|                       | - "Tradjenta tablet (for                     | diabetes) Give 5 mg by   |                     |             |   |           | 1           |                     |
|                       | mouth one time a day                         | for diabetes mellitus type   |                     | 1           |   |           |             |                     |
|                       | 2." On 1/29/2022 at 10                       | 0:00 a.m.  |                     | 1           |   |           |             |                     |
|                       | The MAD ( )                                  | , , , , , , , , , , , , , , , , , , ,  |                     |             |   |           | 1           |                     |
| ,                     | The eMAK (electronic)                        | medication administration 🥼  |                     |             |   |           | A .         | - 1                 |

| STATEMENT OF DEFICIENCE AND PLAN OF CORRECTION  |  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER   |                     | TIPLE<br>ING |  | (X3) DATE SURVEY<br>COMPLETED |                            |  |
|---|--|---|---------------------|--------------|--|-------------------------------|----------------------------|--|
|   |  | 495283  | B WING              |              |  |                               | C                          |  |
| NAME OF PROVIDER OR SI<br>PROMEDICA SKILLED   |  | IG AND REHAB (IMPERIAL)   |                     | 171          | REET ADDRESS, CITY, STATE, ZIP CODE<br>19 BELLEVUE AVENUE<br>CHMOND, VA 23227                                |                               | 02/25/2022                 |  |
| PREFIX (EACH DE   | FICIENCY   | EMENT OF DEFICIENCIES<br>MUST 8E PRECEDED BY FULL<br>C IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | (            | PROVIDER'S PLAN OF CORRECTI<br>(EACH CORRECTIVE ACTION SHOUL<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY) | .D BE                         | (X5)<br>COMPLETION<br>DATE |  |
| 2/28/2022 fa medications and times: - "Insulin Lisp scale: If 150- 251-300=8 ur subcutaneou Diabetes mel a.m., 2/9/202 p.m., and 2/1 - "Topiramate two times a d 5:00 p.m "Metformin h mouth at bedf p.m. and 2/16 - "Basaglar Ku unit/ml Inject if | Resident illed to e adminis pro Solution 200=4 units; 301 illus type 2 at 11:36/2022 at tablet 2 illume for 5/2022 at wikPen solution 2/13/20  | #11 dated 2/1/2022- vidence the following tered on the following dates tion Inject as per sliding mits; 201-250=6 units; -350=10; 351-400=12; re meals and at bedtime for e 2." On 2/5/2022 at 6:30 a.m., 2/13/2022 at 4:30 at 9:00 p.m. 5 mg Give 25 mg by mouth sizures." On 2/13/2022 at et 500 mg Glve 1000 mg by DM." On 2/13/2022 at 9:00 | F 7                 |              |  |                               |                            |  |
| documented the listed above.  | he medi  | cations and treatments as   |                     | -            |  |                               |                            |  |
| in part, "2/14/2<br>doctor) and RF<br>meds (medical<br>(2/13/2022) ev<br>with no advers<br>failed to eviden<br>additional dates   | 2022 18:: P (responding short from the control of t | 24 (6:24 p.m.) MD (medical nsible party) notified of st given on 2/13 lift. Resident monitored mentation regarding the above.   |                     |              |  |                               |                            |  |
| (related to) diab   | petes Da<br>ations) a  | he resident is on insulin r/t<br>ate Initiated: 09/12/2019<br>as MARs (medication<br>Date Initiated:  |                     |              |  |                               |                            |  |

PRINTED. 03/08/2022 FORM APPROVED

| ı | OLITICADA ON MILDIOANA  | A MEDICAID SEKVICES  |                       |   |   | OIMR M  | <u>O. 0938</u> -0391       |
|---|---|--|-----------------------|---|---|---------|----------------------------|
|   | STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER   | (X2) MUL<br>A. BUILDI | TIPLE CONSTRUCTION                                    |   |         | ATE SURVEY<br>OMPLETED     |
| I |   | 495283   | B WING                |   |   | 0:      | C<br>2/25/2022             |
|   | NAME OF PROVIDER OR SUPPLIER PROMEDICA SKILLED NURS   | NG AND REHAB (IMPERIAL)  |                       | STREET ADDRESS, 0<br>1719 BELLEVUE A'<br>RICHMOND, VA |   |         |                            |
|   | PREFIX (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG   | (EACH COR   | ER'S PLAN OF CORRECTIVE ACTION SHOERENCED TO THE APP<br>DEFICIENCY) | OULD BE | (X5)<br>COMPLETION<br>DATE |
|   | ordered by physicia 09/12/2019"  On 2/24/2022 at 10: conducted with LPN LPN #1 stated that the was not documented stated that multiple in that they had not received by the conducted when the week. LPN #1 stated that they did not get LPN #1 stated that they did not get LPN #1 stated that they did not get LPN #1 stated that they did not get LPN #1 stated that hey did not get LPN #1 stated that they did not get LPN #1 stated that he | r blood sugar, lab results as  | F 76                  | 50  |   |         |                            |
|   | conducted with LPN medications not sign that they were not do should be a progress medications were not LPN #5 stated that the to administer medical 8:45 p.m., and was or medications to some stated that they did not medications to Reside   | of the residents. LPN #5 lot administer any ent #11.   |                       |   |   |         |                            |
|   | conducted with ASM ( member) #2, the inter #2 stated that if the el would assume that it v was not signed as con that they were notified 2/13/2022, and had at  | im director of nursing. ASM MAR was not signed off they was not done because it npleted. ASM #2 stated of the nurse leaving on |                       |   |   |         |                            |

## DEPARTMENT OF HEALTH AND HUMAN SERVICES

| CENTE                    | RS FOR MEDICARE             | & MEDICAID SERVICES   |                                       |   | (X3) DATE SURVEY     |
|--------------------------|-----------------------------|---|---------------------------------------|---|----------------------|
| STATEMENT                | OF DEFICIENCIES             | (X1) PROVIDER/SUPPLIER/CUA<br>IDENTIFICATION NUMBER                             |                                       | TIPLE CONSTRUCTION  | COMPLETED            |
| AND PLAN C               | OF CORRECTION               | ROENTH RESTOR ASSESS  | A BUILD                               | NG  | С                    |
|                          |                             | 495283  | B. WING                               |   | 02/25/2022           |
| NAME OF                  | PROVIDER OR SUPPLIER        |   | · · · · · · · · · · · · · · · · · · · | STREET ADDRESS, CITY STATE, ZIP COD   | F                    |
|                          |                             | NC AND BEHAR (IMPERIAL)   |                                       | 1719 BELLEVUE AVENUE  |                      |
| PROME                    | DICA SKILLED NORS           | ING AND REHAB (IMPERIAL)  |                                       | RICHMOND, VA 23227  | CAION WO             |
| (X4) ID<br>PREFIX<br>TAG | (CACH DEFICIENC)            | TEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION) | ID<br>PREFII<br>TAG                   | PROVIDER'S PLAN OF CORRE X (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY) | IOUILD BE COMPLETION |
|                          |                             |   | F 7                                   | 260   |                      |
| F 760                    | Continued From pa           | ge 125  | Г/                                    | 00  |                      |
|                          | were unsuccessful.          | ASM #2 stated that they had   |                                       |   |                      |
|                          | asked LPN #5 to m           | ove to Unit 1 when they were all on Unit 2. ASM #2 stated                       |                                       |   |                      |
|                          | that they had asked         | the other nurse on Unit 2 to  |                                       |   |                      |
|                          | come to help LPN #          | 5 administer medications on   |                                       |   |                      |
|                          | Unit 1, but she had         | not done this. ASM #2 stated  |                                       |   |                      |
|                          | that she was not av         | vare of this until the next day.  |                                       |   |                      |
|                          | ASM #2 stated that          | she had contacted the<br>onsible parties of the residents                       |                                       |   |                      |
|                          | physician and responses the | eir evening medications on  |                                       |   |                      |
|                          | 2/13/22 to notify the       | em, and that no one had   |                                       |   |                      |
|                          | suffered any advers         | se effects.   |                                       |   | ,                    |
|                          | On 2/24/2022 at an          | proximately 4:30 p.m., ASM  |                                       |   |                      |
|                          | #1 the interim adm          | inistrator, ASM #2, the interim   |                                       |   |                      |
|                          | director of nursing a       | and ASM #3, the regional  |                                       |   |                      |
|                          | quality consultant w        | vere notified of the findings.  |                                       | 5   |                      |
|                          | No further informati        | on was provided prior to exit.  |                                       | Tag F842 - Failed to maintain   | Complete             |
| F 842                    | Resident Records -          | Identifiable Information  | F 8                                   | /Accurate Medical Record  | o in prett           |
| SS=D                     | CFR(s): 483.20(f)(5         | s), 483.70(i)(1)-(5)  |                                       |   |                      |
|                          | SARR DOMENTS Decid          | ent-identifiable information.   |                                       | 1. Resident # 4 was discharged  |                      |
| ,                        | (i) A facility may not      | release information that is   |                                       | The Director of Nursing or de   |                      |
|                          | resident-identifiable       | to the public.  |                                       | pleted incident reports for Re  |                      |
|                          | (ii) The facility may       | release information that is   |                                       | missing treatment record sign   |                      |
|                          | resident-identifiable       | to an agent only in   |                                       | December, January, and Febr   | nary regard-         |
|                          | accordance with a c         | contract under which the agent r disclose the information                       |                                       | ing the patient wound care.   |                      |
|                          | event to the extent         | the facility itself is permitted  |                                       | 2. The DON or designee has rev  |                      |
| i                        | to do so.                   |   |                                       | medical records for accuracy.   |                      |
|                          |                             |   |                                       | 3. The DON or designee re-educ  |                      |
|                          | §483.70(i) Medical          | records.  |                                       | nurses on documentation guid  |                      |
|                          | §483.70(i)(1) In acc        | ordance with accepted   |                                       | include entering orders into E  |                      |
|                          | professional standa         | rds and practices, the facility ical records on each resident                   | :                                     | (Electronic Health Record) by   |                      |
| :                        | must maintain medithat are- | Cal records on each resident  | j.                                    | nurse, documenting treatment  |                      |
|                          | (i) Complete;               |   |                                       | (Treatment Administration Re  |                      |
| ,                        | (i) Completel               |   | 10                                    | incontinence care in POC (Po  | oint of Care).       |

|                          | OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>(DCN*IFICATION NUMBER  | (X2) MUL<br>A BUILD |     | CONSTRUCTION   |  | L SURVEY<br>MPLETED        |  |
|--------------------------|--|---|---------------------|-----|--|--|----------------------------|--|
|                          | 2  | 495283  | B WING              |     |  | 0.2  | C<br><b>25/2022</b>        |  |
| NAME OF                  | PROVIDER OR SUPPLIER   | ?   |                     | STR | EET ADDRESS, CITY, STATE, ZIP COI  |  |                            |  |
| PROME                    | DICA SKILLED NURS  | SING AND REHAB (IMPERIAL)   | ĺ                   |     | 9 BELLEVUE AVENUE<br>HMOND, VA 23227   |  |                            |  |
| (X4) IO<br>PREFIX<br>TAG | (EACH DEFICIENC  | ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION   | ID<br>PREFI)<br>TAG | (   | PROVIDER'S PLAN OF CORR<br>(EACH CORRECTIVE ACTION SI<br>CROSS-REFERENCED TO THE AF<br>DEFICIENCY)   | HOULD BE   | (X5)<br>COMPLETION<br>DATE |  |
|                          | all information contregardless of the forecords, except wh (i) To the individual representative whe (ii) Required by Law (iii) For treatment, poperations, as perm with 45 CFR 164.50 (iv) For public healt neglect, or domesti activities, judicial ar law enforcement pupurposes, research medical examiners, a serious threat to he by and in compliance. | umented; iible; and organized facility must keep confidential tained in the resident's records, orm or storage method of the en release is- , or their resident re permitted by applicable law; v; payment, or health care nitted by and in compliance 06; h activities, reporting of abuse, or violence, health oversight and administrative proceedings, irposes, organ donation purposes, or to coroners, funeral directors, and to avert lealth or safety as permitted the with 45 CFR 164.512. |                     |     | The DON or designee will at patient medical records week weeks to validate for accurace Administrator will submit au the QAPI committee for furtirecommendations.  The facility's alleged date of will be April 4, 2022. | dy times 4<br>by. The<br>dit findings ther review an | o                          |  |
| 3                        | record information a<br>unauthorized use.  | cility must safeguard medical against loss, destruction, or all records must be retained  |                     |     |  |  |                            |  |
| . †<br>(<br>(<br>t<br>(  | or-<br>(i) The period of time<br>(ii) Five years from the<br>here is no requirem<br>(iii) For a minor, 3 ye<br>egal age under Stat   | e required by State law; or<br>he date of discharge when<br>ent in State law; or<br>ears after a resident reaches   |                     |     |  | 4 8  |                            |  |
| (                        | i) Sufficient informat   | ion to identify the resident; sident's assessments;   |                     |     |  | 67<br>10   |                            |  |

|                          | OF DEFICIENCIES OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   | (X2) MUL           |      | CONSTRUCTION  |      | ATE SURVEY                 |
|--------------------------|--|---|--------------------|------|---|------|----------------------------|
|                          |  | i   | A BOILE            |      | 3   |      | С                          |
|                          |  | 495283  | B WING             |      |   | 0:   | 2/25/2022                  |
|                          | PROVIDER OR SUPPLIER<br>DICA SKILLED NURSI   | NG AND REHAB (IMPERIAL)   |                    | 1719 | ECT ADDRESS, CITY, STATE, ZIP CODE<br>9 BELLEVUE AVENUE<br>CHMOND, VA 23227                                     |      |                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)   | TEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFI<br>TAG | (    | PROVIDER'S PLAN OF CORRECTIO<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROP<br>DEFICIENCY) | ) BE | (X5)<br>COMPLETION<br>DATE |
| F 842                    |  | ge 127<br>sive plan of care and services  | F8                 | 42   |   |      | 1                          |
|                          | and resident review  |   |                    |      |   |      |                            |
|                          | determinations cond<br>(v) Physician's, nurs<br>professional's progr                         | e's, and other licensed   |                    |      |   |      |                            |
|                          | services reports as i  | ology and other diagnostic<br>required under §483.50.<br>T is not met as evidenced  |                    |      |   |      |                            |
| 1                        | acility document rev   | view, clinical record review,<br>riew, and in the course of a   |                    |      |   |      | i                          |
| i t                      | he facility staff failed   | on, it was determined that I to ensure a complete and ord for 2 of 14 residents in  |                    | 5    |   |      | i                          |
| t                        |  | Residents #4 and #1.  |                    |      |   |      |                            |
| 7/                       | The initiality of the lade.  | i i   |                    |      |   |      | 1                          |
| d                        |  | ne facility staff failed to n's order for a lab test that   |                    | t    |   |      |                            |
| : 6.                     | /19/14 and was disc  | nitted to the facility on harged on 8/8/21. Resident of but not limited to multiple   |                    |      |   |      |                            |
| pi<br>(N<br>ar           | clerosis, peripheral v<br>ressure injury. On tl<br>/linimum Data Set) a<br>n ARD (Assessment | vascular disease, and he most recent MDS a quarterly assessment with Reference Date) of 6/1/21,                               |                    |      |   |      |                            |
| (b<br>re<br>co           | rief interview for me<br>sident was unable to  | "99" out of 15 on the BIMS ntal status), indicating the complete the interview for being severely cognitively aily decisions. |                    |      |   |      |                            |
| A                        | review of the clinical   | record revealed a nurse's documented, "Resident   |                    |      |   | 1    |                            |

|   | OLIVICATION ON MEDICINICE  | G WICESTON WID OF LANCES  |                        |   | OIND 14 | <u>I</u> O. 0938-039       | ï |
|---|--|---|------------------------|---|---------|----------------------------|---|
|   | STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CI IA<br>IDENTIFICATION NUMBER:  | (X2) MULI<br>A BUILDIN | IPLE CONSTRUCTION<br>IG   | (X3) D  | OATE SURVEY                | - |
| Į |  | 495283  | B. WING_               |   | 0       | C<br>12/25/2022            |   |
|   | NAME OF PROVIDER OR SUPPLIER PROMEDICA SKILLED NURSI   | NG AND REHAB (IMPERIAL)   |                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br>1719 BELLEVUE AVENUE<br>RICHMOND, VA 23227                     |         | 212012022                  |   |
|   | PREFIX (EACH DEFICIENCY  | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG    | PROVIDER'S PLAN OF CORREC<br>(EACH CORRECTIVE ACTION SHO<br>CROSS-REFERENCED TO THE APPR<br>DEFICIENCY) | OULD BE | (XS)<br>COMPLETION<br>DATE |   |
|   | status earlier in shift (urinalysis) (1) collect up. MD (medical doc resident to er (Emen (evaluation). Resider status."  A review of the clinic evidence of a physical On 2/24/22 3:39 PM with LPN #3 (License the nurse that wrote to resident to the hospit the order from the dochere. I did not get the because the family we resident going out. I afterwards."  The facility policy Doc reviewed. This policy orders are either hand practitioner wet signal electronically. Only a and transcribe a verbal | ntake and altered mental. Per family request UA cted and lab called for pick ctor) called new order send gency Room) for evaluation and record failed to reveal any ian's order for the UA.  an interview was conducted at Practical Nurse), who was the above note sending the al. She stated that she "Gut ctor and the family was e order into the system as adamant about the forgot to put the order in decimal order."  Sumentation Guidelines was documented, "Physician decimal order."  A. ASM #1, ASM #2, and | F 84                   | 2   |         |                            |   |
|   | ASM #3 (Administrativ<br>Administrator, Director<br>Quality Consultant, res  | re Staff Member) the r of Nursing, and Regional spectively, were made No further information was  |                        |   |         |                            |   |
|   | References:  |   |                        |   |         |                            |   |
|   | Urinalysis - A urinaly     It is often done to chec  | ysis is a test of your urine.   | 1                      |   |         |                            |   |

| OEMIZINO CONTINE   | 10101111   | WHILDIONID CENTRICE   | 1                   |   | OND 140, 0830-035             |
|--|--|---|---------------------|---|-------------------------------|
| STATEMENT OF DEFICIENCE<br>AND PLAN OF CORRECTION  |  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   | 1 ' '               | PLE CONSTRUCTION  | (X3) DATE SURVEY<br>COMPLETED |
|  |  |   | Í                   |   | С                             |
|  |  | 495283  | B WING_             |   | 02/25/2022                    |
| PROMEDICA SKILLE   |  | IG AND REHAB (IMPERIAL)   | 1                   | STREET ADDRESS, CITY, STATE, ZIP CODE<br>1719 BELLEVUE AVENUE<br>RICHMOND, VA 23227                     |                               |
| PRÉFIX (EACH D   | EFICIENCY  | EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORREC<br>(EACH CORRECTIVE ACTION SHO<br>CROSS-REFERENCED TO THE APPI<br>DEFICIENCY) | DULD BE COMPLETION            |
| also have o<br>admitted to<br>or if you are  | kidney pro<br>ne during<br>the hosp<br>pregnan   | oblems, or diabetes. You may<br>a checkup, if you are<br>ital, before you have surgery,<br>t. It can also monitor some  | F 842               | r A   |                               |
| Information  | obtained   | nd treatments.<br>from<br>ov/urinalysis.html  |                     |   |                               |
|  | e medical  | ailed to provide a complete record for wound care lent #1.  | 1                   |   | t                             |
| 10/15/21 with not limited to diabetes med recent MDS quarterly ass reference dayscoring a 15 interview for the second sec | h diagnos  b: periphe  llitus and (minimun  essment  te) of 1/2  out of 15  mental st  | itted to the facility on is that included but were ral vascular disease, atrial fibrillation. The most of data set) assessment, a with an ARD (assessment of 22, coded the resident as on the BIMS (brief atus) score, indicating the titvely impaired. |                     |   |                               |
| 10/27/21 doct<br>area to sacru-<br>treatment per<br>A review of the<br>revealed the f<br>tailbone with v   | umented<br>m. INTI<br>physicia<br>e physicia<br>following,<br>wound cla<br>antyl to we | chensive care plan dated in part, "FOCUS: Open ERVENTIONS: Administer orders." an orders dated 12/22/21, "Cleanse wound to canser, pat dry, apply skin bund bed and cover with  |                     |   |                               |
| administration   | record) 1  | i's TAR (treatment<br>rom 12/1/21-2/25/22,<br>nentation of treatments for   | 1                   |   |                               |

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 03/08/2022 FORM APPROVED

| CENTI                    | ERS FOR MEDICARI                             | E & MEDICAID SERVICES   |                     |     |  | OMB I | VO. 0938-039               |
|--------------------------|--|---|---------------------|-----|--|-------|----------------------------|
|                          | NT OF DEFICIENCIES<br>I OF CORRECTION        | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER                            | (X2) MUI<br>A BUILD |     | CONSTRUCTION   |       | DATE SURVEY<br>COMPLETED   |
|                          |  | 495283  | B: WING             |     |  |       | C<br>02/25/2022            |
| NAME OF                  | PROVIDER OR SUPPLIER                         |   |                     | STF | REET ADDRESS, CITY, STATE, ZIP CODE  |       |                            |
| PROME                    | DICA SKILLED NURS                            | ING AND REHAB (IMPERIAL)  |                     |     | 9 BELLEVUE AVENUE  |       |                            |
|                          |  | <u></u>   |                     | RIC | CHMOND, VA 23227   |       |                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)                             | NTEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SCIDENTIFYING INFORMATION) | ID<br>PREFI)<br>TAG | (   | PROVIDER'S PLAN OF CORRECTI<br>(EACH CORRECTIVE ACTION SHOUL<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY) | LD BE | (XS)<br>COMPLETION<br>DATE |
| F 842                    | Continued From pa                            | ne 130  | F 84                | 42  |  |       |                            |
| 1 0 12                   |  | yx/tailbone on one out of 9   | F 84                | łZ  |  |       |                            |
|                          | onnortunities in Dec                         | cember 2021, seven out of 31  |                     |     |  |       |                            |
|                          | opportunities in Jan                         | uary 2021, and seven out of   |                     |     |  |       |                            |
|                          | 25 opportunities in f                        | February 2021.  |                     |     |  |       |                            |
|                          | An interview was co                          | nducted on 2/23/22 at 12:56   |                     |     |  |       |                            |
|                          |  | When asked if he was  |                     |     |  |       |                            |
|                          | receiving wound car                          | e, Resident #1 stated, "Yes,  |                     |     |  |       |                            |
| !                        | they are glvlng me w                         | vound care. I think it is every   |                     |     |  |       |                            |
|                          |  | thing on the wound and then   |                     |     |  |       |                            |
| i                        | a new dressing. It is                        | s nealing up nicely."   |                     |     |  |       |                            |
|                          | An interview was cor                         | nducted on 2/24/22 at 10:36   |                     |     |  |       |                            |
| - 1                      | AM with LPN #1. W                            |   |                     | 1   |  |       |                            |
| 116                      |  | 1's wound to his tailbone,  |                     |     |  |       | , F                        |
|                          | LPN #1 stated, "Yes,                         | I have. It is healing. We   |                     |     |  |       |                            |
|                          |  | shown the TAR for Resident  |                     |     |  |       |                            |
|                          |  | occyx/tailbone and asked 🛒 🤚  |                     |     |  |       |                            |
|                          |  | n, "LPN #1 stated, "Blanks"   |                     |     |  |       |                            |
|                          | mean that the care w<br>not documented in th | as not provided and it was  |                     |     |  |       |                            |
| - 6                      | not accontented to to                        | e medical record,   |                     |     |  |       |                            |
| 1                        | An interview was con                         | ducted on 2/24/22 at 1:15   |                     |     |  |       |                            |
|                          |  | nen asked what the blanks in  |                     |     |  |       |                            |
| 11                       | the wound care docu                          | mentation means, LPN #5   |                     |     |  |       | a.                         |
|                          | stated, "If there are bl                     | lanks and it was not signed 🐇   |                     | į.  |  |       | 9                          |
|                          | off, then it was not do                      | ne." When asked if holes in   |                     |     |  |       | 1                          |
|                          |  | te a complete medical   |                     |     |  |       |                            |
|                          |  | I, "No, it is not a complete  |                     |     |  |       | [                          |
| 1 n                      | medical record."                             |   |                     |     |  |       | ĭ)                         |
| 1 4                      | n interview was con-                         | ducted on 2/24/22 at 1:58   |                     | 1   |  |       | 10:                        |
|                          |  | interim director of nursing,  |                     |     |  |       | 1                          |
|                          |  | blanks on the TAR mean,   |                     |     |  |       |                            |
| A                        | SM #2 stated, "It me                         | ans that the care was not   |                     |     |  |       |                            |
|                          | iven."                                       | 1   |                     |     |  |       |                            |
|                          | - 2/24/22 -+ 4:00 Dt                         | 1 4 6 1 4 4 4 4   |                     |     |  |       | ,                          |
|                          | n 2/24/22 at 4:30 PM                         |   |                     |     |  |       |                            |
| ( a                      | unninstratur, ASIVI #Z                       | , the director of nursing and 🐩   |                     |     |  |       |                            |

|                          | NT OF DEFICIENCIES<br>OF CORRECTION            | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER                                 | (X2) MULT           |      | CONSTRUCTION  |     | TE SURVEY<br>MPLETED       |
|--------------------------|--|--|---------------------|------|---|-----|----------------------------|
|                          |  |  | 1 2 30 KO           |      |   |     | С                          |
|                          |  | 495283   | B. WING             |      |   | 02  | /25/2022                   |
| NAME OF                  | PROVIDER OR SUPPLIER                           | <del></del>  |                     | STRE | ET ADDRESS, CITY, STATE, ZIP CODE   | ·   |                            |
| PPOME                    | DICA SKILLED NUBS                              | ING AND REHAB (IMPERIAL)   | Ì                   | 1719 | BELLEVUE AVENUE   |     |                            |
| FROME                    | DICA SKILLED HOKO                              |  |                     | RICH | HMOND, VA 23227   |     |                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)                               | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION) | ID<br>PREFIX<br>TAG |      | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROPE<br>DEFICIENCY) | BE  | (X5)<br>COMPLETION<br>DATE |
| F 842                    | Continued From pa                              | ge 131   | F 84                | 2    |   |     |                            |
|                          | #4, the regional dire                          | al quality consultant and ASM ector of risk management,                              |                     |      |   |     |                            |
|                          | above concern.                                 | nce, were made aware of the  |                     |      |   |     |                            |
|                          |  | AM, ASM #3, the regional lated, "The standard of                                     |                     |      |   |     |                            |
|                          |  | ity is our policies and  |                     |      |   |     |                            |
|                          | According to the fac<br>Guidelines" policy, ". | ility's "Documentation All treatments  |                     |      |   |     | 22:                        |
|                          | ordered/completed a                            | are documented in the  |                     |      |   |     | •                          |
|                          | Treatment Administrelectronic."                | ration Record- paper or  |                     | ė.   |   |     |                            |
|                          | No further information                         | on was provided prior to exit.   |                     |      |   |     |                            |
|                          | TVO TOTALIO                                    | on was provided prior to oxit.   |                     |      |   | 3,0 |                            |
|                          |  | failed to provide a complete   |                     |      |   |     |                            |
| 4                        |  | his incontinence care.   |                     |      |   | 9   |                            |
|                          | A review of the comp                           | rehensive care plan dated  |                     |      |   | 11  |                            |
|                          | 10/27/21 documente                             | d in part, "FOCÚS: Urinary 🤚   |                     |      |   |     |                            |
|                          | incontinence related                           |  |                     | (1)  |   | 1   |                            |
|                          | needed."                                       | Provide incontinent care as  |                     |      |   | 1   |                            |
|                          |  |  |                     |      |   |     |                            |
|                          |  | #1's ADL (activities of daily  |                     |      |   |     |                            |
|                          |  | 2/1/21-2/25/22, reveals on of incontinence care for                                  |                     |      |   |     |                            |
|                          |  | ecember, 22 of 93 shifts in  |                     | i.   |   | 1   |                            |
|                          |  | of 75 shifts in February.  |                     |      |   | 1   | ľ                          |
| 1                        | An interview was con-                          | ducted with Resident #1 on   |                     |      |   | i i |                            |
|                          |  | When asked if his needs  |                     |      |   |     |                            |
|                          |  | dent #1 stated, "Most of the   |                     |      |   |     |                            |
|                          |  | ere are some times that I  |                     |      |   | 1   |                            |
| h                        | ave to wait for an ho                          | ur to get cleaned up."   |                     |      |   |     |                            |

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| CLIV                  | TENS FOR MILDICARI   | A MEDICAID SERVICES   |                     |       |  | OWR M    | <u>0</u> . 0938-039        |
|-----------------------|--|---|---------------------|-------|--|----------|----------------------------|
|                       | MENT OF DEFICIENCIES<br>AN OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER  | (X2) MUL'           |       | CONSTRUCTION   | (X3) D   | ATE SURVEY<br>DMPLETED     |
|                       |  | 495283  | B WING              |       |  | 0:       | C<br>2/25/2022             |
|                       | OF PROVIDER OR SUPPLIER  | NG AND REHAB (IMPERIAL)   |                     | 1719  | EET ADDRESS, CITY, STATE, ZIP COD<br>B BELLEVUE AVENUE<br>HMOND, VA 23227                            |          | LIZGILULL                  |
| (X4) I<br>PREF<br>TAG | X (EACH DEFICIENC)   | TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG |       | PROVIDER'S PLAN OF CORRE<br>(EACH CORRECTIVE ACTION SH<br>CROSS-REFERENCED TO THE APP<br>DEFICIENCY) | IOULD BE | (X5)<br>COMPLETION<br>DATE |
| F 84                  | 2 Continued From pa  | ge 132  | F 84                | 2     |  |          |                            |
|                       | PM with CNA (certification When asked the free rounds, CNA #2 state hours. If the resider then, we adjust to masked what it means documentation, CNA blanks, then it was not is complete docume CNA #2 stated, "No."   |   |                     |       |  |          |                            |
|                       | PM with CNA #1. W incontinence rounds, "Incontinence care is every two hours." W incontinence care is property in the work with the with t | heducted on 2/24/22 at 3:29 hen asked the process for CNA #1 stated, supposed to be provided hen asked how frequently provided, CNA #1 stated, y two hours. We do it in and before you leave your |                     | 12 12 |  |          |                            |
|                       | ASM #3, the regional #4, the regional direct   | M, ASM #1, the 2, the director of nursing and quality consultant and ASM or of risk management, e, were made aware of the   |                     |       |  |          |                            |
| F 880<br>SS=E         | Infection Prevention &   |   | F 880               |       |  |          |                            |
| The section as a      | §483.80 Infection Con<br>The facility must estab<br>infection prevention ar<br>designed to provide a   | lish and maintain an  |                     |       |  |          |                            |

### DEPARTMENT OF HEALTH AND HUMAN SERVICES

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| CENTE                    | RS FOR MEDICARI                    | & MEDICAID SERVICES  |                     |                              |  | OMB NO.      | <u>0938-03</u>           |
|--------------------------|------------------------------------|--|---------------------|------------------------------|--|--------------|--------------------------|
| STATEMEN                 | T OF DEFICIENCIES<br>OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER                           | 1 ' '               |                              | NSTRUCTION   | COMF         | SURVEY<br>PLETED         |
|                          |                                    | 495283   | B WING              |                              | _  | 02/2         | 25/2022                  |
|                          |                                    | 455205   |                     |                              | T ADDRESS, CITY, STATE, ZIP CODE   |              |                          |
| NAME OF                  | PROVIDER OR SUPPLIER               |  |                     |                              | BELLEVUE AVENUE  |              |                          |
| PROME                    | DICA SKILLED NURS                  | ING AND REHAB (IMPERIAL)   |                     |                              | MOND, VA 23227   |              |                          |
|                          |                                    |  |                     | - KICH                       |  | 7101         |                          |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)                   | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID<br>PREFIX<br>TAG |                              | PROVIDER'S PLAN OF CORREC<br>(EACH CORRECTIVE ACTION SHO)<br>CROSS-REFERENCED TO THE APPR<br>DEFICIENCY) | ULD BE       | (X5)<br>COMPLETH<br>DATE |
|                          |                                    |  |                     | Ta                           | F880 - Failed to maintain I  | nfection     |                          |
| F 880                    | Continued From pa                  | ge 133   | F 88                | 30 <b>C</b> o                | ntrol Program  |              |                          |
|                          | comfortable enviror                | nment and to help prevent the  |                     | 1                            | Resident # 8, # 9, # 13, and # 1   | 14 were cacl | h                        |
|                          | development and tr                 |  |                     | placed on isolation 2/24/22. |  |              |                          |
|                          | diseases and infect                |  |                     | The DON has reviewed all cur | rent   |              |                          |
|                          | 0.400.00(.) 5-55                   | tien and control   |                     |                              | residents to validate isolation g  |              |                          |
|                          |                                    | n prevention and control   |                     |                              | related to newly admitted and  | ra admittad  |                          |
|                          | program. The facility must es      |  |                     |                              |  |              |                          |
|                          | and control program                | n (IPCP) that must include, at   |                     |                              | residents are in place and form  | urated       |                          |
|                          | a minimum, the foll-               |  |                     |                              | infection surveillance logs.   |              |                          |
|                          |                                    | _  |                     |                              | The DON or designee has re-e   |              |                          |
|                          | §483.80(a)(1) A sys                | tem for preventing, identifying,   |                     |                              | facility staff on the infection c  |              |                          |
|                          | reporting, investigation           | ting, and controlling infections   |                     |                              | program as it relates to isolatic  |              | S                        |
|                          | and communicable                   | diseases for all residents,  |                     |                              | for newly admitted and re-adm  |              |                          |
|                          | staff, volunteers, vis             | sitors, and other individuals  |                     |                              | residents, location of isolation   | supplies and | d                        |
|                          | providing services u               | inder a contractual  |                     |                              | process for verification of vacc   | cination     |                          |
|                          | arrangement based                  | upon the facility assessment g to §483.70(e) and following                     |                     |                              | status of residents on admissio  | n or re-     |                          |
|                          | accepted national s                | tandards   |                     |                              | admission. The Administrator   | or designee  | <b>.</b>                 |
|                          | accepted fiational 5               | (21733133)   |                     |                              | has re-educated the Nursing M  |              |                          |
|                          | \$483.80(a)(2) Writte              | en standards, policies, and  |                     |                              | staff and the Infection Prevent  | -            |                          |
|                          | procedures for the                 | orogram, which must include,   |                     |                              | developing and maintaining in  |              |                          |
|                          | but are not limited to             | o:   |                     |                              | surveillance logs and antibiotic   |              |                          |
|                          | (i) A system of survi              | eillance designed to identify  |                     |                              |  | , 3.0 11414  |                          |
|                          | possible communication             |  |                     |                              | ship program.  | nnlata       |                          |
|                          |                                    | ey can spread to other   |                     | 4.                           | The DON or designee will con   | ipiele       |                          |
|                          | persons in the facility            | om possible incidents of   |                     |                              | nfection control rounds weekl  |              |                          |
| 1                        | communicable dises                 | ase or infections should be  |                     |                              | validate that isolation guideline  |              |                          |
| ļ                        | reported;                          | ase of integrals strong of   |                     |                              | followed for newly admitted at   |              |                          |
|                          |                                    | ansmission-based precautions   |                     |                              | admitted residents. The Admir  |              |                          |
|                          |                                    | event spread of infections;  |                     |                              | designee will audit the infectio   |              |                          |
|                          | (iv)When and how is                | solation should be used for a 🦠  |                     |                              | surveillance logs weekly x 4 w   |              |                          |
| 1                        | resident; including b              | out not limited to:  |                     |                              | nonthly x 2 months to validate   |              |                          |
|                          | (A) The type and du                | ration of the isolation,   |                     |                              | nce. The Administrator will s  | submit audit |                          |
| Į.                       |                                    | infectious agent or organism   |                     |                              | indings to the QAPI committe   |              |                          |
|                          | involved, and                      | حطة حط الماريم طب سيند البياد على على ما                                       |                     |                              | and further recommendations.   |              |                          |
|                          | (B) A requirement th               | hat the isolation should be the  |                     |                              | The facility's alleged date of co  | ompliance    |                          |
|                          | least restrictive poss             | sible for the resident under the   |                     | J.                           |  |              | 4/4/202                  |

will be April 4, 2022.

4/4/2022

|                          | NT OF DEFICIENCIES   | (X1) PROVIDER/SUPPLIER/CLIA  | (X2) MULTIF   | PLE CONSTRUCTION  | (X3) DATE SURVEY |
|--------------------------|--|--|---------------|---|------------------|
| AND PLAN                 | OF CORRECTION  | IDENTIFICATION NUMBER:   | A BUILDING    | S   | COMPLETED        |
|                          |  | 405000   |               |   | С                |
| NAME OF                  | DDOVIDED OD SUDDI IED  | 495283   | B. WING       |   | 02/25/2022       |
| NAME OF                  | PROVIDER OR SUPPLIER   |  |               | STREET ADDRESS, CITY, STATE, ZIP CODE   |                  |
| PROME                    | DICA SKILLED NURSI   | NG AND REHAB (IMPERIAL)  |               | 1719 BELLEVUE AVENUE<br>RICHMOND, VA 23227  |                  |
|                          | CHAMADY CTA  | TENENT OF RESIDENCE  |               | <del></del>   |                  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY   | FEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL GO IDENTIFYING INFORMATION)  | PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTIC<br>(EACH CORRECTIVE ACTION SHOULI<br>CROSS-REFERENCED TO THE APPROF<br>DEFICIENCY) | D BE COMPLETION  |
|                          | must prohibit employ disease or infected secontact with resident contact will transmit (vi)The hand hygiend by staff involved in description of the factorial second of the fa | es under which the facility yees with a communicable skin lesions from direct is or their food, if direct the disease; and exprocedures to be followed irect resident contact.  The for recording incidents acility's IPCP and the sen by the facility.  The store, process, and is to prevent the spread of the recording incidents acility is incidents acility incidents. | F 880         | •   |                  |
| 8                        | a complete infection of<br>staff failed to impleme   | ocility staff failed to maintain ontrol program. The facility nt isolation procedures on   |               |   |                  |
| F                        | Residents #8, #9, #13  | ur of five new admissions,<br>and #14; and failed to<br>htrol tracking logs for three  |               |   |                  |
| C                        | of the past six months   |  | ì             |   | 80               |
| I                        | he findings include:   |  |               |   | 1 88             |
| p<br>fi                  | olicy and initiate isola<br>ve new admissions re   | alled to implement their<br>tion precautions for four of<br>viewed, Residents #8, #9,<br>esidents were not placed in   |               |   | 100              |

| OF 14 LF                    | TIO FOR MEDICARE  | - A MILDIONID BLIVIOLS  | -                   |  | OMB 140 0000-000              |  |
|-----------------------------|---|---|---------------------|--|-------------------------------|--|
|                             | IT OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER  | (X2) MULT           | TIPLE CONSTRUCTION  NG   | (X3) DATE SURVEY<br>COMPLETED |  |
|                             |   | 495283  | B. WING             |  | C<br>02/25/2022               |  |
|                             | PROVIDER OR SUPPLIER  | NG AND REHAB (IMPERIAL)   |                     | STREET ADDRESS, CITY, STATE, ZIP CODE<br>1719 BELLEVUE AVENUE<br>RICHMOND, VA 23227                      | ( Varauraura                  |  |
| (X4) ID<br>PREFIX<br>TAG    | (EACH DEFICIENC)  | TEMENT OF DEFICIENCIES<br>MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORREC<br>(EACH CORRECTIVE ACTION SHO<br>CROSS-REI-ERENCED TO THE APPR<br>DEFICIENCY) | ULD BE COMPLÉTION             |  |
| F 880                       | Continued From pa<br>isolation for possible<br>initially admitted to t  | e COVID-19 when they were   | F 88                | 30   |                               |  |
|                             | administrator and All<br>nursing, was conduct<br>a.m. ASM #1 and A<br>residents were curre<br>stated that they had                                  | member) #1, the interim SM #2, the interim director of cted on 2/23/2022 at 11:30 SM #2 were asked if any ently on isolation. ASM #2 several residents on isolation missions. ASM #2 stated she   |                     |  |                               |  |
| 1                           | 2/23/2022 at 12:15 p  | de of the entire facility on<br>.m. There were no signs on<br>a isolation supplies outside of   |                     | 4  | 1                             |  |
|                             | p.m. of two resident a<br>Resident #9. At this<br>contained a sign rega<br>Droplet Precautions a<br>LPN (licensed practic<br>putting a cart outside | de on 2/23/2022 at 12:40 rooms, Resident #8 and time, each room door now arding Contact Precautions, and Airborne Precautions. all nurse) #6 was observed a resident's door. The cart upplies for the staff to put on oom.  |                     |  |                               |  |
| 2<br>(<br>(<br>(<br>i)<br>r | 2/14/2022. On the modata set), an admission assessment reference esident scored a 15 onterview for mental sesident is not cognitivally decisions.   | nitted to the facility on ost recent MDS (minimum on assessment with an ARD ce date) of 2/20/2022, the out of 15 on the BIMS (brief latus) score, indicating the vely impaired for making   |                     |  |                               |  |
|                             |   | B's physician orders on in a failed to evidence an order produced in a failed to evidence and order produced in a failed in a |                     |  | 17                            |  |

| OLIVILATO CON MEDIOVIN   | IL O MEDIONID DERVICES   |                     |   | 21410 140, 0930-035 |
|--|--|---------------------|---|---------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:                          | (X2) MULTIP         | (X3) DATE SURVEY<br>COMPLETED   |                     |
| J  |  |                     |   | С                   |
|  | 495283   | B. WING             |   | 02/25/2022          |
| NAME OF PROVIDER OR SUPPLIER   |  | S                   | STREET ADDRESS, CITY, STATE, ZIP CODE   |                     |
| PROMEDICA SKILLED NURS   | ING AND REHAB (IMPERIAL)   | 1                   | 719 BELLEVUE AVENUE   |                     |
|  |  | F                   | RICHMOND, VA 23227  |                     |
| PREFIX (EACH DEFICIENC   | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTIC<br>(EACH CORRECTIVE ACTION SHOULI<br>CROSS-REFERENCED TO THE APPROP<br>DEFICIENCY) | D BE COMPLETION     |
| F 880 Continued From pa  | 200 126  | E 000               |   |                     |
|  |  | F 880               |   |                     |
| for isolation. The clinical record failed to evidence documentation of COVID - 19 vaccination status |  |                     |   |                     |
| On 2/23/2022 at 2:0  | 09 p.m. an interview was   |                     |   |                     |
|  | sident #8. When asked when   |                     |   |                     |
|  | aring gowns before entering<br>#8 stated the staff just started =              | - 3                 |   |                     |
|  | lunch that day. When asked   |                     |   |                     |
|  | oor were there since   |                     |   | 3.1                 |
|  | t #8 stated they were just put   |                     |   |                     |
| up today. Observati  | on of the room at that time  |                     |   |                     |
|  | sposal receptacles for the   |                     |   |                     |
|  | hen asked if he was  | 9.                  |   |                     |
|  | COVID-19, Resident #8 stated :<br>acclnations, and that he                     |                     |   |                     |
| didn't want them.  | raccinations, and that he  |                     |   |                     |
| Giorit Want them.  | Ų.   |                     |   |                     |
| An interview was co  | nducted with LPN (licensed   |                     |   |                     |
|  | on 2/23/2022 at 2:15 p.m.  |                     |   |                     |
|  | dent #8 was on isolation, LPN  |                     |   |                     |
|  | came to us from the hospital."   |                     |   |                     |
|  | ut the observation of her de the resident's door, LPN                          | i.                  |   |                     |
|  | there this morning." When  |                     |   | 03                  |
|  | s were put up, LPN #6 stated   |                     |   |                     |
|  | N #6 further stated that she   |                     |   |                     |
|  | When asked how long the  |                     |   |                     |
|  | the facility, LPN #6 stated he   | 19                  |   | - 1                 |
|  | ek. LPN #6 stated she called   |                     |   |                     |
|  | environmental services).<br>dn't know all new residents                        |                     |   |                     |
|  | n. When asked whose  |                     |   | 75                  |
|  | ensure the residents that  | - 3                 |   | 1                   |
| required isolation are   | on isolation, LPN #6 stated,   |                     |   | -                   |
| "It was everyone's."   |  |                     |   | *)                  |
| 14   |  | 1                   |   |                     |
|  | ducted with OSM (other staff   | 1                   |   |                     |
| member) #3, the direct   | ctor of environmental 2 at 2:30 p.m. When asked                                |                     |   |                     |
| 201 AICG2 OH 717215057   | at 2.50 p.m. which asked   | 1.                  |   | 15                  |

| OCITICITO I OTT MEDIOTIT   | E OF MICEOLOGICA OFFICE OF TANGED  |                     |   |                               | 100      |
|--|--|---------------------|---|-------------------------------|----------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  | (X2) MULT           | IPLE CONSTRUCTION   | (X3) DATE SURVEY<br>COMPLETED | Y        |
|  | 405202   | D MING              |   | С                             |          |
|  | 495283   | B WING_             |   | 02/25/2022                    | <u> </u> |
| PROMEDICA SKILLED NURS   |  |                     | STREET ADDRESS, CITY, STATE, ZIP CODE<br>1719 BELLEVUE AVENUE<br>RICHMOND, VA 23227                     |                               |          |
| PREFIX (EACH DEFICIENC   | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORREC<br>(EACH CORRECTIVE ACTION SHO<br>CROSS-REFERENCED TO THE APPI<br>DEFICIENCY) | OULD BE COMPLET               | HON      |
| admitted, or newly   | that a resident who is newly readmitted, is to be on   | F 88                | )<br>י  | 6                             |          |
| admission form." V<br>forms, OSM #3 state<br>When asked if she<br>was supposed to be             | stated "They give me the When asked if she kept these led that she discards them, was notified that Resident #9 e on isolation, OSM #3 stated, |                     |   |                               |          |
| disposal bins in the that that they were i   | f she put the trash and linen<br>room, OSM #3 stated no, and<br>n the process of cleaning  |                     | ř   | #3<br>78                      |          |
| leaves from her dep  | what time the last person<br>partment each day, OSM #3<br>on leaves at 4:00 p.m. When  |                     |   | •                             |          |
| admission comes in   | is put into place if an<br>after 4:00 p.m., OSM #3<br>ome in in the morning we   |                     |   | 1                             |          |
| would put it out." Where resident is not on isc<br>time they enter the fa                        | nen asked if this means the blation precautions between acility after 4:00 p.m. on one   |                     |   |                               |          |
| •  | environmental services staff at 6:00 a.m. on the following "Yes."  |                     |   |                               |          |
| 2/17/2022, On the m  | s readmitted to the facility on ost recent MDS (minimum assessment, with an ARD  |                     |   | i i                           |          |
| (assessment referen  | ce date) of 10/12/2022, the out of 15 on the BIMS (brief   |                     |   |                               |          |
|  | y cognitively impaired for   |                     |   |                               |          |
| 1:00 p.m. failed to evi<br>The clinical record do<br>received COVID vacc<br>on 2/2/2021. There w | an orders on 2/23/2022 at idence an order for isolation. cumented the resident cinations on 1/12/2021 and as no documentation of a             |                     |   |                               |          |
| booster given,   |  |                     |   | 1                             |          |

| CENTE  | NO I ON MEDICARE   | A MEDICAID SERVICES  |                     |      |   | DIMR L | <u>vo. 0938-039</u>        |
|--|--|--|---------------------|------|---|--------|----------------------------|
|  | T OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  | (X2) MUL            |      | CONSTRUCTION  | (X3) I | DATE SURVEY<br>COMPLETED   |
| l  |  | 495283   | B_WING_             |      |   |        | 02/25/2022                 |
|  | PROVIDER OR SUPPLIER  DICA SKILLED NURSI   | NG AND REHAB (IMPERIAL)  |                     | 1719 | EET ADDRESS, CITY, STATE, ZIP CODE<br>9 BELLEVUE AVENUE<br>HMOND, VA 23227                              |        | 012022                     |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FUIL SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG |      | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROVIDERICLENCY) | D BE   | (XS)<br>COMPLETION<br>DATE |
|  | was observed. The Precautions, Drople Precautions were no was a cart containin staff located outside were no trash and lit in the room.  An interview was con 2/23/2022 at 2:15 p. #9 was on isolation patted she had place this afternoon.  | 9 p.m. Resident #9's room  | F 88                | 30   |   |        |                            |
| i<br>C<br>H<br>ii  | nurse) #1 on 2/23/20<br>f Resident #9 was o<br>don't believe so." Wh<br>nas outside her door   | 22 at 2:19 p.m. When asked isolation, RN #1 stated, "I len asked why the resident and signs on her door than lation, RN #1 did not |                     |      |   |        |                            |
| p<br>V<br>#<br>h<br>re<br>is<br>th<br>re<br>as<br>su<br>hc<br>re | practical nurse) #4 or When asked if Reside 4 stated "Yes, she shospital and returned esident returns from the later to the computer and state turned on 2/17/2022 sked whose responsupplies in place, LPN pusekeeping's responstater than the later t | , six days earlier. When ibility is it to get the isolation  |                     |      |   |        |                            |

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:                             | (X2) MULTIPLE CONSTRUCTION |     |   | (X3) DATE SURVEY<br>COMPLETED |                            |
|---|---|----------------------------|-----|---|-------------------------------|----------------------------|
|   |   | A BOILDI                   | .NG |   |                               | С                          |
|   | 495283  | B WING                     |     |   | 1 1                           | 02/25/2022                 |
| NAME OF PROVIDER OR SUPPLIER                        | ING AND REHAB (IMPERIAL)  |                            |     | EÉT ADDRESS, CITY, STAFE, ZIP CODE<br>9 BELLEVUE AVENUE   | •                             |                            |
| - FROMEDICA SKIELEB NORS                            |   |                            | RIC | HMOND, VA 23227   |                               |                            |
| PREFIX (EACH DEFICIENC                              | ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION) | ID<br>PREFIX<br>TAG        | ()  | PROVIDER'S PLAN OF CORRECTIO<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROP<br>DEFICIENCY) | ) BE                          | (X5)<br>COMPLETION<br>DATE |
| F 880 Continued From pa                             | age 139   | F 88                       | 30  |   |                               |                            |
|   | e for housekeeping, and   |                            |     |   |                               |                            |
|   | res at the facility between 5:00  |                            |     |   |                               |                            |
| a.m. and 6:00 a.m.                                  | the following morning. LPN #4   |                            |     |   |                               |                            |
|   | lo not have access to isolation   |                            |     |   |                               |                            |
|   | stated, "I still let my staff   |                            |     |   |                               |                            |
|   | solation." When asked where   |                            |     |   |                               |                            |
|   | ed isolation equipment when<br>n, I PN #4 stated there should                     |                            | 1.  |   |                               |                            |
|   | nd linen cans in the room   |                            |     |   |                               |                            |
|   |   |                            |     |   |                               |                            |
| An interview was co                                 | onducted with OSM #3 on   |                            |     |   |                               |                            |
|   | .m. When asked if she was   |                            |     |   |                               |                            |
|   | was supposed to be on   |                            | 10  |   |                               |                            |
|   | tated she was just notified   |                            | 10  |   |                               |                            |
|   | ed who gives her the  ng a new or readmission that                                |                            | â   |   |                               |                            |
|   | SM #3 stated [the name of   |                            |     |   |                               |                            |
| the admissions coor                                 |   |                            |     |   |                               |                            |
|   | -   |                            |     |   |                               |                            |
|   | nducted with OSM #5, the  |                            | 1   |   |                               |                            |
|   | ator, on 2/23/2022 at 3:17  |                            |     |   |                               |                            |
|   | e process for notifying the on or readmission needs                               |                            |     |   |                               |                            |
|   | ated all residents go on  |                            | į.  |   |                               |                            |
|   | not boosted. If the new   |                            | 1   |   |                               |                            |
|   | cinated, the resident must be   |                            | 1   |   |                               | -                          |
|   | isolation for ten days. When  |                            | Ÿ   |   |                               |                            |
|   | nation is communicated with   |                            | ,   |   |                               |                            |
|   | ated it goes out in an email to   |                            | t.  |   |                               |                            |
|   | ff, and then an "Admission the front of the documents                             |                            |     |   |                               |                            |
|   | en asked who sets up  |                            | ĺ   |   |                               | 1                          |
|   | ated the nurses on the unit.  |                            |     |   |                               |                            |
|   | irses have access to the  |                            |     |   |                               | sl                         |
|   | er 4:00 p.m., OSM #5 stated 🤚   |                            |     |   |                               |                            |
| they should have.                                   |   |                            |     |   |                               | 4                          |
| 1 0 0 1 2 2 2 2 2 2                                 | throughout the facility on  |                            |     |   |                               | ű.                         |
|   | e throughout the facility on n. In the front unit, there                          |                            |     |   |                               |                            |

| CEITIE  | THE POPULATION AND THE   | - OLIVEDICAID GEIVAIGES   |                             |  | CIVID IV | 7. 0530-039                |
|---|--|---|-----------------------------|--|----------|----------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION |  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER.  | (X2) MULTIPL<br>A. BUILDING | E CONSTRUCTION   |          | TE SURVEY<br>MPLETED       |
|   |  | 495283  | B. WING                     |  | C        |                            |
| visitalist extra                                    |  | 493283  |                             |  |          | /25/2022                   |
|   | ·  | NG AND REHAB (IMPERIAL)   | 1                           | TREET ADDRESS, CITY, STAFE, ZIP COD<br>719 BELLEVUE AVENUE<br>ICHMOND, VA 23227                      | E        |                            |
| (X4) ID<br>PREFIX<br>TAG                            | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES  'MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG         | PROVIDER'S PLAN OF CORRE<br>(EACH CORRECTIVE ACTION SH<br>CROSS-REFERENCED TO THE APP<br>DEFICIENCY) | OULD BE  | (X5)<br>COMPLETION<br>DATE |
| F 880   | Continued From page  | ne 140  | F 880                       |  |          |                            |
|   | were three rooms won the doors. These  | rith isolation carts and signs carts were present the of these rooms was Resident   | 1 000                       |  |          |                            |
| 0.00  | 2/16/2022. On the material data set) assessment with an ARD (assess 2/23/2022, the resident the BIMS (brief interindicating the resident for making daily decimals.  |   |                             |  |          |                            |
|   | documented: "Airbor  | dated 2/23/2022 at3:15 p.m.,<br>ne and Droplet Precautions<br>admission date 2/16/2022<br>2022."  |                             |  |          |                            |
| t<br>t<br>t   | 2/24/2022 at 9:00 a.n entered the facility, R Wednesday [2/16/20] been on isolation. He yesterday, sometime and he was told not to Observation of the roldisposal containers for inens. Resident #14 specause he can't go obutside, which he has the facility. Since his herapy in the gym, but wednesday in the gym, but we were the gold in the gym, but we were the gym, and the gym, but we were the gym, and | om failed to evidence any or the isolation trash or stated he was upset out of his room and go done since admission to admission, he had received at now is getting it in his he was vaccinated against stated he was not |                             |  |          |                            |
| 1   | d A tour was made  | throughout the facility on  |                             |  |          |                            |

| OLIVILITO I OTT WEDIONIN   | I W MICHIGATO OF LANGER   |                     |   | OIVID 140. 0000-000           |
|--|---|---------------------|---|-------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                            | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   | (X2) MULT           | FIPLE CONSTRUCTION NG   | (X3) DATE SURVEY<br>COMPLETED |
|  | 405000  | 5 14/14/5           |   | С                             |
|  | 495283  | B. WING             |   | 02/25/2022                    |
| NAME OF PROVIDER OR SUPPLIER   |   |                     | STREET ADDRESS, CITY, STATE, ZIP CO   | ODE                           |
| PROMEDICA SKILLED NURS   | ING AND DEHAR (IMPEDIAL)  | )                   | 1719 BELLEVUE AVENUE  |                               |
|  | THO AND RELIAB (IIIII ERIAE)  |                     | RICHMOND, VA 23227  |                               |
| PREFIX (EACH DEFICIENC   | AI EMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)                             | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF COR<br>(EACH CORRECTIVE ACTION<br>CROSS-REFERENCED TO THE /<br>DEFICIENCY) | SHOULD BE COMPLETION          |
| F000 0 1 15  |   |                     | 12  |                               |
| F 880 Continued From pa  | <del>-</del>  | F 88                | 30  |                               |
| were three rooms were three rooms were three rooms. These previous day. One of | n.m. In the front unit, there with isolation carts and signs e carts were present the of these rooms was Resident |                     |   |                               |
| #14's room.  |   |                     |   |                               |
| Resident #13 was re  | eadmitted to the facility on  |                     |   |                               |
|  | nost recent MDS (minimum  |                     |   | 44                            |
|  | nt, a quarterly assessment,   |                     |   |                               |
|  | sment reference date) of  |                     |   |                               |
|  | nt scored a 14 out of 15 on   | 1                   |   |                               |
|  | view for mental status) score,  | H                   |   |                               |
|  | ent is not cognitively impaired   |                     |   |                               |
| for making daily dec   | sisions.  |                     | 1-  |                               |
| The physician order  | dated, 2/23/2022 at 3:15  |                     |   |                               |
|  | Airborne and Droplet  |                     |   |                               |
|  | of 10 days; admission date  |                     |   |                               |
| 2/15/2022 every shif   |   |                     |   |                               |
| 3.   |   |                     |   |                               |
| An interview was cor   | nducted with Resident #13 on I  |                     |   |                               |
|  | m. When asked if he had   |                     |   |                               |
|  | ce his readmission to the   |                     |   |                               |
|  | stated he had not been on   |                     |   | E                             |
|  | lay.Resident #13 stated he 📗  |                     | (   | i                             |
|  | apy gym up until yesterday.   |                     |   |                               |
|  | oom failed to show any  |                     | A.  |                               |
| •  | or trash or linens. When  |                     | 3:  | 24                            |
|  | inated against COVID,<br>he has had two doses of the  |                     |   |                               |
| Pfizer vaccine.  | The ride ride two deses of the  |                     |   | 111                           |
| THEOL VACCING.   |   |                     |   | 100                           |
| A CNA (certified nursi   | ing assistant) #5 was   |                     |   |                               |
| observed entering Re   |   |                     |   |                               |
|  | n. She wore a mask, gown,   |                     |   |                               |
|  | s. She exited the room at   |                     |   |                               |
|  | was conducted with CNA  |                     |   | N.                            |
|  | asked if she had been   |                     |   |                               |
| taking care of Resider   | nt #13 for the past few days  |                     |   | +                             |

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

| CEIVII                   | EKS FOR MEDICARI                        | E & MEDICAID SERVICES   |                          |   | <u>OMB NO. 0938-039</u>       |
|--------------------------|---|---|--------------------------|---|-------------------------------|
|                          | NT OF DEFICIENCIES<br>FOR CORRECTION    | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER.  | (X2) MULT<br>A. BUII DIN | TIPLE CONSTRUCTION  NG  | (X3) DATE SURVEY<br>COMPLETED |
|                          |   | 495283  | B WING_                  |   | C<br>02/25/2 <b>0</b> 22      |
|                          | PROVIDER OR SUPPLIER                    | ING AND REHAB (IMPERIAL)  |                          | STREET ADDRESS, CITY, STATE, ZIP CO<br>1719 BELLEVUE AVENUE<br>RICHMOND, VA 23227                 |                               |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)                        | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION   | ID<br>PREFIX<br>TAG      | PROVIDER'S PLAN OF CORR<br>(EACH CORRECTIVE ACTION S<br>CROSS-REFERENCED TO THE AR<br>DEFICIENCY) | HOULD BE COMPLETION           |
| F 880                    |   | had. When asked if he had   | F 88                     | 0 –   |                               |
|                          | CNA #5 stated he duntil yesterday [2/23 | nce his return to the facility,<br>lidn't have an isolation cart<br>3/2022] and she had not been<br>equipment other than her<br>ld. |                          |   |                               |
|                          | An interview was co                     | nducted with LPN #1 on  |                          |   |                               |
|                          | 2/24/2022 at 10:34                      | a.m. When asked how the   |                          |   |                               |
|                          |   | hat a new admission needs<br>ated, "I look through the chart,   |                          |   |                               |
|                          |   | came from the hospital with   |                          |   | ř                             |
|                          | the resident, and the                   | DON (interim director of  |                          |   | 1                             |
|                          |   | ons tells us." LPN #1 stated if   |                          |   | 8                             |
| ,                        | positive, then they a                   | om the hospital and is COVID  |                          |   |                               |
| 11                       | precautions.                            | atomatically go on  |                          |   |                               |
|                          | •                                       |   |                          |   | î                             |
| 33                       | An interview was cor                    |   |                          |   |                               |
|                          |   | member) #2, the interim in 2/24/2022 at 11:25 a.m.  |                          | 1   |                               |
|                          |   | cess for isolation for new  |                          | į.  |                               |
|                          | admissions or readm                     | nissions, ASM #2 stated that 🖐  |                          |   | Ţĥ.                           |
|                          |   | it a notice to all departments.   |                          |   |                               |
|                          |   | the residents are supposed SM #2 stated, "It is brought   |                          |   |                               |
|                          |   | for morning meetings] to  |                          |   |                               |
| 1                        | make sure we have e                     | everyone on isolation that  |                          | i.  |                               |
|                          |   | n." When asked if new   |                          |   |                               |
|                          |   | e on isolation precautions, ew admissions should be for   |                          |   |                               |
|                          |   | #2 was informed about the   |                          |   |                               |
| ļi                       | nitial tour observatior                 | n of no isolation carts, along  |                          |   |                               |
|                          |   | dentification of five isolation   |                          |   |                               |
|                          |   | ssked to speak to this. ASM second request was made   |                          |   |                               |
|                          | or the list of residents                |   |                          |   |                               |
| 1                        |   |   | 1                        |   |                               |
|                          | on 2/24/2022 at 2:00                    | p.m. ASM #2 presented a   | 1                        |   |                               |

| STATEMENT OF DEFICIEN   |  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  | (X2) MUI.           | (X2) MULTIPLE CONSTRUCTION   |  |        | (X3) DATE SURVEY           |  |
|---|--|--|---------------------|--|--|--------|----------------------------|--|
| AND PLAN OF CORRECTION  | 1  | IDENTIFICATION NUMBER:   |                     | NG_  |  |        | COMPLETED                  |  |
| 1   | _  | 495283   | B WING              |  |  |        | C<br>02/25/2022            |  |
| NAME OF PROVIDER OR PROMEDICA SKILLE  |  | IG AND REHAB (IMPERIAL)  |                     | STREET ADDRESS, CITY, STATE, ZIP O<br>1719 BELLEVUE AVENUE<br>RICHMOND, VA 23227 |  |        | 02/23/2022                 |  |
| PRÉFIX (EACH D  | DEFICIENCY   | EMENT OF DEFICIENCIES<br>MUST BE PRECEDED BY FULL<br>CIDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG |  | PROVIDER'S PLAN OF CORRECT<br>(EACH CORRECTIVE ACTION SHOU<br>CROSS-REFERENCED TO THE APPRI<br>DEFICIENCY) | JLD BE | (X5)<br>COMPLETION<br>DATE |  |
| #9, #13 and The facility 19 Admission resident did in the vaccion form, was an COVID 19 when eligible for 10 days. Then the resident did the the resident did the the resident did the the the second did the the the the the the the the the the | ents requid #14 were presented on Criteria for thave nation state presented a person revaccines, le), the resident requitine for the 2/14/2022 e interim a e regional e of the ab  | ring isolation. Residents # 8 e on the list.  I an algorithm for COVID - 1 that documented if a COVID and was up to date tus (up to date, per this eceived all recommended including any booster doses sident would be quarantined ident was unvaccinated, iired a private room, and to an days. This form was | F 88                | 80   |  |        |                            |  |
| control surve reviewed.  The entrance (administrative administrator nursing, was a.m. At this to six months of A second requapproximately surveillance to   | e conference staff me and ASM conducted ime a required infection uest was a constant of the co | ed to complete infection five of the past six months ce with the ASM ember) #1, the interim #2, the interim director of 1 on 2/23/2022 at 11:30 uest was made for the past control surveillance logs.  made on 2/24/2022 at . for the infection control  |                     |  |  |        |                            |  |
|   |  | m. ASM #2 presented  |                     |  |  |        |                            |  |

PRINTED: 03/08/2022 FORM APPROVED

| CEN                 | LIEKS FOR MEDICARE   | & MEDICAID SEKVICES  |                      |      | <u> </u>  | <u>_OMB (</u> | <u>NO</u> . 0938-039       |
|---------------------|--|--|----------------------|------|---|---------------|----------------------------|
|                     | MENT OF DEFICIENCIES<br>AN OF CORRECTION   | (X1) PROVIDER/SLIPPLIER/CLIA<br>IDENTIFICATION NUMBER:   | (X2) MUI<br>A BUIL.C |      | ONSTRUCTION   |               | DATE SURVEY<br>COMPLETED   |
|                     |  | 495283   | B WING               |      |   |               | C<br>02/25/2022            |
|                     | OF PROVIDER OR SUPPLIER MEDICA SKILLED NURSI   | NG AND REHAB (IMPERIAL)  |                      | 1719 | ET ADDRESS, CITY, STATE, ZIP CODE<br>BELLEVUE AVENUE<br>HMOND, VA 23227                                 | -             |                            |
| (X4)<br>PREF<br>TAC | IX (EACH DEFICIENCY  | TEMENT OF DEFICIENCIES<br>'MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFI<br>TAG   | (    | PROVIDER'S PLAN OF CORREC<br>(EACH CORRECTIVE ACTION SHO<br>CROSS-REFERENCED TO THE APPR<br>DEFICIENCY) | ULD BE        | (X5)<br>COMPLETION<br>DATE |
| F 8                 | completed. For Sep one entry document logs for October or I December 2021, the Those were dated 1 12/30/2021. The Jar documented three e 1/4/2022. There we documented.  An interview was con 2/24/2022 at 2:00 p.r missing information of all the information she whose responsibility infection control surv will be doing it in the working in the facility who was responsible | t 2021 tracking logs were tember 2021, there was only ed. There were no tracking November of 2021. For ever were only seven entries. 2/18/2021 through huary 2022 tracking logs notices dated 1/2/2022 through re no further entries.  Inducted with ASM #2 on m. When asked where the was, ASM #2 stated this was e could find. When asked it was for completing the eillance, ASM #2 stated she future, but she just started on 1/24/2022. When asked prior to her arrival, ASM #2 | F8                   | 30   |   |               |                            |
|                     | regional quality consup.m. When asked about logs for the past six in "That is all we have." been interim directors the past six months. A documentation from the use of antibiotics from January 2022.  Onn 2/24/2022 at 4:30 the Anti-Infective Utilization pharmacy for September 1.   | ducted with ASM #3, the altant, on 2/24/2022 at 3:39 but the above surveillance nonths, ASM #3 stated, ASM #3 stated there has a of nursing in the facility for ASM #3 was asked to obtain the pharmacy regarding the a September 2021 through p.m. ASM #3 presented action reports from the per 2021 through January 2021 form documented the asummary of the 95  |                      |      |   |               |                            |

|   | CO LOS MILLONOMAN   | OF MICROSOFT DELLA LOCAL   |                     |   | OMB 140, 0330-033             |
|---|---|--|---------------------|---|-------------------------------|
|   | OF DEFICIENCIES<br>OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  | (X2) MULT           | IPLE CONSTRUCTION NG  | (X3) DATE SURVEY<br>COMPLETED |
|   |   |  |                     |   | С                             |
|   |   | 495283   | B WING_             |   | 02/25/2022                    |
|   | ROVIDER OR SUPPLIER   | NG AND REHAB (IMPERIAL)  |                     | STREET ADDRESS, CITY, STATE, ZIP CO<br>1719 BELLEVUE AVENUE<br>RICHMOND, VA 23227                 | DE                            |
| (X4) ID<br>PREFIX<br>TAG                    | (EACH DEFICIENCY  | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORF<br>(EACH CORRECTIVE ACTION S<br>CROSS-REFERENCED TO THE AI<br>DEFICIENCY) | SHOULD BE COMPLETION          |
| F 880                                       | Continued From page   | ge 145   | F 88                | 0   |                               |
| : 1<br>: 1<br>: 1<br>: 1<br>: 1             | anti-infective medical October 2021, 41 of have received an and the month of November residents reviewed from the 105 residents revanti-infective medical | ations. For the month of<br>the 99 residents reviewed<br>ti-infective medication. For<br>ther 2021, 38 of the 110<br>and received an anti-infective<br>ecember 2021 summary, of<br>viewed, 34 had received an<br>tions. For January 2022, of<br>viewed, 32 had received an |                     |   |                               |
| ր<br>դ. n<br>[]                             | eart, "Information ab<br>nonitored and tracke<br>Name of computer p   | urveillance" documented in out infections is gathered, at throughout the month.  brogram] is the electronic  |                     | i.  | 9                             |
| T   | he date entered ger<br>hich is reviewed by  | er infection control trends. nerates surveillance reports the Infection Preventionist included trends that may   |                     |   | M                             |
| a<br>R<br>pe                                | re reviewed and disc<br>oom process and Q   | reak investigations. Results cussed during the Eagle API (quality assurance ment) Infection Control  |                     |   |                               |
|   |   | ASM #3 were made aware on 2/24/2022 at 4:56 p.m.   |                     |   |                               |
| No  | o further information   | was provided prior to exit.  |                     |   | 1                             |
| (qu<br>are<br>wh<br>SA<br>(U)<br>red<br>boo | uarantine) is recome newly admitted to no have had close of RS-CoV-2 infection to date means a prommended COVID oster dose(s) when                        | mission-Based Precautions mended for residents who the facility and for residents ontact with someone with if they are not up to date erson has received all -19 vaccines, including any eligible, with all  |                     |   |                               |

|  |   | @ MICDICALD OFFIAICES   |                         |   | 71VID 140: 0330-(733  |
|--|---|---|-------------------------|---|---|
|  | OF DEFICIENCIES<br>OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  | (XZ) MULT<br>A. BUILDIA | IPLE CONSTRUCTION  IG   | (X3) DATE SURVEY<br>COMPLETED   |
| :  |   |   |                         |   | С   |
| ļ  |   | 495283  | B WING_                 |   | 02/25/2022  |
|  | PROVIDER OR SUPPLIER PICA SKILLED NURSI   | NG AND REHAB (IMPERIAL)   |                         | STREET ADDRESS, CITY, STATE, 2IP CODE<br>1719 BELLEVUE AVENUE<br>RICHMOND, VA 23227   |   |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIENCY  | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG     | PROVIDER'S PLAN OF CORRECTIC<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROP<br>DEFICIENCY)   | D BE COMPLETION   |
| F 881 // SS=E S S P T a a a a s S the street of the street | website: https://www.cdc.gov.nes/stay-up-to-date "In general, quarant asymptomatic reside all COVID-19 vaccin recovered from SAF-90 days; potential exguidance. However, should still be tested section of the guidance betained from the foottps://www.cdc.gov.ong-term-care.html Antibiotic Stewardsh CFR(s): 483.80(a)(3 6483.80(a) Infection or ogram. The facility must ested and control program minimum, the following to monitor and the section of the section | ained from the following  //coronavirus/2019-ncov/vacci html  ine is not needed for ents who are up to date with the doses or who have RS-CoV-2 infection in the prior receptions are described in the some of these residents I as described in the testing froe." This information was Illowing website: //coronavirus/2019-ncov/hcp/l  ip Program  prevention and control ablish an infection prevention (IPCP) that must include, at wing elements: ibiotic stewardship program c use protocols and a | F 881                   | Tag F881 – Failed to maintain Anti-Stewardship Program  1. The facility completed an antibiotic stewardship meeting on 3/17/22. 2. The DON or designee reviewed our residents on antibiotics and formul antibiotic stewardship reports for tand trending. 3. The Administrator re-educated Nu Management staff and the Infection Preventionist on the antibiotic stewardship reports more than the infection Preventionist on the antibiotic stewardship reports meeting 5 times a week for 4 week identify any trends. The Administrator will be submit audit findings to the QAPI of the for review and further recommendation. | intent lated racking rsing n vardship new linical is to rator or wardship fy II |
|  | onths.<br>ne findings include:  |   |                         | <ul><li>dations.</li><li>5. The facility's alleged date of comparing will be April 4, 2022.</li></ul>   | liance 4/4/2022   |

|   | -10 / 0/11MED10/111E   | - W INCEDIO/ (ID OL/VIOLO   |                        |   | OIVID IV  | U. <del>0938-</del> 03    |
|---|--|---|------------------------|---|-----------|---------------------------|
|   | OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  | (X2) MULT<br>A. BUILDE | TIPLE CONSTRUCTION<br>ING   | (X3) D    | ATE SURVEY<br>OMPLETED    |
|   |  | 495283  | B WING                 |   |           | C<br>2/25/2022            |
|   | ROVIDER OR SUPPLIER  | NG AND REHAB (IMPERIAL)   |                        | STREET ADDRESS, CHY, STATE, ZIP O<br>1719 BELLEVUE AVENUE<br>RICHMOND, VA 23227               |           | 277712022                 |
| (X4) ID<br>PREFIX<br>TAG                                | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG    | PROVIDER'S PLAN OF COI<br>( (EACH CORRECTIVE ACTION<br>CROSS-REFERENCED TO THE<br>DEFICIENCY) | SHOULD BE | (XS)<br>COMPLETIO<br>DATE |
| F 881   | Continued From pag   | ge 147  | F 88                   | 31  |           |                           |
| C<br>A<br>E<br>n<br>n<br>tt<br>tt<br>tt<br>w<br>si<br>d | administrator and Ashursing, was conductant. At this time a next months of the anion 2/24/2022 at 2:00 Antibiotic Stewardship or eports for August lovember 2021. When months were, AShue documentation ship is responsible for the facility on 1/124 as responsible for the stewardship reports, and the facility on 1/124 as responsible for the stewardship reports of the facility on 1/124 as responsible for the stewardship reports of the facility on 1/124 as responsible for the stewardship reports of the stewardship reports of the facility on 1/124 as responsible for the stewardship reports of the facility on 1/124 as responsible for the stewardship reports of the stewardship reports of the facility on 1/124 as responsible for the stewardship reports of the stewardship repor | member) #1, the interim SM #2, the interim director of sted on 2/23/2022 at 11:30 equest was made for the past tibiotic stewardship program.  D. p.m. ASM #2 presented p Reports for October 2021, January 2022. There were 2021, September 2021 and then asked where the rest of M #2 stated this was all of the could find. When asked or completing the antibiotic ASM #2 stated she will be but she just started working 1/2022. When asked who the antibiotic stewardship to ming to the facility, ASM |                        |   |           |                           |
| Ar<br>re<br>p.i<br>an<br>sta<br>sh                      | n interview was conc<br>gional quality consulm. When asked for t<br>tibiotic stewardship<br>ated that was all the<br>to has had interim di<br>st six months.   | ducted with ASM #3, the lant, on 2/24/2022 at 3:39 when the remainder of the documentation, ASM #3 y had. ASM #3 stated that rectors of nursing in the  |                        |   |           |                           |
| the<br>pha<br>202<br>ant<br>res<br>ant                  | Anti-Infective Utiliza<br>armacy for Septemb<br>22.The September 2<br>i-infective utilization<br>idents reviewed, 26<br>i-infective medicatio  |   | 1                      |   |           |                           |

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

FRINTED 03/02/2022 FORM APPROVED OMB NO. 0938-0391

| CENTE  | RS FOR MEDICAR   | E & MEDICAID SERVICES  |                      |     |   | OMB N   | O. 0938-039                |
|--|--|--|----------------------|-----|---|---|----------------------------|
| STATEMENT<br>AND PLAN O  | OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | (X2) MUI.<br>A BUILD |     | CONSTRUCTION  | (X3) D  | OATE SURVEY<br>OMPLETED    |
|  |  | 495283   | B, WING              |     |   | 0   | C<br>2/25/2022             |
| 196  | PROVIDER OR SUPPLIER   | ING AND REHAB (IMPERIAL)   |                      | 171 | REE1 ADDRESS, CITY, STATE, ZIP CODI<br>19 BELLEVUE AVENUE<br>CHMOND, VA 23227   |   | 212312022                  |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIENC  | NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG  |     | PROVIDER'S PLAN OF CORRE<br>(EACH CORRECTIVE ACTION SH<br>CROSS-REFERENCED TO THE APP<br>DEFICIENCY)  | OULD BE   | (XS)<br>COMPLETION<br>DATE |
| to the second of | the month of Nover residents reviewed medications. The Date 105 residents reactions and the 105 residents resolute infective medicanti-infective medicanti-infective medicanti-infective medicanti-infective medicanti-infective medical recipies a part and the part and | nti-infective medication. For other 2021, 38 of the 110 had received an anti-infective ecember 2021 summary, of eviewed, 34 had received an ations. For January 2022, of viewed, 32 had received an ation.  Antibiotic Stewardship"  "Tracking is demonstrated by neasures of antibiotic use by ports and individual patient itoring outcomes of antibiotic able reports and individual dis."  d ASM #3 were made aware in on 2/24/2022 at 4:56 p.m. | F 88                 | 31  |   |   |                            |
| F 883 In   | fluenza and Pneun<br>FR(s): 483.80(d)(1)   |  | F 883                | Pr  | ng F883 – Failed to maintain F<br>ogram   |   |                            |
| im §4 po (i) ea rec pot (ii) imr cor imr   | munizations 183.80(d)(1) Influen Before offering the ch resident or the re- ceives education re- tential side effects Each resident is of- munization Octobe nually, unless the in- traindicated or the munized during this  | influenza immunization, esident's representative garding the benefits and of the immunization; fered an influenza 1 through March 31 mmunization is medically resident has already been  |                      | 1.  | Resident # 5 was assessed on the Flu and Pneumonia vaccin # 9 was assessed on 3/18/22 for Pneumonia vaccine. Resident assessed on 3/18/22 for Flu an monia vaccine. Resident # 14 assessed on 2/28/22 for Flu, Pnand on 3/8/22 for COVID 19 v Resident # 8 was assessed on 2 Flu, Pneu-monia and COVID 1 Current Residents have been revalidate Flu, Pneumonia and Covid the Flu, Pneumonia and Covid Current Residents have been revalidate Flu, Pneumonia and Covid Covid Pneumonia and Covid Covid Pneumonia and Covid Pneumonia and Covid Pneumonia and Covid Pneumonia and Covid Pneumonia | te. Resider<br>for Flu and<br># 12 was<br>d Pneu-<br>was<br>neumonia<br>vaccine.<br>2/28/22 for<br>19 | ot                         |

screening and vaccination status.

| OLIVICITO FOR INCIDIO  | UVE OF IMPEDIONALS CITED AND ED  |                               |   | OIND IVO. 0000-000   |
|--|--|-------------------------------|---|--|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  | (XX) MULTIPLE C<br>A BUILDING | ONSTRUCTION   | (X3) DATE SURVEY<br>COMPLETED  |
| [  |  |                               |   | С  |
|  | 495283   | B WING                        |   | 02/25/2022   |
| (X4) ID SUMMARY  | RSING AND REHAB (IMPERIAL)  STATEMENT OF DEFICIENCIES NOY MUST BE PRECEDED BY FULL   | 1719                          | ETADDRESS, CITY, STATE, ZIP CODE BELLEVUE AVENUE HMOND, VA 23227  PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH | COTION (X5)  |
| TAG REGULATORY O   | R I SC IDENTIFYING INFORMATION)  | TAG                           | CROSS-REFERENCED TO THE APP<br>DEFICIENCY)  | PROPRIATE DATE   |
| (iv)The resident's documentation the following: (A) That the resident was provided educand potential side immunization; and (B) That the residimmunization or dimmunization due refusal. | ity to refuse immunization; and medical record includes at indicates, at a minimum, the lent or resident's representative acation regarding the benefits effects of influenza dent either received the influenzation to medical contraindications or | F 883 3.                      | licensed nurses on the Flu, I COVID 19 screening and vaprocess.   | Pneumonia and necination  udit new lidate Flu, screening and ninistrator will QAPI compression of the compliance |
| must develop policithat- (i) Before offering immunization, each representative recipient immunization; (ii) Each resident immunization, unleading contrained already been immunization.  | th resident or the resident's eives education regarding the stial side effects of the softered a pneumococcal ess the immunization is dicated or the resident has  |                               | Will be April 4, 2022.  | 4/4/2022   |
| has the opportunity (iv)The resident's redocumentation that following: (A) That the reside   | to refuse immunization; and nedical record includes tindicates, at a minimum, the nt or resident's representative  |                               |   | 8  |
| and potential side of<br>immunization; and<br>(B) That the resider<br>pneumococcal imm   | ation regarding the benefits effects of pneumococcal nt either received the nunization or did not receive  | 1                             |   | 2 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1  |
| contraindication or  |  |                               |   | 3  |
|  |  |                               |   | 100  |

| CO P. L. V. V. Jack          | TION OIL WEDION   | - WINDOWND OF LANCES   |                              |  | OMP 1417. 0939-038   |
|------------------------------|---|--|------------------------------|--|--|
|                              | T OF DEFICIENCIES<br>OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  | (X2) MULTIPLE<br>A. BUILDING | CONSTRUCTION   | (X3) DATE SURVEY<br>COMPLETED  |
|                              |   | 495283   | B WING                       |  | С  |
| 111115 05                    | DECLINED OF CHECK   | 493283   |                              |  | 02/25/2022   |
|                              | PROVIDER OR SUPPLIER DICA SKILLED NURS  | NG AND REHAB (IMPERIAL)  | 17                           | REET ADDRESS, CITY, STATE, ZIP CODE<br>19 BELLEVUE AVENUE<br>CHMOND, VA 23227                              |  |
| (X4) ID<br>PREFIX<br>TAG     | (EACH DEFICIENCY  | TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG          | PROVIDER'S PLAN OF CORRECT<br>(EACH CORRECTIVE ACTION SHOU<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY) | ILD BE COMPLETION  |
|                              | by: Based on resident refacility document refereivew, it was determined to the second | interview, staff interview, view and clinical record mined the facility staff failed to ste immunization program for views for immunizations,                                      | F 883                        |  | 0<br>0   |
| i                            | The findings include  1. For Resident #5, I provide evidence of   |  |                              |  | ₽<br>•<br>•  |
| tti ir                       | Resident #5 was adr<br>1/13/2022. On the m<br>data set) assessmen<br>with an ARD (assess<br>1/18/2022, the reside<br>he BIMS (brief inter-<br>ndicating the resider<br>mpaired for making of<br>Special Treatments<br>he resident was code  | oneumococcal vaccine, and  |                              |  |  |
| d<br>o<br>T<br>do<br>w<br>ag | ocumentation of the f the influenza or pnotential for the function ocumented the residers unknown if the regainst influenza and   | record failed to evidence administration or the refusal eumococcal vaccinations.  ation dated 1/13/2022 ent was not vaccinated or it sident was vaccinated pneumococcal pneumonia. |                              |  | The state of the s |

| CEITI   | ELIOT OLI MICENIONIA                  | - WIND OF LAND   |  |                                    | CIVID IV. 0330-035            |
|---------|---------------------------------------|--|--|------------------------------------|-------------------------------|
|         | NT OF DEFICIENCIES<br>FOR CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  | (X2) MULT<br>A BUILD                             | FIPLE CONSTRUCTION NG              | (X3) DATE SURVEY<br>COMPLETED |
|         |                                       | 495283   | B WING   |                                    | 02/25/2022                    |
| NAME OF | PROVIDER OR SUPPLIER                  | <u> </u>   | <del>-                                    </del> | STREET ADDRESS, CITY, STATE, ZIP ( |                               |
|         |                                       |  |  | 1719 BELLEVUE AVENUE               |                               |
| PROME   | DICA SKILLED NURSI                    | NG AND REHAB (IMPERIAL)                                |  | RICHMOND, VA 23227                 |                               |
| (X4) ID | SLIMMARY STA                          | TEMENT OF DEFICIENCIES                                 | ID   | PROVIDER'S PLAN OF CO              | PRECTION                      |
| PREFIX  | (EACH DEFICIENCY                      | MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION | PREFIX<br>TAG                                    |                                    | SHOULD BE COMPLETION          |
| F 883   | Continued From page                   | 20.151   | E 00   |                                    | Α                             |
| 1 000   |                                       |  | F 88   | 13                                 |                               |
|         |                                       | on 2/24/2022 at 11:10 a.m. ocess to determine a        |  |                                    |                               |
|         | resident's vaccination                | on status for influenza,                               |  |                                    |                               |
|         | pneumococcal pneu                     | monia and COVID  |  |                                    |                               |
|         |                                       | 1 stated the nurse looks at                            |  |                                    |                               |
|         | the paperwork from                    |  |  |                                    |                               |
|         | admission packet. V                   |  |  |                                    |                               |
|         | vaccinations are doc                  | cumented, LPN #1 stated it                             |  |                                    |                               |
|         |                                       | the immunization tab on the                            |  |                                    |                               |
|         |                                       | ked what process the nurse                             |  |                                    |                               |
|         |                                       | documentation of the                                   |  |                                    |                               |
|         |                                       | stated it depended on the                              |  |                                    |                               |
|         |                                       | status. She stated the nurse                           |  |                                    | 191                           |
|         |                                       | igh the hospital records,<br>se records contain this   |  |                                    | i<br>I                        |
|         |                                       | stated, "Or you can contact                            |  |                                    |                               |
|         |                                       | to find out the information."                          |  |                                    |                               |
|         | When asked if all res                 |  |  |                                    |                               |
|         |                                       | ir vaccination status, LPN #1                          |  |                                    |                               |
|         | stated they should.                   |  |  | f                                  | i                             |
| 1       |                                       |  |  |                                    | 3                             |
|         | An interview was con-                 |  |  | 1.                                 | 3                             |
|         |                                       | nember) #2, the interim                                |  | 1                                  | 9                             |
|         |                                       | 2/24/2022 at 11:25 a.m.                                |  | i                                  | 4                             |
|         |                                       | cility, ASM #2 stated she                              |  |                                    | 1                             |
|         |                                       | OVID tracking to determine                             |  |                                    | £.                            |
|         |                                       | ASM #2 stated she has not                              |  |                                    | 1                             |
|         | completed the tracking                |  |  | Î                                  |                               |
|         |                                       | ation status. When asked                               |  |                                    |                               |
|         |                                       | ollows to determine the                                |  |                                    | 50                            |
|         |                                       | resident, ASM #2 stated 🖐                              |  |                                    |                               |
|         |                                       | process, the nurse asks the                            |  |                                    | ĮĮ.                           |
|         |                                       | ny of the vaccines. When                               |  |                                    |                               |
|         |                                       | ation and consent for the                              |  |                                    |                               |
|         |                                       | ented, ASM #2 stated, "It                              |  |                                    |                               |
|         | nould be in the chart,<br>orking on." | which is one thing I am                                |  |                                    |                               |
| VV      | VINITY OIL                            | 1941   | 1  |                                    |                               |

|                       | MENT OF DEFICIENCIES<br>AN OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  | (X2) MU<br>A. BUILE |  | CONSTRUCTION   |      | DATE SURVEY<br>COMPLETED   |
|-----------------------|--|---|---------------------|--|--|------|----------------------------|
|                       |  | 495283  | B. WING             |  |  |      | C<br>02/25/2022            |
|                       | OF PROVIDER OR SUPPLIER  | NG AND REHAB (IMPERIAL)   |                     | 1719   | EET ADDRESS, CITY, STATE, ZIP CODE<br>B BELLEVUE AVENUE<br>HMOND, VA 23227                                   |      | 212012022                  |
| (X4) I<br>PREF<br>TAG | X (EACH DEFICIENCY   | FEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)  | ID<br>PREF<br>TAG   | х  | PROVIDER'S PLAN OF CORRECTI<br>(EACH CORRECTIVE ACTION SHOUL<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY) | D BE | (X5)<br>COMPLETION<br>DATE |
| F 84                  | documented in part, immunization status need for the followin pneumonia, shingles requires screening for contraindications, dis Information System benefits of the vaccine acknowledge required by the state the vaccineAddition offered dependent or exposure or spread of novel diseases such SM (administrative administrator, ASM # nursing, ASM #3, the and ASM #4, the divisionsultant, for documents of the following that the divisionsultant, for documents of the following that the following the following the following that the following that the following the following that the following th | creening and Vaccinations, "Upon admission, a patient's is reviewed to determine the g vaccinations: influenza, s. Every vaccine offered or eligibility and stribution of the Vaccine which explain the risks and ne, completion of an informed ement or signed consent (if ) and an order to administer nal vaccinations may be n current potential risk of of other diseases, including | FE                  | 83   |  |      |                            |
|                       | facility had nothing in status of Resident #5' pneumococcal vaccin ASM #1, ASM #2 and of the above concern No further information 2. For Resident #9, the provide evidence of eco  | ASM #3 were made aware on 2/24/2022 at 4:56 p.m.  was provided prior to exit.  e facility staff failed to lucation and consent prior luenza vaccination and a   |                     | A Company of the Comp |  |      |                            |

| CENTERO FOR MILLIONA                                | AC OLIMEDICATO OCHAROCO  |                               |  | OWD 110, 0000-000                            |
|---|--|-------------------------------|--|--|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:                                   | (X2) MULTIPLE<br>A_BUILDING _ | : CONSTRUCTION   | (X3) DATE SURVEY<br>COMPLETED                |
|   | 1  |                               |  | С  |
|   | 495283   | B WING                        |  | 02/25/2022                                   |
| NAME OF PROVIDER OR SUPPLIE                         | R  | - 1                           | REET ADDRESS, CITY, STATE, ZIP   | CODE   |
| PROMEDICA SKILLED NUR                               | SING AND REHAB (IMPERIAL)  |                               | 19 BELLEVUE AVENUE   |  |
|   |  | RI                            | CHMOND, VA 23227   |  |
| PREFIX (EACH DEFICIEN                               | TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) | ID<br>PREFIX<br>TAG           | PROVIDER'S PLAN OF CO<br>(EACH CORRECTIVE ACTIO<br>CROSS-REFERENCED TO TH<br>DEFICIENCY) | N SHOULD BE COMPLETION<br>E APPROPRIATE DATE |
| F 883 Continued From p                              | page 153   | F 883                         |  |  |
| ·   | readmitted to the facility on  | 1 000                         |  |  |
|   | most recent MDS (minimum   |                               |  |  |
|   | erly assessment, with an ARD   |                               |  |  |
|   | rence date) of 10/12/2022, the   |                               |  |  |
| resident scored a                                   | 5 out of 15 on the BIMS (brief   |                               |  |  |
|   | al status), indicating the   |                               |  |  |
|   | rely cognitively impaired for  |                               |  |  |
|   | sions, In Section O - Special  |                               |  |  |
|   | edures and Programs, the das having received an                                      |                               |  |  |
| influenza vaccinati                                 |  | 1                             |  |  |
| !   |  |                               | 45   |  |
| The clinical record                                 | documented Resident #9   |                               |  | 7  |
|   | nza vaccination on 11/8/2021,  |                               |  |  |
|   | evnar 13 (pneumococcal   |                               |  |  |
|   | 021. Further review of the   |                               |  | 1  |
| 18. 1   | d to evidence documentation and consent prior to the                                 |                               |  |  |
| administration of th                                |  |                               |  |  |
| dammou du on or u                                   | 1000 10001100.   |                               |  |  |
| A request was mad                                   | de on 2/24/2022 at 1:01 p.m. of  | 30                            |  |  |
|   | n administrator, ASM #2, ASM 🚋   |                               |  |  |
|   | ality consultant, and ASM #4,  |                               |  | i i  |
|   | y regulatory consultant, for the   | 27                            |  | 1  |
| above vaccinations                                  | ucation and the consent for the  | 19                            |  |  |
| above vaccinations                                  |  |                               |  |  |
| On 2/24/2022 at 3:4                                 | 48 p.m. ASM #3 stated the  |                               |  |  |
| facility did not have                               | evidence of the education and  |                               |  |  |
|   | enza and pneumococcal  |                               |  |  |
| vaccinations admin                                  | istered to Resident #9.  |                               |  |  |
| ACM #1 ACM #2 a                                     | nd ASM #3 were made aware  | 1                             |  | 1  |
| ·   | rn on 2/24/2022 at 4:56 p.m.   |                               |  |  |
| OF THE ADOVE CONCE                                  | in on Eletizoee at 4.00 p.int.   |                               |  |  |
| No further informati                                | on was provided prior to exit.   |                               |  | 8  |
| 1   |  |                               |  |  |
|   | failed to provide education  |                               |  | H  |
| and obtain consent                                  | for the influenza vaccination 🧢  |                               |  |  |

| OFFICE AND A COLUMN TO A COLUM | - OF INICIDIONID OF LANDER   |                             |   | CIND 140. 0990-095            |
|--|--|-----------------------------|---|-------------------------------|
| STATEMENT OF DEFICIENCES<br>AND PLAN OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:                             | (X2) MULTIPLE<br>A BUILDING | E CONSTRUCTION  | (X3) DATE SURVEY<br>COMPLETED |
| <br> -   |  |                             |   | С                             |
|  | 495283   | B WING                      | <del></del>   | 02/25/2022                    |
| NAME OF PROVIDER OR SUPPLIER   |  | ST                          | REET ADDRESS, CITY, STATE, ZIP CODE   | <u></u>                       |
| BROWEDICA SKILLED MITBEL   | NC AND DELLAR (MADEDIAL)   | 17                          | 19 BELLEVUE AVENUE  |                               |
| PROMEDICA SKILLED NURSI  | NG AND REHAB (IMPERIAL)  | RI                          | CHMOND, VA 23227  |                               |
| PREFIX (EACH DEFICIENCY  | ITEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION) | ID<br>PREFIX<br>TAG         | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOUL<br>CROSS-REFERENCED TO THE APPROF<br>DEFICIENCY) | D BE COMPLETION               |
| F 883 Continued From pa  | ao 154   | 5.000                       |   |                               |
|  | _  | F 883                       |   |                               |
| and pneumococcal<br>#12.   | vaccinations for Resident  |                             |   |                               |
| D = 11 = 440 · · · · ·   | 1 10 10 11 6 10  |                             |   |                               |
|  | dmitted to the facility on   |                             |   |                               |
|  | admission on 1/1/2020. On Sassessment, a quarterly                             |                             |   |                               |
|  | 1 ARD of 12/17/2021, the   |                             |   |                               |
|  | out of 15 on the BIMS score,   |                             |   |                               |
|  | nt is severely cognitively   |                             |   |                               |
|  | daily decisions. In Section O  |                             |   |                               |
|  | s, Programs and Procedures,  |                             |   |                               |
|  | led as receiving an influenza  |                             |   |                               |
| vaccination on 11/8/2  |  |                             |   |                               |
| pneumococcal vacci   | nation on 4/15/2021.   |                             |   | C.                            |
| The clinical record d  | ocumented the influenza  |                             |   |                               |
|  | ninistered on 11/8/2021. The   |                             |   |                               |
| pneumococcal vacci   | nation was administered on   |                             |   |                               |
| 4/15/2021. There wa  | s no documented evidence   |                             |   |                               |
|  | rided to the resident prior to   | 6                           |   |                               |
|  | both the influenza and   | - 1                         |   |                               |
|  | nations. There was no  | 1                           |   |                               |
| documented evidenc   |  |                             |   |                               |
| administration of the  | pneumococcal vaccination.  |                             |   |                               |
| A request was made   | on 2/24/2022 at 1:01 p.m. of   | i i                         |   |                               |
|  | administrator, ASM #2, the   |                             |   |                               |
|  | sing, ASM #3, the regional   | 1                           |   |                               |
|  | d ASM #4, the divisional   |                             |   |                               |
|  | sultant, for the evidence of   |                             |   |                               |
|  | consent for the above  |                             |   | 1                             |
| vaccinations.  |  |                             |   |                               |
| 1  |  |                             |   | 4                             |
|  | p.m. ASM #3 stated the   |                             |   | 1                             |
|  | vidence of the education and   | 1                           |   |                               |
|  | iza and pneumococcal   |                             |   |                               |
| vaccinations administ  | ered to Resident #12.  | İ                           |   |                               |
| ACM #1 ACM #2  | AC84 #2  |                             |   |                               |
| # ASM #1, ASM #2 and   | ASM #3 were made aware   |                             |   | 1                             |

| STATEMEN                 | IT OF DEFICIENCIES                             | (X1) PROVIDER/SUPPLIERICLIA   | (X2) MUI            | TIPLE C | CONSTRUCTION  | (X3) DA | IE SURVEY                  |
|--------------------------|--|---|---------------------|---------|---|---------|----------------------------|
| AND PLAN                 | OF CORRECTION                                  | IDENTIFICATION NUMBER:  | A BUILD             | ING     |   | CO      | MPLETED                    |
|                          |  |   | 1                   |         |   | İ       | C                          |
|                          |  | 495283  | B WING              |         |   | 02      | /25/2022                   |
| NAME OF                  | PROVIDER OR SUPPLIER                           |   |                     |         | EET ADDRESS, CITY, STATE, ZIP CODE  |         |                            |
| PROME                    | DICA SKILLED NURSI                             | NG AND REHAB (IMPERIAL)   | 1                   |         | BELLEVUE AVENUE   |         |                            |
|                          |  |   |                     | RICH    | HMOND, VA 23227   |         |                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY                               | TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION) | ID<br>PREFIX<br>TAG | Χ       | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPED DEFICIENCY) | D BE    | (X5)<br>COMPLETION<br>DATE |
| E 883                    | Continued From pa                              | ao 155  | F 8                 | 0.2     |   |         |                            |
| 1 000                    | ·  | **  | FO                  | 83      |   |         |                            |
|                          | or the above concer                            | rn on 2/24/2022 at 4:56 p.m.  |                     |         |   |         |                            |
|                          | No further information                         | on was provided prior to exit.  |                     |         |   |         |                            |
|                          | 4. The facility staff fa                       | ailed to evidence   |                     |         |   |         |                            |
|                          |  | ducation provided prior to the  |                     |         |   |         | ro                         |
|                          |  | nza and pneumococcal  |                     |         |   |         | 1                          |
|                          | •  | iled to evidence the status of  |                     |         |   |         |                            |
|                          | the COVID vaccinat                             | ion for Resident #14.   |                     |         |   |         | 10                         |
|                          | Resident #14 was a                             | dmitted to the facility on  |                     | Ť       |   |         |                            |
|                          |  | ission Evaluation dated   |                     |         |   |         |                            |
|                          |  | ted the resident was alert to   |                     |         |   |         |                            |
| 737                      |  | me, Review of the clinical  |                     |         |   |         |                            |
|                          |  | ence education was provided   |                     |         |   |         |                            |
|                          |  | to the refusal of the influenza vaccinations. The review                      |                     |         |   | 3       |                            |
|                          |  | ocumentation of Resident  |                     |         |   |         |                            |
|                          | #14's COVID vaccina                            |   |                     | 10      |   | - 3     |                            |
|                          |  |   |                     |         |   |         |                            |
|                          |  | uation dated, 2/16/2022   |                     | 15      |   |         |                            |
|                          |  | nt #14's COVID vaccination  |                     | 100     |   |         |                            |
|                          |  | e determined. It further dent had not received the                            |                     |         |   |         |                            |
|                          |  | , and documented the  |                     |         |   |         |                            |
|                          |  | as unknown. The form further  |                     |         |   |         |                            |
|                          | documented the vaco                            | cine was recommended to   |                     |         |   |         |                            |
|                          | _  | Iso documented the resident   |                     |         |   |         |                            |
|                          |  | pneumococcal vaccination,   |                     |         |   | ,       |                            |
|                          |  | vaccine status was unable urther documented that the                          |                     | 35      |   |         |                            |
|                          | accine was recomm                              |   |                     | ă .     |   | 7       |                            |
| 1                        |  |   |                     | 1       |   |         |                            |
|                          |  | ducted with Resident #14 on   |                     | 1       |   | - 1     |                            |
|                          |  | When asked when he  |                     | -       |   |         |                            |
|                          |  | esident #14 stated, last  |                     |         |   |         |                            |
|                          |  | 22]. When asked if he was OVID, Resident #14 stated                           |                     | 1       |   |         |                            |
|                          | raccinated against Ct<br>se was not vaccinated |   |                     | 1       |   |         |                            |

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION |   | (X1) PROVIDER/SUPPLIET/CLIA<br>(DENTIFICATION NUMBER:  | (X2) MULTIPLE<br>A BUILDING | (X3) DATE SURVEY<br>COMPLETED   |                 |  |
|---|---|--|-----------------------------|---|-----------------|--|
| -   |   | 405000   |                             |   | С               |  |
|   |   | 495283   | B WING                      |   | 02/25/2022      |  |
| NAME OF PRO   | VIDER OR SUPPLIER   |  |                             | REET ADDRESS, CITY, STATE, ZIP CODE   |                 |  |
| PROMEDIC  | A SKILLED NURSI   | NG AND REHAB (IMPERIAL)  |                             | 9 BELLEVUE AVENUE   |                 |  |
|   |   |  | RIC                         | CHMOND, VA 23227  |                 |  |
| (X4) IO<br>PREFIX<br>TAG                            | (EACH DEFICIENCY  | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)  | PREFIX<br>TAG               | PROVIDER'S PLAN OF CORRECTIO<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS REFERENCED TO THE APPROP<br>DEFICIENCY) | D BE COMPLETION |  |
| F 883 Cd  | ontinued From pag   | ge 156   | F 883                       |   |                 |  |
| AS<br>integral<br>qua<br>the<br>infl<br>doc         | SM #1, the interimerim director of neality consultant, a ality regulatory coe education providuenza and pneum   | e on 2/24/2022 at 1:01 p.m. of administrator, ASM #2, the ursing, ASM #3, the regional and ASM #4, the divisional ansultant, for the evidence of ed prior to the refusal of the nococcal vaccination, and idence the status of the or Resident #14.            |                             |   |                 |  |
| fac<br>pric<br>not                                  | ility did not have e<br>or to the refusal of<br>have any documo<br>ident's COVID vai  | B p.m. ASM #3 stated the evidence of the education the vaccinations, and didentation regarding the eccination status for Resident  |                             |   | i.              |  |
|   |   | ASM #3 were made aware on 2/24/2022 at 4:56 p.m.   |                             |   |                 |  |
| No t  | further information   | n was provided prior to exit.  |                             |   | 8               |  |
| docu  | he facility staff fai<br>umentation of infli<br>/ID vaccinations f  | Jenza, pneumococcal or   |                             |   | 10<br>V         |  |
| 2/14 data (assintering resided daily Tread          | /2022. On the mo<br>set), an admission<br>essment reference<br>fent scored a 15 of<br>view for mental statements is not cognition<br>decisions. In Sectiments, Procedur | itted to the facility on est recent MDS (minimum on assessment with an ARD e date) of 2/20/2022, the out of 15 on the BIMS (brief atus) score, indicating the vely impaired for making estion O - Special es and Programs, the contraction of the received the |                             |   |                 |  |
| influe  | enza and pneumo   | coccal vaccinations. For mented, the resident was  |                             |   | 1               |  |

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                         |   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  | (X2) MULTIPLE CONSTRUCTION A BUILDING |     |  |       | (X3) DATE SURVEY<br>COMPLETED |  |
|---|---|--|---------------------------------------|-----|--|-------|-------------------------------|--|
|   |   |  | X, Bollowo                            |     |  |       | С                             |  |
|   |   | 495283   | B WING                                |     |  |       | 02/25/2022                    |  |
| NAME OF PROVIDER OR SUPPLIER PROMEDICA SKILLED NURSING AND REHAB (IMPERIAL) |   |  |                                       | 171 | REET ADDRESS, CITY, STATE, ZIP CODE<br>9 BELLEVUE AVENUE<br>CHMOND, VA 23227                               |       |                               |  |
| PREFIX (EAC   | H DEFICIENCY  | TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)  | ID<br>PREFI<br>TAG                    |     | PROVIDER'S PLAN OF CORRECT<br>(EACH CORRECTIVE ACTION SHOU<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY) | LD BE | COMPLETION<br>DATE            |  |
| F 883 Continue  | d From pa   | ge 157   | F 8                                   | 883 |  |       | _                             |  |
|   | not offered the vaccinations.                             |  |                                       |     |  |       |                               |  |
| documer<br>vaccinati  | ited "unabli<br>on status o                               | uation, dated 2/14/2022,<br>e to determine" the COVID<br>f Resident #8. It also<br>ident had not received the  |                                       |     |  |       |                               |  |
| influenza   | or pneumo   | occcal vaccinations, but the lations was left blank.   |                                       |     |  |       |                               |  |
| conducte<br>was vacc  | d with Resi<br>inated agai                                | 9 p.m. an interview was<br>dent #8. When asked if he<br>nst COVID, Resident #8<br>e the vaccinations, and he   | 1                                     |     |  |       |                               |  |
| didn't war  |   |  |                                       | -   |  |       | 6.5                           |  |
| ASM #1, t<br>interim dir<br>quality cor<br>quality reg                      | he interim<br>ector of nu<br>nsultant, ar<br>julatory cor | on 2/24/2022 at 4:59 p.m. of administrator, ASM #2, the rsing, ASM #3, the regional ASM #4, the divisional sultant, for the evidence of ations status. | য                                     |     |  |       |                               |  |
|   |   | ASM #3 were made aware on 2/24/2021 at 4:56 p.m.   |                                       |     |  |       | 5.4<br>13.                    |  |
|   | no docum  | a.m. ASM #3 stated the entation of Resident #8's cinations.  |                                       |     |  |       |                               |  |
| No further  | informatior   | was obtained prior to exit.  |                                       | i   |  |       | ļ                             |  |
|   |   |  |                                       |     |  |       | i.                            |  |
|   |   |  |                                       |     |  |       |                               |  |
|   |   |  |                                       | ř   |  |       | II ox                         |  |