PRINTED: 06/02/2022 FORM APPROVED OMB NO. 0938-0391

	T OF DEFICIENCIES OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  (X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		495045	B. WING		C 05/23/2022
		AND REHAB (RICHMOND)	21	REET ADDRESS, CITY, STATE, ZIP CO 25 HILLIARD ROAD CHMOND, VA 23228	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE COMPLETIC BE APPROPRIATE DATE
E 000	An unannounced Er survey was conducte and 5/23/22. The fa compliance with 42 (	mergency Preparedness ed 5/17/22 through 5/20/22 cility was in substantial CFR Part 483.73, g-Term Care Facilities. No	E 000		
F 000	emergency prepared investigated during the INITIAL COMMENTS	Iness complaints were he survey. S	F 000		
	survey was conducted and 5/23/22. Eight condu	edicare/Medicaid standard ed 5/17/22 through 5/20/22 complaints were investigated A00054700 - 00053964 - substantiated; antiated; VA00053584 - 050966 - substantiated; antiated; VA00051025 - 050806 - unsubstantiated).			
	Corrections are requi CFR Part 483 Federa Requirements. The L survey/report will follo	ife Safety Code			
	time of the survey. The	4 bed facility was 167 at the ne survey sample consisted reviews and 11 closed			
	Reasonable Accomm CFR(s): 483.10(e)(3)	odations Needs/Preferences	F 558		
	services in the facility accommodation of re- preferences except w endanger the health o other residents.	sident needs and			

Cotto and bases

Administrator

6/10/2022

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
		495045	B. WNG			C 5/23/2022
	SUMMARY S (EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	21	IREET ADDRESS, CITY, STATE, ZIP CODE  125 HILLIARD ROAD  ICHMOND, VA 23228  PROVIDER'S PLAN OF COR  (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A	RECTION SHOULD BE	(X5) COMPLETION DATE
	by: Based on observation record review, the far accommodations of ensure the call bell [can be pushed to all needed] was within residents in the surve (R317).  The findings include The facility staff faile within their reach.  (R317) was admitted diagnosis that includ weakness.  The most recent MD admission assessmenterence date) of 05 at the time of the survey (R317's) "Admission 05/16/2022 documenter evaluation Neurologic review revealed check Place, Person" indicated those areas stated at On 05/17/22 at appropriate of (R317) and on the side of (R317) and	T is not met as evidenced on, staff interview and clinical icility staff failed to provide resident needs by failing to a device with a button that ert staff when assistance is reach for one of 52 current ey sample, Resident #317  If to the facility with a ed by not limited to: muscle  S (minimum data set), an ent with an ARD (assessment is/23/2022, was "In progress" evey.  Assessment" dated ated in part, "Clinical cal. Orientation." Further eks mark for "Situation, ating (R317) was oriented to boove.  Eximately 1:15 p.m., an In revealed they were lying in was observed hanging over the bedside table on the left	F 558	558 – Reasonable Accom Needs/Preferences  1. R317 no longer residenciality.  2. Utilizing the call light monitoring tool – a compreview of current residencompleted to validate cal within reach or the prefercare planned.  3. The director of nursing designee will educate the department on "Focus on 558" and "call light" processor before the date of com 4. Utilizing the call light monitoring tool – the direction nursing/designee will aud residents per week x 4 we walidate call light placement. Results of the will be reviewed with the committee.	es in the orehensive ots will be ill lights are rence is og/ onursing of-tag edure on opliance. ector of ott 5 eeks to	6/30/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495045	B. WNG		C 05/23/2022	
	ROVIDER OR SUPPLIER	G AND REHAB (RICHMOND)	2125	EET ADDRESS, CITY, STATE, ZIP CO HILLIARD ROAD HMOND, VA 23228		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE COMPLET BE APPROPRIATE DATE	TION
F 558	observation of (R3 bed and the call be the drawer pull on side of (R317) and On 05/18/22 at apposervation of (R3 bed and the call be the drawer pull on side of (R317) and On 05/18/22 at appinterview with (R33 revealed they were was observed handbedside table on the asked if they knew stated that it was how When asked if they sit. When asked help (R317) stated walk by their room On 05/19/22 at appinterview with CNA 9. When asked who CNA #9 stated that resident's reach. When asked who CNA #9 stated that resident's reach. When asked who CNA #9 stated that the someone goes On 05/19/2022 at a (administrative staff)	age 2 17) revealed they were lying in all was observed hanging over the bedside table on the left out of their reach.  Proximately 11:00 a.m., an 17) revealed they were lying in all was observed hanging over the bedside table on the left out of their reach.  Proximately 3:00 p.m., an 17) and observation of (R317) lying in bed and the call bell ging over the drawer pull on the left side of (R317). When where the call bell was (R317) anging on the bedside table.  Proximately 3:00 p.m., an 17) and observation of (R317) and observation of (R317) and observation of (R317) and observation of the call bell was (R317) and observation of the call bell and tated that they could not reach ow they call for assistance or that they wait for someone to and call out to them.  Proximately 8:47 a.m., an (certified nursing assistant) # ere call bell should be placed it is should be within the when shown where the call bell formed of the observations 9 stated the call bell was out ident. When asked how often resident's call bell is checked it should be checked every into the resident's room.	F 558			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _	CONSTRUCTION	(X3) DA	TE SURVEY MPLETED
		495045	B. WING			C <b>5/23/2022</b>
	PROVIDER OR SUPPLIER	AND REHAB (RICHMOND)	21	REET ADDRESS, CITY, STATE, ZIP C 25 HILLIARD ROAD ICHMOND, VA 23228		3/23/2022
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 558 F 580 SS=D	aware of the findings  No further informatio Notify of Changes (Ir CFR(s): 483.10(g)(14 §483.10(g)(14) Notifi (i) A facility must imm	n was presented prior to exit. jury/Decline/Room, etc.) l)(i)-(iv)(15)	F 558	580 – Notify of Chang 1. RR 802 no longer facility. R 63 has been dietician and the plan reviewed with the res	resides in the n seen by the n of care was	
	representative(s) who (A) An accident involves an injury and he physician intervention (B) A significant chan mental, or psychosod deterioration in health status in either life-the clinical complications (C) A need to alter treament due to advect treatment due to advect commence a new forn (D) A decision to transesident from the facil §483.15(c)(1)(ii).  (ii) When making notiful (14)(i) of this section, all pertinent information is available and provide physician.  (iii) The facility must a resident and the resident there is- (A) A change in room as specified in §483.1  (B) A change in resident	ving the resident which as the potential for requiring as the resident's physical, ial status (that is, a nental, or psychosocial reatening conditions or a statement significantly (that is, an existing form of an existing form of area consequences, or to an of treatment); or after or discharge the ity as specified in a specified in sample (g) the facility must ensure that an specified in \$483.15(c)(2) and ded upon request to the also promptly notify the ent representative, if any, or roommate assignment		and MD.  2. Utilizing the "Charcondition" QAPI tool-residents with x-rays of changes from 5.23.20 completed and notific change will be validated.  Director of nursing/designee will licensed nursing staff on f-tag 580" and "Charcondition" procedure the date of compliance 4. Utilizing the "chancondition" QAPI tool-of nursing/designee were sidents per week time weeks with changes in related to weight chanding diagnostic reports to very notification of change. The audits will be reviee QA&A committee.	a review of or weight 122 will be cations of ed by the esignee.  educate the on the "focus ange in on or before e. ange in the director will audit 5 anes four a condition age or x-ray ralidate Results of	6/30/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495045	B. WING		0:	C 5/23/2022
	ROVIDER OR SUPPLIER	G AND REHAB (RICHMOND)	2125	EET ADDRESS, CITY, STATE, ZIP CO HILLIARD ROAD HMOND, VA 23228		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC'	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
	(e)(10) of this section (iv) The facility must update the address phone number of the representative(s).  §483.10(g)(15) Admission to a composite §483.5) must disclosite physical configuration that compart, and must spectroom changes betwounder §483.15(c)(9) This REQUIREMENT by: Based on staff interreview, clinical record a complaint investign the facility staff failed changes in status for survey sample, Resurvey sample, Resurvey sample, Resurvey for the resiright hip.  On the most recent quarterly assessment reference date) of 20 having no cognitive decisions, having so BIMS (brief interview was coded as required.	t record and periodically (mailing and email) and e resident  posite distinct part. A facility distinct part (as defined in se in its admission agreement ration, including the various rise the composite distinct rify the policies that apply to een its different locations of the policies that apply to remain the	F 580			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED	
		495045	B. WNG		0.0	C 5/23/2022
	ROVIDER OR SUPPLIER	AND REHAB (RICHMOND)	2125	EET ADDRESS, CITY, STATE, ZIP COD S HILLIARD ROAD HMOND, VA 23228		312312022
(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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 580	transfers.  A review of the physicevealed the following 11:27 p.m.: "X-ray to pain to right hip and once performed." The #7.  A review of R802's composite following progress of p.m. The note was weare practical nurse) #7. "for subcapital fracture (medical doctor) on comade aware and path local hospital] ER (errevaluation and treatmed to the progress of the progres	g order, dated 4/8/22 at right hip and right kneefor knee. D/c (discontinue) order e order was entered by LPN linical record revealed the ote, dated 4/10/22 at 11:16 witten by LPN (licensed Patient's X-ray was positive e of the right hip. MD was ient was sent to [name of nergency room) for nent."  D2's progress notes revealed ion related to attempts to gy services, or providers regarding the atment for a fractured hip.  Scharge summary from the 1/21/22 revealed R802 was used right hip. During the 0/22 through 4/21/22, R802 in 4/11/22 to repair the right omprehensive care plan led no information related to	F 580			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED
		495045	B. WING		С
NAME OF P	ROVIDER OR SUPPLIER	433043		EET ADDRESS, CITY, STATE, ZIP CODE	05/23/2022
PROMED	ICA SKILLED NURSING	AND REHAB (RICHMOND)	2125	HILLIARD ROAD	
		AND NEMAD (MONIMOND)	RICI	HMOND, VA 23228	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
	because R802 report legs were swollen. The ultrasound of both leg When asked if she defindings or conversate she had. After review LPN #7 stated she made she should assessment findings the provider in the prospective she worked 4/8/22, 4 cared for R802 on eathe X-ray was ordered company did not arrive the X-ray until late in When asked why the arrive until nearly 48 stated: "That's not un asked if she made an X-ray company to determine or to ask if some than originally planned when asked if she confurse practitioner) to could not be performed she did not. When as resulted in a delay or fracture, she stated: "On 5/23/22 at 11:14 and interviewed. When as obtaining mobile X-ray out a form, then calls She stated the X-ray of give a time when they there to perform the X-ray at the she has not heard from	ted right hip pain, and R802's he physician ordered an gs and an X-ray of the hip. ocumented any of these ions, she stated she thought ring R802's progress notes, ust have "just missed it." id have documented the and the conversation with ogress notes. LPN #7 stated /9/22, and 4/10/22, and ich of these days. She stated id 4/8/22, but the X-ray we at the facility to perform the evening on 4/10/22. X-ray company did not hours after the order, she usual for them." When any attempts to contact the elemine when they would be ene could arrive sooner id, she stated she did not intacted the physician/NP let them know the X-ray elemediately, she stated ked if the delay in the X-ray treatment for R802's hip Yes, absolutely."	F 580		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			DATE SURVEY COMPLETED
		495045	B. WNG			C <b>05/23/2022</b>
	ROVIDER OR SUPPLIER	G AND REHAB (RICHMOND)	2125	EET ADDRESS, CITY, STATE, ZIP 5 HILLIARD ROAD HMOND, VA 23228	CODE	03/23/2022
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL PR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	THE APPROPRIATE	(X5) COMPLETION DATE
	will arrive to do the "Sometimes they we next day because the stated if a resident the X-ray company she calls the provid X-ray is delayed, a should be done net often say to send the not to wait for the most to wait for wa	X-ray. She stated:  vill tell you they will be here the hey are so backed up." She has a potential fracture, and cannot come immediately, ler to let them know that the nd will ask the provider what kt. She stated the provider will he resident out to the ER, and nobile X-ray.  4 p.m., ASM (administrative he director of nursing, was to stated the provider should k-ray of a potentially fractured ned immediately.  p.m., ASM #1, the ASM #2 were informed of ity policy, "Change in d, in part: "According to the Directors Association (AMDA) idelines - Condition in the Long-Term ediate notification is ny symptom, sign or apparent cute or sudden in onset and a elation to usual symptoms believed by measures already	F 580			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED
						С
		495045	B. WING			05/23/2022
	ROVIDER OR SUPPLIER	AND REHAB (RICHMOND)		STREET ADDRESS, CITY, STATE, ZIP ( 2125 HILLIARD ROAD RICHMOND, VA 23228	CODE	
(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 X (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE THE APPROPRIA	ACCURATION AND ACCURATION OF THE PARTY OF TH
F 580	2. For Resident #63 (I to notify the physician in January 2022.  On the most recent M quarterly assessment reference date) of 3/1 being severely cognitidally decisions, having the BIMS (brief interviwas coded as having during the look back particles of the second of t	R63), the facility staff failed of a significant weight loss  DS (minimum data set), a with an ARD (assessment 4/22, R63 was coded as vely impaired for making g scored zero out of 15 on ew for mental status). R63 no significant weight loss period.  Ical record revealed the me following dates. On weighed 93 lbs. On 1/14/22, 87 pounds. The loss is a sclinical record revealed provider was notified of this mental status. The loss is a sclinical record revealed provider was notified of this mental status. The loss is a sclinical record revealed provider was notified of this mental status. The loss is a sclinical record revealed provider was notified of this mental status. The loss is a sclinical record revealed provider was notified of this mental status. The loss is a sclinical record revealed provider was notified of this mental status. The loss is a sclinical record revealed provider was notified of this mental status. The loss is a sclinical record revealed provider was notified of this mental status.	F	580		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495045	B. WING		C 05/23/2022	
PROMEDICA SKILLED NURSING AND REHAB (RICHMOND)  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		21 RI	REET ADDRESS, CITY, STATE, ZIP CODE  25 HILLIARD ROAD  CHMOND, VA 23228  PROVIDER'S PLAN OF CORRECTION	N (X5)		
TAG		SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		
F 582 SS=D	reviewed 3/15/22 reversible potential for nutrition/I (body mass index) is (registered dietician) the per protocolreview wand responsible party change."  On 5/19/22 at 5:11 p.r. staff member) #1, the the director of nursing concerns.  No further information Medicaid/Medicare Concerns.  No further information Medicaid in Setting facility and when the resident in Medicaid of-(A) The items and service for which the resident (B) Those other items facility offers and for working facility offers and for working and the amos services; and (ii) Inform each Medicaid changes are made to a specified in §483.10(g) section.	e plan dated 10/8/19 and ealed in part: "[R63] has the hydration imbalanceBMI underweightRD o monitor and f/u (follow up) weights and notify physician of significant weight  m., ASM (administrative administrator, and ASM #2, were informed of these  was provided prior to exit. overage/Liability Notice (18)(i)-(v)  cility must—aid-eligible resident, in admission to the nursing esident becomes eligible for vices that are included in a under the State plan and may not be charged; and services that the which the resident may be unt of charges for those  aid-eligible resident when the items and services (17)(i)(A) and (B) of this	F 582	582 – Medicaid/Medicare Coverage/Liability Notice 1. R 466 no longer resides in facility. 2. Utilizing the "SNF beneficing protection notification review audit – a comprehensive review residents receiving NOMNCs for 5.23.2022 to current will be completed by the Social Service department. 3. The Nursing Home Administrator/designee will educate the social service department on "Focus on F-taggraphics on or before the date of compliance. 4. Utilizing the "SNF beneficing protection notification review" audit – the Social service team/designee will audit 5 NOMNCs per week times four weeks to validate compliance. Results will be reviewed with the QA&A committee.	iary " ew of from ce g ary "	
	§483.10(g)(18) The fac	cility must inform each			6/30/2022	

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
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		495045	B. WING		05/23/2022
	ROVIDER OR SUPPLIER	G AND REHAB (RICHMOND)	2128	EET ADDRESS, CITY, STATE, ZIP O 5 HILLIARD ROAD HMOND, VA 23228	CODE
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	TION SHOULD BE COMPLETION DATE
	periodically during available in the faci services, including covered under Med facility's per diem re (i) Where changes and services covered Medicaid State plan notice to residents areasonably possible (ii) Where changes items and services facility must inform 60 days prior to imp (iii) If a resident diest transferred and doe facility must refund representative, or edeposit or charges aper diem rate, for the resided or reserved facility, regardless of discharge notice rec (iv) The facility must resident within 3 date of discharge from the resident within 3 date of discharge from the resident representative of an abehalf of an individual facility must not conthese regulations. This REQUIREMEN by:  Based on staff interreview, it was determotification facility ta	at the time of admission, and the resident's stay, of services ility and of charges for those any charges for services not dicare/ Medicaid or by the ate.  In coverage are made to items ed by Medicare and/or by the n, the facility must provide of the change as soon as is e.  are made to charges for other that the facility offers, the the resident in writing at least elementation of the change. It is not return to the facility, the to the resident, resident state, as applicable, any already paid, less the facility's retained a bed in the off any minimum stay or quirements.  It refund to the resident or tive any and all refunds due and days from the resident's om the facility.  admission contract by or on all seeking admission to the flict with the requirements of the interest of the facility document mined during the beneficiary isk, the facility staff failed to notification for one of three	F 582		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER	G AND REHAB (RICHMOND)	2125	EET ADDRESS, CITY, STATE, ZIP HILLIARD ROAD HMOND, VA 23228	O5/23/2022	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL IR LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE COMPLETION DATE	
	review on 5/18/22. last six months was AM.  Resident #466 was 10/20/21 with diagrant limited to: fracture of right fem disease and chronic disease. Resident 11/30/21.  The most recent MI assessment, a disclassessment, with a date) of 11/30/21, or 14 out of 15 on the mental status) score not cognitively impart A review of the sociedated 11/30/21 at 2: following, "Discharg scheduled to dischaliving facility (ALF) whealth (HH) and dur (DME). Resident prette pharmacy, her pand the ALF were noweek and expecting.  On 5/18/22 at approbeneficiary notices were resident to the properties of the properties of the properties of the pharmacy.	ask of beneficiary notification The list of discharges for the provided on 5/18/22 at 7:30  admitted to the facility on loses that included but were  ur, schizophrenia, bipolar c obstructive pulmonary #466 was discharged on  DS (minimum data set) harge return not anticipated h ARD (assessment reference oded the resident as scoring a BIMS (brief interview for a, indicating the resident was ired.  all services progress note 38 PM, revealed the e Summary: Resident is rge and return to her assisted with recommended home able medical equipment escriptions were submitted to rimary care physician (PCP) otified of her discharge last her arrival."	F 582			
	#466's Beneficiary P form revealed the fo	rotection Notification Review llowing: "Under #2. Was a				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED
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	PROVIDER OR SUPPLIER	AND REHAB (RICHMOND)		STREET ADDRESS, CITY, STATE, ZIP CODE 2125 HILLIARD ROAD RICHMOND, VA 23228	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE COMPLETION
F 582	NOMNC (notice of M provided to the resid next to "*If NOT issur F582."  An interview was cor AM with OSM (other services worker. Wh responsible for the beneficiary notice. O a notice. Usually I w (responsible party), b did that and I was cotime. It was missed.'  On 5/20/22 at approx (administrative staff radministrator, ASM # OSM #2, the director made aware of the fir record review.	ledicare non-coverage) ent the box was checked es and should have been:  Inducted on 5/18/22 at 10:25 staff member) #4, the social en asked if she was eneficiary notices being stated, "Yes, I did the in Resident #466, I did not do ould email her RP out I have no evidence that I evering our sister facility at the imately 5:30 PM, ASM nember) #1, the 2, the director of nursing and of human resources were endings of the employee	F 582		
F 584 SS=D	A review of the facility Coverage/Liability No which revealed, "In ca covered services are being discharged and expedited review, on! Safe/Clean/Comfortal CFR(s): 483.10(i)(1)-(\$483.10(i) Safe Environment of the resident has a right of the same o	y the NOMNC is required."  ple/Homelike Environment  7)  pnment.  th to a safe, clean,  elike environment, including	F 584		

PRINTED: 06/02/2022 FORM APPROVED OMB NO. 0938-0391

F 584 Continued From page 13 supports for daily living safely.  F 584 (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  F 584 Continued From page 13 supports for daily living safely.  F 584 (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  F 584 Continued From page 13 supports for daily living safely.  F 584 (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER  PROMEDICA SKILLED NURSING AND REHAB (RICHMOND)  STREET ADDRESS, CITY, STATE, ZIP CODE  2125 HILLIARD ROAD RICHMOND, VA 23228  (X4) ID PREFIX TAG  SUMMARY STATEMENT OF DEFICIENCIES PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION)  F 584  Continued From page 13 supports for daily living safely.  STREET ADDRESS, CITY, STATE, ZIP CODE  2125 HILLIARD ROAD RICHMOND, VA 23228  PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  F 584  Continued From page 13 SUPPORTS for daily living safely.  STREET ADDRESS, CITY, STATE, ZIP CODE  2126 HILLIARD ROAD RICHMOND, VA 23228  F 584 — Safe/Clean/Homelike Environment  1. Resident 135's privacy curtain		
PROMEDICA SKILLED NURSING AND REHAB (RICHMOND)  2125 HILLIARD ROAD RICHMOND, VA 23228  (X4) ID PREFIX TAG  PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION)  F 584  Continued From page 13 supports for daily living safely.  2125 HILLIARD ROAD RICHMOND, VA 23228  ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE COMED TO THE APPROPRIATE DEFICIENCY)  F 584  Continued From page 13 Supports for daily living safely.  F 584  RESIDENT TAG  1 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE COMED TO THE APPROPRIATE DEFICIENCY)  TAG  1 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTION SHOULD BE COMED TO THE APPROPRIATE DEFICIENCY)  TAG  1 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTION SHOULD BE COMED TO THE APPROPRIATE DEFICIENCY)  TAG  1 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTION SHOULD BE COMED TO THE APPROPRIATE DEFICIENCY)  TAG  1 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTION SHOULD BE COMED TO THE APPROPRIATE DEFICIENCY)  TAG  1 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTION SHOULD BE COMED TO THE APPROPRIATE DEFICIENCY)  TAG  1 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTION SHOULD BE COMED TO THE APPROPRIATE DEFICIENCY)  TAG  1 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTION SHOULD BE COMED TO THE APPROPRIATE DEFICIENCY)  TAG  1 PROVIDER'S PLAN OF CORRECTION SHOULD BE COMED TO THE APPROPRIATE DEFICIENCY TO	2022	
F 584 Continued From page 13 supports for daily living safely.  (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  F 584 Continued From page 13 Supports for daily living safely.  F 584 (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  F 584 (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  T 584 (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  T 584 (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  T 584 (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  T 584 (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  T 584 (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
supports for daily living safely.  Environment  1. Resident 135's privacy curtain	(X5) OMPLETION DATE	
The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible.  (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk.  (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft.  §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior,  §483.10(i)(3) Clean bed and bath linens that are in good condition;  §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv);  §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and  §483.10(i)(7) For the maintenance of comfortable sound levels.  This REQUIREMENT is not met as evidenced by:  Based on observation, resident interview, staff interview, clinical rebord review and facility	0/2022	
interview, clinical record review and facility  weekly times four weeks to validate clean privacy curtains and best Page 14	2000	

findings to the QAPI committee for review and further

recommendations.

heet Page 14 of 159

	OF DEFICIENCIES F CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING		TION		E SURVEY IPLETED
			495045	B. WING			0.5	C 5/23/2022
	ROVIDER OR SUPPLIER	G A	ND REHAB (RICHMOND)	21	25 HILLIAR	ESS, CITY, STATE, ZIP CODE D ROAD VA 23228	1 03	112312022
(X4) ID PREFIX TAG	(EACH DEFICIE	NC	ITEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION FACH CORRECTIVE ACTION SHOULD E OSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
	facility staff failed to comfortable, home residents in the su and Resident #85; the facility.  The findings included the facility.  The findings included the facility staff privacy curtain in Figure 1. The facility staff privacy curtain in Figure 2. The facility staff privacy curtain in Figure 2. The facility staff privacy curtain in Figure 3. The facility staff privacy curtain in Figure 3. The facility staff privacy assessment of 15 out of 15 on the mental status) asserts a facility asserts and the curtain staff privacy as a facility of 15 out of 15 on the mental status) asserts and the facility of 15 out of 15 on the mental status) asserts and the facility of 15 out of 15 on the mental status) asserts and the facility of 15 out of 15	t with the state of the state o	as determined that the raintain a clean, environment for two of 52 y sample, Resident #135 d in one of five pantries in led to maintain a clean dent #135's (R135) room.  OS (minimum data set), a with an ARD (assessment B/2022, the resident scored MS (brief interview for ment, indicating the lely impaired for making level with R135 in their room. The room revealed a privacy en their bed and their ble stains were observed of the curtain less up onto the le	F 584				

CLIVILI	COT ON WEDICANE &	WEDICAID SERVICES			OMB NO	7. 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO		COME	SURVEY
		495045	B. WING			C / <b>23/2022</b>
	ROVIDER OR SUPPLIER	AND REHAB (RICHMOND)	2125	EET ADDRESS, CITY, STATE, ZIP ( HILLIARD ROAD HMOND, VA 23228		2012022
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
	above.  On 5/18/2022 at 3:35 conducted with OSM director of housekeep privacy curtains were facility. OSM #8 state cleaned and replaced as needed when dirty housekeeping staff st privacy curtains or respected and any softhe curtains. OSM R135's room and state to be washed to remote #8 informed R135 that washed and taken cate On 5/18/2022 at 3:55 conducted with LPN (LPN #4 stated that how and laundered privacy #4 stated that they we concerns regarding R stained or dirty. LPN enter a work order for privacy curtain identification replacement or contact have this done.  The facility provided prodocumented in part, " a safe, clean, comfortate environment, including treatment and supports."	the findings as described  ip.m., an interview was (other staff member) #8, the bing. OSM #8 stated that washed in the laundry at the ed that privacy curtains were when a room was empty or or. OSM #8 stated that hould be inspecting the when cleaning the rooms and other staff to report dirty sident complaints to them to otains should be cleaned off #8 viewed the curtain in ed that the curtain needed by the visible stains. OSM at the curtain would be are of.  p.m., an interview was licensed practical nurse) #4. busekeeping staff washed of curtains as needed. LPN ere not aware of any 135's privacy curtain being #4 stated that they would housekeeping to clean a ed as dirty or needing thousekeeping directly to  colicy, "Focus on F Tag 584"The resident has a right to	F 584			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CO	DISTRUCTION	(X3) DATE SURV	/EY	
		495045	B. WING		C 05/23/20	022
AND MARKS SERVICE		SKILLED NURSING AND REHAB (RICHMOND)  2125 HILLIARD ROAD RICHMOND, VA 23228				
(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 COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE COM	(X5) MPLETION DATE
	maintenance services sanitary, orderly and Adequate and comfor areas"  On 5/18/2022 at 4:49 staff member) #1, the director of nursing an resource director wer concern.  No further information  2. The facility staff fa privacy curtain and w. Resident #85's (R85)  On the most recent M quarterly assessment reference date) of 3/2 15 out of 15 on the BI mental status) assess resident was not cognitive daily decisions.  On 5/18/2022 at appreinterview was conducted fractions.  On 5/18/2022 at appreinterview was conducted fractions.	is necessary to maintain a comfortable interior(5) intable lighting levels in all probabilities administrative administrator, ASM #2, the ad OSM #2, the human remade aware of the above in was presented prior to exit.  Alled to maintain a clean proving overhead light in a room.  ADS (minimum data set), a st with an ARD (assessment 21/2022, the resident scored IMS (brief interview for sment, indicating the intively impaired for making and the company of the size of a quarter. R85 were blood that had gotten depend to the size of a quarter. R85 were blood that had gotten depend the size of a the size of a quarter. R85 were blood that had gotten depend the size of a the size of at least ed that housekeeping had	F 584			

OLIVILITO I OIL WILDIONILL OIL	ALDIOAID OLIVIOLO			OIVID IVO.	0930-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO		(X3) DATE S COMPL	ETED
	495045	B. WING		С	
	499045	B. WING		05/2	3/2022
NAME OF PROVIDER OR SUPPLIER		STRE	EET ADDRESS, CITY, STATE, ZIP	CODE	
PROMEDICA SKILLED NURSING A	ND REHAB (RICHMOND)	1	HILLIARD ROAD HMOND, VA 23228		
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
light to make the room stated that it had not we the nurses had a hard the wound care. Obseroom revealed the top not working.  Additional observations 5/18/2022 at 2:30 p.m. described above.  On 5/18/2022 at 3:35 p. conducted with OSM (director of housekeeping privacy curtains were we facility. OSM #8 stated cleaned and replaced was needed when dirty. housekeeping staff sho privacy curtains daily we and that they expected privacy curtains or residue cleaned and any state of the curtains. OSM # brown stains on the privand stated that the curtain working the cur	the second time the top brighter did not work. R85 vorked for over a month and time seeing when doing ervation of the light in R85's light of the overhead light  s of R85's room on revealed the findings as  o.m., an interview was other staff member) #8, the ng. OSM #8 stated that vashed in the laundry at the d that privacy curtains were when a room was empty or OSM #8 stated that ould be inspecting the when cleaning the rooms other staff to report dirty dent complaints to them to ains should be cleaned off 8 viewed the two dark vacy curtain in R85's room tain needed to be washed tains. OSM #8 informed ould be washed and taken  o.m., an interview was beensed practical nurse) #4. sekeeping staff washed curtains as needed. LPN	F 584			

CENTER	S FOR MEDICARE	& MEDICAID SERVICES			OMB NO. 0938-0391	_	
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	171 - STANFORD (170 - CO)	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED		
		495045	B. WING _		C 05/23/2022		
	ROVIDER OR SUPPLIER	IG AND REHAB (RICHMOND)		STREET ADDRESS, CITY, STATE, ZIP COD 2125 HILLIARD ROAD RICHMOND, VA 23228	E		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE COMPLETION		
F 584	cleaned immediate should enter a wor clean a privacy cur needing replacemed directly to have the lights not working and that staff either entered a work order repairs done.  On 5/19/2022 at 12 conducted with OS orders in the compreded for the marmaintenance staff morning. OSM #9 work orders and remaintenance issue the overhead light the top light was not they would check to if there was a work informed R85 that light repair.  On 5/19/2022 at at #9 stated that they computer system a work order in place room.  On 5/19/2022 at 5: staff member) #1, to director of nursing resource director worder.	age 18 ely. LPN #4 stated that staff k order for housekeeping to rtain identified as dirty or ent or contact housekeeping s done. LPN #4 stated that any were repaired by maintenance or called maintenance directly or der into the computer to have  2:17 p.m., an interview was 6M #9, the director of M #9 stated that staff put work outer system for any repairs intenance staff and that reviewed the work orders every stated that all staff could put in esidents could report is to any staff. OSM #9 viewed in R85's room and agreed that but working. OSM #9 stated that he maintenance system to see order in place. OSM #9 they would take care of the  Oproximately 12:55 p.m., OSM checked the maintenance and they did not have an active of or the overhead light in R85's  11 p.m., ASM (administrative he administrator, ASM #2, the and OSM #2, the human were made aware of the above	F 5	84			

CENTER	S FOR MEDICARE &	MEDICAID SERVICES			CIVID NO. COCC CCC
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO		(X3) DATE SURVEY COMPLETED
		495045	B. WNG		C 05/23/2022
NAME OF P	ROVIDER OR SUPPLIER	.30010		ET ADDRESS, CITY, STATE, ZIP CO	
			3.750000	HILLIARD ROAD	
PROMEDI	CA SKILLED NURSING	AND REHAB (RICHMOND)	CSAR-308	HMOND, VA 23228	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE COMPLETION HE APPROPRIATE  COMPLETION DATE
F 584	3. The facility staff far physical environment of the Station 6 unit.  On 5/18/2022 at 3:20 conducted of the pan facility. Observation sink revealed multiple were water-stained strained bottom. Four chips and two packages andwich crackers ware among the water-stail cabinet floor. A coffe unplugged and laying cabinet. The area are observed to be missing exposing the wall behaviors but did not clear stated that they did not below the sink should the findings above an needed to be cleared stated that there was open area around the left under the sink. O should be no food und paper towels and other stored underneath the	ailed to maintain a clean tunder the sink in the pantry of the Station 6 unit at the of the area underneath the eloose paper towels which tuck to the surface of the r single serve bags of potato ges of peanut butter ere observed to be lying and paper towels on the eloon maker was observed to be gon its side underneath the ound the sink piping was an gdrywall with an open area anind it.  In p.m., an interview was (other staff member) #8, the bing. OSM #8 stated that into the pantry to clean the in inside the cabinets and out think that the cabinets and out think that the cabinets in out and closed. OSM #8 potential for pests with the elsink piping and food being isM #8 stated that there der the sink and the dirty er items should not be	F 584		
	conducted with LPN (	licensed practical nurse) #4. ursing was responsible for			

FORM APPROVED OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495045	B. WING		C <b>05/23/2022</b>
	ROVIDER OR SUPPLIER	G AND REHAB (RICHMOND)	2125	EET ADDRESS, CITY, STATE, ZIP CO HILLIARD ROAD HMOND, VA 23228	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI CRÓSS-REFERENCED TO TI DEFICIENC	ON SHOULD BE COMPLETION HE APPROPRIATE DATE
F 584	nursing assistant) LPN #4 observed that it was "disgust out. LPN #4 stated items stored under water-stained paper needed to be clear did not look like the area and would may would take care of was not a clean en snacks.  On 5/18/2022 at 4: staff member) #1, tdirector of nursing	age 20 y assigned a CNA (certified to clean the pantry every shift, the findings above and stated ing" and needed to be cleaned of that there should be no food neath the sink with er towels and everything need out. LPN #4 stated that it is CNA's had been cleaning this take sure the CNA assigned it. LPN #4 stated that the area vironment to store resident  49 p.m., ASM (administrative the administrator, ASM #2, the and OSM #2, the human tere made aware of the above	F 584		
F 607 SS=D	Develop/Implement CFR(s): 483.12(b)( §483.12(b) The fact implement written p §483.12(b)(1) Prohineglect, and exploit misappropriation of §483.12(b)(2) Estat to investigate any s §483.12(b)(3) Incluparagraph §483.95	ility must develop and policies and procedures that: ibit and prevent abuse, ration of residents and resident property, blish policies and procedures uch allegations, and de training as required at	F 607		

PRINTED: 06/02/2022

	OF DEFICIENCIES F CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
			495045	B. WNG				С
NAME OF F	PROVIDER OR SUPPLIER		493045	B. WING		TREET ADDRESS, CITY, STATE, ZIP CODE	1 0	5/23/2022
		IG A	AND REHAB (RICHMOND)		21	125 HILLIARD ROAD ICHMOND, VA 23228		
(X4) ID PREFIX TAG	(EACH DEFICI	NC'	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 APPROPRI DEFICIENCY)	3E	(X5) COMPLETION DATE
	Based on staff int review, clinical red a complaint investig the facility staff fair report and investig one of 52 resident Resident #802 (Resident #802) (Res	erviord gate ordered at the correction of the co	ew, facility document review, and in the course of ion, it was determined that to implement their policy to an allegation of abuse for the survey sample, The facility staff failed to R802's allegation that a ng assistant) was rough ident in April 2022.  DS (minimum data set), a with an ARD (assessment 22, R802 was coded as pairment for making daily ed 15 out of 15 on the or mental status). R802 g the extensive assistance or bed mobility and	F	607	Abuse/Neglect Policies  1. R 802 no longer resides in the facility.  2. Utilizing the "Investigations QAPI tool – the director of nursing/designee will complete review of any injury of unknown origin from 5.23.2022 to current validate compliance of reporting 3. The Regional Director of Operations will educate the Director of Nursing and Nursing Home Administrator on the "For on F-tag 607" and the "patient protection guideline" on or beforthe date of compliance. The Director of Nursing or Designee re-educate the nursing staff on abuse reporting.  4. Utilizing the "Investigation" QAPI tool – the Nursing home administrator/designee will aud incidents of injuries of unknown origin weekly times four weeks walidate compliance with reporting. Results will be review with the QA&A committee.	a t to cus ore will	6/30/2022

CENTERS FOR MEDICARE & MEDICAID SERVICES

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUC	TION	(X3) DATE SURVEY COMPLETED
		495045	B. WING			C <b>05/23/2022</b>
	ROVIDER OR SUPPLIER	S AND REHAB (RICHMOND)		STREET ADDR 2125 HILLIAR RICHMOND,		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION EACH CORRECTIVE ACTION SHOULD BI OSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
	abusethe facility in alleged violations are investigatedkey to allegations is an enverporting of such allegations is an enverporting of such allegations of any this investigation of any this investigation process determining who, whow for any occurred cause and appropriates and appropriat	re thoroughly investigating abuse vironment that facilitates the egations. Once reported, the mely, thorough, and objective allegations of abuse. Part of the consideration of the ole abuse Utilizing the s, the center focuses on nat, when, where, why and nce to determine the root ate course of action and  clinical record revealed the ote, dated 4/10/22 at 11:16 viriten by LPN (licensed 'Patient's X-ray was positive te of the right hip. MD call was [name of MD] was tient was sent to [name of mergency room) for ment."	F	507		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO		(X3) DATE SURVEY COMPLETED
		495045	B. WNG		C 05/23/2022
	PROVIDER OR SUPPLIER		STRE 2125	REET ADDRESS, CITY, STATE, ZIP CO 5 HILLIARD ROAD CHMOND, VA 23228	
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE COMPLETION DATE
	stated she spoke veresident what happaide "gave [R802] rough." ASM #2 staresident thought the and R802 stated the intentionally hurt the resident was sent to the fracture was didin't have time to usually do." ASM #associated the fracture was didin't have time to usually do." ASM #associated the fracture was didin't have time to usually do." ASM #associated the fracture who handled the redid not. When asked who handled the redid not. When asked residents for whom she did not. When suspended pending stated the TNA was never worked in the On 5/19/22 at 11:20 nurse) #5 was intenshould happen if a was rough with the would report it to the administrator is the She stated she wouspeak to the aide to the room, and asce aide was rough during the day after the could not remember the side of the room of the day after the day af	with R802 and asked the pened. R802 told ASM #2 an a shove and felt she was tated she asked R802 if the he aide intentionally was rough, hey did not think the aide he resident. ASM #2 stated the to the emergency room after iagnosed. She added: "We do some of the things we #2 stated the facility staff cture with the "shove." She of the fracture was a known dif she interviewed the TNA esident roughly, she stated she ed if she interviewed any other in the TNA cared, she stated asked if the TNA was any kind of investigation, she is from an agency and actually the facility again.  20 a.m., LPN (licensed practical reviewed. When asked what resident reports that an aide and during care, she stated she he administrator because the afacility's abuse coordinator. Auld also make every effort to offind out what happened in ertain why the resident felt the	F 607		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING					SURVEY PLETED			
			495045	B. WING				C
	PROVIDER OR SUPPLIER	IG /	AND REHAB (RICHMOND)	STR 2129	REET ADDRESS, CITY, STATE, ZIP CODE 5 HILLIARD ROAD CHMOND, VA 23228		Uə	/23/2022
(X4) ID PREFIX TAG	(EACH DEFICIE	ENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	SHOULD BE		(X5) COMPLETION DATE
	complained to her wrong in the bed a stated she believed days between when when R802 reported. On 5/19/22 at 1:05 She stated she restated on 4/8/22, she because R802 replegs were swollen, ultrasound of both When asked if she regarding a possib swelling, she stated that on 4/10/22 dur - 11:00 p.m.), she is to another staff me roughly by a TNA (earlier in the week, rough handling was LPN #7 stated R80 member that a TNA "mashed down on LPN #7 stated she confirm this report, reported this new in (administrative staff (director of nursing any other member with her about R80 one followed up wit reported this to ASI had reported this to investigation had a stated she could no her an investigation if R802's report of a stated she could not her an investigation if R802's report of a stated she could not her an investigation if R802's report of a stated she could not her an investigation if R802's report of a stated she could not her an investigation if R802's report of a stated she could not her an investigation if R802's report of a stated she could not her an investigation if R802's report of a stated she could not her an investigation if R802's report of a stated she could not her an investigation if R802's report of a stated she could not her an investigation if R802's report of a stated she could not her an investigation if R802's report of a stated she could not her an investigation if R802's report of a stated she could not her an investigation if R802's report of a stated she could not her an investigation if R802's report of a stated she could not her an investigation if R802's report of a stated she could not her an investigation if R802's report of a stated she could not her an investigation if R802's report of a stated she could not her an investigation if R802's report of a stated she could not her an investigation if R802's report of a stated she could not her an investigation in R802's report of a stated she could not her an investigation in R802's report of a stated she could not her an investigation in	that that and it is possible to the control of the	at a TNA had rolled her had hurt her leg. CNA #10 twas approximately two the injury happened and it to anyone.  m., LPN #7 was interviewed. The metal of the physician ed right hip pain, and R802's the physician ordered an ed right hip pain, and R802's the physician ordered an ed right hip pain, and R802's the physician ordered an ed right hip pain and/or stated of the pain and/or the did not. LPN #7 stated ed the evening shift (3:00 p.m. arred that R802 had reported that R802 was handled the program of the hip pain. The source of the hip pain. The source of the hip pain. The did another staff and turned her over and the interview R802 to the stated she immediately	F 607				

CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF A. BUILDING	PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED	
		495045	B. WING			C 5/23/2022	
	PROVIDER OR SUPPLIER	G AND REHAB (RICHMOND)		STREET ADDRESS, CITY, STATE, Z 2125 HILLIARD ROAD RICHMOND, VA 23228			
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE A CROSS-REFERENCED DEFICI	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETION DATE	
F 607	"Yes. That's why I wanted "things to the state again of abuse investigation of abuse investigation of abuse in the state agaillegation of abuse as well as to other regulations. He state agaillegation of abuse investigation of abuse investigation of abuse investigation of abuse investigated per the answer that.  On 5/23/22 at 1:15 administrator, and these concerns.	reported it." She stated she be taken care of."  4 p.m., ASM #2 was asked why the facility never by to report and investigate and a shave investigated plenty of  7 p.m., ASM #1, the interviewed. He stated that if allegation of abuse, he submits reports the allegation to the RR (resident representative), agencies required by the stated. He stated a thorough dinclude staff interviews and the stated he submits a final rency. When asked why R802's was never reported or a policy, he stated he could not	F 60	07			
F 609 SS=D	Complaint deficience Reporting of Allege CFR(s): 483.12(c)(	ry d Violations	F 60	9			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCT	ION	(X3) DATE SURVEY COMPLETED
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		495045	B. WING _			05/23/2022
		AND REHAB (RICHMOND)		2125 HILLIARD 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 CORRECTION ACH CORRECTIVE ACTION SHOULD BI SS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
	involving abuse, neglimistreatment, includir source and misappropare reported immedia hours after the allegat that cause the allegat serious bodily injury, of the events that cause abuse and do not resist the administrator of the officials (including to the administrator of the adm	that all alleged violations ect, exploitation or or injuries of unknown priation of resident property, tely, but not later than 2 tion is made, if the events ion involve abuse or result in or not later than 24 hours if the allegation do not involve ult in serious bodily injury, to be facility and to other the State Survey Agency and the ses where state law provides eterm care facilities) in all all dministrator or his or her ative and to other officials in a law, including to the State action must be taken.  Is not met as evidenced ew, facility document review, and in the course of on, it was determined that to report an allegation of ency, for one of 52 a sample, Resident #802 off failed to report R802's	F 60	Violati 1. R8 facility 2. Ut QAPI t nursin reviev origin valida 3. Th Opera Direct Home on F-t protec the da 4. Ut QAPI t admin incide origin valida report	302 no longer resides in th	a n t to g. cus ore lit n to

STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO	NSTRUCTION		TE SURVEY MPLETED
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		495045	B. WING			5/23/2022
	ROVIDER OR SUPPLIER	G AND REHAB (RICHMOND)	2125	EET ADDRESS, CITY, STATE, ZIP C HILLIARD ROAD HMOND, VA 23228	ODE:	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 609	Continued From pa	age 27	F 609			
	quarterly assessment reference date) of a having no cognitive decisions, having some support of two staff members transfers.  A review of R802's following progress p.m. The note was practical nurse) #7 for subcapital fracture (medical doctor) on made aware and palocal hospital] ER (revaluation and treater further review of R	802's progress notes revealed				
	no other documents circumstances surre A review of the facil incidents), sent to the					
	staff member) #2 w completed a FRI or R802's right hip frac stated when the res the hip pain, the res stated she spoke w resident what happe aide "gave [R802] a	p.m., ASM (administrative ras asked if the facility had any investigating regarding cture in April 2022. ASM #2 sident originally complained of sident was assessed. ASM #2 ith R802 and asked the ened. R802 told ASM #2 and a shove and felt she was ted she asked R802 if the				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING				
		495045	B. WING		C 05/23/2022			
	ROVIDER OR SUPPLIER	G AND REHAB (RICHMOND)	2125	EET ADDRESS, CITY, STATE, ZIP CODE HILLIARD ROAD HMOND, VA 23228	00/20/2022			
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)				
F 609	and R802 stated the intentionally hurt the resident was sent to the fracture was did didn't have time to usually do." ASM # associated the fract stated the cause of event.  On 5/19/22 at 11:20 nurse) #5 was intershould happen if a was rough with the would report it to the administrator is the On 5/19/22 at 11:50 assistant) #10 was learned about the Froughly "the day afficuld not remembe She stated the office complained to her the wrong in the bed are stated she believed days between where when R802 reported On 5/19/22 at 1:05 She stated she rem stated on 4/8/22, she cause R802 reported legs were swollen, ultrasound of both level when asked if she regarding a possible regar	e aide intentionally was rough, bey did not think the aide of the resident. ASM #2 stated the of the emergency room after agnosed. She added: "We do some of the things we see stated the facility staff ture with the "shove." She of the fracture was a known of the fracture was a know	F 609					

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO		(X3) DATE : COMPL	
		495045	B. WING		05/3	
	PROVIDER OR SUPPLIER DICA SKILLED NURSING	G AND REHAB (RICHMOND)	STRE 2125	EET ADDRESS, CITY, STATE, ZIP 5 HILLIARD ROAD HMOND, VA 23228		23/2022
(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 O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION DATE
F 609	that on 4/10/22 durit - 11:00 p.m.), she let to another staff men roughly by a TNA (to earlier in the week, rough handling was LPN #7 stated R802 member that a TNA "mashed down on h LPN #7 stated she confirm this report, a reported this new in (administrative staff (director of nursing), reported this to ASN had reported this to ASN had reported this ea investigation had alr stated she could not her an investigation if R802's report of a roughly was an alleg "Yes. That's why I re wanted "things to be On 5/23/22 at 12:44 interviewed. When a followed their policy abuse policy, she staintentional. We have allegations."  On 5/23/22 at 12:57 administrator, was in he is aware of an allegations. He state regulations. He state	ing the evening shift (3:00 p.m. earned that R802 had reported mber that R802 was handled temporary nursing assistant) and R802 believed that the sthe source of the hip pain. 2 had told another staff had turned her over and her hip" earlier in the week. did not interview R802 to and stated she immediately information to ASM f member) #2, the DON b. She stated when she of the first was told the resident earlier in the week and an interview reactly who told in had been done. LPN #7 for the remember exactly who told in had been done. When asked in staff member treating her gation of abuse, she stated, exported it." She stated she is taken care of."  If p.m., ASM #2 was asked why the facility never to report an allegation of tated: "It certainly was not be investigated plenty of other."  If p.m., ASM #1, the interviewed. He stated that if legation of abuse, he submits exports the allegation to the R (resident representative), agencies required by the	F 609			

	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	Property and a second second		(X3) DATE SURVEY COMPLETED	
	495045	B. WING		C <b>05/23/2022</b>	
		2125	HILLIARD ROAD	03/23/2022	
(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	ID PREFIX TAG	: [1] [1] [1] [1] [1] [1] [1] [1] [1] [1]	D. 175	
investigation should resident interviews FRI to the state ag allegation of abuse policy, he stated he on 5/23/22 at 1:15 administrator, and these concerns.  A review of the fact Abuse, Neglect, Misappropriation Pierocedures for Reeducated upon hire prevention program reporting of any sufficient exploitation, mistre responsible for the coordinating of the alleged or suspected source of the conceimmediate action to violation of any residence.	d include staff interviews and an He stated he submits a final ency. When asked why R802's was never reported per the ecould not answer that.  In p.m., ASM #1, the ASM #2 were informed of dility policy, "Patient Protection: istreatment, and revention," revealed, in part: eportingEmployees are and annually on the abuse in including the immediate spicion of abuse, neglect, atmentThe administrator is investigation process of any ed abuse regardless of the ernas necessary, taking or prevent further potential ident right while the alleged vestigatedimmediately diviolations involving neglect,	F 609			
Investigate/Prevent CFR(s): 483.12(c)(3 §483.12(c) In response	C/Correct Alleged Violation 2)-(4) onse to allegations of abuse,	F 610			
	Continued From painvestigation should resident interviews FRI to the state agallegation of abuse policy, he stated here.  On 5/23/22 at 1:15 administrator, and these concerns.  A review of the fact Abuse, Neglect, Misappropriation Procedures for Reducated upon hire prevention program reporting of any su exploitation, mistre responsible for the coordinating of the alleged or suspects source of the concimmediate action to violation of any resviolation is being in reporting all alleged abuse."  No further information Complaint deficient Investigate/Prevent CFR(s): 483.12(c) In responsedent, exploitation	PROVIDER OR SUPPLIER  ICA SKILLED NURSING AND REHAB (RICHMOND)  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 30 investigation should include staff interviews and resident interviews. He stated he submits a final FRI to the state agency. When asked why R802's allegation of abuse was never reported per the policy, he stated he could not answer that.  On 5/23/22 at 1:15 p.m., ASM #1, the administrator, and ASM #2 were informed of these concerns.  A review of the facility policy, "Patient Protection: Abuse, Neglect, Mistreatment, and Misappropriation Prevention," revealed, in part: "Procedures for ReportingEmployees are educated upon hire and annually on the abuse prevention program including the immediate reporting of any suspicion of abuse, neglect, exploitation, mistreatmentThe administrator is responsible for the investigating, reporting, and coordinating of the investigation process of any alleged or suspected abuse regardless of the source of the concernas necessary, taking immediate action to prevent further potential violation of any resident right while the alleged violation is being investigatedimmediately reporting all alleged violations involving neglect, abuse."  No further information was provided prior to exit.  Complaint deficiency Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4)  §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility	A BUILDING  A95045  B. WING  BROVIDER OR SUPPLIER  ICA SKILLED NURSING AND REHAB (RICHMOND)  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 30 investigation should include staff interviews and resident interviews. He stated he submits a final FRI to the state agency. When asked why R802's allegation of abuse was never reported per the policy, he stated he could not answer that.  On 5/23/22 at 1:15 p.m., ASM #1, the administrator, and ASM #2 were informed of these concerns.  A review of the facility policy, "Patient Protection: Abuse, Neglect, Mistreatment, and Misappropriation Prevention," revealed, in part: "Procedures for ReportingEmployees are educated upon hire and annually on the abuse prevention program including the immediate reporting of any suspicion of abuse, neglect, exploitation, mistreatmentThe administrator is responsible for the investigation process of any alleged or suspected abuse regardless of the source of the concernas necessary, taking immediate action to prevent further potential violation of any resident right while the alleged violation is being investigatedimmediately reporting all alleged violations involving neglect, abuse."  No further information was provided prior to exit.  Complaint deficiency Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4)  §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility	ROMDER OR SUPPLIER  16A SKILLED NURSING AND REHAB (RICHMOND)  SUMMARY STATEMENT OF DEFICIENCES (EACH DEPICE) PROVIDED STATEMENT OF DEPICE PROVIDED STATEMENT OF DEP	

		AND HUMAN SERVICES & MEDICAID SERVICES				RM APPROVED
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _	CONSTRUCTION	(X3) DAT	IO. 0938-0391 TE SURVEY MPLETED C
		495045	B. WNG		0:	5/23/2022
NAME OF P	ROVIDER OR SUPPLIER		ST	REET ADDRESS, CITY, STATE, ZIP CODE		
PROMEDI	CA SKILLED NURSIN	G AND REHAB (RICHMOND)		25 HILLIARD ROAD ICHMOND, VA 23228		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
	violations are thoro §483.12(c)(3) Previneglect, exploitation investigation is in p §483.12(c)(4) Repo investigations to the designated represe accordance with St. Survey Agency, wit incident, and if the a appropriate correcti This REQUIREMEN by: Based on staff intereview, clinical reco a complaint investig the facility staff faile of abuse for one of sample, Resident #1 failed to investigate (temporary nursing care for the resident The findings include On the most recent quarterly assessment reference date) of 2 having no cognitive decisions, having so BIMS (brief interview was coded as requir of two staff members transfers.	e evidence that all alleged ughly investigated.  ent further potential abuse, in, or mistreatment while the rogress.  of the results of all e administrator or his or her intative and to other officials in ate law, including to the State hin 5 working days of the alleged violation is verified we action must be taken.  In is not met as evidenced review, facility document red review, and in the course of lation, it was determined that d to investigate an allegation 52 residents in the survey 802 (R802). The facility staff R802's allegation that a TNA assistant) was rough during tin April 2022.	F 610	Alleged Violation  1. R802 no longer resides facility.  2. Utilizing the "Investigat QAPI tool – the director of nursing/designee will compreview of injuries of unknown from 5.23.2022 to current to validate compliance of an investigation being completed.  3. The Regional Director of Operations will educate the Director of Nursing and Nur Home Administrator on the on F-tag 607" and the "pating protection guideline" on or the date of compliance.  4. Utilizing the "Investigat QAPI tool – the Nursing hor administrator/designee will incidents of injuries of unknown weekly times four we validate compliance with completing investigations. will be reviewed with the Quantities.	in the tions"  plete a wn origin to  ted. of e rsing e "Focus ient before tion" me I audit nown eeks to Results	6/30/2022

PRINTED: 06/02/2022

	OF DEFICIENCIES F CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
			495045	B. WING _				A AMERICA	C /23/2022
	ROVIDER OR SUPPLIER		AND REHAB (RICHMOND)		2	STREET ADDRESS, CITY, STATE, ZIP CODE 2125 HILLIARD ROAD RICHMOND, VA 23228			
(X4) ID PREFIX TAG	(EACH DEFICI	ENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE		(X5) COMPLETION DATE
	following progress p.m. The note was practical nurse) # for subcapital fract (medical doctor) of made aware and plocal hospital] ER evaluation and tree. Further review of no other document circumstances surfaced and progressive for April to R802.  On 5/18/22 at 4:45 staff member) #2 staff member) #3 stated when the restated she spoke were stated thought the and R802 stated the intentionally hurt the resident was sent the fracture was diddn't have time to usually do." ASM #4 associated the fracture who handled the resident when asked who handled the resident was sent the fracture was didn't have time to usually do." ASM #4 associated the fracture was didn't have time to usually do." ASM #4 associated the cause of event. When asked who handled the resident was sent the fracture was didn't have time to usually do." ASM #4 associated the cause of event. When asked who handled the resident manufaced in the resident was sent the fracture was didn't have time to usually do." ASM #4 associated the cause of event. When asked who handled the resident manufaced in the resident was sent the fracture was didn't have time to usually do." ASM #4 associated the cause of event. When asked who handled the resident manufaced in the fracture was didn't have time to usually do." ASM #4 associated the cause of event. When asked who handled the resident manufaced in the fracture was didn't have time to usually do." ASM #4 associated the fracture was didn't have time to usually do." ASM #4 associated the fracture was didn't have time to usually do." ASM #4 associated the fracture was didn't have time to usually do." ASM #4 associated the fracture was didn't have time to usually do." ASM #4 associated the fracture was didn't have time to usually do." ASM #4 associated the fracture was didn't have time to usually do." ASM #4 associated the fracture was didn't have time to usually do." ASM #4 associated the fracture was didn't have time to usually do." ASM #4 associated	no s wrr. 7. "Frure in cate (em at the cate of the cat	te, dated 4/10/22 at 11:16 itten by LPN (licensed Patient's X-ray was positive of the right hip. MD all was [name of MD] was ent was sent to [name of lergency room) for ent."	Fé	510				

STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO			(X3) DATE SURVEY COMPLETED	
		495045	B. WING		1	C 05/23/2022	
	PROVIDER OR SUPPLIER	G AND REHAB (RICHMOND)	2125	EET ADDRESS, CITY, STATE, ZIP HILLIARD ROAD HMOND, VA 23228			
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 610	residents for whom she did not. When suspended pending stated the TNA was never worked in the On 5/19/22 at 11:5 assistant) #10 was learned about the Froughly "the day aff could not remembe She stated the off complained to her twrong in the bed ar stated she believed days between when when R802 reported On 5/19/22 at 1:05 She stated she rem stated on 4/8/22, she because R802 reported legs were swollen, ultrasound of both I When asked if she regarding a possible swelling, she stated that on 4/10/22 during a possible swelling, she stated that on 4/10/22 during the complete stated that on 4/10/22 during the complete stated that on 4/10/22 during the complete stated that on 4/10/23 during the complete stated that on 4/10/24 during the complete stated that on 4/10/25 during the complete stated that a TNA that is the complete stated that a TNA t	asked if the TNA was g any kind of investigation, she is from an agency and actually e facility again.  5 a.m., CNA (certified nursing interviewed. She stated she R802's report of being treated ter it happened," but said she er exactly what day this was. going CNA told her the resident that a TNA had rolled her and had hurt her leg. CNA #10 dit was approximately two and the injury happened and ad it to anyone.  p.m., LPN #7 was interviewed. The physician ordered an allegs and an X-ray of the hip. The p	F 610				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	- 1 3 A	TIPLE CONSTRUCTION NG		E SURVEY PLETED
						С
		495045	B. WING		05	/23/2022
	ROVIDER OR SUPPLIER	AND REHAB (RICHMOND)		STREET ADDRESS, CITY, STATE, ZIP CODE 2125 HILLIARD ROAD RICHMOND, VA 23228		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG		D BE	(X5) COMPLETION DATE
F 610	(director of nursing), any other member of with her about R802 one followed up with reported this to ASM had reported this ear investigation had alrostated she could not her an investigation if R802's report of a roughly was an alleg "Yes. That's why I rewanted "things to be On 5/23/22 at 12:44 interviewed. When a followed their policy abuse, she stated: "intentional. We have allegations."  On 5/23/22 at 12:57 administrator, was in he is aware of an allegations."  On 5/23/22 at 12:57 administrator, was in he is aware of an allegations. He state thoroughly investigation should resident interviews. If RI to the state ager allegation of abuse with policy, he stated.	member) #2, the DON When asked if ASM #2 or if the facility staff followed up is allegation, LPN #7 said no in her. She stated when she if #2, she was told the resident rlier in the week and an eady been done. LPN #7 remember exactly who told had been done. When asked staff member treating her gation of abuse, she stated: reported it." She stated she retaken care of."  p.m., ASM #2 was sked why the facility never to investigate an allegation of it certainly was not rinvestigated plenty of other  p.m., ASM #1, the reterviewed. He stated that if regation of abuse, he submits ports the allegation to the R (resident representative), gencies required by the red the allegation is red. He stated a thorough include staff interviews and he stated he submits a final rey. When asked why R802's was never investigated per he could not answer that.	F	510		

	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO		(X3) DATE SURVEY COMPLETED		
		495045	B. WING		0.5	C 5/23/2022
	ROVIDER OR SUPPLIER	G AND REHAB (RICHMOND)	2125	EET ADDRESS, CITY, STATE, ZIP O HILLIARD ROAD HMOND, VA 23228		72072022
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 610	A review of the faci Abuse, Neglect, Mi Misappropriation Programmer of the administrator investigating, report investigation process abuse regardless of concernas necess to prevent further president right while investigatedimme violations involving must have evidence thoroughly investigated abuse allegations is facilitates the reported, the center and objective investigabuse. Part of this in consideration of the abuseUtilizing the center focuses on dwhere, why and how determine the root of action and responsi	lity policy, "Patient Protection: streatment, and revention," revealed, in part: is responsible for the ting, and coordinating of the ss of any alleged or suspected of the source of the sary, taking immediate action otential violation of any the alleged violation is being diately reporting all alleged neglect, abusethe facility of that all alleged violations are atedkey to investigating an environment that ting of such allegations. Once or conducts a timely, thorough, tigation of any allegations of investigation is the indicators are possible investigation process, the etermining who, what, when, we for any occurrence to cause and appropriate course	F 610			
F 622 SS=E	remain in the facility	arge Requirements )(i)(ii)(2)(i)-(iii) and discharge-	F 622			

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING	(X3) DATE SURVEY COMPLETED	
		495045	B. WING		C
PROMEDICA SKILLED NURSING AND REHAB (RICHMOND)  (X4) ID PREFIX  (EACH DEFICIENCY MUST BE PRECEDED BY FULL			2	TREET ADDRESS, CITY, STATE, ZIP CODE  125 HILLIARD ROAD  RICHMOND, VA 23228  PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	BE COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
F 622	(A) The transfer or di resident's welfare and cannot be met in the (B) The transfer or di because the resident sufficiently so the resident of the resident dependent of the resident (D) The health of indicate of the resident has appropriate notice, to under Medicare or Safeth the application or the facility may not resident while the application of the facility may not resident while the application or the facility may not resident while the application or the facility may not resident while the application of the facility medical facility. The facility medical facility medical facility. The facility medical facility medical facility medical facility medical facility medical facility. The facility medical facility medic	scharge is necessary for the d the resident's needs facility; scharge is appropriate shealth has improved ident no longer needs the the facility; viduals in the facility is ne clinical or behavioral; viduals in the facility would ered; failed, after reasonable and pay for (or to have paid edicaid) a stay at the facility. If the resident does not paperwork for third party hird party, including l, denies the claim and the py for his or her stay. For a seligible for Medicaid after, the facility may charge a se charges under Medicaid; so to operate. So transfer or discharge the open is pending, pursuant to oper, when a resident ght to appeal a transfer or the facility pursuant to § chapter, unless the failure to would endanger the health not or other individuals in the just document the danger or discharge would pose.	F 622	Requirements  1. R124, R106, R33, and R75 returned to the facility.  2. The director of nursing/designee will complete comprehensive review from 5.23.2022 to current for any residents sent to acute care to validate appropriate discharge a transfer paperwork was sent at time of discharge.  3. The director of nursing/designee will educate the licensed nursing staff on "Focus F-tag 622" on or before the date compliance.  4. The director of nursing/designee will audit resident per week times four weeks to validate appropriate discharge a transfer paperwork was sent at time of discharge. Results will be reviewed with the QA&A committee.	ne on of lent :s

	OF DEFICIENCIES F CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED		
			495045		B. WING			05	C / <b>23/2022</b>
	ROVIDER OR SUPPLIER	IG A	AND REHAB (RICHMOND)		21	TREET ADDRESS, CITY, STATE, ZIP CODE 125 HILLIARD ROAD RICHMOND, VA 23228			
(X4) ID PREFIX TAG	(EACH DEFICI	NC'	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 API DEFICIENCY)	HOULD BE		(X5) COMPLETION DATE
	in paragraphs (c)( section, the facility or discharge is do medical record and communicated to to institution or provide (i) Documentation must include: (A) The basis for the (ii) of this section. (B) In the case of paragraphs section, the specific be met, facility atterneeds, and the ser facility to meet the (ii) The documentation (2)(i) of this section (A) The resident's discharge is neces (A) or (B) of this section (A) The resident's discharge is neces (B) A physician who necessary under particulate a min (A) Contact information (C) Advance Direct (D) All special instrongoing care, as an (E) Comprehensive (F) All other neces copy of the residen consistent with §48	of of I)(i) mucum the cumple of the ler. In the transfer of the ler. In th	the circumstances specified (A) through (F) of this last ensure that the transfer mented in the resident's propriate information is receiving health care the resident's medical record transfer per paragraph (c)(1) (a) of this esident need(s) that cannot the total the receiving ed(s). In required by paragraph (c) (a) the made bysician when transfer or younder paragraph (c) (d) on; and transfer or discharge is graph (c)(1)(i)(C) or (D) of ed to the receiving end (b) the following: In of the following: In of the practitioner the of the resident. It is the metal to the receiving provider the of the resident. It is the metal to the receiving end of the practitioner the of the resident. It is the metal the metal that it is the metal that the metal that it is the metal that		F 622				

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
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		495045	B. WING			05/23/2022	
		AND REHAB (RICHMOND)	2125	EET ADDRESS, CITY, STATE, ZIP CO HILLIARD ROAD HMOND, VA 23228	ODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 622	a safe and effective to This REQUIREMENT by: Based on staff interview, and clinical redetermined the facility provision of required receiving facility at the of 52 residents in the #124, #106, #33, and The findings include:  1. For Resident #124 evidence the provision the practitioner responses the practitioner responses and conto the receiving facility discharged to the host and 5/5/22 due to me  On the most recent M quarterly assessment reference date) of 5/1 being severely cognitive decisions, having scool BIMS (brief interview)  A review of R124's cliff following progress not -3/27/22 at 2:03 p.m. responsive to sternal blood pressure). New (emergency room)."	transition of care. T is not met as evidenced  view, facility document ecord review, it was by staff failed to evidence resident information to a le time of discharge for four esurvey sample, Residents of #75.  (R124), the facility failed to le of contact information of le survey sample, residents of the resentative information, commation, instructions for mprehensive care plan goals by when R124 was repital on 3/27/22, 4/19/22, dical emergencies.  IDS (minimum data set), a le with an ARD (assessment le 3/22, R124 was coded as lively intact for making daily lived zero out of 15 on the for mental status).  Inical record revealed the les:  "Resident is non rubs and hypotensive (low order to send out to ER  I.: "Resident found with MD (medical doctor)	F 622				

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED				
			495045		MNG		United States	C
	ROVIDER OR SUPPLIER	G A	ND REHAB (RICHMOND)	B. v	S 21	TREET ADDRESS, CITY, STATE, ZIP CODE 125 HILLIARD ROAD ICHMOND, VA 23228	1 05	/23/2022
(X4) ID PREFIX TAG	(EACH DEFICIE	NC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	F	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
	(director of nursing notified." - 5/5/22 at 12:43 p. open, non-respons Patient was not abl (sic) byNP (nurse sent to ER for evalute to [name of local here to the receiving host dates of discharge.  On 5/18/22 at 4:15 staff member) #2, the she could not locate paperwork sent to the discharges.  On 5/19/22 at 9:30 #1 was interviewed sends the complete the transfer checklis labs or x-rays, the lewith a resident when the hospital. She stagoes with the resident keep a copy to evide the hospital.  On 5/19/22 at 5:11 padministrator and Aconcerns.  A review of the facility revealed only a receiver.	m m m m m m m m	"Patient is lethargic, eyes, unable to follow command. o eat meal. Was assess actitioner) and advised to ion. Pick up by 911 and sent ital]."  4's clinical record revealed equired paperwork the resident was ever sent al for any of the above  1., ASM (administrative director of nursing, stated my additional evidence of hospital for R124's  1., RN (registered nurse) he stated the nursing staff acute care transfer form, a facesheet, any pertinent per and the medication list me resident is discharged to determine the facility does not be what has been sent to		F 622			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO		(X3) DATE S COMPL	ETED
		495045	B. WING		05/2	3/2022
	PROVIDER OR SUPPLIER	AND REHAB (RICHMOND)	2125	EET ADDRESS, CITY, STATE, ZIP C HILLIARD ROAD HMOND, VA 23228		
(X4) ID PREFIX TAG	(EACH DEFICIENCE	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 622	or procedures for the No further information  2. For Resident #106 evidence the provision the practitioner responses the practitioner responses the practitioner responses to the receiving facility on the practitioner responses to the receiving facility discharged to the homedical emergency.  On the most recent Magnaterily assessment reference date) of 4/8 having no cognitive in decisions, having so BIMS (brief interview A review of R106's pure following note dated "Abdominal x-ray review Abdomen is distended hypoactive. No bowe morning Notified do (emergency room)."  Further review of R10 certain the necessary to care for to the receiving hospital the process of the	e facility to follow.  In was provided prior to exit.  In (R106), the facility failed to on of contact information of onsible for care of the presentative information, formation, instructions for imprehensive care plan goals by when R106 was spital on 3/25/22 due to a  In (MDS) (minimum data set), a think with an ARD (assessment as 3/22, R106 was coded as impairment for making daily pred 15 out of 15 on the for mental status).  In (MDS) (minimum data set), a think with an ARD (assessment as 3/22, R106 was coded as impairment for making daily pred 15 out of 15 on the for mental status).  In (MDS) (minimum data set), a think with an ARD (assessment as 3/25/22 due to a set of the side	F 622			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO		сом	(X3) DATE SURVEY COMPLETED	
		495045	B. WING			C 5/23/2022	
	PROVIDER OR SUPPLIER	G AND REHAB (RICHMOND)	2125	ET ADDRESS, CITY, STATE, ZIP ( HILLIARD ROAD HMOND, VA 23228			
(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 (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 622	discharge.  On 5/19/22 at 9:30 #1 was interviewed sends the complete the transfer checklis labs or x-rays, the hwith a resident when the hospital. She stagoes with the reside keep a copy to evid the hospital.  On 5/19/22 at 5:11 administrator and Acconcerns.  No further information.  No further information at the time of discharance at the time of discharance at the sident #33 was at 12/16/22.  Resident #33 was at 12/16/22.  Resident #33 was at 12/16/22.  Resident #33 was at 12/16/22.  The most recent MD assessment, a quart ARD (assessment a quart ARD (assessment a quart ARD (assessment a quart and a the BIMS (brief interindicating the resident impaired. A review of the sends with the sends and the BIMS (brief interindicating the resident impaired. A review of the sends and the sends and the sends at the BIMS (brief interindicating the resident impaired. A review of the sends and the sends at the sends	a.m., RN (registered nurse) She stated the nursing staff of acute care transfer form, st, a facesheet, any pertinent tape, and the medication list in the resident is discharged to ated the transfer checklist ent and the facility does not ence what has been sent to on. ASM #1, the SM #2 were informed of these on was provided prior to exit.  Tailed to evidence provision of formation to a receiving facility arge for Resident #33.  Tansferred to the hospital on the heart failure, diabetes, er and obstructive sleep  S (minimum data set) erly assessment, with an eference date) of 3/8/22, is scoring a 11 out of 15 on view for mental status) score, int was moderately cognitively	F 622				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ER/CLIA (X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
	495045	B. WING		C 05/23/2022	
NAME OF PROVIDER OR SUPPLIER PROMEDICA SKILLED NURSING AND REHAB (RICHMOND)		2125	EET ADDRESS, CITY, STATE, ZIP CODE HILLIARD ROAD HMOND, VA 23228	03/23/2022	
PREFIX (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 BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	En 4 700 ET	
transfer, dressing, hysupervision for locom O-special procedures resident as oxygen "y assessment, unable to coded as yes under so A review of the compre 2/26/22, which reveals has altered cardiovas hypertension and pact INTERVENTIONS: Mand symptoms of CAL especially with activity vomiting, shortness of sweating, dependent or refill, color/warmth of the color of the nursing 2/16/22 at 11:22 AM, in "Resident went out to diagnosis of Hypoxia at RP is aware and NP of went to hospital."  A review of the nursing 2/16/22 at 5:41 PM, re "Writer called hospital is being admitted for Color of the color of the nursing 2/16/22 at 3:41 PM, re "Writer called hospital is being admitted for Color of the color of	ssistance for bed mobility, giene and bathing; otion and eating. Section //treatments coded the es". No annual o see that smoking was ection J.  Tehensive care plan dated ed, "FOCUS: The resident cular status related to emaker. It is in the company of the compa	F 622			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO		(X3) DATE SURVEY COMPLETED	
		495045	B. WING		0:	C 5/23/2022
	ROVIDER OR SUPPLIER	AND REHAB (RICHMOND)	2125	EET ADDRESS, CITY, STATE, ZIP ( HILLIARD ROAD HMOND, VA 23228		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 622	dated or provided for The facility's "Acute Checklist" reveals the Documents Sent with that apply): Documents Sent with that apply): Documents form, face is SBAR (situation, but recommendation), a care orders, bed hold documents if available most recent history of discharge summary, practitioner orders, for results, relevant x-rational form of the factor of the fa	ge 43  r 2/16/22 hospital transfer." Care Transfer Document the following, "Copies of th Resident/Patient (check all tents recommended to //patient: resident/patient heet, current medication list, ckground, assessment, dvance directives, advance d policy. Send these ble: notification of transfer, and physical, recent hospital recent physician/nurse low sheets, relevant lab by results, current care plan."  Inducted on 5/17/22 at PM with Resident #33. When in transferred to the hospital, "Yes, a couple of months spital because I was having  Inducted on 5/19/22 at 7:15 and practical nurse) #1. When re sent with the resident to stated, "I send the clinical on list, orders, care plan. documented anywhere in IPN #1 stated, "There is a rmation in, but I do not allope. I think we are to copy  M, ASM #2, the director of at no further evidence of in was obtainable for the	F 622			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED
		495045	B. WING _		C 05/23/2022
	ROVIDER OR SUPPLIER	GAND REHAB (RICHMOND)		STREET ADDRESS, CITY, STATE, ZIP CODE 2125 HILLIARD ROAD RICHMOND, VA 23228	00/20/2022
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE COMPLETION
	On 5/19/22 at appro (administrative staff administrator, ASM OSM #2, the director made aware of the factor of the Institution or Institution	eximately 5:30 PM, ASM member) #1, the #2, the director of nursing and or of human resources were findings.  illity's policy "Discharge: Non-Emergency Acute , which reveals, "To provide center to other institution or Complete required transfer ble equipment (discharge and wheelchair or stretcher), summary paperwork and ecord."  on was provided prior to exit.  alled to evidence provision of formation to a receiving facility rge for Resident #75. ansferred to the hospital on  dmitted to the facility on s that included but were not bipolar, osteomyelitis and staph aureus.  S (minimum data set) erly assessment, with an eference date) of 3/12/22, s scoring a 11 out of 15 on view for mental status) score, int was moderately cognitively f the MDS Section oded the resident as assistance for bed mobility,	F 6.	22	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO	(X3) DATE SURVEY COMPLETED	
		495045	B. WING		C
NAME OF PROVIDER OR SUPPLIER PROMEDICA SKILLED NURSING AND REHAB (RICHMOND)			STRE 2125	EET ADDRESS, CITY, STATE, ZIP CODE HILLIARD ROAD HMOND, VA 23228	05/23/2022
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL PR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
F 622	supervision for loco A review of the con 5/5/22, which revea wound/skin. INTE medication per phy ordered and notify  A review of the nurs 5/9/22 at 2:54 PM, "Received x-ray res Moderate-sized ret moderate subcutan the calcaneous. Ca osteomyelitis. Cons evaluation."  A review of the nurs 5/9/22 at 3:12 PM, called and states to hospital. Patient ma  On 5/19/22 during t request was made Resident #75's clini the receiving facility  On 5/19/22 at appror revealed, "Resident transfer packet she "Acute Care Transfer reveals the following with Resident/Patie Documents recomm resident/patient: re face sheet, current (situation, backgrour recommendation), a	promotion and eating.  Imprehensive care plan dated aled, "FOCUS: Infection of ERVENTIONS: Administer resician orders. Obtain Labs as physician of results."  Ising progress note dated reveals the following, sults and shows: rocalcaneal skin wound with neous emphysema surrounding annot exclude gas gangrene or sider CT or MRI for further  Ising progress note dated reveals the following, "NP or send patient out to the ade aware of transport."  Ithe closed record review a to provide evidence of ical documentation provided to y on 5/9/22.  Indicate the following is a note to the form of the following is a note to provide evidence of ical documentation provided to y on 5/9/22. The facility's er Document Checklist" g, "Copies of Documents Sent int (check all that apply): needed to accompany sident/patient transfer form, medication list, SBAR	F 622		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		495045	B. WING			C 5/23/2022	
	ROVIDER OR SUPPLIER	G AND REHAB (RICHMOND)		STREET ADDRESS, CITY, STATE, ZIP C 2125 HILLIARD ROAD RICHMOND, VA 23228		012312022	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 622	most recent history discharge summar practitioner orders, results, relevant x-results,	able: notification of transfer, and physical, recent hospital y, recent physician/nurse flow sheets, relevant lab ray results, current care plan."  onducted on 5/19/22 at 7:15 ised practical nurse) #1. When are sent with the resident to et stated, "I send the clinical ation list, orders, care plan." is documented anywhere in LPN #1 stated, There is a formation in, but I do not evelope. I think we are to copy  PM, ASM #2, the director of that no further evidence of ion was obtainable for the  eximately 5:30 PM, ASM f member) #1, the #2, the director of nursing and for of human resources were findings.  cility's policy "Discharge: Non-Emergency Acute of the equipment (discharge and wheelchair or stretcher), summary paperwork and	F	522			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED	
		495045	B. WING		С	
	PROVIDER OR SUPPLIER	IG AND REHAB (RICHMOND)	ST/ 21:	REET ADDRESS, CITY, STATE, ZIP CODE 25 HILLIARD ROAD CHMOND, VA 23228	05/23/2022	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION	
F 623 SS=E	S483.15(c)(3) Noting Before a facility transcriber, the facility (i) Notify the resident representative(s) of the reasons for the language and man facility must send a representative of the Long-Term Care (ii) Record the reasons for the language and man facility must send a representative of the Long-Term Care (iii) Record the reasons for the reasons for the language and man (iii) Include in the reaccordance with paragraph (c)(5) of \$483.15(c)(4) Timing (i) Except as specific (c)(8) of this section discharge required made by the facility resident is transferr (ii) Notice must be before transfer or (iii) Notice must be before transfer or (iiii) Notice must be before transfer or (iv) Notice must be before transfe	ce before transfer. Insfers or discharges a y must- ent and the resident's of the transfer or discharge and move in writing and in a mer they understand. The a copy of the notice to a ne Office of the State mbudsman. Sons for the transfer or sident's medical record in aragraph (c)(2) of this section; otice the items described in this section.  In g of the notice. The died in paragraphs (c)(4)(ii) and in, the notice of transfer or under this section must be a tal least 30 days before the red or discharged. In and the section as practicable	F 623	Transfer/Discharge  1. R124, R106, R33, R75 and returned to the facility.  2. Utilizing the "Unexpected hospital readmission" QAPI to the director of nursing/design will complete a comprehensive review from 5.23.2022 to currifor any residents sent to acute to validate notice requirement prior to discharge were documented in the clinical chamber of nursing/designee will educate licensed nursing staff on "Focus F-tag 623" and the "Care transitions" procedure on or be the date of compliance.  4. Utilizing the "Unexpected hospital readmission" QAPI took the director of nursing/designee will audit five residents per westimes four weeks to validate documented discharge requirements are in the clinical chart. Results of the audits will reviewed with the QA&A committee.	R 68  ol – ee e ent e care ts  ort.  the is on efore	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO			SURVEY
		495045	B. WING		230555	C /23/2022
	ROVIDER OR SUPPLIER	G AND REHAB (RICHMOND)	2125	ET ADDRESS, CITY, STATE, ZIP CODE HILLIARD ROAD HMOND, VA 23228		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 623	(E) A resident has days.  §483.15(c)(5) Controlice specified in must include the form of the control of the con	ents of the notice. The written paragraph (c)(3) of this section illowing: transfer or discharge; te of transfer or discharge; which the resident is paraged; the resident's appeal rights, address (mailing and email), ber of the entity which ests; and information on how form and assistance in and submitting the appeal ess (mailing and email) and of the Office of the State in the Milling and email address and of the agency responsible for advocacy of individuals with bilities established under Part ental Disabilities Assistance est of 2000 (Pub. L. 106-402, c. 15001 et seq.); and illity residents with a mental disabilities, the mailing and elephone number of the for the protection and uals with a mental disorder ne Protection and Advocacy duals Act.	F 623			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO			TE SURVEY MPLETED
		495045	B. WING		0	C 5/23/2022
	ROVIDER OR SUPPLIER	AND REHAB (RICHMOND)	2125	EET ADDRESS, CITY, STATE, ZIP O HILLIARD ROAD HMOND, VA 23228		0.20.2022
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 623	If the information in the effecting the transfer must update the recias practicable once in becomes available.  §483.15(c)(8) Notice In the case of facility the administrator of the written notification provided to the State Survey Astate Long-Term Cathe facility, and the reveal as the plan for the relocation of the residual as the plan for the relocation of the residual as the plan for the relocation of the residual as the plan for the relocation of the residual as the plan for the relocation of the residual as the plan for the relocation of the residual as the plan for the relocation of the residual as the plan for the relocation of the residual as the plan for the relocation of the residual as the plan for the relocation of the residual as the plan for the relocation of the residual as the plan for the relocation of the survey and clinical relocation of the residual reloca	the notice changes prior to or discharge, the facility spients of the notice as soon the updated information  In advance of facility closure closure, the individual who is the facility must provide from to the impending closure agency, the Office of the facility must provide from the impending closure agency, the Office of the facility and adequate dents, as required at §  In is not met as evidenced from the facility document facility document facility staff failed to provide facility staff failed facility staff failed to provide facility staff failed to provide facility staff failed facility staff	F 623			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO			E SURVEY PLETED
		495045	B. WING		121	С
	ROVIDER OR SUPPLIER	G AND REHAB (RICHMOND)	STRE 2125	EET ADDRESS, CITY, STATE, ZIP CODE HILLIARD ROAD HMOND, VA 23228		5/23/2022
(X4) ID PREFIX TAG	(EACH DEFICE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 623	decisions, having s BIMS (brief intervie A review of R124's following progress - 3/27/22 at 2:03 p. responsive to stern blood pressure). No (emergency room) 4/19/22 at 10:41 prectal hemorrhagin notified. Gave orde (director of nursing notified." - 5/5/22 at 12:43 p. open, non-respons Patient was not abl (sic) byNP (nurse send to ER for eval sent to [name of loc Further review of R no evidence that the notified in writing of above dates.  On 5/18/22 at 12:52 member) #4, social She stated she doe when a resident is of stated she only noti resident is discharg resident's home. She trained by a previous the nursing staff cal She stated the writte have to be done by the social worker have	cored zero out of 15 on the ew for mental status).  clinical record revealed the notes: m.: "Resident is non all rubs and hypotensive (low ew order to send out to ER"  c.m.: "Resident found with g, MD (medical doctor) rs to send to ER. DON ) and RP (responsible party)  m.: "Patient is lethargic, eyes eye, unable to follow command. e to eat meal. Was assess practitioner) and advised to uation. Pick up by 911 and	F 623			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO			ATE SURVEY MPLETED
		495045	B. WING		١,	C 05/23/2022
	ROVIDER OR SUPPLIER	G AND REHAB (RICHMOND)	2125	ET ADDRESS, CITY, STATE, ZIP O HILLIARD ROAD HMOND, VA 23228		3312312022
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL PR LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
	staff member) #2, t she could not locate written notification in R124's discharges.  On 5/19/22 at 9:30 #1 was interviewed calls the resident resend a written notification in S/19/22 at 5:11 administrator and A concerns.  A review of the facil revealed only a recalled only a recalled only a recalled in S/19/20 at 5:11 administrator and A concerns.  A review of the facil revealed only a recalled in S/19/20 at 5:11 administrator and A concerns.  A review of the facil revealed only a recalled in S/19/20 at 5:11 administrator and A concerns.  A review of the facil revealed only a recalled in S/19/20 at 5:11 administrator and A concerns.  On the most recent #10 provide written notic ombudsman for Resident was discharmedical emergency.  On the most recent quarterly assessment reference date) of 4/19/20 at 5:11 administrator and A concerns.	p.m., ASM (administrative he director of nursing, stated e any additional evidence of to the ombudsman or RR for a.m., RN (registered nurse). She stated the nursing staff expresentative, but does not ecation of transfer to anyone.  p.m., ASM #1, the SM #2 were informed of these ity policy, "Focus of F623," apitulation of the regulatory ument did not provide policies e facility to follow.  on was provided prior to exit.  6 (R106), the facility failed to be to the RR and the sident #106 (R124) when the reged on 3/25/22 due to a must with an ARD (assessment /8/22, R106 was coded as impairment for making daily cored 15 out of 15 on the	F 623			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO			ATE SURVEY DMPLETED
		495045	B. WING			C 05/23/2022
	ROVIDER OR SUPPLIER	NG AND REHAB (RICHMOND)	2125	EET ADDRESS, CITY, STATE, ZIP HILLIARD ROAD HMOND, VA 23228		
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION DATE
F 623	following note date "Abdominal x-ray Abdomen is dister hypoactive. No bo morningNotified (emergency room)  Further review of no evidence that the were notified in wron 3/25/22.  On 5/18/22 at 12:5 member) #4, social She stated she dowhen a resident is stated she only no resident is dischart resident's home. So trained by a previous the nursing staff cashes stated the writh have to be done by the social worker in notification to the fidischarged to the could not locat written notification R106's discharge.  On 5/19/22 at 9:30 #1 was interviewed calls the resident residen	revealed colonic ileus. Inded and round, bowel sounds wel movement this doctoradvised to send to ER o."  R106's clinical record revealed the RR and the ombudsman iting of any of the discharges  R2 p.m., OSM (other staff all services, was interviewed. The services, was interviewed. The stated the stated this is how she was the social worker. She stated alls the resident representative. The notification to the RR would by the nursing staff. She stated the are never provided written the director of nursing, stated the any additional evidence of to the ombudsman or RR for a.m., RN (registered nurse) the stated the nursing staff epresentative, but does not fication of transfer to anyone.	F 623			

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO		(X3) DATE SURVEY COMPLETED
			 		С
		495045	B. WNG		05/23/2022
NAME OF P	ROVIDER OR SUPPLIER		STRE	EET ADDRESS, CITY, STATE, ZIP C	CODE
PROMEDI	CA SKILLED NURSING	AND REHAB (RICHMOND)	- COUNTY TO SEE	HILLIARD ROAD	
			RICI	HMOND, VA 23228	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	ION SHOULD BE COMPLETION DATE
F 623	Continued From pag	e 53	F 623		
	,,,,		1 023		
	concerns.	SM #2 were informed of these			
	GONGONIO.				
	No further informatio	n was provided prior to exit.			
	3. The facility staff fa	iled to evidence written			
	notification to the om				
	(responsible party) for	or a discharge of a resident to			
		Resident #33. Resident			
	#33 was transferred	to the hospital on 2/16/22.			
		lmitted to the facility on			
		is that included but were not heart failure, diabetes,			
	7	r and obstructive sleep			
	apnea.	and obstructive sleep			
	apriou.				
	The most recent MDS	S (minimum data set)			
	[ [ ] [ [ [ [ [ [ [ [ [ [ [ [ [ [ [ [ [	erly assessment, with an			
	ARD (assessment re-	ference date) of 3/8/22,			
		s scoring a 11 out of 15 on			
		riew for mental status) score,			
		it was moderately cognitively			
	impaired.				
	A review of the purcir	ng progress note dated			
		revealed the following,			
	"Resident went out to				
		and altered mental status.			
		ordered transfer. Resident			
	went to hospital."				
	An interview was con	ducted on 5/18/22 at 2:15			
	and the state of the	staff member) #3, the			
		or. When asked who			
	provides written notifi				
		ents being transferred to the			
		ted, "We do not have the			
	ombudsman notificati	on for this resident in			

OLIVILI	TO I OIT MEDIONITE	A MEDIONID CENTICES				
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING			E SURVEY PLETED
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		495045	B. WNG		O.F	3/23/2022
	PROVIDER OR SUPPLIER	G AND REHAB (RICHMOND)	2125	ET ADDRESS, CITY, STATE, ZIP C HILLIARD ROAD HMOND, VA 23228		
(X4) ID PREFIX TAG	(EACH DEFICE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 623	February or March notification to the on Nursing notifies the a few weeks ago."  An interview was come ask who notifies the hospital transfer, Lind RP, I do not know when asked who notifies the hospital transfer, Lind RP, I do not know when asked who not stated. I do not who will be the stated and the following to the factorial transfer or display transfer or dis	in There should be a written or imbudsman and the RP. at RP by phone. I started here should be a practical nurse) #1. When the RP or ombudsman upon PN #1 stated, "I would call the who notifies the ombudsman. Into the RP in writing, LPN into the RP in writing, LPN into the RP in writing."  In writing and or of human resources were findings.  In the scharge policy with no date, ing, "Before a facility transfers ident, the facility must notify a resident's representative (s) is scharge and the reasons for and in a language and stand. Timing of notice: de as soon as practicable is charge when the resident's efficiently to allow a more	F 623			

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & ME	EDICAID SERVICES			OMB NO. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CON A. BUILDING B. WING	ISTRUCTION	(X3) DATE SURVEY COMPLETED C
	495045			05/23/2022
NAME OF PROVIDER OR SUPPLIER  PROMEDICA SKILLED NURSING AN	D REHAB (RICHMOND)	2125 1	ET ADDRESS, CITY, STATE, ZIP CODE HILLIARD ROAD MOND, VA 23228	
PREFIX (EACH DEFICIENCY N	EMENT OF DEFICIENCIES IUST BE PRECEDED BY FULL CIDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION) CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE COMPLETION
limited to: diabetes, bip methicillin resistant stap methicillin resistant stap.  The most recent MDS (it assessment, a quarterly ARD (assessment referenceded the resident as set the BIMS (brief interview indicating the resident wimpaired.  A review of the nursing processed to the subcutaneous that calcaneous are subcutaneous the calcaneous. Cannot osteomyelitis. Consider evaluation."  A review of the nursing processed for the subcutaneous that calcaneous are subcutaneous that calcaneous that calcaneous are subcutaneous that calcaneous are subcutaneous that calcaneous are subcutaneous that calcaneous that calcaneous are subcutaneous that calcaneous are subcutaneous that calcaneous that calca	at included but were not olar, osteomyelitis and oth aureus.  minimum data set) assessment, with an ence date) of 3/12/22, coring a 11 out of 15 on of for mental status) score, as moderately cognitively progress note dated als the following, and shows: caneal skin wound with a emphysema surrounding exclude gas gangrene or CT or MRI for further  orogress note dated als the following, "NP department out to the envare of transport."  cted on 5/19/22 at 7:15 oractical nurse) #1. When or ombudsman upon 1 stated, "I would call the notifies the ombudsman." is the RP in writing, LPN y anyone in writing."	F 623		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO			3) DATE SURVEY COMPLETED	
		495045	B. WING			C <b>05/23/2022</b>	
	PROVIDER OR SUPPLIER		2125	EET ADDRESS, CITY, STATE, ZIP COD 5 HILLIARD ROAD HMOND, VA 23228		701201212	
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 623	provides written no ombudsman for rehospital, OSM #3 sombudsman notific because still in Manotification to the control of the decause still in Manotification to the control of the decause still in Manotification to the control of the decause still in Manotification to the control of the decause still in Manotification to the control of the decause of the Maccording to the fabefore Transfer/Disreveals the following or discharges a rest the resident and the fabefore transfer or discharges a rest the move in writing manner they under Notice must be mabefore transfer or control of the move in writing manner they under Notice must be mabefore transfer or control of the most recent states of the most recent assessment, a quality assessment references ident scored 11	otification to the RP and esidents being transferred to the stated, "We do not have the ication for this resident yes, ay. There should be a written ombudsman and the RP. he RP by phone. I started here "  proximately 5:30 PM, ASM aff member) #1, the M #2, the director of nursing and ctor of human resources were e findings.  acility's "Notice Requirements ischarge" policy with no date, ing, "Before a facility transfers ischent, the facility must notify he resident's representative (s) discharge and the reasons for g and in a language and erstand. Timing of notice: ade as soon as practicable discharge when the resident's ufficiently to allow a more	F 623				

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 06/02/2022 FORM APPROVED OMB NO. 0938-0391

CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING C 495045 B. WING 05/23/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2125 HILLIARD ROAD PROMEDICA SKILLED NURSING AND REHAB (RICHMOND) RICHMOND, VA 23228 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) Continued From page 57 F 623 resident was moderately cognitively impaired for making daily decisions. The nurse's note dated, 2/25/2022 at 7:34 p.m. documented, "At [initials of hospital] ER (emergency room)." The nurse's note dated 2/28/2022 at 9:05 a.m. documented, "Resident went LOA (leave of absence) to wound clinic appt (appointment) on 2/25/2022 and did not return. Resident was sent to [initials of hospital] ER for evaluation. Admission Dx (diagnosis) osteomyelitis. RP (responsible party) aware, NP (nurse practitioner) aware." On 5/17/2022 a request was made for the notice to the ombudsman of R68's transfer to the hospital on 2/25/2022. An interview was conducted with OSM (other staff member) #4, social services on 5/18/2022 at 12:51 p.m. When asked if she is responsible for the notification to the ombudsman when a resident is sent to the hospital, OSM #4 stated the facility does not notify the ombudsman when they go to the hospital, only when the residents are discharged home. OSM #4 stated that is how she was trained by the social worker that used to work at the facility. ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, and OSM (other staff member) #2, the human resources director, were made aware of the above concern on 5/18/2022 at 4:57 p.m.

No further information was provided prior to exit.

NAME OF PROVIDER OR SUPPLIER  PROMEDICA SKILLED NURSING AND REHAB (RICHMOND)  (44) ID PRIEFIX TAG  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  F 625  Continued From page 58  F 625  SS=E  CFR(s): 483.15(d)(1) Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2)  \$483.15(d)(1) Notice before transfer. Before a nursing facility must provide written information to the resident or exident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (iii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility spolicies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section.  \$483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for		OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
NAME OF PROWIDER OR SUPPLIER  PROMEDICA SKILLED NURSING AND REHAB (RICHMOND)  (X4) ID PREFIX (EACH DEPICIENCY MUST BE PRECEDED BY FULL TAGK  F 625 (Continued From page 58 F 625 (CFK)s): 483.15(d)(1) Notice of Bed Hold Policy and returning facility ransfers a resident to a hospital or the resident or resident representative that specifies.  (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility;  (ii) The reserve bed payment policy in the state plan, under § 447,40 of this chapter, if any;  (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section.  §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for				_		С	
PROMEDICA SKILLED NURSING AND REHAB (RICHMOND)  SUMMARY STATEMENT OF DEFICIENCIES (EACH DETICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  F 625 F 625 Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1) Notice before transfer. Before a nursing facility must provide written information to the resident or persident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447(4) of this chapter, if any; (iii) The reserve bed payment policy in the state plan, under § 447(4) of this chapter, if any; (iii) The nursing facility solicies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section.  §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for			495045	B. WING		3000	
F625 F625 SS=E Continued From page 58 Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1) Notice of bed-hold policy and return- system of the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies (i) The duration of the state bed-hold policy, if any, during which the residence in the nursing facility: (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any, (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section.  §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for			AND REHAB (RICHMOND)	2	125 HILLIARD ROAD		
Notice of Bed Hold Policy Before/Upon Trnsfr  CFR(s): 483.15(d) (1) (2)  §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section.  §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI	BE COMPLETION	
facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section.  This REQUIREMENT is not met as evidenced by:  Based on staff interview, facility document review, and clinical record review, it was determined that the facility staff failed to provide written notice of the facility's bed hold policies at the time of discharge for five of 52 residents in the survey sample, Residents #124, #106, #33,	F 625 SS=E	Notice of Bed Hold Pc CFR(s): 483.15(d)(1) §483.15(d) Notice of §483.15(d)(1) Notice nursing facility transfet the resident goes on nursing facility must pthe resident or reside specifies- (i) The duration of the any, during which the return and resume resfacility; (ii) The reserve bed pplan, under § 447.40 (iii) The nursing facility bed-hold periods, which paragraph (e)(1) of this resident to return; and (iv) The information spot this section. §483.15(d)(2) Bed-hold the time of transfer of hospitalization or therafacility must provide to resident representative specifies the duration described in paragrap This REQUIREMENT by: Based on staff interview, and clinical recidetermined that the fawritten notice of the fathe time of discharge for the stage of the fathe time of discharge for the stage of the	policy Before/Upon Trnsfr (2)  bed-hold policy and return- before transfer. Before a ers a resident to a hospital or cherapeutic leave, the provide written information to ent representative that  state bed-hold policy, if resident is permitted to sidence in the nursing  ayment policy in the state of this chapter, if any; y's policies regarding ch must be consistent with as section, permitting a  becified in paragraph (e)(1)  d notice upon transfer. At a resident for apeutic leave, a nursing of the resident and the entire written notice which of the bed-hold policy h (d)(1) of this section. is not met as evidenced  ew, facility document cord review, it was cility staff failed to provide cility's bed hold policies at or five of 52 residents in	No. 10-CONTROLL	Before/Upon Transfer  1. R124, R106, R33, R75 and R returned to the facility.  2. Utilizing the "Unexpected hospital readmission" QAPI tool the director of nursing/designed will complete a comprehensive review from 5.23.2022 to currer for any residents sent to acute of to validate bed hold notification documented in the clinical charts. The director of nursing/designee will educate the licensed nursing staff on "Focus F-tag 625" and the "Care transitions" procedure on or befund the date of compliance.  4. Utilizing the "Unexpected hospital readmission" QAPI tool the director of nursing/designee will audit five residents per weel times four weeks to validate bedund notifications are document in the clinical chart. Results of the audits will be reviewed with the	nt care nis t. ne on fore	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _	CONSTRUCTION	(X3) DATE SURV COMPLETE	
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72	PROVIDER OR SUPPLIER	S AND REHAB (RICHMOND)	S' 2'	TREET ADDRESS, CITY, STATE, ZIP C 125 HILLIARD ROAD RICHMOND, VA 23228	<b>05/23/2</b> ODE	022
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	#75, and #68.  The findings included 1. The facility staff for the facility's bed in (R124) when the result medical emergencies 5/5/22.  On the most recent quarterly assessment reference date) of 50 being severely cognidecisions, having so BIMS (brief interview A review of R124's of following progress in -3/27/22 at 2:03 p.m responsive to sternate blood pressure). New (emergency room)." -4/19/22 at 10:41 p.m rectal hemorrhaging, notified. Gave orders (director of nursing) notified." -5/5/22 at 12:43 p.m open, non-responsive Patient was not able (sic) byNP (nurse proposed to ER for evaluation evidence that the series of the series of R12 no evidence that the	ailed to provide written notice nold policies to Resident #124 sident was discharged due to so on 3/27/22, 4/19/22, and MDS (minimum data set), a not with an ARD (assessment /13/22, R124 was coded as itively intact for making daily fored zero out of 15 on the variety for mental status).  Silinical record revealed the otes:  1.: "Resident is non I rubs and hypotensive (low variety order to send out to ER  MD (medical doctor)  1. to send to ER. DON  1. and RP (responsible party)  1. "Patient is lethargic, eyes e, unable to follow command. to eat meal. Was assess oractitioner) and advised to ation. Pick up by 911 and all hospital]."  24's clinical record revealed resident was provided with policies for of any of the	F 625			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO	INSTRUCTION	(X3) DATE SURVEY COMPLETED
		495045	B. WING		C 05/23/2022
900000000000000000000000000000000000000	ROVIDER OR SUPPLIER	G AND REHAB (RICHMOND)	2125	EET ADDRESS, CITY, STATE, ZIP HILLIARD ROAD HMOND, VA 23228	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES INCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE COMPLETION DATE
F 625	member) #3, the a interviewed. She s residents who are stated the resident bed hold.  On 5/18/22 at 4:15 staff member) #2, she could not locat bed hold notification.  On 5/19/22 at 9:30 #1 was interviewed notice is provided admissions office sthe resident is adm.  On 5/19/22 at 5:11 administrator and aconcerns.  A review of the facine revealed only a reclanguage. The doctor procedures for the A review of the facine revealed, in part: "Frequired by state or from admissions off.  No further information.	in p.m., OSM (other staff dmissions director, was tated bed holds are done for discharged to the hospital. She receives a paper notice of the p.m., ASM (administrative the director of nursing, stated are any additional evidence of this for R124's discharges.  In a.m., RN (registered nurse)  I. She stated the bed hold on admission and the should follow up with them after itted to the hospital.  In p.m., ASM #1, the asM #2 were informed of these lity policy, "Focus on F625," apitulation of the regulatory ument did not provide policies the facility to follow.  Ity policy, "Discharge: Other imergency Acute Setting," Provide bed hold policy as recounty regulations (available)	F 625		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO		(X3) DATE SURVEY COMPLETED
		495045	B. WING		C 05/23/2022
	ROVIDER OR SUPPLIER  CA SKILLED NURSING	S AND REHAB (RICHMOND)	2125	EET ADDRESS, CITY, STATE, ZIP HILLIARD ROAD HMOND, VA 23228	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE COMPLETION DATE
	On the most recent quarterly assessme reference date) of 4 having no cognitive decisions, having so BIMS (brief interview A review of R106's pfollowing note dated "Abdominal x-ray re Abdomen is distend hypoactive. No bown morningNotified do (emergency room)."  Further review of R1 no evidence that the bed hold policies for On 5/18/22 at 2:15 pmember) #3, the addinterviewed. She staresidents who are distated the resident rebed hold.  On 5/18/22 at 4:15 pstaff member) #2, the she could not locate bed hold notifications.  On 5/19/22 at 9:30 at #1 was interviewed.	MDS (minimum data set), a mt with an ARD (assessment /8/22, R106 was coded as impairment for making daily cored 15 out of 15 on the w for mental status).  Drogress notes revealed the 13/25/22 at 11:49 a.m.: vealed colonic ileus. ed and round, bowel sounds el movement this octoradvised to send to ER  106's clinical record revealed a resident received notice of the discharge on 3/25/22.  D.m., OSM (other staff missions director, was ted bed holds are done for scharged to the hospital. She eceives a paper notice of the communication of the missions director of nursing, stated any additional evidence of so for R106's discharges.  D.m., RN (registered nurse) She stated the bed hold admission and the ould follow up with them after	F 625		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE (	CONSTRUCTION		TE SURVEY MPLETED
		495045	B. WING		. 0	C 5/23/2022
	ROVIDER OR SUPPLIER  CA SKILLED NURSING	AND REHAB (RICHMOND)	21:	REET ADDRESS, CITY, STATE, ZIP CODE 25 HILLIARD ROAD CHMOND, VA 23228		
(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 COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 625	On 5/19/22 at 5:11 padministrator and Asconcerns.  No further information The findings include  3. The facility staff fabed hold notification receiving facility for was transferred to the Resident #33 was at 7/13/21 with diagnost limited to: congestive dementia, pacemake apnea.  The most recent MD assessment recoded the resident at the BIMS (brief interindicating the resident impaired.  A review of the nursi 2/16/22 at 11:22 AM, "Resident went out to diagnosis of Hypoxia RP is aware and NP went to hospital."  A review of the nursi 2/16/22 at 5:41 PM, in "Writer called hospital"	o.m., ASM #1, the SM #2 were informed of these SM #3 we hospital on 2/16/22.  Idmitted to the facility on sis that included but were not be heart failure, diabetes, ar and obstructive sleep SM (minimum data set) erly assessment, with an efference date) of 3/8/22, as scoring a 11 out of 15 on view for mental status) score, at was moderately cognitively so the hospital with a land altered mental status. Ordered transfer. Resident sign progress note dated revealed the following, and and was told that resident Chronic CHF, Peripheral	F 625			

CENTER	S FOR MEDICARE	& MEDICAID SERVICES			OND NO. 0930-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO		(X3) DATE SURVEY COMPLETED
		495045	B. WNG		C 05/23/2022
	ROVIDER OR SUPPLIER	G AND REHAB (RICHMOND)	2125	EET ADDRESS, CITY, STATE, ZIP 6 HILLIARD ROAD HMOND, VA 23228	CODE
(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 O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE COMPLETION DATE
F 625	An interview was co approximately 2:00 asked if he had bee Resident #33 stated ago, I went to the he trouble breathing.  An interview was cop PM with OSM (othe admissions coordinated provides the bed how transferred to the holds are done for the and entered into the tothe resident. In the done for this resider computer to indicate started here a few word of the stated here a few word of the state of the fact of the state of the state bed hold require facilities to is bed hold policies. The provided to the resident's representation of the state bed hold registed in the state bed hold registed in the state bed hold registed in the resident's representation of the state bed hold registed in the resident's representation of the state bed hold registed in the resident's representation of the state bed hold registed in the resident's representation of the state bed hold registed in the resident's representation of the state bed hold registed in the resident's representation of the state of the resident representation of the state of the resident representation of the state of the state of the resident representation of the state of the resident representation of the state of the stat	PM with Resident #33. When in transferred to the hospital, id, yes, a couple of months ospital because I was having anducted on 5/18/22 at 2:15 in staff member) #3, the lator. When asked who lid notice for residents being ospital, OSM #3 stated, "Bed transfers out to the hospital experience and a paper is sent to not see a bed hold was late. There is nothing in the late a bed hold was done. I weeks ago."  Eximately 5:30 PM, ASM member) #1, the #2, the director of nursing and or of human resources were	F 625		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO		100000 C	DATE SURVEY COMPLETED
		495045	B. WING			C 05/23/2022
	ROVIDER OR SUPPLIER	G AND REHAB (RICHMOND)	2125	EET ADDRESS, CITY, STATE, ZIP HILLIARD ROAD HMOND, VA 23228	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 625	Continued From pa	ige 64	F 625			
	No further informati	ion was provided prior to exit.				
	bed hold notification receiving facility for was transferred to the Resident #75 was a 9/2/21 with diagnost limited to: diabetes methicillin resistant.  The most recent ME assessment, a quart ARD (assessment a quart ARD (assessment a the BIMS (brief interior to the transfer interior transfer interior to the transfer interior transfer interior to the transfer interior transfer i	failed to evidence provision of n at the time of discharge to a r Resident #75. Resident #75 the hospital on 5/9/22.  admitted to the facility on sis that included but were not s, bipolar, osteomyelitis and a staph aureus.  DS (minimum data set) rterly assessment, with an reference date) of 3/12/22, as scoring a 11 out of 15 on erview for mental status) score, ent was moderately cognitively				
	5/9/22 at 2:54 PM, r "Received x-ray resi Moderate-sized retri moderate subcutant the calcaneous. Car	sing progress note dated reveals the following, sults and shows: rocalcaneal skin wound with eous emphysema surrounding nnot exclude gas gangrene or sider CT or MRI for further				
	5/9/22 at 3:12 PM, recalled and states to	sing progress note dated reveals the following, "NP send patient out to the ide aware of transport."				
	reviewed which reve hospital transfer pac	eximately 2:45 PM, a note was ealed, "Resident #75 no dated ocket sheet for 5/9/22." The e Transfer Document				

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			OMB NO. 0936-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO		(X3) DATE SURVEY COMPLETED C
		495045	B. WING		05/23/2022
	PROVIDER OR SUPPLIER DICA SKILLED NURSING	G AND REHAB (RICHMOND)	212	REET ADDRESS, CITY, STATE, ZIP C	
			- KIC	CHMOND, VA 23228	
(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 (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE COMPLETION DATE
F 625	Checklist" reveals the Documents Sent with that apply): Docume accompany resident transfer form, face is SBAR (situation, back recommendation), a care orders, bed hold documents if available most recent history a discharge summary, practitioner orders, for results, relevant x-ray and interview was concerned by the second of the second o	the following, "Copies of the Resident/Patient (check all tents recommended to at/patient: resident/patient sheet, current medication list, ackground, assessment, advance directives, advance old policy. Send these ble: notification of transfer, and physical, recent hospital of the resident physician/nurse flow sheets, relevant lab any results, current care plan."  Inducted on 5/19/22 at 3:15 or staff member) #3, the ator. When asked who ald notice for residents being pospital, OSM #3 stated, bed transfers out to the hospital experience as bed hold was ant. There is nothing in the expectation of the stage of the providence of the	F 625		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				SURVEY
		495045	B. WING			C /23/2022
	ROVIDER OR SUPPLIER	G AND REHAB (RICHMOND)	212	EET ADDRESS, CITY, STATE, ZIP ( 5 HILLIARD ROAD :HMOND, VA 23228	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 625	of the state bed hor require facilities to bed hold policies, provided to the res resident's represent in the cases of embours."  No further informat 5. The facility staff bed hold notification receiving facility for was transferred to was transferred to the horize to the number of the horize to the horize to the number of the horize to the horize to the number of the horize to the horize to the horize to the number of the horize to	Id policy. These provisions issues two notices related to The second notice must be ident and if applicable the stative at the time of transfer or ergency transfer, within 24 ion was provided prior to exit. failed to evidence provision of at the time of discharge to a Resident #68. Resident #68 the hospital on 2/25/22. Ionducted with OSM (other staff usiness office manager, on o.m. When asked the process d notice when a resident is ospital, OSM #1 stated, when the hospital, admissions gives rsing staff, it goes to the	F 625			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X	(X3) DATE SURVEY COMPLETED		
		495045	B. WING			C 05/23/2022		
	ROVIDER OR SUPPLIER	AND REHAB (RICHMOND)		STREET ADDRESS, CITY, STATE, ZIP CODE 2125 HILLIARD ROAD RICHMOND, VA 23228		USIZSIZUZZ		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE		
F 625	wasn't done." OSM it wasn't done.  On 5/19/22 at appro (administrative staff administrator, ASM it OSM #2, the director made aware of the filter of the filt	ximately 5:30 PM, ASM member) #1, the #2, the director of nursing and r of human resources were indings.  Comprehensive Care Plan )  nensive Care Plans acility must develop and thensive person-centered esident, consistent with the rth at §483.10(c)(2) and includes measurable rames to meet a resident's indingent and psychosocial fied in the comprehensive mprehensive care plan must g-are to be furnished to attain ent's highest practicable in the psychosocial well-being as .24, §483.25 or §483.40; and would otherwise be required 8.25 or §483.40 but are not resident's exercise of rights ding the right to refuse 3.10(c)(6).  services or specialized is the nursing facility will	F 65	5				
	findings of the PASA rationale in the resid	RR, it must indicate its ent's medical record. the resident and the						

PRINTED: 06/02/2022 FORM APPROVED OMB NO. 0938-0391

CLIVILI	TO TON WILDICANE	& WEDICAID SERVICES			OIVIB	NO. 0938-0391
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION		ATE SURVEY OMPLETED
		495045	B. WING		8	C 05/23/2022
NAME OF P	PROVIDER OR SUPPLIER		er	REET ADDRESS, CITY, STATE, ZIP CO		05/23/2022
		G AND REHAB (RICHMOND)	21	25 HILLIARD ROAD ICHMOND, VA 23228	JUE	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 656	resident's represen  (A) The resident's g desired outcomes.  (B) The resident's p future discharge. Fa whether the resident community was ass local contact agence entities, for this pun (C) Discharge plans plan, as appropriate requirements set for section. This REQUIREMEN by: Based on observat interviews and facilit determined the facil and/or implement th for three of 52 resid Residents #33, #16  The findings include  1. The facility staff facomprehensive care Resident #33. The reflect smoking until after surveyor obsers moking on 5/17/22  Resident #33 was of at 4:00 PM and agai Staff provided cigare from a locked box th  Resident #33 was ac 7/13/21 with diagnose	tative(s)- goals for admission and preference and potential for acilities must document this desire to return to the sessed and any referrals to sessed and any referrals to sessed and expropriate pose. In the comprehensive care the in paragraph (c) of this this not met as evidenced sions, resident interviews, staff try document review, it was sity staff failed to develop the comprehensive care plan tents in the survey sample, and #63.  The plan for smoking for care plan was not updated to after surveyor entrance and tryation of Resident #33  The beserved smoking on 5/17/22 the non 5/19/22 at 1:00 PM. The plan for smoking on the plan for smoking o	F 656	656 – Develop/Implem Comprehensive Care Plans 1. R33 had a new sm assessment completed appropriate care plans 16 care plan for dialysis was updated and the communication sheets initiated with the dialys was seen by the dieticic care plan was updated current plan of care.  2. Utilizing the Care Ptool – a comprehensive current residents who sresidents requiring dial resident with a signification change since 5.23.2022 completed by the Direct Nursing/designee to valappropriate updates to care.  3. The director of nursing/designee will elicensed nursing staff of F-tag 656 and "Smoking guideline" hemodialysis," and "checondition" procedure of the date of compliance 4. Utilizing the Care Ptool – the Director of nursing/designee will aresidents per week time weeks who currently so residents on dialysis or residents that have a signed weight change to validate weight change to validate and the condition of the dialysis or residents that have a signed condition of the dialysis or residents that have a signed condition of the condition of the condition of the dialysis or residents that have a signed condition of the dialysis or residents that have a signed condition of the condition of the condition of the dialysis or residents that have a signed condition of the conditi	lan loking land updated. R s monitoring were sis clinic. R63 an and the to reflect the lanning QAPI e review of smoke, lysis and any ant weight will be ctor of lidate the plan of educate the or "Focus on es," hange of on or before lanning QAPI udit five es four moke, those any gnificant	6/30/2022 t Page 69 of 159

appropriate updates to the plan of

care.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO		(X3)	DATE SURVEY COMPLETED
		495045	B. WING			C 05/23/2022
	ROVIDER OR SUPPLIER	G AND REHAB (RICHMOND)	2125	EET ADDRESS, CITY, STATE, ZIP CO HILLIARD ROAD HMOND, VA 23228	ODE	00/20/2022
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
	dementia, pacemakapnea.  The most recent MI assessment, a qual ARD (assessment recoded the resident the BIMS (brief interindicating the reside impaired. A review G-functional status requiring extensive transfer, dressing, has supervision for loco O-special procedure resident as oxygen  A review of the composed of the	DS (minimum data set) rterly assessment, with an reference date) of 3/8/22, as scoring a 11 out of 15 on rview for mental status) score, ent was moderately cognitively of the MDS Section coded the resident as assistance for bed mobility, rygiene and bathing; motion and eating. Section es/treatments coded the "yes".  prehensive care plan dated 'FOCUS: History of smoking ropriate smoking. Complete Smoking ty guidelines. Secure smoking station or other designated ow to smoke in designated	F 656			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO		(X3) DATE SURVEY COMPLETED
		495045	B. WING		C 05/23/2022
	ROVIDER OR SUPPLIER	IG AND REHAB (RICHMOND)	2125	EET ADDRESS, CITY, STATE, ZIP CODE HILLIARD ROAD HMOND, VA 23228	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
F 656	on their care plan, that smokes should When ask why it significant with the safety issue."  On 5/19/22 at appropriate administrative state administrative state administrator, ASM OSM #2, the direct made aware of the According to the factorial comprehensive per each patient that in and timeframes to nursing, mental and identified."  According to the factorial comprehensive particularly as moking evaluation supervision that is equipment needed guidelines."  No further informative 2a. The facility state #16's (R16) comprehensive particularly state #16's (R16) was admitted (1).	LPN #1 stated, "Yes, a resident d have it on their care plan." hould be on the care plan, LPN id be there because it is a roximately 5:30 PM, ASM ff member) #1, the M #2, the director of nursing and for of human resources were indings.  Incility's policy "Interdisciplinary ted 2018, which reveals, "The pand implement a reson-centered care plan for includes measurable objectives meet a patient's medical, d psychosocial needs that are cility's policy "Smoking 2019, which reveals, "The IDT	F 656		
	included but were r				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		495045	B. WING			00000	C 23/2022
	PROVIDER OR SUPPLIER	AND REHAB (RICHMOND)	2	STREET ADDRESS, CITY, STATE, ZIP CO 2125 HILLIARD ROAD RICHMOND, VA 23228	DDE	1 00/	23/2022
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC'	ON SHOULD BE HE APPROPRIA		(X5) COMPLETION DATE
F 656	On the most recent annual assessment reference date) of 0: scored 14 out of 15 for mental status), in cognitively intact for Section "O Special Trograms" coded (Resident.  The physician's orded documented in part, fistula (3) site thrill/b fistula site thrill/bruit 03/11/2022. Start D.  The comprehensive 05/22/2019 documented in part, of thrill/bruit, evidence disease), dependent Initiated: 05/22/2019 documented in part, of thrill/bruit, evidence excessive bleeding pabnormalities to physophysical patholograms. Review of the eTAR administration record 2022 documented in thrill/bruit every day sthrill/bruit check." Furevealed blanks (not 03/25/2022.  Review of (R16's) eT	MDS (minimum data set), an with an ARD (assessment 2/24/2022, the resident on the BIMS (brief interview dicating the resident is making daily decisions. Freatments, Procedures and 16) for "Dialysis" while a set summary for (R16) "Check AV (arterial/venous) ruit (4) every day shift for AV check. Order Date: ate: 03/12/2022."  care plan for (R16) dated anted in part, "Focus. Renal doto: ESRD (end stage renal decon renal dialysis. Date "Under "Interventions" it "Check access site for lack decof infection, swelling, or der facility guidelines. Report sician Date Initiated:  (electronic treatment bit for (R16) dated March part, "Check AV fistula site shift for AV fistula site unther review of the eTAR signed) on 03/17/22 and AR dated April 2022 as stated above. Further	F 656				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO		(X3) DATE SURVEY COMPLETED	
		405045	B. WING			С
NAME OF P	ROVIDER OR SUPPLIER	495045		ET ADDRESS, CITY, STATE, ZIP CODE	05	/23/2022
		G AND REHAB (RICHMOND)	2125	HILLIARD ROAD HMOND, VA 23228		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL PR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 656	O4/15/2022, O4/24/ Review of (R16's) of documented in par review of the eTAR 05/13/2022.  On 05/19/2022 at a interview was conducted in paractical nurse) #5 (R16's) eTARs for I After reviewing the above LPN # 5 was for the bruit and thrif the eTAR was bla and thrill was not of comprehensive car asked if the care ple monitoring (R16's) blanks on the eTAR stated that the care On 05/19/2022 at a (administrative staff and ASM # 2, direct aware of the finding No further information References:  (1) When you slide you should feel a grant art and a grant and	eTAR dated May 2022 t, as stated above. Further revealed a blank on  approximately 2:45 p.m., an fucted with LPN (licensed bregarding the blanks on March, April and May 2022. eTARs for the dates listed breaked to interpret the blanks fill checks. LPN # 5 stated that ank it indicated that the bruit hecked. After reviewing the re plan for (R16) LPN # 5 was an was being implemented for bruit and thrill if there were as dated above. LPN # 5 re plan was not being followed.  Approximately 5:10 p.m., ASM f member) # 1, administrator for of nursing were made	F 656			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		O	(X3) DATE SURVEY COMPLETED	
		495045	B. WING			C 05/23/2022	
	ROVIDER OR SUPPLIER	IG AND REHAB (RICHMOND)	2125	EET ADDRESS, CITY, STATE, ZIP COI HILLIARD ROAD HMOND, VA 23228	DE		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	ON SHOULD BE IE APPROPRIATI	(X5) COMPLETION DATE	
F 656	Ofingertips, is%20st  (2) The last stage of is when your kidne body's needs. This from the website: https://medlineplus  2b. The facility sta comprehensive car with the dialysis ce communication for The facility staff fail dialysis communication for The facility staff fail dialysis communication for The physician's order of the physician's orde	en%20you%20slide%20your%2 till%20in%20good%20condition of chronic kidney disease. This eys can no longer support your is information was obtained of gov/ency/article/000500.htm. off failed to implement (R16's) ore plan for coordinating care enter by completing the dialysis ore. led to provide complete ation forms for (R16's) on 12022, 05/06/2022, 05/09/2022, 2022, 05/16/2022 and on order for (R16) documented in order physician order M-W-F orday-Friday) 0530-0900 (5:30 order date: 05/02/2022."	F 656				
	to evidence docume	rms" for (R16's) dialysis failed entation of the following: ialysis site , patient status,					

: [1] [1] [1] [1] [1] [1] [1] [1] [1] [1]		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO		(X3) DATE SURVEY COMPLETED	
		495045	B. WING		C 05/23/2022	
	PROVIDER OR SUPPLIER	G AND REHAB (RICHMOND)	2125	EET ADDRESS, CITY, STATE, ZIP HILLIARD ROAD HMOND, VA 23228		
(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 C (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE COMPLÉTIC O THE APPROPRIATE DATE	DN
F 656	laboratory tests, ar 05/02/2022, 05/04/2 05/11/2022, 05/04/2 05/18/2022 and (R1 05/02/2022, 05/04/2 05/16/2022.  On 05/19/2022 at al interview was condupractical nurse) #5 "Hemodialysis Comdated 05/02/2022, 05/09/2022, 05/11/2 and on 05/18/2022. procedure for compcommunication form of the form that includialysis site, patient nurse. After reviewing communication form stated that the forms reviewing the compressive of the dialysis facility if communication form incomplete. LPN # 5 was asked implemented for cootthe dialysis facility if communication form incomplete. LPN # 5 was not being follow.  On 05/19/2022 at approximation (administrative staff and ASM # 2, directed aware of the findings.)  No further information.  3. The facility staff facilit	and the nurse's signature on 2022, 05/06/2022, 05/09/2022, 2022, 05/16/2022 and on 16's) temperature on 2022, 05/13/2022 and 2022, 05/13/2022 and 2022, 05/13/2022 and 2022, 05/13/2022 and 2022, 05/06/2022, 2022	F 656			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO		(X3) DATE SURVEY COMPLETED
		495045	B. WING		C 05/23/2022
7.0000-200-000-000-000	ROVIDER OR SUPPLIER  CA SKILLED NURSING	AND REHAB (RICHMOND)	2125	EET ADDRESS, CITY, STATE, ZIP CODE HILLIARD ROAD HMOND, VA 23228	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION
F 656	12/7/21 and 1/14/22  On the most recent I quarterly assessmer reference date) of 3/ being severely cogn daily decisions, having the BIMS (brief interwas coded as having during the look back. A review of R63's careviewed 3/15/22 reviewed 3/15/22	MDS (minimum data set), a at with an ARD (assessment 14/22, R63 was coded as itively impaired for making ing scored zero out of 15 on view for mental status). R63 g no significant weight loss period.  The plan dated 10/8/19 and vealed, in part: "[R63] has the /hydration imbalanceBMI is underweightRD to monitor and f/u (follow up) weights and notify physician by of significant weight weight weight and parts: "Incal record revealed the the following dates: dent weighed 93 lbs. On weighed 87 pounds. The second revealed in notes related to this loss, at the provider was notified of	F 656		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495045	B. WING		C 05/23/2022	
		AND REHAB (RICHMOND)	2125	EET ADDRESS, CITY, STATE, ZIP CODE HILLIARD ROAD HMOND, VA 23228		
(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 B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE	
F 656	would contact the phy interventions, if approstated a 6.45% weigh significant weight loss addressed by the RD RD should document regarding awareness and any interventions physician. After reviet to nutrition, OSM #12 not followed when the not addressed by the On 5/19/22 at 5:11 p.1 staff member) #1, the the director of nursing concerns.	visician, and recommend opriate for the resident. She at loss in 30 days is a set, and should have been at the time. She stated the in the clinical record of the significant weight loss recommended to the wing R63's care plan related stated R63's care plan was a significant weight loss was facility staff.  The matter of these in the recommended to the wing R63's care plan was a significant weight loss was facility staff.  The matter of these in the recommend of these in the residuent was provided prior to exit.	F 656			
SS=D	be- (i) Developed within 7 the comprehensive as (ii) Prepared by an intincludes but is not lim (A) The attending phy (B) A registered nurse resident. (C) A nurse aide with resident. (D) A member of food (E) To the extent practithe resident and the resident.	ensive Care Plans brehensive care plan must days after completion of bresessment. breidsciplinary team, that	F 657			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE (	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495045	B. WING		C 05/23/2022
	ROVIDER OR SUPPLIER	G AND REHAB (RICHMOND)	21	REET ADDRESS, CITY, STATE, ZIP CODE 25 HILLIARD ROAD CHMOND, VA 23228	,
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE COMPLETION
	and their resident resident's care plan (F) Other appropriat disciplines as determor as requested by the (iii)Reviewed and resteam after each assessments. This REQUIREMENT by:  Based on observation staff interview and fadtermined facility splan for one of 52 resident #61.  The findings included The facility staff failed elopement after 1:1 required for Resident quarterly assessment quarterly assessment period.  On 5/17/2022 at approbservation was many was observed dresses.	e participation of the resident epresentative is determined the development of the staff or professionals in mined by the resident's needs the resident. Existed by the interdisciplinary essment, including both the staff quarterly review.  In the staff or professionals in mined by the resident's needs the resident. Existed by the interdisciplinary essment, including both the staff quarterly review.  In the survey was staff failed to revise the care essidents in the survey sample, existed to revise the care plan for monitoring was no longer.	F 657	Revision  1. R61 no longer resides in the facility.  2. Utilizing the Exit Seeking Carlan tool – the director of nursing/designee will audit curresidents with known exit seeking behavior to validate appropriate plans of care.  3. The director of nursing/designee will educate the licensed nursing staff on "Focus F-tag 657" and the "interdisciplicare planning" procedure on or before the date of compliance.  4. Utilizing the Exit Seeking Carlan tool – the director of nursing/designee will audit five residents per week times four weeks to validate any new elopement attempts or actual elopements have appropriate caplan revisions. Results will be reviewed with the QA&A committee.	rent ing te the s on inary

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		()	(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER	G AND REHAB (RICHMOND)		STREET ADDRESS, CITY, STATE, ZIP O 2125 HILLIARD ROAD RICHMOND, VA 23228	CODE	05/23/2022	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL PR LSC IDENTIFYING INFORMATION)	ID PREFI) TAG		TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
	was observed to be staff 1:1 supervision. Additional observar 2:45 p.m., 5/17/202 at 8:30 a.m. reveals. The comprehensive documented in particulated to: cognitive 12/01/2021. Revis "Interventions/Task Supervision, Date I The progress notes - "12/14/2021 17:4" party) notified left in building. MD (mediaware. Now on 10 - "12/23/2021 14:01 monitored frequent! No behaviors display bracelet in place." - "1/4/2022 15:36 (3 (social services), Ul activities assistant a care conference Not stable currently with changes currently."  On 5/18/2022 at 3:5 conducted with LPN #4 stated that was to show the resinterventions in place. LPN #4 stated that when there was a conference was a conf	icelet on the right wrist. R61 in the room alone with no in.  Itions of R61 on 5/17/2022 at 22 at 4:15 p.m. and 5/18/2022 at 0.1:1 staff supervision.  It is care plan for R61 in the seeking/elopement risk in it is in mark. Date Initiated: ion on: 12/01/2021." Under so it it documented in part, if 1:1 initiated: 12/17/2021"  In for R61 documented in part, if 1:4 p.m.) RP (responsible in the sage of his exit from it is in a made on 1 monitoring by staff." If (2:01 p.m.) Resident in its in monitoring and in the rapy met for resident's in monitoring reports resident is in no acute medical issuesNo	F	657			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO			(X3) DATE SURVEY COMPLETED	
		495045	B. WING			C 05/23/2022	
	ROVIDER OR SUPPLIER	NG AND REHAB (RICHMOND)	2125	ET ADDRESS, CITY, STATE, ZIP CO HILLIARD ROAD HMOND, VA 23228	DE.		
(X4) ID PREFIX TAG	(EACH DEFIC	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 657	the problems, goal appropriate or new stated that R61 with had not been sincunit at the end of R61's care plan with documented 1:1 stated that R61 with manager. RN #1 agency and had betated that R61 had been working the purpose of the picture of the care RN #1 reviewed the R61 which documented with reventions and so not current because supervision any lower than the picture of the care RN #1 reviewed the R61 which documenter the cause supervision and so the picture of the care RN #1 reviewed the R61 which documenter than the picture of the care RN #1 reviewed the R61 which documenter than the care plan guides members of healthcare team in patient's needs. It methods of care the receive A compreber reviewed and team after each as comprehensive, quireview assessmenter of the R61 with a state of the review a	e care plan meetings to see if als and interventions were still eded to be changed. LPN #4 as not on 1:1 observation and the they had been working on the December. LPN #4 stated that has not up to date if it supervision because they did not me.  1:30 a.m., an interview was N (registered nurse) #1, unit stated that they worked with an een there for 2 months. RN #1 and not been on 1:1 since they on the unit. RN #1 stated that a care plan was to give staff a being provided to the resident. The comprehensive care plan for ented 1:1 supervision under stated that the care plan was see they did not require 1:1 inger.  "Interdisciplinary Care Planning" unmented in part, "The is a communication tool that of the interdisciplinary in how to meet each individual also identifies the types and not the patient should behensive care plan must including both the patiently, and significant change	F 657				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
		495045	B. WING			10000000	C <b>23/2022</b>
PROMEDICA SKI		S AND REHAB (RICHMOND)	•	2125 HILLIA	ORESS, CITY, STATE, ZIP CODE ARD ROAD D, VA 23228		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B ROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
direct #2, th aware	e human reso of the above	and OSM (other staff member) urce director were made	F	657			
SS=D CFR(s §483. The s as out must- (i) Me This F by: Base review a com the fac standa for one Reside The fac chang and as 2022. The fir On the quarter referent having decision	s): 483.21(b)(3) 21(b)(3) Compervices provided in the control of t	orehensive Care Plans ed or arranged by the facility, comprehensive care plan,  Il standards of quality.  It is not met as evidenced eview, facility document and review, and in the course of ation, it was determined that dot to follow professional e for nursing documentation, ents in the survey sample, ed to document acute en, resident report of injury, ults for Resident #802 in April	F	558			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C		(X3	3) DATE SURVEY COMPLETED
		495045	B. WNG			C 05/23/2022
PROMED (X4) ID	SUMMARY	G AND REHAB (RICHMOND)  STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL	STREET ADDRESS, CITY, STATE, ZIP CODE  2125 HILLIARD ROAD  RICHMOND, VA 23228  ID PROVIDER'S PLAN OF CORRECTION			(X5) COMPLETION
PREFIX TAG		DR LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	THE APPROPRIATE	DATE
F 658	transfers.  A review of R802's following progress p.m. The note was practical nurse) #7 for subcapital fract (medical doctor) or made aware and plocal hospital] ER (evaluation and treatment of the provider	clinical record revealed the note, dated 4/10/22 at 11:16 written by LPN (licensed . "Patient's X-ray was positive ure of the right hip. MD in call was [name of MD] was atient was sent to [name of emergency room) for atment."	F 658	Professional Standards.  R 802 no longer facility.  Utilizing the "charcondition" QAPI tool comprehensive review with injuries of unknown from 5.23.2022 to completed by the District Nursing/designee to documentation is in record related to charcondition.  The director of nursing/designee will licensed nursing staff on f-tag 658" and "Charcondition" procedures the date of compliance 4. Utilizing the "Charcondition" QAPI tool of nursing/designee winjuries of unknown of times four weeks to windocumentation in the chart.	rds resides in the ange in I – a ew of residen nown origin urrent will be irector of validate the clinical anges in Il educate the f on the "focu hange in e on or before ice. ange in – the directo will audit any origin weekly validate	e us

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER	IG AND REHAB (RICHMOND)	STRE 2125	EET ADDRESS, CITY, STATE, ZIP CO HILLIARD ROAD HMOND, VA 23228	DDE	05/23/2022	
(X4) ID PREFIX TAG	(EACH DEFICE	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIAT		
F 658	that the rough hand pain. LPN #7 state this to the supervis staff member) #2, 1 When asked if she conversations, she stated: "I just did not repeated that she sconversations.  On 5/23/22 at 11:1/2 interviewed. She st documented. She st documented. She soptions for nursing progress notes, paradministration note assessments in the record). She stated documented because better care of the redocumented, it's terministrator, and with the concerns. Due on 5/17/22 at 1:15 administrator, and with the seconcerns. Due on 5/17/22 at 12:00 facility uses its policy resource (Lippincot reference.  A review of the facil Resource Manual," entries are documented a summary of an evan earlier time in the	adding was the source of the hip and she immediately reported for and to ASM (administrative the DON (director of nursing). It is documented any of these as tated she did not. She not think of it at the time." She should have documented these stated all nursing care should be stated all nursing care should be stated there are several a documentation, including hin assessments, medication as, and other formal at EMR (electronic medical did all nursing care should be use it helps the whole staff take esident. She stated: "If it's not echnically not done."	F 658				

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTER	S FOR MEDICARE	& MEDICAID SERVICES			OMB N	IO. 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	IPLE CONSTRUCTION		TE SURVEY MPLETED
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	ROVIDER OR SUPPLIER	IG AND REHAB (RICHMOND)		STREET ADDRESS, CITY, STAT 2125 HILLIARD ROAD RICHMOND, VA 23228		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECT CROSS-REFERENC	LAN OF CORRECTION IVE ACTION SHOULD BE SED TO THE APPROPRIATE FICIENCY)	(X5) COMPLETION DATE
F 658	with the present tir time of the event in complete record or functional represer of the patient in the interdisciplinary applanning and care record documentatine Quality Assura Improvement (QAFA According to "Funcincredibly Easy," L. Philadelphia PA padocumentation is a documentation is a documentation is a nursing care. Patie and need to be accepted to the accepted to the accepted to the patient and family possible. Many nur they document or fenormous effect or other members of the present and family of the programment	me and identifies the actual in the narrative note A contains an accurate and intation of the actual experience a center and reflects an approach to assessment, care delivery. Review of clinical tion is an important aspect of ince and Performance PI) process."  Idamentals of Nursing Made ippincott, Williams and Wilkins, age 23: "Nursing in highly significant issue since in fundamental feature of intercords are legally valid, curate and comprehensive so immunicated effectively to the Unless the content of vides an accurate depiction of care, quality of care may not be seed on not realize that what fail to record can produce an in the care that is provided by the health care team."	F6	58		
F 684 SS=E	applies to all treatment facility residents. B		F 68	84		

PRINTED: 06/02/2022 FORM APPROVED

F 684  Continued From page 84 that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, clinical record review, and in the course of a complaint investigation, it was determined that the facility staff failed to provide care and services in a manner to promote a resident's highest level of well-being for two of 52 residents in the survey sample, Residents #802 and #16.  The findings include:  1. For Resident #802 (R802), the facility staff failed to provide timely radiology services and treatment for R802's fractured right hip.  On the most recent MDS (minimum data set) a	CENTE	KS FOR WEDICARE	MEDICAID SERVICES			OMB NO. 0938-0391
NAME OF PROVIDER OR SUPPLIER  PROMEDICA SKILLED NURSING AND REHAB (RICHMOND)  (K4) ID PREFIX TAG  REGULATORY OR LSC IDENTIFYING INFORMATION)  F 684  Continued From page 84 that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices.  This REQUIREMENT is not met as evidenced by:  Based on staff interview, facility document review, clinical record review, and in the course of a complaint investigation, it was determined that the facility staff failed to provide care and services in a manner to promote a resident's highest level of well-being for two of 52 residents in the survey sample, Resident #802 and #16.  The findings include:  1. For Resident #802 (R802), the facility staff failed to provide timely radiology services and treatment for R802's fractured right hip.  On the most recent MDS (minimum data set) a						
NAME OF PROVIDER OR SUPPLIER  PROMEDICA SKILLED NURSING AND REHAB (RICHMOND)  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFIGIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  F 684  Continued From page 84 that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by:  Based on staff interview, facility document review, clinical record review, and in the course of a complaint investigation, it was determined that the facility staff failed to provide care and services in a manner to promote a resident's highest level of well-being for two of 52 residents in the survey sample, Residents #802 and #16.  The findings include:  1. For Resident #802 (R802), the facility staff failed to provide timely radiology services and treatment for R802's fractured right hip.  On the most recent MDS (minimum data set) a			495045	B. WING		
PROMEDICA SKILLED NURSING AND REHAB (RICHMOND)  (X4) ID PREFIX TAG  SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  F 684  Continued From page 84 that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by:  Based on staff interview, facility document review, clinical record review, and in the course of a complaint investigation, it was determined that the facility staff failed to provide care and services in a manner to promote a resident's highest level of well-being for two of 52 residents in the survey sample, Residents #802 and #16.  The findings include:  1. For Resident #802 (R802), the facility staff failed to provide timely radiology services and treatment for R802's fractured right hip.  On the most recent MDS (minimum data set), a	NAME OF I	PROVIDED OD SLIDDLIED	400040	15. 710		05/23/2022
RICHMOND, VA 23228   SUMMARY STATEMENT OF DEFICIENCIES   PREFIX TAG   SUMMARY STATEMENT OF DEFICIENCIES   PREFIX TAG   PROVIDER'S PLAN OF CORRECTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)   PREFIX TAG   PROVIDER'S PLAN OF CORRECTION SHOULD BE (EACH DEFICIENCY)   PROVIDER'S PLAN OF CORRECTION SHOULD BE (EACH DEFICIENCY)   PREFIX TAG   PROVIDER'S PLAN OF CORRECTION SHOULD BE (EACH DEFICIENCY)   PROVIDER'S PLAN OF CORSCRETEMENT OF CORSCRETION AND CORSCRETEMENT OF CORSCRETEMENT OF CORSCRETION PAPEOPRIATE DEFICIENCY    1. F684	TV WILL OF	NO VIDEN ON SOFFEIER		1	Will the Particular of Control of the Control of th	
SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)   PREFIX TAG   PROVIDER'S PLAN OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY      F 684   Continued From page 84	PROMED	DICA SKILLED NURSING	AND REHAB (RICHMOND)			
F 684  Continued From page 84 that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, clinical repord review, and in the course of a complaint investigation, it was determined that the facility staff failed to provide a resident's highest level of well-being for two of 52 residents in the survey sample, Resident #802 (R802), the facility staff failed to provide timely radiology services and treatment for R802's fractured right hip.  PREFIX TAG  PREFIX TAG  CEACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  F 684  684 — Quality of Care  1. R802 no longer resides in the facility. R16 fluid restriction worksheet was updated by the dietician. 2. Utilizing the "Change in condition" QAPI tool the director of nursing/designee will review any radiology reports or fluid restrictions from 5.23.2022 to current to validate appropriate documentation in the clinical chart. 3. The director of nursing/designee will educate the licensed nurses on "focus on f-tag 684" and "change in condition" procedure on or before the date of					RICHMOND, VA 23228	
that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, clinical record review, and in the course of a complaint investigation, it was determined that the facility staff failed to provide care and services in a manner to promote a resident's highest level of well-being for two of 52 residents in the survey sample, Residents #802 and #16.  The findings include:  1. R802 no longer resides in the facility. R16 fluid restriction worksheet was updated by the dietician.  2. Utilizing the "Change in condition" QAPI tool the director of nursing/designee will review any radiology reports or fluid restrictions from 5.23.2022 to current to validate appropriate documentation in the clinical chart.  3. The director of nursing/designee will educate the licensed nurses on "focus on f-tag feat" and "change in condition" procedure on or before the date of	PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	D BE COMPLETION
quarterly assessment with an ARD (assessment reference date) of 2/3/22, R802 was coded as having no cognitive impairment for making daily decisions, having scored 15 out of 15 on the BIMS (brief interview for mental status). R802 was coded as requiring the extensive assistance of two staff members for bed mobility and transfers.  A review of R802's clinical record revealed the following progress note, dated 4/10/22 at 11:16 p.m. The note was written by LPN (licensed practical purse) #7 "Patientle X reviewed page 12.2. Compliance.  4. Utilizing the "Change in condition" QAPI tool the director of nursing/designee will review five residents per week times five weeks to validate residents with radiology diagnostics or fluid restrictions have appropriate documentation in the clinical chart. Results will be reviewed with the QA&A	F 684	that residents received accordance with propractice, the compressore plan, and the restriction of the provided in a manner to promote of well-being for two sample, Residents #  The findings include:  1. For Resident #802 failed to provide time treatment for R802's  On the most recent Manaterial properties of two samples assessments for R802's and the provide time treatment for R802's.  On the most recent Manaterial properties of 2/3 having no cognitive in decisions, having see BIMS (brief interview was coded as requiring of two staff members transfers.  A review of R802's cl following progress no p.m. The note was well practical nurse) #7. "If for subcapital fractures (medical doctor) on comade aware and patillocal hospital] ER (em	e treatment and care in fessional standards of hensive person-centered esidents' choices.  T is not met as evidenced view, facility document deview, and in the course of ation, it was determined that it to provide care and services of a resident's highest level of 52 residents in the survey 802 and #16.  It (R802), the facility staff ly radiology services and fractured right hip.  MDS (minimum data set), a st with an ARD (assessment 8/22, R802 was coded as impairment for making daily ored 15 out of 15 on the for mental status). R802 and the extensive assistance for bed mobility and inical record revealed the ste, dated 4/10/22 at 11:16 critten by LPN (licensed Patient's X-ray was positive to of the right hip. MD all was [name of MD] was ent was sent to [name of nergency room) for	F 68	1. R802 no longer resides in facility. R16 fluid restriction worksheet was updated by the dietician. 2. Utilizing the "Change in condition" QAPI tool the direct nursing/designee will review a radiology reports or fluid restrictions from 5.23.2022 to current to validate appropriate documentation in the clinical chart. 3. The director of nursing/designee will educate licensed nurses on "focus on f-684" and "change in condition procedure on or before the da compliance. 4. Utilizing the "Change in condition" QAPI tool the direct nursing/designee will review firesidents per week times five to validate residents with radio diagnostics or fluid restrictions appropriate documentation in clinical chart. Results will be reviewed with the QA&A	tor of iny  e  the -tag " te of  tor of ive weeks ology s have

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

FORM APPROVED

PRINTED: 06/02/2022 CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED C
		495045	B. WING		05/23/2022
	ROVIDER OR SUPPLIER  CA SKILLED NURSING	S AND REHAB (RICHMOND)	21	REET ADDRESS, CITY, STATE, ZIP CODE 25 HILLIARD ROAD CHMOND, VA 23228	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETION
	diagnoses including osteopenia, and ost A review of R802's resident received as (milligrams) on 4/7/2 of 6 out of 10; on 4/1 level of 4 out of 10; pain level of 3 out or p.m. for a pain level was documented as administrations.  Further review of R8 no other documenta circumstances surror assessments of R80 urgent radiology ser providers regarding treatment for a fractic A review of the physic revealed the following 11:27 p.m.: "X-ray to pain to right hip and once performed." The #7.  A review of R802's docal hospital dated a admitted with a fractic hospital stay from 4/1 underwent surgery on hip fracture, and exprequiring admission to the solution of the physic stay from 4/1 underwent surgery on hip fracture, and exprequiring admission to the solution of the physical stay from 4/1 underwent surgery on the fracture, and exprequiring admission to the solution of the physical stay from 4/1 underwent surgery of the physical stay fro	to the facility on 10/28/21 with right femur fracture, eoarthritis.  clinical record revealed the s-needed Tylenol 650 mg 22 at 4:57 p.m. for a pain level 8/22 at 5:14 p.m. for a pain on 4/9/22 at 9:00 a.m. for a f 10; and on 4/10/22 at 5:41 of 4 out of 10. The Tylenol effective after all  802's progress notes revealed tion related to the unding R802's injury, nursing 12's injury, attempts to obtain vices, or communication with the potential delay in	F 684		

STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	INSTRUCTION	(X3) DATE SURVEY		
AND PLAN O	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING			PLETED	
					9999	С	
		495045	B. WING			/23/2022	
NAME OF F	PROVIDER OR SUPPLIER		100000000000000000000000000000000000000	EET ADDRESS, CITY, STATE, ZIP	CODE		
PROMED	ICA SKILLED NURSING	S AND REHAB (RICHMOND)	1 100000000	HILLIARD ROAD HMOND, VA 23228			
(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 O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION DATE	
F 684	dated 10/28/21 reversible a hip fracture.  On 5/19/22 at 1:05 She stated she rem stated on 4/8/22, she because R802 repolegs were swollen. Ultrasound of both lew When asked if she of findings or conversashe had. After revie LPN #7 stated she rem She stated she shou assessment findings the provider in the pshe worked 4/8/22, cared for R802 on ethe X-ray was order company did not arrow the X-ray until late in When asked why X-until nearly 48 hours "That's not unusual kind of care the resident with a sked if R802 during the 48 hour gwas provided incontrand repositioned free best practice to contresident with a poter stated she had not the stated: "No, it's not done that." When as attempts to contact the stated in the stated	ge 86 caled no information related to p.m., LPN #7 was interviewed. cembered R802 very well. She ce contacted the physician orted right hip pain, and R802's The physician ordered an cegs and an X-ray of the hip. documented any of these ations, she stated she thought wing R802's progress notes, must have "just missed it." all have documented the ce and the conversation with rogress notes. LPN #7 stated 4/9/22, and 4/10/22, and ach of these days. She stated ded 4/8/22, but the X-ray ive at the facility to perform in the evening on 4/10/22. Tray company did not arrive to after the order, she stated: for them." When asked what dent received between the ordered and the X-ray was act: "I gave some Tylenol." I was turned and repositioned ap, she stated the resident inence care, and was turned quently. When asked if it is inue to turn and reposition a intially fractured hip, she mought of it in this way. She We probably shouldn't have ked if she made any he X-ray company to y would arrive or to ask if	F 684				

	TEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X DENTIFICATION NUMBER: A. BUILDING			(X3) DATE SURVEY COMPLETED		
		495045	B. WING			C 05/23/2022
	ROVIDER OR SUPPLIER	G AND REHAB (RICHMOND)	2125	EET ADDRESS, CITY, STATE, ZIP CO HILLIARD ROAD HMOND, VA 23228	DDE	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL PR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
	she contacted the practitioner) to let the performed immenot. When asked if in a delay or treatment she stated: "Yes, at the stated the X-ray give a time when the stated of the shift, she determine a more evill arrive to do the "Sometimes they will a resident the the the stated: "As	d she did not. When asked if physician/NP (nurse hem know the X-ray could not ediately, she stated she did the delay in the X-ray resulted nent for R802's hip fracture, bsolutely."  4 a.m., LPN #5 was asked about the process for rays, she stated the nurse fills lis the mobile X-ray company. By company usually does not never anticipate someone will be a X-ray. She stated if she the beginning of her shift and from the X-ray company by the will call the company back to exact time when the company X-ray. She stated:  Ill tell you they will be here the never so backed up." She has a potential fracture, and cannot come immediately, er to let them know that the new will ask the provider what the state of the stated the provider will be resident out to the ER, and nobile X-ray. When asked if a X-ray of a potentially fractured elay of treatment for the	F 684			

STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO	INSTRUCTION	(X3) DATE SUI COMPLET	
		495045	B. WING		C 05/23/	2022
	ROVIDER OR SUPPLIER	AND REHAB (RICHMOND)	STRE 2125	EET ADDRESS, CITY, STATE, ZIP ( HILLIARD ROAD HMOND, VA 23228		2022
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) OMPLETION DATE
	immediately.  On 5/23/22 at 1:15 padministrator, and A these concerns.  A review of the facility related to preventing resident's injury.  No further information of the facility staff for restriction.  (R16) was admitted included but were not disease (4), depended on the most recent formula assessment or reference date) of 02 scored 14 out of 15 of for mental status), incognitively intact for Section "O Special T Programs" coded (R resident.  The physician's orde part, "Fluid Restriction (milliliters)/ (per) 24 provided by Nursing:	y cannot be obtained  o.m., ASM #1, the aSM #2 were informed of  ty policy, "Clinical Records revealed no information g a delay in treatment for a  on was provided prior to exit.  y ailed to monitor (R16's) fluid  to the facility with diagnoses but limited to: end stage renal ent on renal dialysis.  MDS (minimum data set), an with an ARD (assessment 2/24/2022, the resident on the BIMS (brief interview dicating the resident is making daily decisions. freatments, Procedures and field for "Dialysis" while a  or summary documented in on - Total: 1500 mLs hours every shift Total for may: 240 ml - ht: 120 ml. Order Date:	F 684			

	MENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (A. BUILDING		V	(X3) DATE SURVEY COMPLETED		
		495045	B. WING			C 05/23/2022
	ROVIDER OR SUPPLIER	IG AND REHAB (RICHMOND)	2125	ET ADDRESS, CITY, STATE, ZIP C HILLIARD ROAD HMOND, VA 23228	ODE	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
	o5/22/2019 documinsufficiencies reladisease), depende Initiated: 05/22/20 documented in par Date Initiated: 10/3  The eTAR (electrorecord) documented stated above. The opportunities for defluids taken at 6:30 p.m. Further review evidence the amount with each meal and in a 24 hour period evidence documented the amount of the composition of the compositio	the care plan for (R16) dated the tented in part, "Focus. Renall ted to: ESRD (end stage renall the ted to: ESRD (end sta	F 684			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495045	B. WING		C 05/23/2022
	ROVIDER OR SUPPLIER	G AND REHAB (RICHMOND)	S 2	STREET ADDRESS, CITY, STATE, ZIP CODE 1125 HILLIARD ROAD RICHMOND, VA 23228	05/25/2022
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE COMPLETION
F 684	was important to ,m LPN # 5 stated that much fluid it could of congestive heart fa On 05/19/2022 at a (administrative staff and ASM # 2, direct aware of the finding	nonitor a resident's fluid intake if a resident receives too cause shortness of breath, ilure or swelling in their legs.  pproximately 5:10 p.m., ASM f member) # 1, administrator tor of nursing were made is.	F 684		
SS=D	Foot Care CFR(s): 483.25(b)(2) §483.25(b)(2) Foot To ensure that reside and care to maintain health, the facility modified in the provide foot care with professional state to prevent complicate medical condition(s) (ii) If necessary, as appointments with a arranging for transpappointments. This REQUIREMENT by: Based on observation interview and clinical determined that the foot care services for survey sample, Resident The facility staff failed.	care.  Idents receive proper treatment in mobility and good foot must:  In and treatment, in accordance andards of practice, including tions from the resident's  I) and isst the resident in making a qualified person, and ortation to and from such  IT is not met as evidenced in staff interview, resident all record review, it was facility staff failed to provide or one of 52 residents in the ident #30.  But the determinant of the staff failed to provide or one of 52 residents in the ident #30.  But the determinant of the staff failed to provide or one of 52 residents in the ident #30.  But the determinant of the staff failed to provide or one of 52 residents in the ident #30.	F 687		

OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE (	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495045	B. WING		C 05/23/2022
SUMMARY ( (EACH DEFICIEN	G AND REHAB (RICHMOND)  STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	21	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) BE COMPLETION
R30 was admitted to that included but we and atherosclerotic.  On the most recent annual assessment reference date) of 3 15 out of 15 on the limental status) assess resident is not cognidaily decisions. See requiring extensive a personal hygiene an in range of motion to extremities.  On 5/18/2022 at 10: conducted with R30 a wheelchair in their had a concern with the residents in the faciliation to the podiatrist in over a yard knew they had a podiatrist was comin trimmed. R30 stated the podiatrist was comin trimmed. R30 stated the podiatrist was comin unit to get their nails happened. R30 stated that long, thick to have the proper tools stated that they wore	to the facility with diagnosis are not limited to quadriplegia heart disease.  MDS (minimum data set), an a with an ARD (assessment st/2/2022, the resident scored BIMS (brief interview for assment, indicating the itively impaired for making oction G documented R30 assistance of one person for and having functional limitations to both upper and lower as a R30 was observed sitting in a room. R30 stated that they the communication with lity. R30 stated that they had a staff could not trim because are and they had not seen a a rear. R30 stated that they diatrist who came to the ould ever tell them when the ang so they could get their nails do that they never found out ome until after he had already 0 stated that they had asked as to let them know when the ang so they would stay on the	F 687	1. R30 was seen by the podiatrist. 2. The Director of nursing/designee will review current residents to validate podiatry of is addressed if needed. 3. The director of nursing/designee will educate licensed nurses on "Focus on Focus on F	the -tag /e are

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	 True concession and accession	PLE CONSTRU		* 10 mm # 13 13 10 10 10	E SURVEY PLETED
		495045	B. WING			0.5	C 5/23/2022
	NAME OF PROVIDER OR SUPPLIER  PROMEDICA SKILLED NURSING AND REHAB (RICHMOND)			2125 HILLI	DRESS, CITY, STATE, ZIP CODE ARD ROAD D, VA 23228	, ,,	72022
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NOY MUST BE PRECEDED BY FULL IR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
	longer they would be The comprehensive documented in part daily living) function R/T (related to) incomplete C3 (cervical vertebrough (active range of month hand limitations. Date in the particle of the case of	core able to do so.  e care plan for R30 c, "Altered ADL (activities of a related to physical limitations omplete quadrpilegia [sic] at ra #3) level. Has no AROM tion) of legs; shoulder, elbow, ate Created: 6/4/2007; 2016" Under s" it documented in part, hygiene, grooming, dressing, g as needed. Date Initiated:  conference notes dated ocumented in part, "Ancillary ince the last care conference. Is providedAncillary services do benefit from. No ancillary ed at this time"  all record for R30 failed to ation of any podiatry services  consistency 9:25 a.m., a co ASM (administrative staff ector of nursing for the most	F 68	37			

	MENT OF DEFICIENCIES LAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  (X2) MULTIPLE CONSTRUCTION  A. BUILDING  (X2)			(X3) DATE SURVEY COMPLETED			
		495045	B. WING				C
	PROVIDER OR SUPPLIER	G AND REHAB (RICHMOND)		STREET AD	ODRESS, CITY, STATE, ZIP CODE ARD ROAD ND, VA 23228	<u> </u>	/23/2022
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
	coming and gives the they are seeing. Life residents who they prior to the podiatrist podiatrist visits were the residents relied they were coming, were allowed to trim were not diabetic if tobserved R30's toer stated that they nee podiatrist. LPN #6 dry, cracked and this R30's thick nails, lovin the feet, the nursi toenails and would care. LPN #6 agree toenails revealed the thick, dry, jagged and toenail, the second a observed to be long.  On 5/19/2022 at 9:3's conducted with RN (manager. RN #1 stakenow when a resider podiatrist and they let them on a list. RN # worker provided them to be seen when whethen the nurses coordinate room and who was son the first floor. RN keep the list after residence of the social worker. OSM	hem a list of residents that PN #6 stated that they add any know need attention to the list at coming and that the e not posted anywhere and on the staff to tell them when LPN #6 stated that the nurses in toenails of residents who they were able. LPN #6 mails with their permission and add to be trimmed by the described the toenails as long, lick. LPN #6 stated that with wer leg swelling and swelling ing staff would not trim their defer them to the podiatrist for ed that observation of R30's e great toenail to be long, and curved over to the second and third toenails were good, dry, thick and jagged.  30 a.m., an interview was (registered nurse) #1, unit ated that the nurses let them ent needed to see the est social services know to put #1 stated that the social m a list of residents who were seen the podiatrist came in and ted who was seen in their seen in an examination area N #1 stated that they did not	F	687			

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) ND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) A. BUILDING		(A)	SURVEY PLETED			
							С
		495045	B. WING			05	/23/2022
	PROVIDER OR SUPPLIER DICA SKILLED NURSING	IG AND REHAB (RICHMOND)		2125 HILLI	T ADDRESS, CITY, STATE, ZIP CODE IILLIARD ROAD MOND, VA 23228		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
	OSM #4 stated that in they requested a and facesheets for OSM #4 stated that room to see all residence of the state of the	at prior to the podiatrist coming a census list of all residents all residents to plan their visit. It the podiatrist goes room to idents when in the facility. It they received two to three the podiatrist came in contacted responsible parties needed. OSM #4 stated that nurses station of the date so isidents up and ready for the stated that on the day of the would go through the census ist to let them know who was OSM #4 stated that if any their room, the podiatrist them know. OSM #4 stated as not available they were put ext visit. OSM #4 stated that note if they cannot find them. It they did not see a note for all look in their files for one.  50 p.m., OSM #4 provided a nand management note for 22 which documented, "N/R-M #4 provided a second and management note dated ocumented podiatry services the At that time an interview of OSM #4. OSM #4 stated feen by the podiatrist on they were not in their room. It they discuss the podiatry and meeting where the director and they should pass the ursing units. OSM #4 stated ficular residents they let them liatry visits but there was no	F	687			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING			E SURVEY PLETED			
		495045	B. WNG		04	C 5/23/2022
	ROVIDER OR SUPPLIER	G AND REHAB (RICHMOND)		STREET ADDRESS, CITY, STATE, ZIP CODE 2125 HILLIARD ROAD RICHMOND, VA 23228	1 00	112312022
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL PR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
	that the nurses wo sure R30 was in the was on the unit. Of services were provingly have been our podiatrist came by should be made as coming in so they wastated that if R30 reduced by the bedocumentation in this.  The progress notes refusal of podiatry so the progress notes refusal of podiatry so the progress notes request was made regarding podiatry so to evidence a policies to evidence a policies to evidence a policies or foot care.  On 5/23/2022 at ap #2 stated that they had and podiatry so the progress notes request was made regarding podiatry so to evidence a policies to evidence a policies or foot care.  On 5/23/2022 at ap #2 stated that they had and podiatry so the progress of the progr	to residents. OSM #4 stated and be responsible for making eir room when the podiatrist SM #4 stated that podiatry ided to all residents and R30 at of the room when the OSM #4 stated that residents ware when the podiatrist was would be ready. OSM #4 efused the service there should in the progress notes regarding as for R30 failed to evidence services on 3/18/2022.  Proximately 10:00 a.m., a to ASM #2 for the facility policy services and foot care.  111 a.m., ASM #2 provided and in the progress notes regarding podiatry services were contracted.  Proximately 1:30 p.m., ASM had provided any policies they ervices were contracted.  Intrance on 5/17/22 at 12:00 did the facility's standard of at online and their policies.  Indamentals of Nursing and Wilkins 2007 Lippincott thia, page 349, "Daily bathing rimming of toenails promotes is infection, stimulates in, and controls odors by	F 687			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED
		495045	B. WING		C 05/23/2022
	ROVIDER OR SUPPLIER	IG AND REHAB (RICHMOND)	2125	EET ADDRESS, CITY, STATE, ZIP CODE HILLIARD ROAD HMOND, VA 23228	00/20/2022
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETION
F 689 SS=D	under toenails. For for bed ridden patis susceptible to foot peripheral vascula consult a podiatr On 5/19/2022 at 5 staff member) #1, director of nursing resource director vindings.  No further informat Free of Accident H CFR(s): 483.25(d) Accident The facility must et §483.25(d)(1) The as free of accident \$483.25(d)(2) Each supervision and as accidents. This REQUIREME by: Based on staff intereview, it was dete evaluate smoking fresidents, Resident evidence that they assessment for Retassessment for Retasses The findings including the susceptible of the findings in susceptible of th	om between the toes and bot care is particularly important ent and those especially infection such as patients with r disease and diabetes mellitus ist if the nails need trimming"  11 p.m., ASM (administrative the administrator, ASM #2, the and OSM #2, the human were made aware of the district of t	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DA	(X3) DATE SURVEY COMPLETED	
		495045	B. WING _			C 05/23/2022	
	PROVIDER OR SUPPLIER	G AND REHAB (RICHMOND)		STREET ADDRESS, CITY, STATE, ZIP CO 2125 HILLIARD ROAD RICHMOND, VA 23228		312312322	
(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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE	
	at 4:00 PM and again Staff provided cigare from locked box the staff were present with Resident #33 did not behavior.  A list of smoking time 9:00 AM, 1:00 PM, 42 Resident #33 was at 7/13/21 with diagnost limited to: congestive dementia, pacemake apnea.  The most recent MD assessment, a quart ARD (assessment recoded the resident at the BIMS (brief internindicating the resident impaired. A review of G-functional status of requiring extensive at transfer, dressing, hysupervision for locondorspecial procedure resident as oxygen massessment, unable coded as yes under statistical at nurses and the staff procedure resident as oxygen assessment, unable coded as yes under staff procedure resident as oxygen assessment, unable coded as yes under staff procedure resident as oxygen assessment, unable coded as yes under staff procedure resident as oxygen assessment, unable coded as yes under staff procedure resident as oxygen assessment, unable coded as yes under staff procedure resident as oxygen assessment, unable coded as yes under staff procedure resident as oxygen assessment, unable coded as yes under staff procedure resident as oxygen assessment, unable coded as yes under staff procedure resident as oxygen assessment, unable coded as yes under staff procedure.	ettes and lighter to residents by brought with them. Two with residents as they smoked. In exhibit any unsafe smoking times of 4:00 PM and 8:00 PM.  Idmitted to the facility on sis that included but were not be heart failure, diabetes, for and obstructive sleep  OS (minimum data set) terly assessment, with an efference date) of 3/8/22, for second a 11 out of 15 on exiew for mental status) score, for the MDS Section coded the resident as assistance for bed mobility, ygiene and bathing; motion and eating. Section estreatments coded the esternal dated eated, "FOCUS: History of ity/Inappropriate smoking.	F 6	689 – Free of Accident Hazards/Supervision/Do 1. R33 smoking assess updated. 2. Utilizing the "Smok tool – the director of nursing/designee will comprehensive audit to updated smoking assess in place. 3. The director of nursing/designee will edicensed nursing staff or f-tag 689 and "smoking guideline before the date of complete date will also residents per week times weeks to validate current assessments are in place will be reviewed with the committee.	evices sment was ing" QAPI omplete a o validate sments are ducate the n "Focus on es" on or pliance. ing" QAPI udit five es four ent smoking se. Results	6/30/2022	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
		495045	B. WING				C 05/23	3/2022
	ROVIDER OR SUPPLIER	G AND REHAB (RICHMOND)		2125 HIL	ADDRESS, CITY, STATE, ZIP CODE LLIARD ROAD OND, VA 23228			
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	22	(X5) COMPLETION DATE
F 689	plan did not include observation of resident was completed with Resident was smoked, while Resident #33 states came here.  On 5/17/22 at 4:10 conducted with OS the laundry aide. Www. www. www. www. www. www. www. ww	ed smoking times." The care a smoking till 5/18/22 after dent smoking.  conducted on 5/17/22 at 4:00 at 33. When asked how long he he has been a resident, and, I have been smoking since I are provided by the sm	F	689				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE (	(X3) DATE SURVEY COMPLETED	
		495045	B. WING		C 05/23/2022
	ROVIDER OR SUPPLIER	G AND REHAB (RICHMOND)	21:	REET ADDRESS, CITY, STATE, ZIP CODE 25 HILLIARD ROAD CHMOND, VA 23228	1 00/20/2022
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE COMPLETION
	S483.25(g) (Assisted (Includes naso-gased both percutaneous percutaneous endocenteral fluids). Based comprehensive assensure that a reside strain of nutritional status desirable body weight balance, unless the demonstrates that a preferences indicated samples of the samples o	and nutrition and hydration.  Stric and gastrostomy tubes, endoscopic gastrostomy and escopic jejunostomy, and sed on a resident's sessment, the facility must ent-  Intains acceptable parameters is, such as usual body weight or ght range and electrolyte eresident's clinical condition this is not possible or resident the otherwise;  If ered sufficient fluid intake to diration and health;  If ered a therapeutic diet when all problem and the health care herapeutic diet.  Nor is not met as evidenced  Inview, facility document record review, it was a facility staff failed to address ant weight loss for one of 52 vey sample, Resident #63  If //2/1 and 1/14/22, R63  Weight loss, and the facility ment interventions.	F 692	Maintenance  1. R63 was seen by the dies and an updated nutrition assessment was completed.  2. Utilizing the "change in condition" QAPI tool – the dies of nursing/designee will compressed of any significant weight changes from 5.23.2022 to contour validate updated nutrition assessments were completed assessments were completed or before the date of compliant dietician on "focus on f-tag 65 or before the date of compliant dietician will review five residing per week times four weeks to validate significant changes in weight have updated nutrition assessments completed. Results to reviewed with the QA&A committee.	rector plete a ght urrent al . e the 92" on nce. stered ents