	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	CONSTRUCTION		TE SURVEY MPLETED		
						R-C		
		495283	B. WING			3/04/2020		
NAME OF PI	ROVIDER OR SUPPLIER			REET ADDRESS, CITY, STATE, ZIP CO	DE			
PROMEDI	CA SKILLED NURSING	G AND REHAB (IMPERIAL)		719 BELLEVUE AVENUE RICHMOND, VA 23227				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETIOI DATE		
{F 000}	INITIAL COMMENT	rs	{F 000}					
	survey conducted w through 3/4/2020. T conducted 1/21/202 Corrections are req CFR Part 483 Fede regulations for all of Corrected deficience CMS-2567B. The census in this 94 at the time of the consisted of 10 curr #201 through #210	•						
{F 656} SS=D	CFR(s): 483.21(b)( §483.21(b) Compre §483.21(b)(1) The f implement a compr care plan for each r resident rights set fe §483.10(c)(3), that objectives and time medical, nursing, an needs that are iden assessment. The cr describe the followi (i) The services that or maintain the resi physical, mental, ar required under §483. (ii) Any services that under §483.24, §48	chensive Care Plans facility must develop and ehensive person-centered resident, consistent with the orth at §483.10(c)(2) and includes measurable frames to meet a resident's nd mental and psychosocial tified in the comprehensive omprehensive care plan must ng - t are to be furnished to attain dent's highest practicable nd psychosocial well-being as 3.24, §483.25 or §483.40; and at would otherwise be required 33.25 or §483.40 but are not resident's exercise of rights	{F 656}					

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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

	-	D HUMAN SERVICES MEDICAID SERVICES					FORM	): 05/20/2022 MAPPROVED ). 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		495283	B. WING					-C 04/2020
NAME OF PF	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CC	DDE	03/	04/2020
				17	719 BELLEVUE AVENUE			
PROMEDI	CA SKILLED NURSING A	ND REHAB (IMPERIAL)		R	ICHMOND, VA 23227			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ITEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD B		(X5) COMPLETION DATE
{F 656}	provide as a result of recommendations. If a findings of the PASAF rationale in the reside (iv)In consultation with resident's representat (A) The resident's goat desired outcomes. (B) The resident's pre- future discharge. Faci- whether the resident's community was assess local contact agencies entities, for this purpo (C) Discharge plans in plan, as appropriate, i requirements set forth section. This REQUIREMENT by: Based on observation interview, facility docu record review, it was of staff failed to impleme plan for three of ten re- sample, Residents #2 facility staff failed to in comprehensive care p treatment. The facility Resident #206's comp oxygen administration follow Resident #202's	.10(c)(6). ervices or specialized the nursing facility will PASARR a facility disagrees with the RR, it must indicate its nt's medical record. In the resident and the ive(s)- als for admission and ference and potential for lities must document a desire to return to the seed and any referrals to a and/or other appropriate se. In the comprehensive care in accordance with the in paragraph (c) of this is not met as evidenced h, resident interview, staff iment review and clinical determined that the facility ent the comprehensive care esidents in the survey 03, #206 and #202. The inplement Resident #203's olan for pressure injury staff failed to implement orehensive care plan for b. The facility staff failed to s pain care plan to offer	{F 6	556}				

Facility ID: VA0154

If continuation sheet Page 2 of 45

	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0.0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE COMF	
		495283	B. WING				-C 04/2020
NAME OF P	ROVIDER OR SUPPLIER		•		STREET ADDRESS, CITY, STATE, ZIP CODE	•	
PROMED	CA SKILLED NURSING A	AND REHAB (IMPERIAL)			1719 BELLEVUE AVENUE RICHMOND, VA 23227		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
{F 656}	Continued From page	2	{F 6	656	;}		
	11/27/19. Resident # but were not limited to muscle wasting and h #203's admission MD assessment with an A date) of 12/3/19, code cognitively intact. Se #203 as having three ulcers (injuries) (1), p Resident #203's comp 12/18/19 documented treatment per physicia A nurse's note dated Resident #203 preser pressure injury (1) on measured nine cm (cc cm (width) by four cer A physician's order da 3/3/20 documented, " UNIT/GM (gram) (Col wound topically every wound care. CLEAN NORMAL SALINE, P/ TO AREAS WITH SLI SACRAL DRESSING A physician's order da 3/3/20 documented, " UNIT/GM (Collagena: topically as needed fo SACRAL WOUND W DRY, APPLY SANTY	ARD (assessment reference ad the resident as being ction M coded Resident unstageable pressure resent upon admission. brehensive care plan dated d, "SacrumAdminister an orders" 3/2/20 documented thet with a stage four the sacrum (2) that entimeters) (length) by nine ntimeters (depth). ated 1/9/20 and active on Santyl Ointment (3) 250 lagenase). Apply to sacrum day and evening shift for SACRAL WOUND WITH AT DRY, APPLY SANTYL OUGH AND APPLY ." ated 1/9/20 and active on Santyl Ointment 250 se). Apply to SACRUM or wound care. CLEAN ITH NORMAL SALINE, PAT					

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391	
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED	
		495283	B. WING				-C <b>04/2020</b>	
NAME OF P	ROVIDER OR SUPPLIER		•		STREET ADDRESS, CITY, STATE, ZIP CODE			
PROMEDI	CA SKILLED NURSING A	AND REHAB (IMPERIAL)			1719 BELLEVUE AVENUE RICHMOND, VA 23227			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE	
{F 656}	A physician's order da 3/3/20 documented, " 0.057% (4). Apply to and evening shift for y (milliliters) to gauze, a A physician's order da 3/3/20 documented, " Hypochlorite) (4). Ap topically every day an alteration. Apply sant cover with anasept m (abdominal dressing p On 3/3/20 at 5:18 p.m nurse) #4 was observ #203's sacral wound #2 (unit manager) wa #4 stated she had prii for the wound care sh showed a copy of the santyl. LPN #4 clean wound with 0.9% safe applied santyl to sloug bed, applied dermapr surrounding the wour with an optifoam dress did not apply anasept pad. Resident #203's Marc administration record treatment orders sche and 3:15 p.m. (excep order). Review of Re TAR on 3/4/20 reveal scheduled at 7:15 a.m	ated 1/9/20 and active on Sodium Hypochlorite Liquid sacrum topically every day wound care- apply 5-15 ml apply to sacrum." ated 2/25/20 and active on Anasept Liquid (Sodium ply to sacrum wound ad evening shift for skin tyl nickel thick to wound bed, oist guaze (sic), ABDs bads) and tape." n., LPN (licensed practical red providing Resident care. RN (registered nurse) s present in the room. LPN net the physician's order for sed Resident #203's sacral ewash saline solution, gh (dead skin) on the wound ep skin prep (5) on the skin ad then covered the wound sing dated 3/3/20. LPN #4 moist gauze or an ABD ch 2020 TAR (treatment ) documented the above eduled each day at 7:15 a.m. t the as needed santyl sident #203's March 2020 ed all three orders n. and 3:15 p.m. (for santyl, hypochlorite) were signed off	{F 6	656	5}			

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMF	
		495283	B. WING				/04/2020
NAME OF P	ROVIDER OR SUPPLIER	L		5	STREET ADDRESS, CITY, STATE, ZIP CODE		
PROMED	CA SKILLED NURSING	AND REHAB (IMPERIAL)		1719 BELLEVUE AVENUE RICHMOND, VA 23227			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE
{F 656}	Resident #203 during on 3/3/20). None of th wound treatment orde order were signed off On 3/4/20 at 8:53 a.m conducted with Resid confirmed the only we sacral wound on 3/3/2 observed by the surve On 3/4/20 at 12:51 p. conducted with LPN ( LPN #2 was asked th care plan. LPN #2 st outline of the patient of to follow." LPN #2 st computer system and plans to ensure the ca implemented. On 3/4/20 at 1:12 p.m #203's sacral wound The same optifoam d covering the resident" On 3/4/20 at 1:34 p.m treatment cart was co with Resident #203's observed in the treatm On 3/4/20 at 1:41 p.m conducted with LPN # cared for Resident #2 evening shifts on 3/3/ provided any sacral w #203 on 3/3/20, LPN sacral wound care was	<ul> <li>the day and evening shifts he three scheduled sacral ers or the as needed santyl by LPN #4.</li> <li>h., an interview was lent #203. The resident bound care provided on his 20 was the wound care eyor.</li> <li>m., an interview was licensed practical nurse) #2.</li> <li>e purpose of a resident's ated, "The care plan is the care that you are supposed ated nurses can go on the look at residents' care are plans are being</li> <li>h., observation of Resident dressing was conducted. ressing dated 3/3/20 was is sacral wound.</li> <li>h., observation of the unit onducted. Anasept labeled name and ABD pads were</li> </ul>	{F 6	556}			

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		ID HUMAN SERVICES MEDICAID SERVICES					RINTED: 05/20/2022 FORM APPROVED JB NO. 0938-0391	
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		ONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495283	B. WING				R-C 03/04/2020	
NAME OF P	ROVIDER OR SUPPLIER		•	STR	REET ADDRESS, CITY, STATE, ZIP COD	)E		
PROMEDI	CA SKILLED NURSING	AND REHAB (IMPERIAL)			9 BELLEVUE AVENUE CHMOND, VA 23227			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE APPROPRIATE	(X5) COMPLETION DATE	
{F 656}	3/3/20 but did not pro When asked why she sacral wound care tre stated she would be a On 3/4/20 at 2:13 p.m conducted with LPN a she provided Resider wound care on 3/3/20 LPN #4 stated the ph to cleanse the wound apply santyl to the slo with a dressing. LPN wound with normal sa optifoam dressing. A wound care orders or reviewed with LPN #4 whole bunch of order completed the 1/9/20 apply anasept (sodiuu pad on Resident #202 LPN #4 was asked if wound care treatmen TAR on 3/3/20. LPN not because she was LPN #4 was asked the anasept and normal sa anasept contained m saline. On 3/4/20 at 3:48 p.m conducted with LPN # apply barrier cream to 3/3/20, so if she did s and sodium hypochlo did so in error, thinkin cream. LPN #1 state	dent #203's bottom on vide any sacral wound care. e signed off the scheduled eatments on 3/3/20, LPN #1 at the facility at 3:00 p.m. h., an interview was #4. LPN #4 was asked if ht #203's scheduled sacral b. LPN #4 stated, "Yes." ysician's order documented with normal saline, pat dry, bugh and cover the wound #4 stated she cleansed the aline, applied santyl and an II of Resident #203's sacral in the March 2020 TAR were 4. LPN #4 stated, "That's a s." LPN #4 stated she santyl order but did not m hypochlorite) or an ABD 3's sacral wound on 3/3/20. she signed any sacral ts off on Resident #203's #4 stated, she probably did rushing to leave the facility.	{F 6	556}				

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		MEDICAID SERVICES				O. 0938-039
	OF DEFICIENCIES - CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	· · ·	E SURVEY IPLETED
			A. BUILDING			R-C
		495283	B. WING			3/04/2020
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
		AND REHAB (IMPERIAL)		1719 BELLEVUE AVENUE		
FROMEDI	ICA SKIELED NOKSING			RICHMOND, VA 23227		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
{F 656}	Continued From page	e 6	{F 656]	}		
	and did not provide s resident on 3/3/20.	acral wound care for the				
On 3/4/20 at 3:52 p.m., an intervie conducted with RN #2. RN #2 star observed LPN #4 perform Resider wound care, with a surveyor prese but she did not provide and did nor else provide sacral wound care for on 3/3/20.		2. RN #2 stated she rform Resident #203's sacral urveyor present, on 3/3/20 de and did not see anyone				
	were discontinued or order dated 3/4/20 dd BID (twice daily): Cle apply nickel thick lay moistened anasept g day and evening shif signed this order. Or interview was conduc confirmed Resident # orders were changed she was reviewing th multiple orders so sh and consolidated into practitioner. LPN #3 moistened gauze wa Resident #203's sacr On 3/4/20 at 4:23 p.m member) #1 (the adm director of nursing) a director of operations	e had the orders clarified o one order by the nurse confirmed anasept s supposed to be applied to				
	above concern. The facility policy title CARE PLANNING" d "Implementation. On developed, the staff r	nce the care plan is				

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391	
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		E CONSTRUCTION	(X3) DATE COMF		
		495283	B. WING				-C 04/2020	
NAME OF P	ROVIDER OR SUPPLIER	L	<b>I</b>		STREET ADDRESS, CITY, STATE, ZIP CODE	•		
PROMEDI	CA SKILLED NURSING A	AND REHAB (IMPERIAL)			1719 BELLEVUE AVENUE RICHMOND, VA 23227			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
{F 656}	may include, but is no -administering treatm No further information References: (1) "A pressure injury skin and underlying s bony prominence or r device. The injury car open ulcer and may b -Unstageable Pressur full-thickness skin and skin and tissue loss ir damage within the uld because it is obscure tissue) -Stage 4 Pressure Inj tissue loss Full-thickne with exposed or direct tendon, ligament, car Slough and/or eschar This information was https://cdn.ymaws.com ce/resmgr/npuap_pression (2) "The sacrum is a s structure that is located vertebrae and that is This information was https://medlineplus.go htm (3) "SANTYL Ointment	d in the care plan. Theses of limited to: ents and medications" In was presented prior to exit. is localized damage to the oft tissue usually over a elated to a medical or other in present as intact skin or an be painful re Injury: Obscured d tissue loss Full-thickness in which the extent of tissue cer cannot be confirmed d by slough or eschar (dead ury: Full-thickness skin and less skin and tissue loss tly palpable fascia, muscle, tilage or bone in the ulcer. "may be visible" obtained from the website: m/npuap.site-ym.com/resour issure_injury_stages.pdf	{F 6	556	}			
	from wounds so they	can start to heal." This ned from the website:						

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		ID HUMAN SERVICES MEDICAID SERVICES					FORM	D: 05/20/2022 MAPPROVED D: 0938-0391
STATEMENT O	EMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, <i>i</i>		LE CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		495283	B. WING					-C 04/2020
NAME OF PR	OVIDER OR SUPPLIER		•		STREET ADDRESS, CITY, STATE, ZIP CODE			
PROMEDIC	A SKILLED NURSING A	AND REHAB (IMPERIAL)			1719 BELLEVUE AVENUE			
					RICHMOND, VA 23227			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE		(X5) COMPLETION DATE
{F 656}	Continued From page	8	{F 6	656	3}			
	https://santyl.com/							
	Solution is a clear, iso mechanical removal of application site while broad-spectrum antim hypochlorite via Nega Therapy Device." Thi from the website: https://anacapa-tech.l obial-wound-irrigation (5) "DermaPrep Liquid forms a long-lasting we shield peri-wound skin adhesives, and friction the risk of pain and skin adhesive removal." To obtained from the wel http://dermarite.com/p 2. Resident #206 was 9/5/18. Resident #20 were not limited to str disorder. Resident #20 were for limited to st	delivering 0.057% hicrobial sodium tive Pressure Wound is information was obtained het/product/anasept-antimicr -solution/ d Barrier Skin Protectant vaterproof film designed to in from bodily fluids, nal forces. It helps reduce kin damage during tape and This information was bsite: product/dermaprep/ a admitted to the facility on 6's diagnoses included but toke, paralysis and anxiety 206's quarterly MDS with an ARD (assessment 0/20, coded the resident as ct. Section G coded ing totally dependent on two I mobility and transfers. resident has having received eare plan for Resident's #206 ented, "Has/At risk for at related to COPD (chronic						

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						O. 0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	ECONSTRUCTION	· · · ·	E SURVEY IPLETED
			A. BUILDING			
		495283	B. WING			R-C
		495265			03	3/04/2020
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
PROMED	CA SKILLED NURSING	AND REHAB (IMPERIAL)				
	Ι		F	RICHMOND, VA 23227		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL & LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE
{F 656}	Continued From pag	ae 9	{F 656}			
(,	10	Review of Resident #206's	[1 000]			
		led a physician's order dated				
		us oxygen at the rate of two				
	liters per minute.					
	On 3/3/20 at approxi	imately 4:30 p.m., 3/3/20 at				
		) at 11:06 a.m., Resident				
		lying in bed receiving oxygen				
		connected to an oxygen				
		is running. The oxygen				
		t at a rate between one and a				
		ers as evidenced by the ball				
		low meter positioned between				
		ter and two liter lines (at eye veyor conducted the 3/3/20				
	5:37 p.m. observatio	-				
	On 3/4/20 at 12:51 p	o.m., an interview was				
		(licensed practical nurse) #2,				
		Resident #206 during the day				
	shift on 3/3/20 and 3	8/4/20. LPN #2 was asked				
	the purpose of a resi	ident's care plan. LPN #2				
		an is the outline of the patient				
		pposed to follow." LPN #2				
		go on the computer system				
		s' care plans to ensure the				
		implemented. LPN #2 was				
		here the ball in an oxygen eter should be if a resident				
		der for two liters. LPN #2				
		ne should run through the				
		at this time, Resident #206's				
		was observed with LPN #2.				
		lying in bed. The oxygen				
		served with the flow rate set				
	at a rate between on	ne and a half liters and two				
		by the ball in the concentrator				
	flow meter positione	d between the one and a half				
		es at eye level. LPN #2				

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		ID HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED D. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		495283	B. WING				/04/2020
NAME OF P	ROVIDER OR SUPPLIER	I		5	STREET ADDRESS, CITY, STATE, ZIP CODE		
PROMEDI	CA SKILLED NURSING	AND REHAB (IMPERIAL)			1719 BELLEVUE AVENUE RICHMOND, VA 23227		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
{F 656}	adjusted the flow mete the oxygen flow mete two liters. On 3/4/20 at 4:23 p.m member) #1 (the adm director of nursing) at director of operations above concern. No further information 3. Resident #202 was 9/11/19; and was reco 1/18/2020, with diagn limited to diabetes (1) morbid obesity. On the (minimum data set) a change assessment v reference date of 1/3/ coded as having no c making daily decision pain of at least five ou during the look back p Resident #202 refuse the survey. On 3/3/2020 at 5:28 p observed sitting up in television. This obser not reveal any expression A review of Resident	er and stated it looked like r was running a little under h., ASM (administrative staff hinistrator), ASM #2 (the hd ASM #3 (the regional ) were made aware of the h was presented prior to exit. a admitted to the facility on ently readmitted on loses including, but not ), bipolar disorder (2), and he most recent MDS ssessment, a significant with an assessment (2020, Resident #202 was ognitive impairment for hs. She was coded as having ut of 10 intensity frequently beriod. d to be interviewed during b.m., Resident #202 was her bed, watching vation of Resident #202 did ssions or indications of pain. a.m., Resident #202 was e in bed. Her eyes were of Resident #202, failed to hs or indications of pain.	{F 6	556)	}		

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		E CONSTRUCTION	(X3) DATE COMF	
		495283	B. WING				/04/2020
NAME OF PI	ROVIDER OR SUPPLIER		I	5	STREET ADDRESS, CITY, STATE, ZIP CODE	1 00,	0
PROMEDI	CA SKILLED NURSING	AND REHAB (IMPERIAL)			1719 BELLEVUE AVENUE RICHMOND, VA 23227		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
{F 656}	5-325 mg (milligrams) every 4 hours as need above." A review of Resident 2020 MARs (medicati revealed this medicati 2/26/2020 at 8:15 p.m 3/1/2020 at 9:01 p.m. on 3/2/2020 at 8:25 p Further review of Resident non-pharmacological attempted prior to the as-needed pain medic 3/1/2020 and 3/2/202 A review of Resident plan dated 9/12/19 ar revealed, in part: "Pai medication per physic non-pharmacological assist with pain and n On 3/4/2020 at 12:55 practical nurse) #2 wa the purpose of a care plan is the outline of p supposed to follow. W staff makes sure that implemented, she sta available online for th	<ul> <li>minophen (Norco) (3) Tablet</li> <li>Give 1 tablet by mouth</li> <li>ded for pain level 5 and</li> <li>#202's February and March</li> <li>ion administration records)</li> <li>ion was administered on</li> <li>n. for a pain level of four; on</li> <li>for a pain level of one; and</li> <li>m. for a pain level of four.</li> <li>ident #202's MARs and</li> <li>preveal evidence that</li> <li>interventions were</li> <li>administration of the</li> <li>cation on 2/26/2020,</li> <li>w202's comprehensive care</li> <li>nd revised on 1/31/2020</li> <li>in in backAdminister pain</li> <li>cian ordersImplement</li> <li>interventions: Positioning to</li> <li>nonitor for effectiveness."</li> <li>p.m., LPN (licensed</li> <li>as interviewed. When asked</li> <li>plan, she stated the care</li> <li>patient care that the staff is</li> <li>/hen asked how the facility</li> <li>the care plan is</li> </ul>	{F 6	\$56}			
	being followed after regarding as-needed	nt #202's care plan was eviewing the documentation pain medication ck of non-pharmacological					

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FO	ED: 05/20/2022 RM APPROVED NO. 0938-0391	
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í	IPLE CONSTRUC		(X3) DATE SURVEY COMPLETED		
		495283	B. WING _			C	R-C 3/04/2020	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDR	RESS, CITY, STATE, ZIP CODE			
PROMED	CA SKILLED NURSING	AND REHAB (IMPERIAL)		1719 BELLEV RICHMOND				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF COR EACH CORRECTIVE ACTION OSS-REFERENCED TO THE # DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
{F 656} {F 657} SS=D	interventions being of can't say that. It was followed." On 3/4/2020 at 3:03 p #1, a unit manager, w asked how the facility care plan is being imp that most often, it req between all the discip On 3/4/2020 at 4:18 p staff member) #1, the director of nursing, an director of operations concerns. ASM #1 ar provide any additionat these concerns prior No further information References: (1) "Diabetes (mellitu blood glucose, or blo- high." This information https://medlineplus.gr Care Plan Timing and CFR(s): 483.21(b)(2) §483.21(b) Comprehe §483.21(b)(2) A comp be- (i) Developed within 7 the comprehensive a	ffered, LPN #2 stated, "No. I definitely not being o.m., RN (registered nurse) vas interviewed. When v makes sure a resident's plemented, RN #1 stated uires communication plines. o.m., ASM (administrative e administrator, ASM #2, the nd ASM #3, the regional v, were informed of these nd ASM #2 were asked to al information addressing to exit. n was provided prior to exit. s) is a disease in which your od sugar, levels are too n is taken from the website pv/diabetes.html. d Revision (i)-(iii) ensive Care Plans prehensive care plan must 7 days after completion of ssessment. terdisciplinary team, that nited to	{F 6					

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	-	D HUMAN SERVICES				FOR	M APPROVED 0. 0938-0391
STATEMENT	CENTERS FOR MEDICARE & MEDICAID SERVICES           STATEMENT OF DEFICIENCIES           AND PLAN OF CORRECTION           (X1) PROVIDER/SUPPLIER/CLIA           IDENTIFICATION NUMBER:					(X3) DATE COMF	SURVEY PLETED
		495283	B. WING				R-C / <b>04/2020</b>
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
PROMEDI	CA SKILLED NURSING A	ND REHAB (IMPERIAL)			1719 BELLEVUE AVENUE RICHMOND, VA 23227		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	IMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORF DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION S ATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE AF DEFICIENCY)					(X5) COMPLETION DATE
{F 657}	resident. (C) A nurse aide with resident. (D) A member of food (E) To the extent prace the resident and the r An explanation must I medical record if the p and their resident rep not practicable for the resident's care plan. (F) Other appropriate disciplines as determine or as requested by the (iii)Reviewed and revit team after each asses comprehensive and q assessments. This REQUIREMENT by: Based on observation document review and was determined that the review and revise the for one of ten residen Resident #203. Residen discontinuation. The findings include: Resident #203 was an 11/27/19. Resident # but were not limited to	e with responsibility for the responsibility for the and nutrition services staff. ticable, the participation of esident's representative(s). be included in a resident's participation of the resident resentative is determined e development of the staff or professionals in need by the resident's needs e resident. sed by the interdisciplinary ssment, including both the uarterly review 'f is not met as evidenced n, staff interview, facility clinical record review, it the facility staff failed to comprehensive care plan ts in the survey sample, dent #203's isolation contact continued on 2/24/20. The eview and revise the sive care plan to reflect this	{F 6	657	}		

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STATEMENT (	OF DEFICIENCIES	MEDICAID SERVICES	(X2) MULTIPLE CO	ONSTRUCTION		IO. 0938-039		
	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING			IPLETED		
						R-C		
		495283	B. WING			3/04/2020		
NAME OF P	ROVIDER OR SUPPLIER			EET ADDRESS, CITY, STATE, ZIP COD	)E			
PROMEDI	CA SKILLED NURSING	AND REHAB (IMPERIAL)		9 BELLEVUE AVENUE HMOND, VA 23227				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE		
{F 657}	Continued From page	e 14	{F 657}					
		ARD (assessment reference ed the resident as cognitively						
	contact precautions f difficile] (1). Further clinical record reveale	s order dated 2/20/20 for						
	dated 1/9/20 docume Alteration; Diarrhea r	ent comprehensive care plan ented, "Bowel Elimination elated to: dx (diagnosis) Contact Precautions- Date "						
	observed lying in bed precautions were not evidenced by no sign no isolation personal	n., Resident #203 was I. Isolation contact being implemented as o on the resident's door and protective equipment be room or inside of the						
	LPN #2 was asked th care plan. LPN #2 st outline of the patient to follow." When ask should reflect the disc contact precautions, When asked why, LP change. If not on iso	m., an interview was (licensed practical nurse) #2. he purpose of a resident's lated, "The care plan is the care that you are supposed ed if a resident's care plan continuation of isolation LPN #2 stated, "Yes Ma'am." N #2 stated, "Because it's a lation anymore, it should be e resident is) not on isolation						

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		495283	B. WING				-C 04/2020
NAME OF PI	ROVIDER OR SUPPLIER		•	5	STREET ADDRESS, CITY, STATE, ZIP CODE	·	
PROMEDI	CA SKILLED NURSING	AND REHAB (IMPERIAL)			1719 BELLEVUE AVENUE RICHMOND, VA 23227		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
{F 657}	director of nursing) at director of operations above concern. The facility policy title CARE PLANNING" d the care plan is imple interdisciplinary team the interventions are plan needs to be revis	inistrator), ASM #2 (the nd ASM #3 (the regional ) were made aware of the d, "INTERDISCIPLINARY ocumented, "Evaluation. As mented, members of the need to evaluate whether effective or whether the care	{F 6	857}			
	Reference:	· · · · · · · · · · · · · · · · · · ·					
{F 658} SS=D	that can cause diarrh intestinal conditions s close to half a million information was obtai https://vsearch.nlm.ni meta?v%3Aproject=n medlineplus-bundle& 460.1291684497.158 160688 Services Provided Me	uch as colitis. C. diff causes illnesses each year." This ned from the website: h.gov/vivisimo/cgi-bin/query- nedlineplus&v%3Asources= query=c+diff&_ga=2.128152 3375515-1667741437.1550 eet Professional Standards	{F 6	\$58}			
	as outlined by the cor must- (i) Meet professional This REQUIREMENT by: Based on observatio	d or arranged by the facility, nprehensive care plan,					

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	OF DEFICIENCIES	MEDICAID SERVICES		LE CONSTRUCTION		O. 0938-039 E SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	· /			PLETED
					F	
		495283	B. WING		03	/04/2020
NAME OF P	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE		
PROMEDI	CA SKILLED NURSING	AND REHAB (IMPERIAL)		1719 BELLEVUE AVENUE		
				RICHMOND, VA 23227		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETIO DATE
{F 658}	Continued From page	e 16	{F 658	3}		
(,		the facility staff failed to	1 000	-1		
		andards of practice for one				
		e survey sample, (Residents				
	#203). LPN (Licensed					
		treatment for Resident #203				
		o document the completed Licensed practical nurse) #1				
		nted sacral wound care				
		ed for Resident #203 on				
	3/3/20. LPN #1 signe					
	treatments on the res					
	complete the treatme	tion record and did not				
	The findings include:					
	Resident #203 was a	dmitted to the facility on				
		203's diagnoses included				
		o high blood pressure,				
	-	neart disease. Resident DS (minimum data set) with				
		t reference date) of 12/3/19,				
		s being cognitively intact.				
		sident #203 as having three				
	unstageable pressure					
	present upon admiss	ion.				
	A physician's order d	ated 1/9/20 and active on				
		'Santyl Ointment (2) 250				
		llagenase). Apply to sacrum				
		/ day and evening shift for SACRAL WOUND (3)				
		INE, PAT DRY, APPLY				
		WITH SLOUGH (dead skin)				
	AND APPLY SACRA					
	A physician's order d	ated 1/9/20 and active on				
	3/3/20 documented, '					1

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMF	
		495283	B. WING				04/2020
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
PROMEDI	CA SKILLED NURSING A	AND REHAB (IMPERIAL)			719 BELLEVUE AVENUE RICHMOND, VA 23227		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ЗE	(X5) COMPLETION DATE
{F 658}	0.057% (4). Apply to and evening shift for y (milliliters) to gauze, a A physician's order da 3/3/20 documented, " Hypochlorite) (5). Ap topically every day an alteration. Apply san cover with anasept m (abdominal dressing p On 3/3/20 at 5:18 p.m providing Resident #2 LPN #4 cleansed Res with 0.9% safewash s to slough on the wour skin prep (4) on the s then covered the wour dressing dated 3/3/20 Review of Resident # including the March 2 administration record notes, on 3/4/20 failed the treatment LPN #4 Further review of Res TAR (treatment admin documented the abov treatments scheduled 3:15 p.m. Review of 2020 TAR on 3/4/20 r signed off all three or	sacrum topically every day wound care- apply 5-15 ml apply to sacrum." ated 2/25/20 and active on Anasept Liquid (Sodium ply to sacrum wound ad evening shift for skin tyl nickel thick to wound bed, oist guaze (sic), ABDs bads) and tape." a., LPN #4 was observed 203's sacral wound care. sident #203's sacral wound saline solution, applied santyl ad bed, applied dermaprep kin surrounding the wound and with an optifoam b. 203's clinical record, 020 treatment (TAR) and 3/3/20 nurses' d to reveal documentation of provided on 3/3/20. sident #203's March 2020 histration record) re physician orders for each day at 7:15 a.m. and Resident #203's March evealed on 3/3/20 LPN #1 ders scheduled at 7:15 a.m.	{F 6	558}			

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		495283	B. WING				-C <b>04/2020</b>
NAME OF P	ROVIDER OR SUPPLIER		<b>I</b>	S	STREET ADDRESS, CITY, STATE, ZIP CODE		
PROMED	CA SKILLED NURSING A	AND REHAB (IMPERIAL)			1719 BELLEVUE AVENUE RICHMOND, VA 23227		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE
{F 658}	she signed any sacra on Resident #203's T, stated she probably d rushing to leave the fa On 3/4/20 at 3:48 p.m conducted with LPN # apply barrier cream to 3/3/20 so if she did si and sodium hypochlo did so in error, thinkin cream. LPN #1 state- cream to Resident #2 provide sacral wound 3/3/20. On 3/4/20 at 4:23 p.m member) #1 (the adm director of nursing) ar director of nursing) ar director of nursing) ar director of operations above concern. The facility policy title TREATMENT ADMIN documented, "Medica administered are doct following administration standards" On 3/4/20 at 5:40 p.m staff utilizes facility policy practice. No further information References:	<ul> <li>t4. LPN #4 was asked if</li> <li>I wound care treatments off</li> <li>AR on 3/3/20. LPN #4</li> <li>id not because she was</li> <li>acility.</li> <li>a., an interview was</li> <li>t1. LPN #1 stated she did</li> <li>b Resident #203's bottom on</li> <li>gn off the santyl, anasept</li> <li>rite orders on the TAR, she</li> <li>ig she was signing off barrier</li> <li>d she only applied barrier</li> <li>03's bottom and did not</li> <li>care for the resident on</li> <li>a., ASM (administrative staff</li> <li>inistrator), ASM #2 (the</li> <li>ad ASM #3 (the regional</li> <li>) were made aware of the</li> <li>d, "MEDICATION AND</li> <li>ISTRATION GUIDELINES"</li> <li>tions and treatments</li> </ul>	{F 6	558}			

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		ND HUMAN SERVICES MEDICAID SERVICES					FORM	): 05/20/202 APPROVE ). 0938-039
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF A. BUILDING			(X3) DATE SURVEY COMPLETED		
		495283	B. WING					-C 04/2020
NAME OF PI	ROVIDER OR SUPPLIER			STREET	ADDRESS, CITY, STATE, ZIP COL	DE		
		AND REHAB (IMPERIAL)		1719 BE	LLEVUE AVENUE			
FRONEDI	CA SKILLED NORSING	AND REHAD (IMPERIAL)		RICHM	OND, VA 23227			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIAT	Ē	(X5) COMPLETION DATE
{F 658}	Continued From page	e 19	{F 65	8}				
		oft tissue usually over a						
		related to a medical or other						
	open ulcer and may b	n present as intact skin or an						
	-Unstageable Pressu							
		d tissue loss Full-thickness						
		n which the extent of tissue						
		cer cannot be confirmed d by slough or eschar (dead						
	tissue)"							
		obtained from the website:						
		m/npuap.site-ym.com/resour						
	ce/resmgr/npuap_pre	essure_injury_stages.pdf						
	(2) "SANTYL Ointme	nt is an FDA-approved						
		that removes dead tissue						
		can start to heal." This ined from the website:						
	https://santyl.com/							
	vertebrae and that is This information was	shield-shaped bony ed at the base of the lumbar connected to the pelvis." obtained from the website: ov/ency/imagepages/19464.						
	forms a long-lasting v shield peri-wound ski adhesives, and frictio	nal forces. It helps reduce kin damage during tape and This information was bsite:						
	Solution is a clear, is	crobial Wound Irrigation otonic liquid that helps in the of the debris from the						

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MELLTIDI	E CONSTRUCTION		O. 0938-039 E SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	. ,		· · · ·	PLETED
					6	<b>२-</b> С
		495283	B. WING		03	/04/2020
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
PROMED	ICA SKILLED NURSING	AND REHAB (IMPERIAL)		1719 BELLEVUE AVENUE RICHMOND, VA 23227		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
{F 658}	application site while broad-spectrum antin hypochlorite via Nega Therapy Device." Th from the website:	delivering 0.057%	(F 658	}		
{F 686} SS=D		event/Heal Pressure Ulcer	{F 686	}		
	resident, the facility m (i) A resident receives professional standard pressure ulcers and d ulcers unless the indi demonstrates that the (ii) A resident with pre- necessary treatment with professional star promote healing, prev- new ulcers from deve This REQUIREMENT by: Based on observatio interview, facility docu- record review, it was staff failed to provide treatment of a pressur residents in the surve and Resident #202). provide Resident #202 wound care per physi- facility staff failed to a gauze and an abdom	re ulcers. thensive assessment of a nust ensure that- is care, consistent with ls of practice, to prevent does not develop pressure vidual's clinical condition ey were unavoidable; and essure ulcers receives and services, consistent indards of practice, to vent infection and prevent				

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE COMP	SURVEY PLETED
		495283	B. WING				R-C <b>/04/2020</b>
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	•	
PROMED	CA SKILLED NURSING A	AND REHAB (IMPERIAL)			1719 BELLEVUE AVENUE RICHMOND, VA 23227		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE
{F 686}	sacral wound care tw order and the facility s treatment was provide pressure injury on 2/2 The findings include: 1. Resident #203 was 11/27/19. Resident # but were not limited to muscle wasting and h #203's admission MD an ARD (assessment coded the resident as Section M coded Res unstageable pressure present upon admissi A nurse's note dated Resident #203 preser pressure injury (1) on measured nine cm (cd cm (width) by four cel A physician's order da 3/3/20 documented, " UNIT/GM (gram) (Col wound topically every wound care. CLEAN NORMAL SALINE, P/ TO AREAS WITH SL SACRAL DRESSING A physician's order da 3/3/20 documented, " UNIT/GM (Collagena: topically as needed for	ice that date per physician's staff failed to evidence ed to Resident #202's 26/2020. a admitted to the facility on 203's diagnoses included o high blood pressure, heart disease. Resident 'S (minimum data set) with reference date) of 12/3/19, a being cognitively intact. ident #203 as having three e ulcers (injuries) (1), ion. 3/2/20 documented need with a stage four the sacrum (2) that entimeters) (length) by nine ntimeters (depth). ated 1/9/20 and active on 'Santyl Ointment (3) 250 Ilagenase). Apply to sacrum a day and evening shift for SACRAL WOUND WITH AT DRY, APPLY SANTYL OUGH AND APPLY ." ated 1/9/20 and active on 'Santyl Ointment 250 se). Apply to SACRUM or wound care. CLEAN ITH NORMAL SALINE, PAT	{F 6	586	}		

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED D. 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		495283	B. WING				R-C / <b>04/2020</b>
NAME OF PF	ROVIDER OR SUPPLIER			Ś	STREET ADDRESS, CITY, STATE, ZIP CODE		
PROMEDI	CA SKILLED NURSING A	AND REHAB (IMPERIAL)			1719 BELLEVUE AVENUE RICHMOND, VA 23227		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
{F 686}	A physician's order da 3/3/20 documented, " 0.057% (4). Apply to and evening shift for (milliliters) to gauze, a A physician's order da 3/3/20 documented, " Hypochlorite) (4). Ap topically every day an alteration. Apply sant cover with anasept m (abdominal dressing p Resident #203's comp 12/18/19 documented treatment per physicia On 3/3/20 at 5:18 p.m nurse) #4 was observ #203's sacral wound #2 (unit manager) wa #4 stated she had prii for the wound care sh showed a copy of the santyl. LPN #4 clean wound with 0.9% safe applied santyl to sloup bed, applied dermapri surrounding the wour with an optifoam dress did not apply anasept pad.	Y SACRAL DRESSING." ated 1/9/20 and active on Sodium Hypochlorite Liquid sacrum topically every day wound care- apply 5-15 ml apply to sacrum." ated 2/25/20 and active on Anasept Liquid (Sodium ply to sacrum wound d evening shift for skin tyl nickel thick to wound bed, oist guaze (sic), ABDs bads) and tape." prehensive care plan dated d, "SacrumAdminister an orders" n., LPN (licensed practical red providing Resident care. RN (registered nurse) s present in the room. LPN nted the physician's order the was providing and 1/9/20 physician's order for sed Resident #203's sacral ewash saline solution, gh (dead skin) on the wound ep skin prep (5) on the skin id then covered the wound sing dated 3/3/20. LPN #4 moist gauze or an ABD	{F 6	\$86}			
	administration record	ch 2020 TAR (treatment ) documented the above eduled each day at 7:15 a.m.					

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		E CONSTRUCTION	(X3) DATE COMF	
		495283	B. WING				/04/2020
NAME OF P	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE	1 00.	•
PROMED	ICA SKILLED NURSING	AND REHAB (IMPERIAL)			1719 BELLEVUE AVENUE RICHMOND, VA 23227		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
{F 686}	and 3:15 p.m. (excep order). Review of Re TAR on 3/4/20 reveal nurse caring for Resid and evening shifts on orders scheduled at 7 santyl, anasept and s the three scheduled s orders or the as need off by LPN #4. On 3/4/20 at 8:53 a.m conducted with Resid confirmed the only we sacral wound on 3/3/2 observed as documen On 3/4/20 at 1:12 p.m #203's sacral wound The same optifoam d covering the resident On 3/4/20 at 1:34 p.m treatment cart was co with Resident #203's observed in the treatm On 3/4/20 at 1:41 p.m conducted with LPN # cared for Resident #2 evening shifts on 3/3/ provided any sacral w #203 on 3/3/20, LPN presence of a survey wound care. LPN #1 cream to Resident #2 did not provide any sa asked why she signed	t the as needed santyl sident #203's March 2020 ed on 3/2/20, LPN #1, the dent #203 during the day 3/3/20, signed off all three 7:15 a.m. and 3:15 p.m., for odium hypochlorite. None of acral wound treatment led santyl order were signed n., an interview was lent #203. The resident bund care provided on his 20 was the wound care nted above. n., observation of Resident dressing was conducted. ressing dated 3/3/20 was 's sacral wound. n., observation of the unit onducted. Anasept labeled name and ABD pads were	{F 6	\$86}			

If continuation sheet Page 24 of 45

CENTERS FOR MEDICARE & MEDICAID SERVICES     OMB NO. 0938-02       STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION     (X1) PROVIDERNUPPLIER/CLA IDENTIFICATION NUMBER:     (X2) MULTIPLE CONSTRUCTION A BUILDING     (X3) DATE SURVEY       NAME OF PROVIDER OR SUPPLIER     495283     STREET ADDRESS, CITY, STATE, ZIP CODE     R-C 03/04/2020       NAME OF PROVIDER OR SUPPLIER     STREET ADDRESS, CITY, STATE, ZIP CODE     RCMOND, VA 23227       (X4) ID PREFIX TAG     SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)     ID PREFIX TAG     PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE DEFICIENCY)     (X4) OOM#LETK DATE       (X4) ID PREFIX TAG     Continued From page 24 she would be at the facility at 3:00 p.m.     ID ON 3/4/20 at 2:13 p.m., an interview was conducted with LPN #4. LPN #4 was asked if she provided Resident #203's scheduled sacral wound care on 3/3/20. LPN #4 stated, "Yes." LPN #4 stated the physician's order documented to cleanse the wound with normal saline, pat dry, apply santyl to the slough and cover the wound with a dressing. All of Resident #203's sacral wound care orders on the March 2020 TAR were reviewed with LPN #4. LPN #4 stated, "That's a whole bunch of orders." LPN #4 stated she     That's a whole bunch of orders." LPN #4 stated she			ID HUMAN SERVICES				FORM	05/20/2022 APPROVED
495283     B. WING	STATEMENT C	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	. ,			(X3) DATE COMP	SURVEY LETED
NAME OF PROVIDER OR SUPPLIER       STREET ADDRESS, CITY, STATE, ZIP CODE         PROMEDICA SKILLED NURSING AND REHAB (IMPERIAL)       1719 BELLEVUE AVENUE RICHMOND, VA 23227         (X4) ID PREFIX TAG       SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       ID PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION)       PREFIX TAG         {F 686}       Continued From page 24 she would be at the facility at 3:00 p.m.       {F 686} she provided Resident #203's scheduled sacral wound care on 3/3/20. LPN #4 stated, "Yes." LPN #4 stated the physician's order documented to cleanse the wound with normal saline, pat dry, apply santyl to the slough and cover the wound with a dressing. LPN #4 stated, secral wound care orders on the March 2020's Sacral wound care orders on the March 2020's Care       Image: State S			495283	B. WING				
PROMEDICA SKILLED NURSING AND REHAB (IMPERIAL)       RICHMOND, VA 23227         (X4) ID PREFIX TAG       SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       ID PREFIX TAG       PROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD BE (EACH ORRECTIVE ACTION SHOULD BE DEFICIENCY)       COMPLETM (EACH ORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)       COMPLETM DATE         {F 686}       Continued From page 24 she would be at the facility at 3:00 p.m.       {F 686}       {F 686}         On 3/4/20 at 2:13 p.m., an interview was conducted with LPN #4. LPN #4 was asked if she provided Resident #203's scheduled sacral wound care on 3/3/20. LPN #4 stated, "Yes." LPN #4 stated the physician's order documented to cleanse the wound with normal saline, pat dry, apply santyl to the slough and cover the wound with a dressing. LPN #4 stated she cleansed the wound with normal saline, applied santyl and an optifoam dressing. All of Resident #203's sacral wound care orders on the March 2020 TAR were reviewed with LPN #4. LPN #4 stated, "That's a	NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STAT	TE, ZIP CODE		-#2020
PROMEDICA SKILLED NURSING AND REHAB (IMPERIAL)       RICHMOND, VA 23227         (X4) ID PREFIX TAG       SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       ID PREFIX TAG       PROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD BE (EACH ORRECTIVE ACTION SHOULD BE DEFICIENCY)       COMPLETM (EACH ORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)       COMPLETM DATE         {F 686}       Continued From page 24 she would be at the facility at 3:00 p.m.       {F 686}       {F 686}         On 3/4/20 at 2:13 p.m., an interview was conducted with LPN #4. LPN #4 was asked if she provided Resident #203's scheduled sacral wound care on 3/3/20. LPN #4 stated, "Yes." LPN #4 stated the physician's order documented to cleanse the wound with normal saline, pat dry, apply santyl to the slough and cover the wound with a dressing. LPN #4 stated she cleansed the wound with normal saline, applied santyl and an optifoam dressing. All of Resident #203's sacral wound care orders on the March 2020 TAR were reviewed with LPN #4. LPN #4 stated, "That's a					1719 BELLEVUE AVENUE			
PREFIX TAG       (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       PREFIX TAG       (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)       COMPLETIC DATE         {F 686}       Continued From page 24 she would be at the facility at 3:00 p.m.       {F 686}       F 686}       F 686}         On 3/4/20 at 2:13 p.m., an interview was conducted with LPN #4. LPN #4 was asked if she provided Resident #203's scheduled sacral wound care on 3/3/20. LPN #4 stated, "Yes." LPN #4 stated the physician's order documented to cleanse the wound with normal saline, pat dry, apply santyl to the slough and cover the wound with a dressing. LPN #4 stated she cleansed the wound with normal saline, applied santyl and an optiforam dressing. All of Resident #203's sacral wound care orders on the March 2020 TAR were reviewed with LPN #4. LPN #4 stated, "That's a       PREFIX TAG	PROMEDI	CA SKILLED NURSING A	AND REHAB (IMPERIAL)					
she would be at the facility at 3:00 p.m. On 3/4/20 at 2:13 p.m., an interview was conducted with LPN #4. LPN #4 was asked if she provided Resident #203's scheduled sacral wound care on 3/3/20. LPN #4 stated, "Yes." LPN #4 stated the physician's order documented to cleanse the wound with normal saline, pat dry, apply santyl to the slough and cover the wound with a dressing. LPN #4 stated she cleansed the wound with normal saline, applied santyl and an optifoam dressing. All of Resident #203's sacral wound care orders on the March 2020 TAR were reviewed with LPN #4. LPN #4 stated, "That's a	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECT CROSS-REFERENC	TIVE ACTION SHOULD BE CED TO THE APPROPRIA		COMPLETION
completed the 1/9/20 santyl order but did not         apply anasept (sodium hypochlorite) or an ABD         pad on Resident #203's sacral wound on 3/3/20.         LPN #4 was asked if she signed any sacral         wound care treatments off on Resident #203's         TAR on 3/3/20.       LPN #4 stated, she probably did         not because she was rushing to leave the facility.         LPN #4 was asked the difference between         anasept and normal saline.         On 3/4/20 at 3:48 p.m., another interview was         conducted with LPN #1.         apply barrier cream to Resident #203's bottom on         3/3/20 so if she did sign off the santyl, anasept         and sodium hypochlorite orders on the TAR, she         did so in error, thinking she was signing off barrier         cream.       LPN #1 again stated she only applied         barrier cream to Resident #203's bottom and did         not provide sacral wound care for the resident on         3/3/20.         On 3/4/20 at 3:52 p.m., an interview was	{F 686}	she would be at the fa On 3/4/20 at 2:13 p.m conducted with LPN # she provided Resider wound care on 3/3/20 LPN #4 stated the phy to cleanse the wound apply santyl to the slo with a dressing. LPN wound with normal sa optifoam dressing. Al wound care orders or reviewed with LPN #4 whole bunch of orders completed the 1/9/20 apply anasept (sodiur pad on Resident #203 LPN #4 was asked if wound care treatment TAR on 3/3/20. LPN # not because she was LPN #4 was asked the anasept contained mo saline. On 3/4/20 at 3:48 p.m conducted with LPN # apply barrier cream to 3/3/20 so if she did si and sodium hypochlo did so in error, thinkin cream. LPN #1 again barrier cream to Reside not provide sacral wo 3/3/20.	acility at 3:00 p.m. a., an interview was #4. LPN #4 was asked if at #203's scheduled sacral b. LPN #4 stated, "Yes." ysician's order documented with normal saline, pat dry, ough and cover the wound #4 stated she cleansed the aline, applied santyl and an II of Resident #203's sacral a the March 2020 TAR were b. LPN #4 stated, "That's a s." LPN #4 stated she santyl order but did not m hypochlorite) or an ABD B's sacral wound on 3/3/20. she signed any sacral ts off on Resident #203's #4 stated, she probably did rushing to leave the facility. e difference between saline. LPN #4 stated ore disinfectant than normal h., another interview was #1. LPN #1 stated she did o Resident #203's bottom on gn off the santyl, anasept rite orders on the TAR, she ng she was signing off barrier n stated she only applied dent #203's bottom and did und care for the resident on	{F 686		FICIENCY)		

Facility ID: VA0154

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	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM	): 05/20/2022 MAPPROVED ). 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		495283	B. WING					-C 04/2020
NAME OF P	ROVIDER OR SUPPLIER			s	TREET ADDRESS, CITY, STATE, ZIP	CODE	03/	04/2020
					719 BELLEVUE AVENUE			
PROMEDI	CA SKILLED NURSING A	AND REHAB (IMPERIAL)			RICHMOND, VA 23227			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD B		(X5) COMPLETION DATE
{F 686}	conducted with RN #2 observed LPN #4 per wound care, with a sub but she did not provid else provide sacral wo on 3/3/20. All four of the above s were discontinued on order dated 3/4/20 do BID (twice daily): Clea apply nickel thick laye moistened anasept ga day and evening shift signed this order. On interview was conduct confirmed Resident # orders were changed she was reviewing the multiple orders so she and consolidated into practitioner. LPN #3 of moistened gauze was Resident #203's sacra On 3/4/20 at 4:23 p.m member) #1 (the adm director of nursing) ar director of operations above concern. On 3/4/20 at 4:25 p.m treatment administrati requested via a list gir at 5:40 p.m., ASM #1 "MEDICATION AND T ADMINISTRATION G documented, "Medica	<ul> <li>2. RN #2 stated she form Resident #203's sacral inveyor present, on 3/3/20 e and did not see anyone bund care for Resident #203</li> <li>acral wound care orders 3/4/20. A new physician's cumented, "Wound Care anse with wound cleanser, er santyl and cover with auze and dry dressing every for skin alteration." LPN #3 3/4/20 at 2:10 p.m., an ted with LPN #3. LPN #3 203's sacral wound care on this date. LPN #3 stated e orders and noticed e had the orders clarified one order by the nurse confirmed anasept s supposed to be applied to al wound.</li> <li>ASM (administrative staff inistrator), ASM #2 (the nd ASM #3 (the regional ) were made aware of the</li> <li>a facility policy regarding ion for pressure injuries was ven to ASM #1. On 3/4/20 provided a policy titled, FREATMENT</li> </ul>	{F 6	586}				

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	-	ID HUMAN SERVICES MEDICAID SERVICES			FOF	ED: 05/20/202 RM APPROVEI IO. 0938-039
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING		(X3) DA CON	TE SURVEY MPLETED
		495283	B. WING			R-C 3/04/2020
NAME OF P	ROVIDER OR SUPPLIER		STR	EET ADDRESS, CITY, STATE, ZIP CO		
PROMEDI	CA SKILLED NURSING	AND REHAB (IMPERIAL)	1719	BELLEVUE AVENUE		
			RIC	HMOND, VA 23227		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE
{F 686}	practice and state sp guidelines" ASM # policy regarding press No further information References: (1) "A pressure injury skin and underlying s bony prominence or in device. The injury can open ulcer and may b -Unstageable Pressur full-thickness skin an skin and tissue loss in damage within the ul- because it is obscure tissue) -Stage 4 Pressure Inj tissue loss Full-thickr with exposed or direct tendon, ligament, car Slough and/or eschar This information was https://cdn.ymaws.co ce/resmgr/npuap_presson (2) "The sacrum is a structure that is locat vertebrae and that is This information was https://medlineplus.ge htm (3) "SANTYL Ointme	ccordance with standards of ecific and federal 1 did not provide a specific sure injuries. In was presented prior to exit. It is localized damage to the forfit tissue usually over a related to a medical or other in present as intact skin or an be painful re Injury: Obscured d tissue loss Full-thickness in which the extent of tissue cer cannot be confirmed ad by slough or eschar (dead fury: Full-thickness skin and hess skin and tissue loss etly palpable fascia, muscle, tilage or bone in the ulcer. r may be visible" obtained from the website: m/npuap.site-ym.com/resour essure_injury_stages.pdf shield-shaped bony ed at the base of the lumbar connected to the pelvis." obtained from the website: tov/ency/imagepages/19464.	{F 686}			
	htm (3) "SANTYL Ointme prescription medicine					

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	-	ID HUMAN SERVICES				FORM	APPROVED
STATEMENT	DF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE COMP	LETED
		495283	B. WING				-C 04/2020
NAME OF P	ROVIDER OR SUPPLIER	I			STREET ADDRESS, CITY, STATE, ZIP CODE	1	
PROMED	CA SKILLED NURSING A	AND REHAB (IMPERIAL)			1719 BELLEVUE AVENUE RICHMOND, VA 23227		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE
{F 686}	information was obtain https://santyl.com/ (4) "Anasept® Antimic Solution is a clear, iso mechanical removal of application site while broad-spectrum antim hypochlorite via Nega Therapy Device." The from the website: https://anacapa-tech.io obial-wound-irrigation (5) "DermaPrep Liquin forms a long-lasting wishield peri-wound skin adhesives, and friction the risk of pain and shadhesive removal." To obtained from the weat http://dermarite.com/p 2. Resident #202 was 9/11/19, and most reco 1/18/2020, with diagn limited to diabetes (1) morbid obesity. On the (minimum data set), a assessment with an a of 1/3/2020, Resident no cognitive impairmed decisions. She was co ulcer. A review of Resident revealed the following "Apply to between the Cleanse with Normal	ned from the website: crobial Wound Irrigation otonic liquid that helps in the of the debris from the delivering 0.057% nicrobial sodium ative Pressure Wound is information was obtained net/product/anasept-antimicr n-solution/ d Barrier Skin Protectant vaterproof film designed to n from bodily fluids, nal forces. It helps reduce kin damage during tape and This information was bsite: product/dermaprep/ a admitted to the facility on cently readmitted on losses including, but not 0, bipolar disorder (2), and the most recent MDS a significant change assessment reference date is #202 was coded as having ent for making daily oded as having a pressure	{F 6	\$86			

Facility ID: VA0154

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORI	M APPROVED D. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		E CONSTRUCTION	(X3) DATE COMF	E SURVEY PLETED
		495283	B. WING				/04/2020
NAME OF P	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE	1 00	• = • = •
PROMEDI	CA SKILLED NURSING	AND REHAB (IMPERIAL)			1719 BELLEVUE AVENUE RICHMOND, VA 23227		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
{F 686}	daily. One time a day A review of Resident (treatment administra blank space for the w 2/26/2020. A review of Resident plan dated 12/30/201 area to sacrumAdm physician orders." On 3/4/2020 at 12:55 practical nurse) #2 wa Resident #202's TAR what the blank space means it wasn't done forgot to click it off. M unless we asked the On 3/4/2020 at 3:03 p #1, a unit manager, w shown Resident #202 asked what the blank stated, "It probably di The nurse who took of 2/26/2020 was unava time of the survey. On 3/4/2020 at 4:18 p staff member) #1, the director of nursing, ar director of operations concerns. ASM #1 ar	for Wound." #202's February 2020 TAR tion record) revealed a round treatment on #202's comprehensive care 9, revealed, in part: "Open ninister treatment per p.m., LPN (licensed as interviewed. When shown for 2/26/2020, and asked meant, LPN #2 stated, "It ." She then added, "Or they /e wouldn't know which person." o.m., RN (registered nurse) vas interviewed. When 2's TAR for 2/26/2020, and space meant, RN #2	{F 6	\$86}			
	concern prior to exit. No further informatior	n was provided prior to exit.					

Facility ID: VA0154

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED 0. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		495283	B. WING				-C <b>04/2020</b>
NAME OF PI	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE	1 00	•
PROMEDI	CA SKILLED NURSING A	AND REHAB (IMPERIAL)			1719 BELLEVUE AVENUE RICHMOND, VA 23227		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
{F 686}	Continued From page	29	{F 6	686]	}		
	References:						
	blood glucose, or bloo	s) is a disease in which your od sugar, levels are too n is taken from the website ov/diabetes.html.					
	(2) "Bipolar disorder (formerly called manic-depressive illness or manic depression) is a mental disorder that causes unusual shifts in mood, energy, activity levels, concentration, and the ability to carry out day-to-day tasks." This information is taken from the website https://www.nimh.nih.gov/health/topics/bipolar-dis order/index.shtml.						
	prescription medicine from wounds so they	nt is an FDA-approved that removes dead tissue can start to heal." This rom the manufacturer's santyl.com/.					
	Faced Foam and Born Core provides gentle ideal healing environr absorbent Liquitrap or amounts of heavy ext and locks it away. The Optifoam increases fli Optifoam Gentle Silici unique layers to provi information is taken fr website https://www.shopwou oam-silicone-faced-fo -with-liquitrap-core.htm	n Gentle Sacrum Silicone der Dressing with Liquitrap adhesion and maintains an ment. It features a super ore that draws in large udate, converts it into a gel e low profile design of exibility and comfort. one Dressing features five ide added protection." This rom the manufacturer's ndcare.com/p-medline-optif pam-sacrum-border-dressing ml?gclid=EAIaIQobChMIho_ DgzFEAQYBCABEgIVtfD_B					

Facility ID: VA0154

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TATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE	SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COMP	
					R	-C
		495283	B. WING		03/0	04/2020
NAME OF P	ROVIDER OR SUPPLIER		STF	REET ADDRESS, CITY, STATE, ZIP CO	DE	
PROMED	CA SKILLED NURSING	AND REHAB (IMPERIAL)		9 BELLEVUE AVENUE		
	I		RIC	CHMOND, VA 23227		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETIO DATE
{F 686}	10	e 30	{F 686}			
{F 695} SS=D		tomy Care and Suctioning	{F 695}			
	needs respiratory car care and tracheal suc care, consistent with practice, the compreh care plan, the resider and 483.65 of this sul This REQUIREMENT by: Based on observatio interview facility docu record review, it was staff failed to provide services for one of ter sample, Resident #20 administer oxygen to physician prescribed and failed to administ in a sanitary manner. The findings include: 1. a. Resident #20 were not limited to str disorder. Resident #20 wreference date) of 2/1 being cognitively intag	Ad tracheal suctioning. Jure that a resident who e, including tracheostomy stioning, is provided such professional standards of hensive person-centered hts' goals and preferences, bpart. T is not met as evidenced n, resident interview, staff ment review and clinical determined that the facility respiratory care and n residents in the survey D6. The facility staff failed to Resident #206 per the rate of two liters per minute ter oxygen to Resident #206 vas admitted to the facility on 16's diagnoses included but roke, paralysis and anxiety 206's quarterly MDS vith an ARD (assessment 0/20, coded the resident as				

Facility ID: VA0154

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		ID HUMAN SERVICES MEDICAID SERVICES				F	NTED: 05/20/2022 ORM APPROVED NO. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION	(X3) [	DATE SURVEY COMPLETED
		495283	B. WING				R-C 03/04/2020
NAME OF PI	ROVIDER OR SUPPLIER	•		ST	IREET ADDRESS, CITY, STATE, ZIP CODE	•	
DROMEDI				17	19 BELLEVUE AVENUE		
PROMEDI	CA SKILLED NURSING	AND REHAB (IMPERIAL)		R	ICHMOND, VA 23227		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
{F 695}	Continued From page	e 31	(F 6	95}			
	oxygen therapy.			,			
	continuous oxygen at minute. The compret Resident's #206 date "Has/At risk for respir COPD (chronic obstru (lung disease)Interv via nasal canula (sic) On 3/3/20 at approxin 5:37 p.m. and 3/4/20 #206 was observed by via a nasal cannula c concentrator that was concentrator flowmett one and a half liters a by the ball in the conc positioned between th two liter lines (at eye	s order dated 2/12/20 for t the rate of two liters per hensive care plan for d 10/1/18 documented, atory impairment related to uctive pulmonary disease) ventions: oxygen at 2 liters " mately 4:30 p.m., 3/3/20 at at 11:06 a.m., Resident ying in bed receiving oxygen onnected to an oxygen s running. The oxygen er was set at a rate between and two liters as evidenced					
	the nurse caring for R shift on 3/3/20 and 3/ describe where the ba flow meter should be physician's order for to two-liter line should ru ball. At this time, Res concentrator was obs Resident #206 was ly concentrator flow met rate between one and as evidenced by the b	(licensed practical nurse) #2, Resident #206 during the day 4/20. LPN #2 was asked to all in an oxygen concentrator if a resident has a two liters. LPN #2 stated the un through the middle of the sident #206's oxygen					

Facility ID: VA0154

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED D. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	COMF	E SURVEY PLETED
		495283	B. WING				/04/2020
NAME OF P	ROVIDER OR SUPPLIER	1		5	STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
PROMEDI	CA SKILLED NURSING	AND REHAB (IMPERIAL)			1719 BELLEVUE AVENUE RICHMOND, VA 23227		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
{F 695}	and two liter lines at e the flow meter and sta oxygen flow meter wa liters. On 3/4/20 at 4:23 p.m member) #1 (the adm director of nursing) an director of operations above concern. The facility policy title ADMINISTRATION" of concentrator, plug in set flow meter to corm No further information b. On 3/3/20 at 11:48 observed lying in bed resident's oxygen nas observed lying on the reach. The oxygen n labeled with a date of On 3/3/20 at approxin #206 was observed ly nasal cannula in her cannula tubing was la Resident #206 was a changed her oxygen date and stated, "No. On 3/4/20 at 12:48 p. conducted with CNA #1, the CNA caring fo day shift on 3/3/20. O	eye level. LPN #2 adjusted ated it looked like the as running a little under two h., ASM (administrative staff hinistrator), ASM #2 (the hd ASM #3 (the regional ) were made aware of the d, "OXYGEN documented, "3. For oxygen power cord, turn unit on and ect flow rate" h was presented prior to exit. a.m., Resident #206 was with her eyes closed. The sal cannula and tubing was e floor, out of the resident's asal cannula/tubing was 5 3/1/20. mately 4:30 p.m., Resident ying in bed with the oxygen hose. The oxygen nasal abeled with a date of 3/1/20. sked if the facility staff had masal cannula/tubing on this	{F 6	595)			

Facility ID: VA0154

If continuation sheet Page 33 of 45

	MENT OF HEALTH AN						FORM	): 05/20/2022 / APPROVED ). 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		495283	B. WING					-C 04/2020
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, 2	ZIP CODE	00/	04/2020
PROMED	ICA SKILLED NURSING A	ND REHAB (IMPERIAL)			719 BELLEVUE AVENUE RICHMOND, VA 23227			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORRECTIVE CROSS-REFERENCED			(X5) COMPLETION DATE
{F 695}	cannula was in the re- talked to Resident #20 not responsible for ch- tubing but she did see oxygen tubing on 3/3/ could not remember w residents' oxygen tubing On 3/4/20 at 12:51 p.1 conducted with LPN ( the nurse caring for R shift on 3/3/20. LPN # seeing Resident #200 cannula on the floor of did not change out the see anyone change the 3/3/20. LPN #2 states cannula should be ob the floor. When aske "Cause the floor is dir their nose." On 3/4/20 at 2:01 p.m member) #1 (the adm staff changed residen ASM #1 stated she w On 3/4/20 at 2:58 p.m (registered nurse) #1 changed oxygen tubing and did so during root On 3/4/20 at 3:06 p.m conducted with RN #1 oxygen tubing/nasal of 3/3/20 and that resider	sident's nose every time she 06. CNA #1 stated she was anging residents' oxygen e staff changing residents' 20. CNA #1 stated she what staff she saw changing ing on 3/3/20. m., an interview was licensed practical nurse) #2, resident #206 during the day #2 stated she did not recall to soxygen tubing/nasal on 3/3/20. LPN #2 stated she tubing/nasal cannula or he tubing/nasal cannula or he tubing/nasal cannula on d that new tubing/nasal tained if it is observed on d why, LPN #2 stated, ty. Don't want to put that in the tubing on 3/3/20. ould obtain this information. A., ASM #1 stated RN was the only staff that tog/nasal cannula on 3/3/20 m rounds.	{F 6	\$95}				

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		ID HUMAN SERVICES MEDICAID SERVICES				FORI	D: 05/20/2022 MAPPROVED D. 0938-0391
STATEMENT (	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION	COM	SURVEY
		495283	B. WING				-C <b>/04/2020</b>
NAME OF P	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00	
PROMEDI	CA SKILLED NURSING	AND REHAB (IMPERIAL)		17	19 BELLEVUE AVENUE		
				R	ICHMOND, VA 23227		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
{F 695}	Continued From page	e 34	{F 6	595}			
	director of operations above concern.	) were made aware of the					
		n., ASM #3 stated he was as able to pick oxygen					
	ASM #1. Resident #2 the oxygen tubing/na on 3/3/20. Resident :	lent #206, in the presence of 206 was asked if she picked sal cannula up off the floor #206 stated she was d), not able to pick oxygen and did not do so.					
	ADMINISTRATION" o oxygen not in use, sto	documented, "2. When pre oxygen tubing and nasal eparate, labeled plastic					
{F 757} SS=D	Drug Regimen is Fre	n was presented prior to exit. e from Unnecessary Drugs -(6)	{F 7	'57}			
		sary Drugs-General. regimen must be free from An unnecessary drug is any					
	§483.45(d)(1) In exce duplicate drug therap	essive dose (including y); or					
	§483.45(d)(2) For exe	cessive duration; or					
	§483.45(d)(3) Withou	t adequate monitoring; or					
	§483.45(d)(4) Withou	t adequate indications for its					

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 05/20/2022 MAPPROVED D. 0938-0391
STATEMENT (	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		495283	B. WING _				-C <b>04/2020</b>
NAME OF P	ROVIDER OR SUPPLIER			STR	REET ADDRESS, CITY, STATE, ZIP CODE		
PROMEDI	CA SKILLED NURSING	AND REHAB (IMPERIAL)			I9 BELLEVUE AVENUE CHMOND, VA 23227		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
{F 757}	Continued From page use; or	e 35	{F 7	57}			
	§483.45(d)(5) In the p consequences which reduced or discontinu	indicate the dose should be					
	stated in paragraphs section. This REQUIREMENT by: Based on observatio document review, and was determined that ensure one of 10 resi Resident #202, was f medications. The faci as-needed pain medi when the resident's p severity indicated on failed to attempt non- interventions prior to pain medication.	mbinations of the reasons (d)(1) through (5) of this is not met as evidenced n, staff interview, facility d clinical record review, it the facility staff failed to dents in the survey sample, ree from unnecessary ility staff administered an cation to Resident #202 ain level did not reach the the physician order and pharmacological administering the as needed					
	9/11/19; and was most 1/18/2020, with diagn limited to diabetes (1) morbid obesity. On the (minimum data set) a change assessment was reference date of 1/3, coded as having no comaking daily decision	ssessment, a significant with an assessment /2020, Resident #202 was cognitive impairment for us. She was coded as having ut of 10 intensity frequently					

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		ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 05/20/2022 M APPROVED O. 0938-0391	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495283	B. WING			R-C 03/04/2020		
NAME OF P	ROVIDER OR SUPPLIER	I		STF	REET ADDRESS, CITY, STATE, ZIP CODE			
PROMEDI	CA SKILLED NURSING	AND REHAB (IMPERIAL)		171	19 BELLEVUE AVENUE			
				RIC	CHMOND, VA 23227			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	ILD BE	(X5) COMPLETION DATE	
{F 757}	the survey. On 3/3/2020 at 5:28 p observed sitting up in television. This obser not reveal any express On 3/4/2020 at 10:25 observed lying supine closed. Observation of reveal any expression A review of Resident revealed the following "Hydrocodone-Acetan 5-325 mg (milligrams every 4 hours as nee above." The review of Reside revealed the following "Tylenol TabletGive needed for pain level	ed to be interviewed during p.m., Resident #202 was her bed, watching vation of Resident #202 did asions or indications of pain. a.m., Resident #202 was e in bed. Her eyes were of Resident #202, failed to ns or indications of pain. #202's clinical record g order, dated 2/4/2020: minophen (Norco) (3) Tablet ). Give 1 tablet by mouth ded for pain level 5 and nt #202's clinical record also g order dated 1/23/2020: 650 mg every 4 hours as of 1-4. Not to exceed >3	{F 7	57}	DEFICIENCY)			
	A review of Resident 2020 MARs (medicat revealed the as need administered on the or ratings as follows: -2/26/2020 at 8:15 p.1 -3/1/2020 at 9:01 p.m - 3/2/2020 at 8:25 p.m No Tylenol was admin Further review of Res nursing notes failed to non-pharmacological	(grams) in 24 hours." #202's February and March ion administration records) ed Norco medication was dates, times with pain scale m. for a pain level of four, h. for a pain level of one, n. for a pain level of four. histered on these dates. sident #202's MARs and p reveal evidence that interventions were administration of the						

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		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	CONSTRUCTION	· · · ·	
ND PLAN OF CORRECTION IDENTIFICATION NUMBER:  495283 NAME OF PROVIDER OR SUPPLIER		A. BUILDING		COMPLETED R-C		
		B. WING			R-C 3/04/2020	
		STI	REET ADDRESS, CITY, STATE, ZIP COD			
PROMEDI	CA SKILLED NURSING	AND REHAB (IMPERIAL)		19 BELLEVUE AVENUE CHMOND, VA 23227		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE APPROPRIATE	(X5) COMPLETIOI DATE
{F 757}	Continued From page	e 37	{F 757}			
. ,	as-needed pain medi 3/1/2020 and 3/2/202	cation on 2/26/2020,				
	plan dated 9/12/19 ar revealed, in part: "Pa medication per physic	#202's comprehensive care nd revised on 1/31/2020 in in backAdminister pain cian ordersImplement interventions: Positioning to				
	assist with pain and r	nonitor for effectiveness."				
		as interviewed. When asked educated by the facility on				
	the education was re- offering non-pharmac	stated she had. She stated garding the importance of cological interventions prior				
	and the importance o numerical pain rating	s-needed pain medication, f documenting the resident's , providing the resident was #2 was shown the order for				
	Norco and the MARs #2 was asked if the a	as described above. LPN s needed Norco medication ed according to the physician				
		r." She stated the ly have been administered if				
	When asked if she con non-pharmacological	interventions were provided				
		•				
		interventions being offered,				

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		ID HUMAN SERVICES MEDICAID SERVICES				F	NTED: 05/20/2022 FORM APPROVED B NO. 0938-0391	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		· · ·		TIPLE C	(X3)	(X3) DATE SURVEY COMPLETED		
	495283		B. WING			R-C 03/04/2020		
NAME OF PI	ROVIDER OR SUPPLIER		•	STR	EET ADDRESS, CITY, STATE, ZIP CODE			
PROMEDI	CA SKILLED NURSING	AND REHAB (IMPERIAL)			9 BELLEVUE AVENUE HMOND, VA 23227			
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREF TAG		PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
{F 757}	Continued From page 38 director of nursing, and ASM #3, the regional director of nursing, and ASM #3, the regional director of operations, were informed of these concerns. ASM #1 and ASM #2 were asked to provide any additional information regarding the identified concern.  A review of the facility document "Pain Practice Guide" revealed, in part: "Pain scale values, coupled with the subjective interview provides a more complete description of a patient's painThe Numeric Pain Rating Scale is used for alert and oriented personsInterventions include non-pharmacological as well as pharmacological. Non-pharmacological as well as pharmacological. Non-pharmacological as of the lowest dose or result in discontinuation of medicationGenerally start with a low dose and titrate upward until a balance is achieved between pain relief and medication side effectsOpioid analgesics are used to treat moderate to severe pain that does not respond to other categories of analgesics. Opioids may be the first line of treatment in moderate to severe pain." No further information was provided prior to exit. References: (1) "Diabetes (mellitus) is a disease in which your blood glucose, or blood sugar, levels are too high." This information is taken from the website https://medlineplus.gov/diabetes.html. (2) "Bipolar disorder (formerly called manic-depressive illness or manic depression) is a mental disorder that causes unusual shifts in mood, energy, activity levels, concentration, and		{F 7	757}				

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	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION		IO. 0938-039 E SURVEY
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  495283 NAME OF PROVIDER OR SUPPLIER		A. BUILDING	· · ·	COMPLETED R-C 03/04/2020		
		B. WING				
			EET ADDRESS, CITY, STATE, ZIP COI		5/04/2020	
PROMEDI	ICA SKILLED NURSING	AND REHAB (IMPERIAL)		) BELLEVUE AVENUE HMOND, VA 23227		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
{F 757}	information is taken fi https://www.nimh.nih. order/index.shtml. (3) "NORCO is indica pain severe enough t and for which alterna inadequate." This info website	rom the website .gov/health/topics/bipolar-dis .ted for the management of o require an opioid analgesic	{F 757}			
{F 880} SS=D	?setid=66a328bc-055 " Infection Prevention & CFR(s): 483.80(a)(1)		{F 880}			
	infection prevention a designed to provide a comfortable environm	blish and maintain an and control program a safe, sanitary and nent and to help prevent the nsmission of communicable				
	program. The facility must esta	prevention and control blish an infection prevention (IPCP) that must include, at ving elements:				
	reporting, investigatin and communicable di staff, volunteers, visit providing services un arrangement based u	pon the facility assessment to §483.70(e) and following				

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		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MI II TI	PLE CONSTRUCTION		<u>10. 0938-039</u> TE SURVEY	
	CORRECTION	IDENTIFICATION NUMBER:	· ,	G	· · · ·	COMPLETED	
A95283 NAME OF PROVIDER OR SUPPLIER					R-C		
		B. WING		0	3/04/2020		
			STREET ADDRESS, CITY, STATE, ZIP CO	DE			
PROMEDICA SKILLED NURSING AND REHAB (IMPERIAL)				1719 BELLEVUE AVENUE			
		· · · · · · · · · · · · · · · · · · ·		RICHMOND, VA 23227			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
{F 880}	Continued From pag	je 40	{F 88	0}			
. ,		n standards, policies, and		-1			
	• • • • • •	rogram, which must include,					
	but are not limited to						
		(i) A system of surveillance designed to identify					
	possible communicable diseases or infections before they can spread to other persons in the facility;						
		om possible incidents of					
		se or infections should be					
	reported;						
		insmission-based precautions					
	-	vent spread of infections; olation should be used for a					
	resident; including b						
	-	ration of the isolation,					
	depending upon the involved, and	infectious agent or organism					
	least restrictive poss	at the isolation should be the ible for the resident under the					
	circumstances.	as under which the facility					
	. ,	es under which the facility /ees with a communicable					
		skin lesions from direct					
		ts or their food, if direct					
	contact will transmit						
		e procedures to be followed lirect resident contact.					
	§483.80(a)(4) A syst	em for recording incidents					
	identified under the f	facility's IPCP and the					
	corrective actions ta	ken by the facility.					
	§483.80(e) Linens.						
	,	dle, store, process, and					
		s to prevent the spread of					
	§483.80(f) Annual re						

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391	
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
495283		B. WING			R-C 03/04/2020			
NAME OF F	ROVIDER OR SUPPLIER			STR	REET ADDRESS, CITY, STATE, ZIP CODE			
PROMED	ICA SKILLED NURSING	AND REHAB (IMPERIAL)			19 BELLEVUE AVENUE CHMOND, VA 23227			
(X4) ID PREFIX TAG				×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE	
{F 880}	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		{F 8	80}				

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						O. 0938-039
STATEMENT OF DEFICIENCIES       (X1) PROVIDER/SUPPLIER/CLIA         AND PLAN OF CORRECTION       IDENTIFICATION NUMBER:			CONSTRUCTION	· · ·	E SURVEY IPLETED	
		A. BUILDING		R-C		
		495283	B. WING			3/04/2020
NAME OF PROVIDER OR SUPPLIER			REET ADDRESS, CITY, STATE, ZIP CODE		5/04/2020	
0.002 01 11				19 BELLEVUE AVENUE	-	
PROMEDI	CA SKILLED NURSING	AND REHAB (IMPERIAL)		CHMOND, VA 23227		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF COF	RRECTION	(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)		COMPLÉTIO
{F 880}	Continued From page	e 42	{F 880}			
	observed lying on the	e floor, out of the resident's				
		asal cannula/tubing was				
	On 3/3/20 at approxir	mately 4:30 p.m., Resident				
		ying in bed with the oxygen				
		nose. The oxygen nasal				
		abeled with a date of 3/1/20.				
		sked if the facility staff had nasal cannula/tubing on this				
	date and stated, "No.	-				
	On 3/4/20 at 12:48 p.					
		(certified nursing assistant) or Resident #206 during the				
	-	CNA #1 stated she did not				
	-	oxygen tubing/nasal cannula				
		). CNA #1 stated the nasal				
	cannula was in the re	esident's nose every time she				
		06. CNA #1 stated she was				
	-	nanging residents' oxygen				
		e staff changing residents'				
		/20. CNA #1 stated she what staff she saw changing				
	residents' oxygen tub					
	On 3/4/20 at 12:51 p.					
		(licensed practical nurse) #2,				
		Resident #206 during the day #2 stated she did not recall				
		#2 stated she did hot recail 6's oxygen tubing/nasal				
	-	on 3/3/20 and she did not				
		g/nasal cannula or see				
	-	ubing/nasal cannula on				
	3/3/20. LPN #2 state	d that new tubing/nasal				
		otained if it is observed on				
	the floor. When aske "Cause the floor is di	ed why, LPN #2 stated,				

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391	
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
	495283		B. WING			R-C 03/04/2020		
NAME OF P	ROVIDER OR SUPPLIER	L		5	STREET ADDRESS, CITY, STATE, ZIP CODE	<u>,                                     </u>		
PROMEDI	CA SKILLED NURSING A	AND REHAB (IMPERIAL)			1719 BELLEVUE AVENUE RICHMOND, VA 23227			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
{F 880}	Continued From page	e 43	F ٤	380}	}			
	On 3/4/20 at 2:01 p.m member) #1 (the adm staff changed residen ASM #1 stated she w On 3/4/20 at 2:58 p.m (registered nurse) #1 changed oxygen tubin and did so during roo On 3/4/20 at 3:06 p.m conducted with RN # oxygen tubing/nasal o 3/3/20 and that reside On 3/4/20 at 4:23 p.m director of nursing) an	n., ASM (administrative staff ninistrator) was asked if any ats' oxygen tubing on 3/3/20. ould obtain this information. n., ASM #1 stated RN was the only staff that ng/nasal cannula on 3/3/20 m rounds. n., an interview was 1. RN #1 stated he changed cannula for one resident on ent was not Resident #206. n., ASM #1, ASM #2 (the nd ASM #3 (the regional						
	<ul> <li>director of operations) were made aware of the above concern.</li> <li>On 3/4/20 at 4:35 p.m., ASM #3 stated he was told Resident #206 was able to pick oxygen tubing up off the floor.</li> <li>On 3/4/20 at 4:40 p.m., an interview was conducted with Resident #206, in the presence of ASM #1. Resident #206 was asked if she picked the oxygen tubing/nasal cannula up off the floor on 3/3/20. Resident #206 stated she was paraplegic (paralyzed), not able to pick oxygen tubing up off the floor and did not do so.</li> <li>The facility policy titled, "OXYGEN ADMINISTRATION" documented, "2. When oxygen not in use, store oxygen tubing and nasal cannula or mask in separate, labeled plastic bag"</li> </ul>							

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		D HUMAN SERVICES MEDICAID SERVICES				FORM	): 05/20/2022 MAPPROVED ). 0938-0391	
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			STRUCTION	(X3) DATE SURVEY COMPLETED		
		495283	B. WING	B. WING		R-C 03/04/2020		
NAME OF P	ROVIDER OR SUPPLIER			STREE	T ADDRESS, CITY, STATE, ZIP CODE	<u> </u>		
PROMED	CA SKILLED NURSING A	ND REHAB (IMPERIAL)			ELLEVUE AVENUE IOND, VA 23227			
(X4) ID PREFIX TAG	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRE			FIX (EACH CORRECTIVE ACTION SHOULD BE COMPLET				
{F 880}		e 44 was presented prior to exit.	(F 8	80}				

Event ID: Z8K213

Facility ID: VA0154

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