STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495247	A. BUILDING _____ B. WING _____	C 07/12/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NANS POINTE REHABILITATION AND NURSING	200 WEST CONSTANCE ROAD SUFFOLK, VA 23434

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 07/05/22 through 07/08/22 and 7/11/22 through 7/12/22. Corrections are required for compliance with 42 CFR Part 483.73, Requirement for Long Term Care Facilities. No emergency preparedness complaints were investigated during the survey.	E 000		
E 006 SS=C	Plan Based on All Hazards Risk Assessment CFR(s): 483.73(a)(1)-(2) §403.748(a)(1)-(2), §416.54(a)(1)-(2), §418.113(a)(1)-(2), §441.184(a)(1)-(2), §460.84(a)(1)-(2), §482.15(a)(1)-(2), §483.73(a)(1)-(2), §483.475(a)(1)-(2), §484.102(a)(1)-(2), §485.68(a)(1)-(2), §485.625(a)(1)-(2), §485.727(a)(1)-(2), §485.920(a)(1)-(2), §486.360(a)(1)-(2), §491.12(a)(1)-(2), §494.62(a)(1)-(2) [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following:] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach.* (2) Include strategies for addressing emergency events identified by the risk assessment. * [For Hospices at §418.113(a):] Emergency Plan. The Hospice must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following: (1) Be based on and include a documented,	E 006		8/19/22

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

Electronically Signed | 08/16/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495247	A. BUILDING _____ B. WING _____	C 07/12/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NANS POINTE REHABILITATION AND NURSING	200 WEST CONSTANCE ROAD SUFFOLK, VA 23434

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 006	Continued From page 1 facility-based and community-based risk assessment, utilizing an all-hazards approach. (2) Include strategies for addressing emergency events identified by the risk assessment, including the management of the consequences of power failures, natural disasters, and other emergencies that would affect the hospice's ability to provide care. *[For LTC facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing residents. (2) Include strategies for addressing emergency events identified by the risk assessment. *[For ICF/IIDs at §483.475(a):] Emergency Plan. The ICF/IID must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing clients. (2) Include strategies for addressing emergency events identified by the risk assessment. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility staff failed to have documentation of the facility's updated Emergency Preparedness Plan.	E 006	1)Interdisciplinary team together with corporate resources updated the Emergency Preparedness Plan. 2)All residents may be impacted by this	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495247	A. BUILDING _____ B. WING _____	C 07/12/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NANS POINTE REHABILITATION AND NURSING	200 WEST CONSTANCE ROAD SUFFOLK, VA 23434

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 006	Continued From page 2 The findings included: During an interview on 07/08/22 at 9:47 A.M. with the Interim Administrator and the Administrator In Training (AIT), the Interim Director was asked for documentation of the facility's community based risk assessments that will assist the facility in addressing the needs of their patients. The Interim Administrator and the Administrator In Training, stated the facility had not conducted a risk assessment of it's emergency preparedness plan. The documentation presented indicated the Emergency Preparedness Plan had not been updated since 04/13/18.	E 006	deficient practice. 3)Staff in-serviced on the EPP plan on July 29th, 2022 at Facility Education Fair Day; IDT review final updates July Quality Assurance meeting August 18, 2022. 4)Administrator/designee will audit EPP for 3x months for any required updates and will be reviewed monthly in Quality Assurance.	
E 007 SS=C	EP Program Patient Population CFR(s): 483.73(a)(3) §403.748(a)(3), §416.54(a)(3), §418.113(a)(3), §441.184(a)(3), §460.84(a)(3), §482.15(a)(3), §483.73(a)(3), §483.475(a)(3), §484.102(a)(3), §485.68(a)(3), §485.625(a)(3), §485.727(a)(3), §485.920(a)(3), §491.12(a)(3), §494.62(a)(3). [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following:] (3) Address [patient/client] population, including, but not limited to, persons at-risk; the type of services the [facility] has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession plans.** *[For LTC facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain	E 007		8/19/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495247	A. BUILDING _____ B. WING _____	C 07/12/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NANS POINTE REHABILITATION AND NURSING	200 WEST CONSTANCE ROAD SUFFOLK, VA 23434

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 007	Continued From page 3 an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do all of the following: (3) Address resident population, including, but not limited to, persons at-risk; the type of services the LTC facility has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession plans. *NOTE: ["Persons at risk" does not apply to: ASC, hospice, PACE, HHA, CORF, CMCH, RHC/FQHC, or ESRD facilities.] This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility staff failed to have documentation of the facility's patient population and services the facility would be able to provide during an emergency. The findings included: During an interview on 07/08/22 at 9:55 A.M. with the Interim Administrator and the Administrator in Training (AIT), the Interim Administrator was asked for documentation of the facility's patient population and services the facility would be able to provide during an emergency. The Interim Director and the Administrator in Training, stated the facility had not conducted a patient population assessment nor had they reviewed what services would be provided during an emergency. The documentation presented indicated the Emergency Preparedness Plan had not been updated since 04/13/18.	E 007	1)Interdisciplinary team together with corporate resources updated the Emergency Preparedness Plan to include current patient population and services that would be provided during an emergency. 2)All residents may be impacted by this deficient practice. 3)Staff in-serviced on the EPP plan on July 29th, 2022 at Facility Education Fair Day; IDT review final updates ADHOC July Quality Assurance meeting August 18, 2022. 4)Administrator/designee will audit EPP for 3x months for any required updates and will be reviewed monthly in Quality Assurance.	
E 013 SS=C	Development of EP Policies and Procedures	E 013		8/19/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495247	A. BUILDING _____ B. WING _____	C 07/12/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NANS POINTE REHABILITATION AND NURSING	200 WEST CONSTANCE ROAD SUFFOLK, VA 23434

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 013	Continued From page 4 CFR(s): 483.73(b) §403.748(b), §416.54(b), §418.113(b), §441.184(b), §460.84(b), §482.15(b), §483.73(b), §483.475(b), §484.102(b), §485.68(b), §485.625(b), §485.727(b), §485.920(b), §486.360(b), §491.12(b), §494.62(b). (b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years. *[For LTC facilities at §483.73(b):] Policies and procedures. The LTC facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. *Additional Requirements for PACE and ESRD Facilities: *[For PACE at §460.84(b):] Policies and procedures. The PACE organization must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must	E 013		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495247	A. BUILDING _____ B. WING _____	C 07/12/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NANS POINTE REHABILITATION AND NURSING	200 WEST CONSTANCE ROAD SUFFOLK, VA 23434

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 013	Continued From page 5 address management of medical and nonmedical emergencies, including, but not limited to: Fire; equipment, power, or water failure; care-related emergencies; and natural disasters likely to threaten the health or safety of the participants, staff, or the public. The policies and procedures must be reviewed and updated at least every 2 years. *[For ESRD Facilities at §494.62(b):] Policies and procedures. The dialysis facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years. These emergencies include, but are not limited to, fire, equipment or power failures, care-related emergencies, water supply interruption, and natural disasters likely to occur in the facility's geographic area. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility staff failed to have documentation of the facility's Emergency Preparedness Plan policy and procedures had been updated on an annual basis. The findings included: During an interview on 07/08/22 at 10:12 A.M. with the Interim Administrator (IA) and the Administrator in Training (AIT) were asked for documentation of the facility's Emergency Preparedness updated policy and procedures.	E 013	1)Interdisciplinary team together with corporate resources updated the Emergency Preparedness Plan policy and procedures 2)All residents may be impacted by this deficient practice. 3)Staff in-serviced on the EPP plan on July 29th, 2022 at Facility Education Fair Day; IDT review final updates ADHOC July Quality Assurance meeting August 18, 2022. 4)Administrator/designee will audit EPP for 3x months for any required updates and will be reviewed monthly in Quality	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495247	A. BUILDING _____ B. WING _____	C 07/12/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NANS POINTE REHABILITATION AND NURSING	200 WEST CONSTANCE ROAD SUFFOLK, VA 23434

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 013	Continued From page 6 The IA stated the facility had not updated the Emergency Preparedness Plan policy and procedures. The documentation presented indicated the Emergency Preparedness Plan had not been updated since 04/13/18.	E 013	Assurance	
E 037 SS=C	EP Training Program CFR(s): 483.73(d)(1) §403.748(d)(1), §416.54(d)(1), §418.113(d)(1), §441.184(d)(1), §460.84(d)(1), §482.15(d)(1), §483.73(d)(1), §483.475(d)(1), §484.102(d)(1), §485.68(d)(1), §485.625(d)(1), §485.727(d)(1), §485.920(d)(1), §486.360(d)(1), §491.12(d)(1). *[For RNCHIs at §403.748, ASCs at §416.54, Hospitals at §482.15, ICF/IIDs at §483.475, HHAs at §484.102, "Organizations" under §485.727, OPOs at §486.360, RHC/FQHCs at §491.12:] (1) Training program. The [facility] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the [facility] must conduct training on the updated policies and procedures. *[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following:	E 037		8/19/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495247	A. BUILDING _____ B. WING _____	C 07/12/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NANS POINTE REHABILITATION AND NURSING	200 WEST CONSTANCE ROAD SUFFOLK, VA 23434

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 037	Continued From page 7 (i) Initial training in emergency preparedness policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, consistent with their expected roles. (ii) Demonstrate staff knowledge of emergency procedures. (iii) Provide emergency preparedness training at least every 2 years. (iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the procedures necessary to protect patients and others. (v) Maintain documentation of all emergency preparedness training. (vi) If the emergency preparedness policies and procedures are significantly updated, the hospice must conduct training on the updated policies and procedures. *[For PRTFs at §441.184(d):] (1) Training program. The PRTF must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) After initial training, provide emergency preparedness training every 2 years. (iii) Demonstrate staff knowledge of emergency procedures. (iv) Maintain documentation of all emergency preparedness training. (v) If the emergency preparedness policies and procedures are significantly updated, the PRTF must conduct training on the updated policies and	E 037		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495247	A. BUILDING _____ B. WING _____	C 07/12/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NANS POINTE REHABILITATION AND NURSING	200 WEST CONSTANCE ROAD SUFFOLK, VA 23434

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 037	Continued From page 8	E 037		

procedures.

*[For PACE at §460.84(d):] (1) The PACE organization must do all of the following:
(i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, contractors, participants, and volunteers, consistent with their expected roles.
(ii) Provide emergency preparedness training at least every 2 years.
(iii) Demonstrate staff knowledge of emergency procedures, including informing participants of what to do, where to go, and whom to contact in case of an emergency.
(iv) Maintain documentation of all training.
(v) If the emergency preparedness policies and procedures are significantly updated, the PACE must conduct training on the updated policies and procedures.

*[For LTC Facilities at §483.73(d):] (1) Training Program. The LTC facility must do all of the following:
(i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected role.
(ii) Provide emergency preparedness training at least annually.
(iii) Maintain documentation of all emergency preparedness training.
(iv) Demonstrate staff knowledge of emergency procedures.

*[For CORFs at §485.68(d):](1) Training. The CORF must do all of the following:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495247	A. BUILDING _____ B. WING _____	C 07/12/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NANS POINTE REHABILITATION AND NURSING	200 WEST CONSTANCE ROAD SUFFOLK, VA 23434

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 037	Continued From page 9 (i) Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. All new personnel must be oriented and assigned specific responsibilities regarding the CORF's emergency plan within 2 weeks of their first workday. The training program must include instruction in the location and use of alarm systems and signals and firefighting equipment. (v) If the emergency preparedness policies and procedures are significantly updated, the CORF must conduct training on the updated policies and procedures. *[For CAHs at §485.625(d):] (1) Training program. The CAH must do all of the following: (i) Initial training in emergency preparedness policies and procedures, including prompt reporting and extinguishing of fires, protection, and where necessary, evacuation of patients, personnel, and guests, fire prevention, and cooperation with firefighting and disaster authorities, to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures.	E 037		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495247	A. BUILDING _____ B. WING _____	C 07/12/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NANS POINTE REHABILITATION AND NURSING	200 WEST CONSTANCE ROAD SUFFOLK, VA 23434

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 037	Continued From page 10 (v) If the emergency preparedness policies and procedures are significantly updated, the CAH must conduct training on the updated policies and procedures. *[For CMHCs at §485.920(d):] (1) Training. The CMHC must provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least every 2 years. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility staff failed to have documentation of the facility's staff receiving annual emergency preparedness training. The findings included: During an interview on 07/08/22 at 11:41 A.M. with the Interim Administrator (IA) and the, the Administrator in Training (AIT) the IA was asked for documentation of the staff Emergency Preparedness annual training and testing. The IA, stated the facility had not implemented annual training and testing. The documentation presented indicated the Emergency Preparedness Plan written training and testing program had not been updated and implemented since 04/13/18.	E 037	1)Interdisciplinary team together with corporate resources provided staff with annual emergency preparedness training at Staff Education Fair July 29, 2022 2)All residents may be impacted by this deficient practice. 3)Staff in-serviced on the EPP plan on July 29th, 2022 at Facility Education Fair Day. Staff educator will conduct annual training no later than June 30th each year. 4)Staff Educator/designee will audit employee educational files monthly for 3x months to ensure documentation of emergency preparedness training.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495247	A. BUILDING _____ B. WING _____	C 07/12/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NANS POINTE REHABILITATION AND NURSING	200 WEST CONSTANCE ROAD SUFFOLK, VA 23434

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	Continued From page 11	F 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 07/05/22 through 07/08/22 and 07/11/22 through 07/12/22. Significant corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. Seven (7) complaints were investigated during the survey: VA00055522-Substantiated, with a deficiency, VA00054831-Substantiated, with a deficiency, VA00054645-Substantiated, with a deficiency, VA00054349-Substantiated, with a deficiency, VA00055161-Substantiated, with a deficiency, VA00055456-Substantiated, with a deficiency, VA00055450-Substantiated, without a deficiency. The census in this 148 certified bed facility was 94 at the time of the survey. The survey sample consisted of 41 current Resident reviews and 6 closed record reviews.	F 000		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or	F 580		8/19/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495247	A. BUILDING _____ B. WING _____	C 07/12/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NANS POINTE REHABILITATION AND NURSING	200 WEST CONSTANCE ROAD SUFFOLK, VA 23434

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 580	Continued From page 12 clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, clinical record review, a review of	F 580	1.Resident #318 discharged from the facility 5/20/22	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495247	A. BUILDING _____ B. WING _____	C 07/12/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NANS POINTE REHABILITATION AND NURSING	200 WEST CONSTANCE ROAD SUFFOLK, VA 23434

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 580	Continued From page 13 facility documents and during a complaint investigation, the facility's staff failed to notify family of significant weight loss for 1 of 47 residents (Resident #318), in the survey sample. The findings Included: The POS (Physician Order Summary) for May 2021 reads: Weigh Daily every day shift for Heart Failure Monitoring ALERT MD FOR WT GAIN OF 3LB IN ONE DAY, 5LB IN ONE WEEK, INCREASED EDEMA, SOB. Order date: 3/04/21. Start Date: 3/05/21. House Supplement in the morning 237 ml QD Order Date: 04/09/2022. Start Date: 04/10/2022. The Medication Administration Record (MAR) for May 2022 read: Furosemide Tablet 40 MG Give 1 tablet by mouth two times a day for CHF -Start Date 04/06/2021 1700 -D/C Date 05/23/2022 1204. All doses were administered. Resident #318 was originally admitted to the facility on 10/03/2017 and discharged on 5/20/22 to an acute care facility. The current diagnoses included; CHRONIC COMBINED SYSTOLIC (CONGESTIVE) AND DIASTOLIC (CONGESTIVE) HEART FAILURE AND CHRONIC ATRIAL FIBRILLATION, UNSPECIFIED. The significant change Minimum Data Set (MDS) assessment with an assessment reference date	F 580	2.Residents with weight loss have the potential to be affected by this practice. An audit of all weight loss in last 30 days will be completed to ensure RP notification of weight loss has been completed. 3.Director of Nursing will reeducate all licensed staff regarding notification of RP regarding weight loss. 4.Director of nursing or designee to audit weights weekly x 4 weeks to ensure all notifications are made. Any variances will be corrected and reeducation completed. The results of the audits will be reported to QAPI team for additional oversight.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495247	A. BUILDING _____ B. WING _____	C 07/12/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NANS POINTE REHABILITATION AND NURSING	200 WEST CONSTANCE ROAD SUFFOLK, VA 23434

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 580	Continued From page 14	F 580		

(ARD) of 04/15/22 coded the Resident as completing the Brief Interview for Mental Status (BIMS) and scoring 8 out of a possible 15. This indicated Resident #318 cognitive abilities for daily decision making were moderately impaired.

In section "G" (Physical functioning) the resident was coded as requiring extensive assistance of one person with bed mobility, dressing, bathing, eating and personal hygiene. Requiring extensive assistance of one person with dressing, toileting and personal hygiene. Requires total dependence with toileting.

The Care Plan reads that Resident #318 Focus: Resident is obese r/t excess energy intake. Date Initiated: 10/09/2017. Revision on: 03/08/2021. Resolved Date: 03/08/2021. Goal: Will consume adequate energy to lose 1-2 lbs. per month towards IBW= 160 lbs. Date Initiated: 10/09/2017. Revision on: 03/17/2022. Target Date: 07/20/2022. Interventions: Will consume adequate energy to lose 1-2 lbs per month towards IBW= 160 lbs. Date Initiated: 10/09/2017. Revision on: 02/24/2022. Resolved Date: 03/08/2021. Monitor and evaluate weight / weight changes. Date Initiated: 10/09/2017. Revision on: 03/08/2021. Resolved Date: 03/08/2021 Notify RD, family, and physician of significant weight changes.

Focus: The resident is on diuretic therapy r/t HTN/CHF. Date Initiated: 11/21/2021. Revision on: 11/21/2021. Goals: The resident will be free of any discomfort or adverse side effects of diuretic therapy through the review date. Date Initiated: 11/21/2021. Revision on: 03/17/2022. Target Date: 07/20/2022. Interventions: Administer DIURETIC medications as ordered by

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495247	A. BUILDING _____ B. WING _____	C 07/12/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NANS POINTE REHABILITATION AND NURSING	200 WEST CONSTANCE ROAD SUFFOLK, VA 23434

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 580	Continued From page 15	F 580		

physician. Monitor for side effects and effectiveness Q-SHIFT. Date Initiated: 11/21/2021.

A review of weights:
4/21/22 through 5/10/22 204.0 Lbs.
5/20/2022 161.2 Lbs,
5/19/2022 162.0 Lbs,
5/18/2022 163.6 Lbs.,
5/16/2022 163.9 Lbs.
5/15/2022 164.1 Lbs.,
5/14/2022 164.6 Lbs.

A review of most recent Dietary/Nutrition progress notes dated 4/09/22 revealed that resident had a significant weight change. Weighing 205.6 pounds. It reads: Resident #316 has a history of weight changes. Monitor daily weights. Continue to monitor resident closely via daily weights and add an oral nutritional supplement daily to promote kcal intake. Recommend house supplement.

A review of previous Dietary/Nutrition progress note dated 2/28/22 reveal that resident weighed 220.0 pounds. No recommendations due to resident having a previous history of weight changes of gains and losses.

On 7/06/22 at approximate 7:55 PM a telephone interview was conducted with Resident #316's daughter concerning his weight loss. She said that she was concerned when she noticed that her father had lost weight and no one from the facility had informed her of it.

On 7/12/22 at approximately 6:12 PM an interview was conducted with the Dietician (OSM/Other Staff member #6) concerning

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495247	A. BUILDING _____ B. WING _____	C 07/12/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NANS POINTE REHABILITATION AND NURSING	200 WEST CONSTANCE ROAD SUFFOLK, VA 23434

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 580	Continued From page 16 Resident #318s weights. She said that Resident #318s diet had been downgraded from a regular diet to a mechanical soft diet and a house supplement. The forty pound weight loss had been confirmed with a re-weight. The resident had already been discharged from the facility six days after his weight was taken. I'm not sure if that was his true weight." She also said that the staff should have notified the family of his weight loss because it's normally not her responsibility. According to Medical records Resident #318 was discharged from the facility on 5/20/22 and was not present at the facility on 5/27/22. On 7/11/22 at approximately 2:35 PM an interview was conducted with LPN #2 concerning Resident #316. She said that his legs would swell because he would be in his wheel chair a lot. On 7/12/22 at approximately 5:48 PM an interview was conducted with the unit manager (LPN #5) concerning Resident #318. He said that the family and physician should have been notified of Resident's weight change. This is a complaint deficiency.	F 580		
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to	F 584		8/19/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495247	A. BUILDING _____ B. WING _____	C 07/12/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NANS POINTE REHABILITATION AND NURSING	200 WEST CONSTANCE ROAD SUFFOLK, VA 23434

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 584	Continued From page 17 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)(5) Adequate and comfortable lighting levels in all areas; §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, and staff interviews, and review of facility documents, the facility staff failed to ensure the facility's floors including resident rooms and common area were kept clean sanitary and homelike. The findings included:	F 584	1.Housekeeping staff have been hired to ensure that rooms and common areas are kept clean and sanitary. 2.All resident rooms have the potential to be affected by this practice. 3.Environmental Director ordered a buffer and confirmed it has been shipped. The	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495247	A. BUILDING _____ B. WING _____	C 07/12/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NANS POINTE REHABILITATION AND NURSING	200 WEST CONSTANCE ROAD SUFFOLK, VA 23434

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 584	Continued From page 18 On 7/6/22 resident rooms 119, 103, and 115 were observed with many stains and heavily soiled floors. On 7/11/22 the corridors were heavily soiled and paths of wetness throughout the resident care areas and evidence of wheels rolling through the wetness and tracking it throughout the building were obvious. An interview was conducted with the Director of Environmental Services on 7/11/22 at approximately 4:28 p.m. The Director of Environmental Services stated two staff member quit before the weekend of 7/9/22 - 7/10/22 therefore the manpower needed to provide facility services wasn't available and they are with needed equipment to keep the floors clean. The Director of Environmental Services stated the scrubber has been out of order for approximately a month and they have one buffer but the electrical cord has been broken for 2.5 weeks and the Maintenance Director has been attempting to obtain a replacement cord. The Director of Environmental Services also stated she provides the manpower which is three housekeepers and two floor techs daily and the scrubber is utilized to maintain the floors based on the number of staff allowed on a daily basis and her staffing pattern doesn't include sufficient staff to physically mop the floors and neither would physical mopping the floor remove the scuff marks caused by the wheel chairs. The Director of Environmental Services stated the cleaning equipment is owned by the facility and she had notified the appropriate personnel of the needed equipment but the owner hadn't obtained it at the time of our interview.	F 584	new floor scrubber will be used daily to ensure the cleanliness of the facility and resident rooms. Floors will be waxed and buffed daily and as needed. 4.Director of Environmental services will audit 10 resident rooms weekly for 4 weeks for cleanliness for compliance. The results of these audits will be reported to the QAPI team by the Director of Environmental services to ensure on going compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495247	A. BUILDING _____ B. WING _____	C 07/12/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NANS POINTE REHABILITATION AND NURSING	200 WEST CONSTANCE ROAD SUFFOLK, VA 23434

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 584	Continued From page 19 On 7/12/22 at approximately 8:00 p.m., the above findings were shared with the Administrator, Director of Nursing and Corporate Consultant. The Administrator in Training stated on 7/7/22 the walk behind scrubber was ordered and she had no estimated date of delivery and the Interim Administrator stated the owner stated the buffer would be ordered tonight 7/12/22.	F 584		
F 620 SS=D	Admissions Policy CFR(s): 483.15(a)(1)-(7) §483.15(a) Admissions policy. §483.15(a)(1) The facility must establish and implement an admissions policy. §483.15(a)(2) The facility must- (i) Not request or require residents or potential residents to waive their rights as set forth in this subpart and in applicable state, federal or local licensing or certification laws, including but not limited to their rights to Medicare or Medicaid; and (ii) Not request or require oral or written assurance that residents or potential residents are not eligible for, or will not apply for, Medicare or Medicaid benefits. (iii) Not request or require residents or potential residents to waive potential facility liability for losses of personal property. §483.15(a)(3) The facility must not request or require a third party guarantee of payment to the facility as a condition of admission or expedited admission, or continued stay in the facility. However, the facility may request and require a resident representative who has legal access to a resident's income or resources available to pay for facility care to sign a contract, without	F 620		8/19/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495247	A. BUILDING _____ B. WING _____	C 07/12/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NANS POINTE REHABILITATION AND NURSING	200 WEST CONSTANCE ROAD SUFFOLK, VA 23434

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 620	Continued From page 20	F 620		

incurring personal financial liability, to provide facility payment from the resident's income or resources.

§483.15(a)(4) In the case of a person eligible for Medicaid, a nursing facility must not charge, solicit, accept, or receive, in addition to any amount otherwise required to be paid under the State plan, any gift, money, donation, or other consideration as a precondition of admission, expedited admission or continued stay in the facility. However,-
(i) A nursing facility may charge a resident who is eligible for Medicaid for items and services the resident has requested and received, and that are not specified in the State plan as included in the term "nursing facility services" so long as the facility gives proper notice of the availability and cost of these services to residents and does not condition the resident's admission or continued stay on the request for and receipt of such additional services; and
(ii) A nursing facility may solicit, accept, or receive a charitable, religious, or philanthropic contribution from an organization or from a person unrelated to a Medicaid eligible resident or potential resident, but only to the extent that the contribution is not a condition of admission, expedited admission, or continued stay in the facility for a Medicaid eligible resident.

§483.15(a)(5) States or political subdivisions may apply stricter admissions standards under State or local laws than are specified in this section, to prohibit discrimination against individuals entitled to Medicaid.

§483.15(a)(6) A nursing facility must disclose and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495247	A. BUILDING _____ B. WING _____	C 07/12/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NANS POINTE REHABILITATION AND NURSING	200 WEST CONSTANCE ROAD SUFFOLK, VA 23434

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 620	Continued From page 21 provide to a resident or potential resident prior to time of admission, notice of special characteristics or service limitations of the facility. §483.15(a)(7) A nursing facility that is a composite distinct part as defined in §483.5 must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under paragraph (c)(9) of this section. This REQUIREMENT is not met as evidenced by: Based on a closed record review, staff interview and a complaint investigation, the facility staff failed to provide one resident (Resident #317) with an admissions package including admissions policies, transfer/discharge agreement and financial agreement in the survey sample of 47 residents. The findings included: Resident #317 was admitted to the facility from a hospital on 1/21/22 with diagnoses of muscle weakness, osteoporosis, hypertension and depression. Complainant alleges resident nor Authorized Representative were provided with an admission packet, including admission agreement and financial agreement. A review of the closed clinical record did not reveal an admission agreement was provided or signed by the resident or Authorized Representative. During an interview on 7/6/22 at 4:10 PM the Regional Admissions Director confirmed Resident	F 620	1)Resident #317 had been discharged and could not correct admissions package 2)All new admitted residents may be impacted by this deficient practice. An audit of all current residents residing at Nans Pointe Rehab was conducted to identify any missing admission package documents. 3)Education has been provided to Admission Director regarding the admissions package including admissions policies, transfer/discharge agreement and financial agreements. Admissions director set up a workflow that included admission package being signed within 3 days of admission. 4)Administrator/designee will audit new admissions for completed signed admission agreement weekly for 4 weeks for compliance. The results of these audits will be reported to the QAPI Team monthly to ensure on going compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495247	A. BUILDING _____ B. WING _____	C 07/12/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NANS POINTE REHABILITATION AND NURSING	200 WEST CONSTANCE ROAD SUFFOLK, VA 23434

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 620	Continued From page 22 #317 was not provided with an Admission Agreement, Transfer/Discharge Agreement nor a Financial Agreement. An Admission policy and procedure was requested but not provided during the survey. Compliant Deficiency	F 620		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff interview and facility documentation, the facility staff failed to ensure that 1 of 47 residents (Resident #86) in the survey sample received a complete and accurate assessment Minimum Data Set (MDS). The findings included: 1. The facility staff failed to ensure Resident #86's, quarterly MDS assessment with an Assessment Reference Date (ARD) of 06/09/22 was coded correctly under section N0450 (Antipsychotic Medication Review.) Resident #86 was admitted to the facility on 02/07/22. Diagnosis for Resident #86 included but not limited to dementia without behavioral disturbances. The current Minimum Data Set (MDS), a quarterly assessment with an Assessment Reference Date (ARD) of 06/09/22 coded the Resident #86 with a 01 out of a possible score of 15 on the Brief	F 641	1.Resident #86 quarterly MDS of 6/9/22 was corrected on 6/20/22 in accordance with RAI guidelines in section “N0450.” 2.All residents may have potentially been impacted. 100% audit of current resident’s most recent MDS assessments will be audited for accurate coding of Section N. Variances will be investigated and corrections made in accordance with RAI manual instructions. 3.Facility team members responsible for completing Section N of the MDS will be re-educated by the regional MDS coordinator on accurate coding of the MDS in accordance with the RAI manual instructions. 4.The MDS staff will audit assessments completed by MDS staff other than themselves. 3 MDS assessments per week x8 weeks to ensure accurate coding in Section N. Variances will be investigated and corrected as appropriate.	8/19/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495247	A. BUILDING _____ B. WING _____	C 07/12/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NANS POINTE REHABILITATION AND NURSING	200 WEST CONSTANCE ROAD SUFFOLK, VA 23434

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 641	Continued From page 23 Interview for Mental Status (BIMS) indicating severe cognitive impairment. A review of Resident #86's quarterly MDS with an ARD of 06/09/22 was coded for receiving antipsychotic medications. The section N on the MDS under medications was coded as being received by the resident for 7 days during the last 7 days. Under section N0450 (B) was coded for not having a gradual dose reduction (GDR). Resident #86's person-centered care plan created on 11/29/21 documented resident uses psychotropic medications. The goal set for the resident by the staff was that the resident will reduce the use of psychotropic medication through the review date of 09/18/22. Some of the intervention to manage the resident's goal include to administer psychotropic medications as ordered by the physician, monitor for side effects and effectiveness every shift and consult with pharmacy, physician to consider dose reductions when clinically appropriate at least quarterly. On 05/25/22, a psychiatric evaluation follow-up progress revealed that Resident #86 is being seen today for evaluation of status and review of medication adjustment. Further review of the progress noted documented staff identifies no behavioral issues so a recommendation to decrease the resident's Seroquel from 25 mg every morning and 50 mg every night to 25 mg twice daily as a GDR attempt. A review of Resident #86's Medication Administration Report (MAR) revealed the following orders: -Starting on 03/16/22 - Seroquel 25 mg tablet -give 1 tablet by mouth daily every morning and	F 641	The weekly audits will be provided to the administrator for trending. A summary of the weekly audits will be provided to the QAPI committee for additional oversight.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495247	A. BUILDING _____ B. WING _____	C 07/12/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NANS POINTE REHABILITATION AND NURSING	200 WEST CONSTANCE ROAD SUFFOLK, VA 23434

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 641	Continued From page 24	F 641		

50 mg daily at bedtime for mood stabilizer.
-Starting on 05/25/ 22 - Start Seroquel 25 mg tablet - give 1 tablet by mouth twice a day for mood stabilizer.

An interview was conducted with MDS Coordinator #1 on 07/12/22 at approximately 10:36 a.m. She said the psychiatric evaluation progress note dated 05/25/22 included the recommendation to decrease Resident #86's Seroquel from 50 mg at bedtime to 25 mg at bedtime. She said the MDS dated 06/09/22 was coded incorrectly. The MDS Coordinator continued to say, a correction will be made to the MDS mentioned to reflect the GDR made on 05/25/22.

A debriefing was conducted with the Administrator, Director of Nursing (DON) 07/05/22 at approximately 5:52 p.m. The Administration team were informed of the above findings; no further information was provided prior to exit.

CMS's RAI Version 3.0 Manual - Chapter 1: Resident assessment Instrument (RAI).
-An accurate assessment requires collecting information from multiple sources, some of which are mandated by regulations. Those sources must include the resident and direct care staff on all shifts, and should also include the resident's medical record, physician, and family, guardian, or significant other as appropriate or acceptable. It is important to note here that information obtained should cover the same observation period as specified by the MDS items on the assessment, and should be validated for accuracy (what the resident's actual status was during that observation period) by the IDT

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495247	A. BUILDING _____ B. WING _____	C 07/12/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NANS POINTE REHABILITATION AND NURSING	200 WEST CONSTANCE ROAD SUFFOLK, VA 23434

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 641	Continued From page 25 completing the assessment. As such, nursing homes are responsible for ensuring that all participants in the assessment process have the requisite knowledge to complete an accurate assessment.	F 641		
F 645 SS=D	PASARR Screening for MD & ID CFR(s): 483.20(k)(1)-(3) §483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability. §483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission, (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services; or (ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission- (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability.	F 645		8/19/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495247	A. BUILDING _____ B. WING _____	C 07/12/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NANS POINTE REHABILITATION AND NURSING	200 WEST CONSTANCE ROAD SUFFOLK, VA 23434

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 645	Continued From page 26 §483.20(k)(2) Exceptions. For purposes of this section- (i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital. (ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual- (A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital, (B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and (C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services. §483.20(k)(3) Definition. For purposes of this section- (i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1). (ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility staff failed to conduct a level I PASARR for one Resident (Resident #30) in the survey	F 645	1.Resident #30 PASARR Level 1 was completed 2.All new admissions may be impacted by	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495247	A. BUILDING _____ B. WING _____	C 07/12/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NANS POINTE REHABILITATION AND NURSING	200 WEST CONSTANCE ROAD SUFFOLK, VA 23434

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 645	Continued From page 27 sample of 47 residents. The findings included: Resident #30 was admitted to the facility on 9/24/21 with diagnoses that included Anoxic brain damage, muscle weakness, history of prostate cancer, dementia, epilepsy, heart disease, diabetes, anxiety, insomnia PTSD and impaired safety awareness. The facility staff failed to conduct a level I PASARR. This resident was assessed as having scored an eight on the (BIMS) Brief Interview for Mental Status. A review of the clinical records indicated that Resident #30 did not have a level I PASARR screening. During an interview on on 07/07/22 at 3:15 p.m. the social service director stated Resident #30 had not been screened for a Level I PASARR.	F 645	this deficient practice. 3.Social Work team audited 100% resident charts for PASARR Level 1 and confirmed documentation. New Director of Admissions trained on PASARR process. 4.Director of Social Work to audit new admission packages for PASARR Level 1 weekly for 4 weeks for compliance. The Director of Social work will report audits to the QAPI team monthly to ensure on going compliance.	
F 658 SS=E	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based resident and staff interviews, facility document review, and clinical record review, the facility staff failed to follow professional standards of nursing practices for 3 out of 47 residents (Resident #68, #22 and #84) in the survey	F 658	1.Resident #68, #22 and #84 was not administered medications and there were no adverse reactions. 2.All residents receiving medications has the potential to be affected by this	8/19/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495247	A. BUILDING _____ B. WING _____	C 07/12/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NANS POINTE REHABILITATION AND NURSING	200 WEST CONSTANCE ROAD SUFFOLK, VA 23434

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 658	Continued From page 28 sample. The findings included: 1. The facility staff failed to follow physician orders for the administering of medication for Resident #68. Resident #68 was originally admitted to the facility on 09/05/18. Diagnosis for Resident #68 included but are not limited to Bipolar disorder, major depression and anxiety. The most recent Minimum Data Set (MDS) a quarterly assessment with an Assessment Reference Date (ARD) of 05/31/22 coded the resident on the Brief Interview for Mental Status (BIMS) with a score of 12 out of a possible score of 15, which indicated moderate cognitive impairment for daily decision-making. In section "G" (Physical functioning) the MDS coded Resident #68 requiring total dependence of one with bathing, extensive assistance of one with toilet use and personal hygiene and supervision with limited assistance of one with bed mobility, transfer, dressing and eating for Activities of Daily Living (ADL) care. Resident #68's person-centered care plan initiated on 09/10/21 identified the resident uses psychotropic medications related to anxiety, depression and Bipolar disorder. The goal set for the resident by the staff was that the resident will remain free of psychotropic drug related complications, including movement disorder, discomfort, hypotension, gait disturbance, constipation/impaction or cognitive/behavioral impairment through review date of 06/30/22. Some of the interventions/approaches the staff would use to accomplish this goal is to administer psychotropic medications as ordered by	F 658	practice. An audit of all residents receiving insulin and psychotropic medications was completed. 3.Staff were educated on following physician orders to include medication administration timely and accurately. 4.Director of Nursing or designee will audit daily MAR variance report weekly for 4 weeks for compliance. The results of these audits will be reported to the QAPI team monthly to ensure on going compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495247	A. BUILDING _____ B. WING _____	C 07/12/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NANS POINTE REHABILITATION AND NURSING	200 WEST CONSTANCE ROAD SUFFOLK, VA 23434

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 658	Continued From page 29	F 658		

physician, monitor for side effects and effectiveness every shift.

An interview was conducted with Resident #68 on 07/12/22 at approximately 1:00 p.m. The resident voiced concerns that he did not receive any of his nighttime medications on 07/11/22 at 8:00 p.m., and 9:00 p.m., until 2:00 a.m., on 07/12/22. The resident said all of my nighttime medication were given late.

During the review of Resident #68's Medication Administration Record (MAR) for July 2022 revealed the following orders:
-Lamictal 200 mg - give 1 tablet twice a day at (9:00 a.m., and 8:00 p.m.) for bipolar disorder.
-Trazadone 100 mg - give 1 tablet daily at bedtime (9:00 p.m.) for depression.
-Risperidone 4 mg - give 1 tablet daily at bedtime (9:00 p.m.) for bipolar disorder.
-Clonazepam 0.5 mg - give one tablet by mouth daily at bedtime (9:00 p.m.) for anxiety disorder.

A review of Resident #68's Medication Administration Audit Report for 07/11/22 - 07/12/22 was documented the following medications were signed off as being administered at the following times on 07/12/22: Lamictal 200 mg at 2:02 a.m., Trazadone 100 mg at 2:02 a.m., Risperidone 4 mg at 2:01 a.m., and Clonazepam 0.5 mg at 2:02 a.m. All the medications mentioned were due on 07/11/22 either at 8:00 p.m., or 9:00 p.m.

On 07/12/22 at approximately 2:50 p.m., a phone interview as conducted with License Practical Nurse (LPN) #10 who said Resident #86's nighttime medications were due on 07/11/22 at 8:00 p.m. and 9:00 p.m. The medications were

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495247	A. BUILDING _____ B. WING _____	C 07/12/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NANS POINTE REHABILITATION AND NURSING	200 WEST CONSTANCE ROAD SUFFOLK, VA 23434

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 658	Continued From page 30	F 658		

given late but not at 2:00 a.m., more like 12:00 a.m., 07/12/22. She said, I was running late and that's why the resident's medications were administered after the scheduled times. She said medications can be given one hour before or one hour after the scheduled administration time and still be considered given timely. The medications were given after the one hour window which made the medication administered late.

A review of Resident #319's clinical record revealed no negative outcomes related to the above medications being administered late.

A debriefing was conducted with the Administrator and Director of Nursing (DON) 07/12/22 at approximately 5:25 p.m. The DON said the nurse should have administered Resident #68's medications as ordered by the physician. The nurses are allowed to administer the medication one hour before or one hour after the scheduled time and they are expected to remain in that window time frame.

The facility policy titled Medication Administration revised on 10/01/21.
-Policy: Medications are administered by license nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice, in a manner to prevent contamination or infections.

11 (b). Administer within 60 minutes prior to or after scheduled times unless otherwise ordered by the physician.

2. The facility staff failed to administer Resident

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495247	A. BUILDING _____ B. WING _____	C 07/12/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NANS POINTE REHABILITATION AND NURSING	200 WEST CONSTANCE ROAD SUFFOLK, VA 23434

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 658	Continued From page 31	F 658		

#22's Lantus insulin as ordered by the physician.

On 7/7/22 at approximately 11:25 a.m., an interview was conducted with Resident #22. Resident #22 stated the night nursing staff consistently administers her medications including her Lantus insulin at an extremely late hour. She stated on 7/6/22 the Lantus was administered just before 12 midnight instead of near the 8:00 p.m., hour. Resident #22 also she felt the fluctuations in her blood sugars were related to the inconsistencies in administration of the Lantus. Resident #22 stated she had an appointment with her Endocrinologist on 5/27/22 and new orders were provided but the staff isn't following the orders.

The following nurse's not was documented on 5/27/22 at 7:42 p.m., the Resident returned from her Endocrinology appointment with new orders to administer Lantus before bed, discontinue the 10 units of Amdelog before meals, and begin sliding scale insulin before meals. The orders were clarified with Endocrinologist office, and entered to begin tomorrow. The Resident has no acute concerns at this time.

Resident #22 physician order summary revealed the following order dated 5/28/22; Lantus Solution 100 units/milliliter; Inject 40 unit subcutaneous at bedtime related for type two diabetes. The medication was scheduled at 8:00 p.m.

A medication audit report of Resident #22 Lantus administration revealed the following; 7/4/22 the Lantus was administered at 10:19 p.m., 7/5/22 11:49 p.m., 7/6/22 11:49 p.m., 7/7/22 9:33 p.m., 7/8/22 10:23 p.m.,7/9/22 10:06 p.m., 7/10/22 9:06

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495247	A. BUILDING _____ B. WING _____	C 07/12/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NANS POINTE REHABILITATION AND NURSING	200 WEST CONSTANCE ROAD SUFFOLK, VA 23434

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 658	Continued From page 32	F 658		

p.m. and 7/11/22 10:32 p.m.

On 7/12/22 at approximately 8:00 p.m., the above findings were shared with the Administrator, Director of Nursing and Corporate Consultant. The Director of Nursing stated the medication pass protocol is medications can be administer one hour before the scheduled time or one hour after the scheduled time unless the physician and/or practitioner authorizes a change in time.

3. Information gleamed during a complaint investigation revealed the facility's staff failed to administer Resident #84's morning medications on 4/14/22 in accordance to the physician's orders.

Resident #84 was originally admitted to the facility and readmitted 3/9/22 after an acute care hospital stay. The current diagnoses included; stroke, aphasia and a seizure disorder.

The quarterly Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 6/16/22 coded the resident as not having the ability to complete the Brief Interview for Mental Status (BIMS). The staff interview was coded for long and short term memory problems as well as severely impaired for daily decision making. In section "G" (Physical functioning) the resident was coded as requiring total care of one with all activities of daily living.

An interview was conducted with the Complainant on 7/12/22 at approximately 9:00 a.m. The complainant stated the shortness of staff is the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495247	A. BUILDING _____ B. WING _____	C 07/12/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NANS POINTE REHABILITATION AND NURSING	200 WEST CONSTANCE ROAD SUFFOLK, VA 23434

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 658	Continued From page 33 primary reason his wife isn't receiving her medication as ordered and scheduled by the physician. He stated the Unit his wife resides on is staff by Agency staff who are unfamiliar with her and others who resides on the unit. He further stated on 4/14/22 the nurse assigned to the Unit his wife resides on didn't administer the resident's medications because he had experienced problems with her before and he and the Administrative staff decided she was to no longer render care to his wife. An interview was conducted with Licensed Practical Nurse (LPN) #6 ON 7/7/22 at approximately 1:00 p.m. LPN #6 stated on the day in question Resident #84 hadn't received her morning medications (8:00 and 9:00 a.m.) as ordered and the spouse complained to the Administrator. LPN #6 stated at approximately 1:00 p.m., the Administrator instructed her to administer the resident's morning medications and she did. LPN #6 stated Resident #84's spouse is very intimidating and it is almost impossible to keep regular staff on the Unit. On 7/12/22 at approximately 8:00 p.m., the above findings were shared with the Administrator, Director of Nursing and Corporate Consultant. An opportunity was offered to the facility's staff to present additional information but no additional information was provided and no concerns were voiced.	F 658		
F 677 SS=D	COMPLAINT DEFICIENCY ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2)	F 677		8/19/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495247	A. BUILDING _____ B. WING _____	C 07/12/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NANS POINTE REHABILITATION AND NURSING	200 WEST CONSTANCE ROAD SUFFOLK, VA 23434

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 677	Continued From page 34 §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews and clinical record review the facility staff failed to ensure 1 of 47 residents (Resident #3) in the survey sample who were unable to carry out activities of daily living receives the necessary services to maintain fingernail care. The findings included: The facility staff failed to provide necessary fingernail care for Resident #3, a resident who was dependent on staff for activities of daily living (ADL). Resident #3 was admitted to the facility on 10/08/20. Diagnosis for Resident #3 included but not limited to Dementia without behavioral disturbances. The most recent Minimum Data Set (MDS) a quarterly assessment with an Assessment Reference Date (ARD) of 06/24/22 coded the resident on the Brief Interview for Mental Status (BIMS) with a score of 03 out of a possible score of 15, which indicated severe cognitive impairment for daily decision-making. The resident was not coded for rejection of care to include Activities of Daily Living (ADL). In section "G" (Physical functioning) the resident was coded as requiring extensive assistance of one with bathing and limited assistance of one for personal hygiene. Resident #3's person-centered care plan revised	F 677	1.Resident #3 immediately had fingernails trimmed and cleaned. 2.All resident requiring assistance with having fingernails trimmed could be affected by this practice. 3.Director of nursing conducted a 100% audit on resident fingernail care and educated licensed staff on ADL care with a focus on fingernail trimming. 4.Director of Nursing or designee to inspect 10 residents for clean trimmed nails per week for 4 weeks to ensure compliance. The results of the audits will be reported by the Director of Nursing to the QAPI team monthly to ensure on going compliance. 5.Date of compliance August 19, 2022	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495247	A. BUILDING _____ B. WING _____	C 07/12/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NANS POINTE REHABILITATION AND NURSING	200 WEST CONSTANCE ROAD SUFFOLK, VA 23434

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 677	Continued From page 35	F 677		

on 10/28/22 identified the resident with ADL self-care performance deficit related to dementia. The goal set for the resident by the staff was that the resident will remain current level of function through the review date of 10/06/22.
Some of the interventions/approaches the staff would use to accomplish this to assist Resident #3 as needed to complete ADL's and to check nail length and time and clean on bath day and as necessary to report any changes to the nurse.

On 07/05/22 at approximately 3:27 p.m., during the initial tour Resident #3 was observed lying in the bed fully dressed with both hands placed on her stomach. Her fingernails were approximately 2 inches beyond the tip of his fingers and the nails were long, thick with jagged edges. The fingernails were observed with a brown substance under them. The resident held her hands out and said, you can cut them (referring to her fingernails) if you like, they are long.

On 07/07/22 at approximately 9:45 a.m., Resident #3's fingernails remain unchanged, the fingernails were still long, chipped, jagged edges with a brown substance under them. On the same day at approximately 10:33 a.m., License Practical Nurse (LPN) #2 and this surveyor went to Resident #3's room to assess her resident's fingernails. After, the LPN assessed the fingernails, she said they are extremely long, they need to be cut, cleaned, trimmed and filed. The LPN said the Certified Nursing Assistant (CNA's) should be looking at the resident's fingernails on a daily basis and to inform the nurse when nail care need to be provided. On the same day at approximately 2:30 p.m., the resident's fingernails were closely cut, cleaned and well-manicured.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495247	A. BUILDING _____ B. WING _____	C 07/12/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NANS POINTE REHABILITATION AND NURSING	200 WEST CONSTANCE ROAD SUFFOLK, VA 23434

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 677	Continued From page 36 A debriefing was conducted with the Administrator, Director of Nursing (DON) on 07/05/22 at approximately 5:52 p.m. The DON said, the CNA's should be doing a head-toe-assessment on a daily basis to include looking at fingernails for cleaning, cutting and trimming. The facility's policy titled Activities of Daily Living (ADLs) revised on 11/01/21. Policy Explanation and Compliance Guidelines: 3. A resident who is unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.	F 677		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interviews, clinical record review, facility documentation review, the facility staff failed to provide 1 of 47 residents (Resident #323) in the survey sample with respiratory care in accordance with professional standards of practice. The findings included:	F 695	1.Resident #323 orders for oxygen were updated on 7/7/22, resident has since been discharged from the facility on 7/16/22. 2.Residents receiving oxygen may have potentially been at risk. 100% audit of current residents was completed to ensure that there was a physician/practitioner order for the oxygen	8/19/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495247	A. BUILDING _____ B. WING _____	C 07/12/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NANS POINTE REHABILITATION AND NURSING	200 WEST CONSTANCE ROAD SUFFOLK, VA 23434

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 695	Continued From page 37 Resident #323 was admitted to the facility on 05/31/22. Diagnosis for Resident #323 included but are not limited to acute and chronic respiratory failure with hypoxia. Resident #323's Minimum Data Set (an assessment protocol) an annual assessment with an Assessment Reference Date (ARD) of 06/06/22 coded the resident's Brief Interview for Mental Status (BIMS) score 12 of a possible 15 with moderate cognitive impairment for daily decision-making. In section "O" (Special Treatment and Programs) was coded for the use of oxygen therapy. During the initial tour on 07/05/22 at approximately 3:10 p.m., Resident #323 was observed lying in bed with oxygen on at 4 liters minute via nasal cannula. On 07/06/22 at approximately 9:35 a.m., Resident #323 was lying in bed with her oxygen setting on 4 liters minute via nasal cannula. The resident said she has been on oxygen since being admitted to the facility on 05/31/22. Review of the Order Summary Report (OSR) for July 2022 revealed an order for Respiratory Therapy (RT) to evaluate Resident #323 for oxygen and breathing needs and to wean oxygen. Further review of OSR revealed no directions specified to the flow amount of oxygen to be used. On 07/07/22 at approximately 10:25 a.m., License Practical Nurse (LPN) #2 and this surveyor went to Resident #323's room to check the oxygen setting. After checking Resident #323's oxygen setting, the LPN said, Resident	F 695	and that oxygen was being administered at the prescribed amount. Variances will be investigated, and corrective action will be taken as appropriate. 3.Licensed nursing staff were re-educated by DON/designee on the importance of obtaining orders for oxygen to include flow rate. Oxygen orders and administration of oxygen will be documented in the resident’s medical record. 4.Director of Nursing/designee will audit 5 residents receiving oxygen per week and validate that the oxygen is ordered including flow rate, being administered as prescribed and documented in the resident’s record. Variances will be investigated, and responsible staff will be re-educated as appropriate. A summary of the weekly audits will be provided to the QAPI committee for additional oversight.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495247	A. BUILDING _____ B. WING _____	C 07/12/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NANS POINTE REHABILITATION AND NURSING	200 WEST CONSTANCE ROAD SUFFOLK, VA 23434

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 695	Continued From page 38	F 695		

#323 is on oxygen at 4 liters. The LPN checked the oxygen order in the computer. She said there is no oxygen flow rate. The LPN continued to say the Respiratory Therapy (RT) need to do an oxygen assessment.

A debriefing was conducted with the Administrator, Director of Nursing (DON) 07/12/22 at approximately 5:25 p.m. The DON said the RT should have completed an oxygen assessment on Resident #323 to determine the oxygen flow rate or whether oxygen was actually needed.

The facility's policy titled Oxygen Administration revised 11/01/21. Oxygen is administered to residents who need it, consistent with professional standards of practice, the comprehensive person-centered care plans, and the residents' goals and preferences.

Policy Explanation and Compliance Guidelines:
1. Oxygen is administered under orders of a physician, except in the case of an emergency. In such case, oxygen is administered and orders for oxygen are obtained as soon as practicable when the situation is under control.

3. Staff shall document the initial and ongoing assessment of the resident's condition warranting oxygen and the response to oxygen therapy.

4. The resident's care plan shall identify the interventions for oxygen therapy, based upon the resident's assessment and orders, such as, but not limited to:
a. The type of oxygen delivery system.
b. When to administer, such as continuous or intermittent and/or when to discontinue.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495247	A. BUILDING _____ B. WING _____	C 07/12/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NANS POINTE REHABILITATION AND NURSING	200 WEST CONSTANCE ROAD SUFFOLK, VA 23434

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 695	Continued From page 39 c. Equipment setting for the prescribed flow rates. d. Monitoring of SpO2 (oxygen saturation) levels and/or vital signs, as ordered. e. Monitoring for complications associated with the use of oxygen.	F 695		
F 697 SS=G	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, clinical record review, and review of facility documents, the facility staff failed to provide pain management to include scheduled narcotic analgesics (Hydromorphone HCl 2 milligrams (mg) and Lyrica 25 mg) which resulted in frequent unnecessary and often excruciating pain, constituting harm for 1 of 47 residents (Resident #267), in the survey sample The findings included: The facility staff failed to provide scheduled around-the-clock pain medications to Resident #267, by failing to obtain and administer the prescribed narcotic analgesics (Hydromorphone HCl 2 milligrams (mg) and Lyrica 25 mg), they also failed to institute their protocol for obtaining controlled medication from their medication storage system (CUBEX) and to ensure the nurses were educated to obtain controlled and non-controlled medication from the storage	F 697	1)Resident #267 has since been discharged from the facility on 8/3/22. 2)Other residents on controlled medications may have been at risk. Control medications of current residents were reviewed on 7/18/22 by a licensed nurse to ensure there was a sufficient supply of the medications to meet the needs of the residents; new prescriptions were obtained, as necessary. Licensed nursing staff were re-educated on the medication administration policy. 3)The administrator and DON have worked diligently with the pharmacy to implement systems to ensure that mediations are available to administer to residents in a timely manner. Licensed staff have been re-educated by DON/ADON on what to do when medications are not available. Licensed nurses were educated on locations in which backup medications may be	8/19/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495247	A. BUILDING _____ B. WING _____	C 07/12/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NANS POINTE REHABILITATION AND NURSING	200 WEST CONSTANCE ROAD SUFFOLK, VA 23434

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 697	Continued From page 40 system, which resulted in unnecessary and often excruciating pain, constituting harm. Resident #267 was originally admitted to the facility on 6/14/22 and readmitted on 7/4/22 after an acute care hospital stay. The current diagnoses included; surgical interventions related to an abdominal wall infection, DVT, diabetes with neuropathic pain, and end-stage renal disease status post a renal transplant. The 5 Day Medicare Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 6/16/22 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 11 out of a possible 15. This indicated Resident #267's cognitive abilities for daily decision-making were moderately impaired. In section "G" (Physical functioning) the resident was coded as requiring total care of one person with bathing, extensive assistance of two people with bed mobility, extensive assistance of one person with personal hygiene, dressing, and toileting, supervision after set-up with eating and transfers and locomotion occurred only once or twice. Resident #267 was interviewed on 7/6/22 at approximately 11:05 a.m. The resident was in bed holding her abdomen with her left hand. She spoke very softly and slowly and she presented with an extremely flat affect. Resident #267 stated she was very concerned because she wasn't receiving her medications and the staff told her it was because the pharmacy hadn't delivered her medications to the facility. Resident #267 stated she was experiencing stomach pain and she felt it was related to the stomach surgery she had while hospitalized. She stated the	F 697	obtained and to notify the physician/practitioner when medications are not available if other medications can be substituted that are available. The facility will notify the pharmacy to determine when the medication will be available and if possible, the medication may be obtained from the local backup pharmacy. The administrator/DON will review instances of “meds not available from the pharmacy” with the pharmacy representative as needed and through the QAPI process. 4)The DON/designee will review the EMR dashboard report daily (M-F) to identify medications that have not been administer. Variances will be investigated and corrected as appropriate. Findings of the weekly audits will be reported to the QAPI committee. The DON/designee will review 4 control records twice a week x8 weeks to ensure that prescribed medications were administered as ordered and pain levels controlled. Variances will be investigated, and responsible nurse will be re-educated. A summary of the weekly audits will be provided to the QAPI committee for further oversight.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495247	A. BUILDING _____ B. WING _____	C 07/12/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NANS POINTE REHABILITATION AND NURSING	200 WEST CONSTANCE ROAD SUFFOLK, VA 23434

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 697	Continued From page 41	F 697		

physician at the hospital stated she had a very odorous and infected stomach wound at the time she arrived at the hospital and it required surgical interventions to promote healing. Resident #267 stated at the time of the interview she was experiencing pain at a level of eight to nine out of a level of zero to ten and ten characterized as excruciating pain. Resident #267 stated she felt if she had received the Lyrica the pain would be more tolerable but they didn't have that either. On 7/7/22 at approximately 10:30 a.m., another interview was conducted with Resident #267, who was in bed and speaking very softly. The resident stated she was still experiencing stomach pain at a level of eight/nine out of ten and her nurse stated the pharmacy still hadn't delivered her medications.

An interview was conducted with Licensed Practical Nurse (LPN) #9 on 7/7/22 at approximately 10:45 a.m. LPN #9 stated the resident didn't tell her she was experiencing pain but she would give her some Tylenol and Registered Nurse (RN) #4 was currently working with the pharmacy to deliver the resident's medications to the facility.

An Interview was conducted with Registered Nurse #4 on 7/7/22 at approximately 2:20 p.m. RN #4 stated she transcribed the resident's admission orders on 7/4/22 and sent the orders to the pharmacy and on 7/6/22 she was informed the medications hadn't arrived to the facility, therefore, a call was placed to the pharmacy to determine the reason for the delay. RN #4 stated the pharmacy stated there was a problem with how the medication orders were entered and then they were taken out therefore the orders couldn't be filled. RN #4 stated she re-entered the orders

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495247	A. BUILDING _____ B. WING _____	C 07/12/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NANS POINTE REHABILITATION AND NURSING	200 WEST CONSTANCE ROAD SUFFOLK, VA 23434

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 697	Continued From page 42	F 697		

and the pharmacy promised to deliver the medications on 7/7/22 but on 7/8/22 at 5:00 p.m., they still hadn't arrived. RN #4 stated the pharmacy assured her the medications would be delivered on 7/9/22. This meant Resident #267 was without significant prescribed medications from the time of admission on 7/4/22 through 7/8/22.

A review of the 7/4/22 hospital's discharge summary revealed the resident was diagnosed with an abdominal wall infection which required her to undergo an excisional debridement which revealed full-thickness necrosis. The 7/4/22 hospital's discharge summary revealed orders for Hydromorphone HCl (Dilaudid) tablet 2 milligrams (mg); give one tablet by mouth every 4 hours for pain, an order for Hydromorphone HCl tablet 2mg; give 1 tablet by mouth every 3 hours as needed for pain, Lyrica Capsule 25 mg (Pregabalin) Give 1 capsule by mouth two times a day for neuropathy, and Acetaminophen 500 mg Tablets; give 1,000 mg by mouth three times daily for pain. A review of the physician's order summary revealed the above orders for analgesics. A review of the Medication Administration Record (MAR) revealed the scheduled analgesics (Hydromorphone HCl tablet 2 mg and Lyrica Capsule 25 mg) were not administered and there was no evidence that non-pharmacological interventions were attempted to reduce the resident's pain. A review of the CUBEX medications system list revealed Dilaudid wasn't included in the CUBEX medication system but Lyrica 25 mg capsules were available. The resident didn't have a baseline care plan for her 7/4/22, readmission in the clinical record.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495247	A. BUILDING _____ B. WING _____	C 07/12/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NANS POINTE REHABILITATION AND NURSING	200 WEST CONSTANCE ROAD SUFFOLK, VA 23434

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 697	Continued From page 43	F 697		

An interview was conducted with the Director of Nursing (DON) on 7/12/22 at approximately 7:00 p.m. The DON stated the management team and the Medical Director were aware there were problems procuring medications in a timely manner and they began strategizing on backup pharmacies but it wasn't finalized. The DON also stated on average it is two days before a newly admitted resident's medications arrive at the facility from the pharmacy but most medications are available in the house stock or the CUBEX medication system. The DON also stated in Resident #267's case the nurse should have notified the Physician and or Practitioner that the Lyrica was available but required their authorization through the pharmacy and what they needed to do so she could obtain access to the narcotics in the CUBEX medication system.

During the above interview, the DON stated that because Dilaudid wasn't readily available in the CUBEX medication system the nurse should have shared with the Physician/Practitioner what similar medications were available so he/she could make a decision on which medication to prescribe until the Dilaudid was delivered. The DON further stated the nurse should have informed the Physician and or Practitioner of the need for him/her to directly notify the pharmacy so the nurse could obtain the medication from the CUBEX medication system. The DON finally stated another problem in Resident #267's case was there was mostly contract staff rendering care on the unit and they were incompetent in using the CUBEX medication system to obtain medications.

On 7/12/22 at approximately 8:00 p.m., the above findings were shared with the Administrator,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495247	A. BUILDING _____ B. WING _____	C 07/12/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NANS POINTE REHABILITATION AND NURSING	200 WEST CONSTANCE ROAD SUFFOLK, VA 23434

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 697	Continued From page 44 Director of Nursing, and Corporate Consultant. An opportunity was offered to the facility's staff to present additional information but no additional information was provided and no further concerns were voiced. Hydromorphone HCl (Dilaudid) belongs to the group of medicines called narcotic analgesics (pain medicines). It acts on the central nervous system (CNS) to relieve pain. It is an extended-release capsule and extended-release tablets are used to relieve pain in opioid-tolerant patients severe enough to require around-the-clock pain relief for a long period of time. (https://www.mayoclinic.org/drugs-supplements/hydromorphone-oral-route/description/drg-20074171) Pregabalin (Lyrica) capsules, oral solution (liquid), and extended-release (long-acting) tablets are used to relieve neuropathic pain (pain from damaged nerves) that can occur in your arms, hands, fingers, legs, feet, or toes if you have diabetes and postherpetic neuralgia [PHN; burning, stabbing pain or aches that may last for months or years after an attack of shingles] (https://medlineplus.gov/druginfo/meds/a605045.html)	F 697		
F 727 SS=D	RN 8 Hrs/7 days/Wk, Full Time DON CFR(s): 483.35(b)(1)-(3) §483.35(b) Registered nurse §483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week.	F 727		8/19/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495247	A. BUILDING _____ B. WING _____	C 07/12/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NANS POINTE REHABILITATION AND NURSING	200 WEST CONSTANCE ROAD SUFFOLK, VA 23434

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 727	Continued From page 45 §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by: Based on information obtained during the Sufficient and Competent Nurse Staffing task, the facility staff failed to staff a Registered Nurse (RN) for at least 8 consecutive hours a day, 7 days a week which could potentially affect all residents. The facility staff failed to staff an RN for at least 8 consecutive hours for 7 days The findings included: During the nursing staff review for 1/09/22, 2/05/22 and 2/06/22 the facility staff was unable to verify RN presence in the facility for at least 8 consecutive hours on 2/27/22. On 7/12/22 at approximately 6:00 PM., an interview was conducted with ASM (Administrative Staff Member/Clinical Support). She said that the facility should have coverage for 8 hours everyday. The above findings were shared with the Administrator, the Assistant administrator at approximately 9:30 PM. No comments were made concerning the above issue.	F 727	1.No specific resident has been identified 2.All residents may be affected by this practice. 3.The Administrator Educated New Staffing Coordinator on RN 8 hour / 7 day a week requirement. Staffing coordinator to post rotating master schedule with all RN coverage every 8 weeks and to utilize company resources and communicate with Director of Nursing any variances. 4.Director of Nursing or designee to audit schedule weekly for 8 weeks for RN coverage for compliance. The results of these audits will be reported by the Director of nursing monthly to the QAPI team ensure on going compliance.	
F 760 SS=E	Residents are Free of Significant Med Errors	F 760		8/19/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495247	A. BUILDING _____ B. WING _____	C 07/12/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NANS POINTE REHABILITATION AND NURSING	200 WEST CONSTANCE ROAD SUFFOLK, VA 23434

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 760	Continued From page 46 CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interviews, and clinical record review, the facility staff failed to ensure a resident wasn't subjected to significant medication errors (omission of critical medications) for 2 of 47 residents (Resident #267 and #319), in the survey sample. The findings included: 1. Resident #267 was originally admitted to the facility 6/14/22 and readmitted 7/4/22 after an acute care hospital stay. The current diagnoses included; surgical interventions related to an abdominal wall infection, DVT, diabetes with neuropathic pain, and end-stage renal disease status post a renal transplant. The 5 Day Medicare Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 6/16/22 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 11 out of a possible 15. This indicated Resident #267's cognitive abilities for daily decision making were moderately impaired. In section "G" (Physical functioning) the resident was coded as requiring total care of one person with bathing, extensive assistance of two people with bed mobility, extensive assistance of one person with personal hygiene, dressing, and toileting, supervision after set-up with eating and transfers and locomotion occurred only once or twice.	F 760	1)Residents #267 and #319 have since been discharged from the facility. 2) Residents on prescribed medications may have been at risk. Medications of current residents were reviewed on 7/18/22 by licensed nurses to ensure there was a sufficient supply of the medications to meet the needs of the residents; new prescriptions were obtained, as necessary. 3) The administrator and DON have worked diligently with the pharmacy to implement systems to ensure that medications are available to administer to residents in a timely manner. Licensed staff have been re-educated by DON/ADON on what to do when medications are not available. Licensed nurses were educated on locations in which backup medications may be obtained and to notify the provider when medications are not available if other medications can be substituted that are available. The facility will notify the pharmacy to determine when the medication will be available and if possible, the medication may be obtained from the local backup pharmacy. The administrator/DON will review instances of “meds not available from the pharmacy” with the pharmacy representative as needed and through the QAPI process.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495247	A. BUILDING _____ B. WING _____	C 07/12/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NANS POINTE REHABILITATION AND NURSING	200 WEST CONSTANCE ROAD SUFFOLK, VA 23434

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 760	Continued From page 47 Resident #267 was interviewed on 7/6/22 at approximately 11:05 a.m. The resident was in bed holding her abdomen with the left hand. She spoke very softly and slow and she presented with an extremely flat affect. Resident #267 stated she was very concerned because she wasn't receiving her medications and the staff told her it was because the pharmacy hadn't delivered her medications to the facility. Resident #267 stated she was experiencing stomach pain and she felt it was related to the stomach surgery she had while hospitalized. She stated the physician at the hospital stated she had a very odorous and infected stomach wound at the time she arrived to the hospital and it required surgical interventions to encourage healing. Resident #267 stated at the time of the interview she was experiencing pain at a level of eight to nine out of a level of zero to ten and ten characterized excruciating pain. Resident #267 stated she felt if she had received the Lyrica the pain would be more tolerable but they didn't have that either. On 7/7/22 at approximately 10:30 a.m., another interview was conducted with Resident #267, who was in bed and speaking very softly. The resident stated she was still experiencing stomach pain at a level of eight/nine out of ten and her nurse stated the pharmacy still hadn't delivered her medications. The resident was also concerned because she wasn't receiving required medications to prevent organ rejection for she received a kidney transplant in 2015 and her physician explained it was extremely important to continue the medications prednisone, mycophenolate, tacrolimus for prevention of organ rejection of the transplanted kidney.	F 760	4) The DON/designee will review the EMR dashboard report daily [M-F] to identify medications that have not been administered. Variances will be investigated and corrected as appropriate. Findings of the weekly audits will be reported to the QAPI Committee.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495247	A. BUILDING _____ B. WING _____	C 07/12/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NANS POINTE REHABILITATION AND NURSING	200 WEST CONSTANCE ROAD SUFFOLK, VA 23434

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 760	Continued From page 48	F 760		

Review of the physician's order summary revealed Resident #267 had orders on admission 7/4/22, for Cefuroxime Axetil Tablet 500 mg one tablet by mouth every 12 hours for Infection for 5 Days, Prednisone Tablet 5 mg; one tablet by mouth one time a day for status post a transplant, Lyrica Capsule 25 mg one capsule by mouth two times a day for neuropathic pain, Tacrolimus Capsule 1 mg one capsule by mouth every 12 hours for immunosuppression status post a transplant and Hydromorphone HCl Tablet 2 mg one tablet by mouth every 4 hours for pain but the medications were not administered until 7/8/22 because the pharmacy failed to delivery the medications to the facility because of problems with how the orders were written and the facility nurses failed to work with physician and/or practitioner to obtain some of the medications from the house stock or CUBEX medication system.

On 7/12/22 at approximately 8:00 p.m., the above findings were shared with the Administrator, Director of Nursing and Corporate Consultant and the definition of a significant medication error was shred with facility's team as medication error which may cause the resident discomfort or jeopardizes ones health and safety. An opportunity was offered to the facility's staff to present additional information but no additional information was provided and no concerns were voiced.

2. The facility staff failed to ensure the following significant medications (Metoprolol Succinate and Eliquis) were administered to Resident #319 on 02/09/22 (7a-7p shift). Diagnosis for Resident #319 included but not limited to Hypertension

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495247	A. BUILDING _____ B. WING _____	C 07/12/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NANS POINTE REHABILITATION AND NURSING	200 WEST CONSTANCE ROAD SUFFOLK, VA 23434

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 760	Continued From page 49	F 760		

(high blood pressure) and chronic Atrial Fibrillation (a-fib).

The Minimum Data Set (MDS) a Medicare 5-day assessment with an Assessment Reference Date (ARD) of 02/09/22 coded the resident on the Brief Interview for Mental Status (BIMS) with a score of 13 out of a possible score of 15, which indicated no cognitive impairment for daily decision-making. Resident #319 was coded extensive assistance of one with bathing, limited assistance of one with bed mobility, transfer, dressing, toilet use and personal hygiene and setup help only with eating for Activities of Daily Living (ADL).

Review of the Order Summary Report (OSR) for February 2022 revealed the following orders:
-Metoprolol Succinate ER 25 mg - give 1 tablet by mouth one time a day at 10:00 a.m, for high blood pressure starting on 02/09/22.
-Eliquis Tablet 2.5 mg - give 2.5 mg by mouth two times a day at 9:00 a.m,, and 5:00 p.m., for blood clot prevention starting on 02/09/22.

A review of the Medication Administration Record (MAR) for 02/09/22 at 9:00 a.m., and 10:00 a.m. revealed the medications mentioned above was coded a nine (9) indicating to refer to see nurse's notes. The nurses noted indicated that Resident #319 left the facility against medical advice on 02/09/22 at 2:00 p.m. Resident #319 remained in the facility for 4 hours after her medications should have been adminstered but wasn't.

Further review of Resident #319's clinical record revealed no negative outcomes related to the above medications not being administered.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495247	A. BUILDING _____ B. WING _____	C 07/12/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NANS POINTE REHABILITATION AND NURSING	200 WEST CONSTANCE ROAD SUFFOLK, VA 23434

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 760	Continued From page 50	F 760		

A phone called was placed to License Practical Nurse (LPN) #7 on 07/12/22 at approximately 8:40 a.m. The LPN was assigned to administer Resident #319 his scheduled morning medications on 02/09/22 at 9:00 a.m., and 10:00 a.m. The LPN said she work for agency and did not have access to the Cubex machine. She said the Director of Nursing was suppose to pull Resident #319 medications (Metoprolol 25 mg and Eliquis 2.5 mg) from the Cubex machine but she never did so the resident never received the morning medication mentioned. She said both medications were in the Cubex machine.

A debriefing was conducted with the Administrator and Director of Nursing 07/12/22 at approximately 5:25 p.m. The DON said Resident #319's medications should have been pulled from the Cubex machine and administered Resident #319 at the time ordered by the physician.

The facility's policy titled Cubex, the policy did not have a created or revision date.
-Policy: Nursing and pharmacy staff will use the Cubex Station as an inventory, charging and information system for the control and distribution of medications for emergency, first-dose use and other situation where medications are not readily from the pharmacy until the next scheduled delivery.

Procedure
B. Cubex Station access privileges.
The following privileges will be at the facilities discretion.
1. All nurses will have access privileges to non-controlled medications.

Complaint deficiency

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495247	A. BUILDING _____ B. WING _____	C 07/12/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NANS POINTE REHABILITATION AND NURSING	200 WEST CONSTANCE ROAD SUFFOLK, VA 23434

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 804 SS=F	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility staff failed to provide food that was prepared by methods that conserved the nutritive flavor and appearance. The findings included: During the kitchen observations at 11:07 a.m. on 07/07/22 during the lunch meal preparation, the facility staff was noted to serve mixed vegetables, lasagna, garlic bread, strawberry short cake and several beverages. The lasagna was the main entree for the lunch meal. During the temperature checks and observations made of the lasagna, the appearance of the lasagna was noted to be burned (blackened) and crusted in appearance. The texture of the lasagna was rubbery and mushy. This surveyor tasted the lasagna and it was not pleasing. The lasagna had a burned taste. The lasagna was noted to have burned food participles.	F 804	1. Resident # 6 stated upon interview by nursing home administrator he enjoyed of lasagna. The nursing home Administrator rounded the facility and interviewed 20% of the residents and the response was positive to the meal. 2. Re-education of Culinary Services Manager (CSM) and staff on Next Level policies & Procedures regarding Nutritive Value, Appearance & Palatability 3. Food Committee to occur Bi-Monthly, Hosted by CSM, minutes to be recorded on Food Committee form and shared with QAPI team. 4. Culinary Department will complete an initial Resident satisfaction audit of alert & oriented residents (evidenced by BIMS) by no later than 08/31/2022. CSM will report findings to the QAPI committee for review and recommendation. The administrator will present results of the audits to the quality assurance committee x 3 months. The QAPI committee may modify this plan	8/19/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495247	A. BUILDING _____ B. WING _____	C 07/12/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NANS POINTE REHABILITATION AND NURSING	200 WEST CONSTANCE ROAD SUFFOLK, VA 23434

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 804	Continued From page 52 During an interview on 07/07/22 at 12:47 p.m. with Resident #6, he was asked about the lasagna lunch meal. Resident #6 stated the lasagna did not have an appeasing appearance nor did it taste that great. Resident #6 stated he only ate half of the serving. During an interview at 12:07 p.m. on 07/07/22 after three serving pans of the lasagna had been plated and carted to the floor, the cook was asked what happened to the lasagna. The cook stated, they had no aluminum foil to cover while cooking and the lasagna was cooked in direct heat which caused the food to have a burned and crusted texture and appearance. During an interview at 12:14 p.m. on 07/07/22 with the dietary manager. She stated that the supply truck did not have aluminum foil on it so we had to cook the food the best they could.	F 804	to ensure the facility remains in compliance. All results will be discussed during food committee meetings.Test Tray Audits to be completed five (5) times weekly x 12 weeks by CSM to check accuracy, condiments, and proper temperature. This will occur in the repeating order of Breakfast on Monday & Thursday, Lunch on Tuesday & Friday, Dinner on Wednesdays. All results will be reported & discussed in stand-up & stand-down as deemed appropriate. Findings will be reported to the QAPI committee for review and recommendation. The administrator will present results of the audits to the quality assurance committee x 3 months. The QAPI committee may modify this plan to ensure the facility remains in compliance.	
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility.	F 812		8/19/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495247	A. BUILDING _____ B. WING _____	C 07/12/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NANS POINTE REHABILITATION AND NURSING	200 WEST CONSTANCE ROAD SUFFOLK, VA 23434

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 53 §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations and staff interview, the facility staff failed to store and served food under sanitary conditions. The findings included: During the kitchen observations at 11:07 a.m. on 07/07/22 the left wall next to the eight burner stove and two door oven, was noted to copious amounts of burnt grease and food particles. Behind the stove was burned food particles and food crumbs. Food and debris was observed behind the standing two part oven. The wall next to the eight burner stove was observed to have a hole that measured an estimated 10 inches long and 3 inches wide. Rust was noted on the electrical sockets in front of the the eight burner stove. The wall behind the ice machine was observed to have an estimated 8 inch by 3 inch hole. The plaster was observed to be coming off. Trash and debris was observed behind the ice machine. The dish washing machine was observed to have a large 4 to 5 gallon clear plastic container catching water. The dish washer stated, the dish washer has been like that for several months.	F 812	1.All items noted on 2567 will be corrected by 8/17/22. 2.Re-education of Culinary Services Manager and staff (CSM) on Next Level Policies & Procedures for Sanitation & Storage 3.Sanitation audits will be completed with a Next Level Regional and the facility administrator one (1) time a week x 12 weeks on weekly sanitation audit form. Findings will be reported to the QAPI committee for review and recommendation. The administrator will present results of the audits to the quality assurance committee x 3 months. The QAPI committee may modify this plan to ensure the facility remains in compliance * (CMS mock survey tool will be used on next level app as seen below and monitored for increase/decrease in score) 4.The CSM will complete the manager checklist twice daily five (5) times a week x 12 weeks to ensure proper food storage and sanitation practices and report findings to the QAPI committee for review and recommendation. The administrator will present results of the audits to the quality assurance committee x 3 months. The QAPI committee may modify this plan	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495247	A. BUILDING _____ B. WING _____	C 07/12/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NANS POINTE REHABILITATION AND NURSING	200 WEST CONSTANCE ROAD SUFFOLK, VA 23434

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 54 During an interview with the assistant maintenance worker, he stated, the water will not drain properly. The dish washer service techs have come out several times and they have not identified the problem. The assistant maintenance worker was asked for work orders and receipts of service/repairs. No service reports or work orders were provided. During an interview at 12:24 p.m. with the dietary manager, she stated, the kitchen has been like this for a while. We new a new kitchen.	F 812	to ensure the facility remains in compliance.	
F 814 SS=F	Dispose Garbage and Refuse Properly CFR(s): 483.60(i)(4) §483.60(i)(4)- Dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility staff failed to maintain outside refuse area free of debris and trash. The findings included: During the outside observation of the trash dumpster area at 1:15 P.M. on 07/07/22, the area was observed to have trash and debris on the ground around the two dumpster area. The Dietary Manager stated, housekeeping and maintenance were responsible for maintaining the areas.	F 814	1.Director of Maintenance immediately removed debris from area around dumpster. 2.All residents may be impacted by this practice. 3.Director of Maintenance and Environmental service Director educated on keeping area around dumpster free of debris. Housekeeping and Maintenance will inspect the dumpster daily to ensure area clean of debris and any variance placed into the correct receptacle. 4.Director of maintenance will audit the area around the dumpsters weekly for 4 weeks for compliance. The results of the audits will be reported by the Maintenance and Housekeeping Directors monthly to the QAPI team to ensure on going	8/19/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495247	A. BUILDING _____ B. WING _____	C 07/12/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NANS POINTE REHABILITATION AND NURSING	200 WEST CONSTANCE ROAD SUFFOLK, VA 23434

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 814	Continued From page 55	F 814	compliance.	
F 840 SS=E	Use of Outside Resources CFR(s): 483.70(g)(1)(2) §483.70(g) Use of outside resources. §483.70(g)(1) If the facility does not employ a qualified professional person to furnish a specific service to be provided by the facility, the facility must have that service furnished to residents by a person or agency outside the facility under an arrangement described in section 1861(w) of the Act or an agreement described in paragraph (g)(2) of this section. §483.70(g)(2) Arrangements as described in section 1861(w) of the Act or agreements pertaining to services furnished by outside resources must specify in writing that the facility assumes responsibility for- (i) Obtaining services that meet professional standards and principles that apply to professionals providing services in such a facility; and (ii) The timeliness of the services. This REQUIREMENT is not met as evidenced by: Based on record review, staff interview and a review of the facility's contracts, it was determined that the facility staff failed to obtain a dialysis contract that would describe the care and services provided by the dialysis center for one resident (Resident #7) in the survey sample of 47 residents. The findings included: 1. Resident #7 was admitted to the facility on 2/12/19 with diagnoses which included congestive	F 840	1.Administrator secured an agreement with local Dialysis facility. 2.All residents needing the services of Dialysis off site may be impacted by this practice. 3.The administrator will educate the Social Worker regarding the including dialysis agreements in the admission process. 4.Administrator will audit agreements monthly for 3 months to ensure there is up to date dialysis agreements for	8/19/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495247	A. BUILDING _____ B. WING _____	C 07/12/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NANS POINTE REHABILITATION AND NURSING	200 WEST CONSTANCE ROAD SUFFOLK, VA 23434

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 840	Continued From page 56 heart failure, peripheral vascular disease, COPD, hypertension, anxiety, depression, end stage renal disease, morbid obesity and GERD. During the entrance conference, one resident (Resident #7) was identified as receiving dialysis care and services outside of the facility. A 6/29/22 Quarterly Minimum Data Set (MDS) assessed this resident as a 14 in the area of Brief interview for mental status (BIMS). In the area of Activities of Daily Living (ADL's) this resident was assessed as requiring extensive assistance in the areas of transfer, dressing, toileting and personal hygiene. A Care Plan dated 4/21/22 indicated: Focus:- Resident #7 needs hemodialysis r/t End Stage Renal Disease. Goal-no signs or symptoms of complications from dialysis; Interventions: Obtain vital signs and weight per protocol. A physician order dated 6/22/22 indicated: "Order Summary - Dialysis Tuesday, Thursday, and Saturday." Review of the facility's contracts for outside services, indicated the facility did not have a dialysis contract. During an interview on 07/05/22 at 2:43 PM, the Interim Administrator (IA) confirmed that the facility did not have a contract with the dialysis services.	F 840	compliance. The results of these audits will be reported by the administrator monthly to the QAPI team to ensure on going compliance.	
F 865 SS=D	QAPI Prgm/Plan, Disclosure/Good Faith Attmpt CFR(s): 483.75(a)(2)(h)(i) §483.75(a) Quality assurance and performance improvement (QAPI) program.	F 865		8/19/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495247	A. BUILDING _____ B. WING _____	C 07/12/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NANS POINTE REHABILITATION AND NURSING	200 WEST CONSTANCE ROAD SUFFOLK, VA 23434

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 865	Continued From page 57 §483.75(a)(2) Present its QAPI plan to the State Survey Agency no later than 1 year after the promulgation of this regulation; §483.75(h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section. §483.75(i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews the facility staff failed to present its QAPI plan to the State Survey Agency and to ensure Good faith attempts by the committee to identify and correct quality deficiencies. The findings included; On 7/05/22 at approximately 5:01 PM during the initial tour an interview was conducted with the Acting administrator to set up an appointment to discuss the facility's QA/QAPI Plan. She stated," No QAPI meetings have been conducted in over a year." There was no mention of re-establishing QA/QAPI meeting when waivers for them expired on May 7, 2022 During the course of the survey quality deficiencies were identified in the areas of medication procurement.	F 865	1.QAPI committee formed and met on 7/26/22. 2.All residents may be impacted by this practice 3.The Administrator will educate the Interdisciplinary team regarding QAPI Policy and Procedure. Staff education on QAPI process at Staff education day July 29th. QAPI conducted in July 2022 and future QAPI meetings will be held monthly through end of year 2022. 4.Regional Director of Operations to audit QAPI minutes monthly for 3 months to ensure compliance. The results of the audits will be reported to the QAPI team to ensure on going compliance	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495247	A. BUILDING _____ B. WING _____	C 07/12/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NANS POINTE REHABILITATION AND NURSING	200 WEST CONSTANCE ROAD SUFFOLK, VA 23434

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 865	Continued From page 58	F 865		

1. The DON stated the management team and the Medical Director were aware there were problems procuring medications timely and they had begun strategizing on back-up pharmacies but; it wasn't finalized. The DON also stated on the average it takes two days before a new admission's medications arrives to the facility which in this particular resident's case was pertinent to meeting her care needs. She also stated most medications are available in the house stock or the Cubix medication system but some of the medications Resident #267 required were specialty medications related to the kidney transplant and not stocked as well as the ordered analgesic Dilaudid and the specific antibiotic which she required. The DON stated in Resident #267's case the nurse should have notified the Physician and/or Practitioner that the Lyrica was available in the Cubix medication system but required their authorization through the pharmacy and what action was required for the facility's nurse to gain access to the medication.

2. The facility's staff failed to assess, monitor pain threshold accurately and to administer pain medication in a timely manner from 1623 (4:23 PM) on 7/07/22 to 7/08/22 at 1507 (3:07 PM) the resident would remain in pain therefore refusing the wound care of an advanced stage pressure ulcer as well as refusing meals for Resident #366.

On 7/11/22 at approximately 4:20 PM an interview was conducted with the Director of Rehab. Services concerning QA/QAPI meetings. She said that she last attending a QAPI meeting a year ago.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495247	A. BUILDING _____ B. WING _____	C 07/12/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NANS POINTE REHABILITATION AND NURSING	200 WEST CONSTANCE ROAD SUFFOLK, VA 23434

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 865	Continued From page 59 On 7/11/22 at approximately 4:35 PM an interview was conducted with the facility's Medical Director concerning QA/QAPI meetings. He stated that he's only been at the facility a few weeks but handles issues on a case by case basis. We had informal discussions across the table." 7/11/22 8:40 PM An interview was conducted with the Unit Manager (LPN #5) concerning QA/QAPI meetings. He said that they haven't had any meetings in over a year. There was no mention of re-establishing QA/QAPI meeting when waivers for them expired May 7, 2022 On 07/12/22 at approximately 7:04 PM a brief interview was conducted with the Acting Administrator. She stated, "We scheduled our QAPI meeting for next week. We had our first risk meeting after being here at 72 hours." On 7/12/22 at approximately 9:30 PM., the above findings were shared with the administrator, the Acting administrator concerning the above issues. An opportunity was offered to the facility's staff to present additional information but no additional information was provided.	F 865		
F 868 SS=E	QAA Committee CFR(s): 483.75(g)(1)(i)-(iii)(2)(i) §483.75(g) Quality assessment and assurance. §483.75(g)(1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other	F 868		8/19/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495247	A. BUILDING _____ B. WING _____	C 07/12/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NANS POINTE REHABILITATION AND NURSING	200 WEST CONSTANCE ROAD SUFFOLK, VA 23434

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 868	Continued From page 60 individual in a leadership role; §483.75(g)(2) The quality assessment and assurance committee must: (i) Meet at least quarterly and as needed to identifying issues with respect to which quality assessment and assurance activities are necessary. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews the facility staff failed to meet on a quarterly basis and as needed to identify issues with respect to which quality assessment and assurance activities are necessary. maintain a quality assessment and assurance committee consisting at a minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; The findings included; On 7/05/22 at approximately 5:01 PM during the initial tour an interview was conducted with the Acting administrator to set up an appointment to discuss the facility's QA/QAPI Plan. She stated," No QAPI meetings have been conducted in over a year." There was no mention of re-establishing QA/QAPI meeting when waivers for them expired May 7, 2022 No documents were provided. On 7/11/22 at approximately 4:20 PM an interview was conducted with the Director of rehab. Services concerning QA/QAPI meetings. She	F 868	1.QAPI committee formed and met on 7/26/22. 2.All residents may be impacted by this practice 3.The Administrator will educate the Interdisciplinary team regarding QAPI Policy and Procedure. Staff education on QAPI process at Staff education day July 29th. QAPI conducted in July 2022 and future QAPI meetings will be held monthly through end of year 2022. 4.Regional Director of Operations to audit QAPI minutes monthly for 3x to ensure compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495247	A. BUILDING _____ B. WING _____	C 07/12/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NANS POINTE REHABILITATION AND NURSING	200 WEST CONSTANCE ROAD SUFFOLK, VA 23434

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 868	Continued From page 61 said that she last attending a QAPI meeting a year ago. On 7/11/22 at approximately 4:35 PM an interview was conducted with the facility's Medical Director concerning QA/QAPI meetings. He stated that he's only been at the facility a few weeks but handles issues on a case by case basis. We had informal discussions across the table." 7/11/22 8:40 PM, an interview was conducted with the Unit Manager (LPN #5) concerning QA/QAPI meetings. He said that they haven't had any meetings in over a year. On 07/12/22 at approximately 7:04 PM a brief interview was conducted with the Acting Administrator. She stated, "We scheduled our QAPI meeting for next week. We had our first risk meeting after being here at 72 hours." There was no mention of re-establishing QA/QAPI meeting when waivers for them expired May 7, 2022 On 7/12/22 at approximately 9:30 PM., the above findings were shared with the administrator, the Acting administrator concerning the above issues. An opportunity was offered to the facility's staff to present additional information but no additional information was provided.	F 868		
F 881 SS=D	Antibiotic Stewardship Program CFR(s): 483.80(a)(3) §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:	F 881		8/19/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495247	A. BUILDING _____ B. WING _____	C 07/12/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NANS POINTE REHABILITATION AND NURSING	200 WEST CONSTANCE ROAD SUFFOLK, VA 23434

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 881	Continued From page 62 §483.80(a)(3) An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use. This REQUIREMENT is not met as evidenced by: Based on information obtain during the Infection Control task, staff interview, and facility documentation review, the facility staff failed to ensure 1 of 47 residents (Resident #268), didn't receive antibiotics therapy when clinical guidelines for prescribing an antibiotics was not met. The facility staff administered Macrobid 100 milligrams (mg) and Cipro 250 mg (antibiotic) to Resident #68, for a bacteria resistant to the drug. The findings included: Resident #268 was originally admitted to the facility 4/28/22 and died in the facility 5/30/22. The resident's diagnoses included; a stroke with hemiparesis and aphasia. The admission Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 5/3/2022 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 0 out of a possible 15. This indicated Resident #268's cognitive abilities for daily decision making were severely impaired. On 7/11/22 at 10:30 a.m., an Infection Control interview was conducted with the Infection Preventionist. The Infection Preventionist stated Resident #268 presented with not eating or drinking well for six days, abdominal pain, and nausea, therefore a urine specimen was ordered on 5/17/22. A nurse's note dated 5/18/22, at 12:54 a.m., stated on 5/17/22 a urine specimen was collected via straight catheter, without	F 881	1. No adverse outcomes were noted for resident number #68. 2. Any resident with orders for antibiotics are at risk when an antibiotic stewardship program is not followed. 3. Infection preventionist and nursing staff will be educated on Antibiotic stewardship program to include MCgreers criteria for establishing appropriate antibiotic usage. 4. DON or designee will monitor all residents with new orders for antibiotics 3x per week for 4 weeks to ensure proper criteria is met. Results will be reviewed and shared with QAPI team.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495247	A. BUILDING _____ B. WING _____	C 07/12/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NANS POINTE REHABILITATION AND NURSING	200 WEST CONSTANCE ROAD SUFFOLK, VA 23434

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 881	Continued From page 63	F 881		

incident. The physician's order summary revealed an order for an antibiotic; Macrobid 100 mg; one capsule by mouth twice daily for 4 doses. It was started and administered on 5/19/22 through 5/21/22. The urine culture and sensitivity specimen results were reported to the facility on 5/20/22 and it revealed one bacteria (Klebsiella pneumonia) 25,000 colonies/milliliter (ml). A nurse's note dated 5/21/22 at 12:17 p.m., read the urine culture and sensitivity results were received from the lab and the Nurse Practitioner was notified of the results and an order was obtained for Cipro 250 mg one tablet by mouth twice daily for 7 days 5/23/22 through 5/28/22.

On 7/11/22 at approximately 10:30 a.m., the Infection Preventionist stated based on the urine culture and sensitivity information the resident didn't meet the criteria for use of antibiotic because greater than 100,000 colonies/ml represents a urinary tract infection. The Infection Preventionist stated it was unknown if the Practitioner was informed of the colony count or simply the susceptibilities.

On 7/12/22 at approximately 8:00 p.m., the above findings were shared with the Administrator, Director of Nursing and Corporate Consultant. An opportunity was offered to the facility's staff to present additional information but no additional information was provided and no further concerns were voiced.

As outlined in the original McGeer Criteria, 3 important conditions should be met when applying these surveillance definitions:
All symptoms must be new or acutely worse. Many residents have chronic symptoms, such as cough or urinary urgency that are not associated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495247	A. BUILDING _____ B. WING _____	C 07/12/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NANS POINTE REHABILITATION AND NURSING	200 WEST CONSTANCE ROAD SUFFOLK, VA 23434

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 881	Continued From page 64 with infection; however, a new symptom or a change from baseline may be an indication that an infection is developing. Alternative noninfectious causes of signs and symptoms (eg, dehydration, medications) should generally be considered and evaluated before an event is deemed an infection. Identification of infection should not be based on a single piece of evidence but should always consider the clinical presentation and any microbiologic or radiologic information that is available. Microbiologic and radiologic findings should not be the sole criteria for defining an event as an infection. Similarly, diagnosis by a physician alone is not sufficient for a surveillance definition of infection and must be accompanied by documentation of compatible signs and symptoms (https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3538836/).	F 881		
F 882 SS=D	Infection Preventionist Qualifications/Role CFR(s): 483.80(b)(1)-(4)(c) §483.80(b) Infection preventionist The facility must designate one or more individual(s) as the infection preventionist(s) (IP) (s) who are responsible for the facility's IPCP. The IP must: §483.80(b)(1) Have primary professional training in nursing, medical technology, microbiology, epidemiology, or other related field; §483.80(b)(2) Be qualified by education, training, experience or certification; §483.80(b)(3) Work at least part-time at the facility; and	F 882		8/19/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495247	A. BUILDING _____ B. WING _____	C 07/12/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NANS POINTE REHABILITATION AND NURSING	200 WEST CONSTANCE ROAD SUFFOLK, VA 23434

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 882	Continued From page 65 §483.80(b)(4) Have completed specialized training in infection prevention and control. §483.80 (c) IP participation on quality assessment and assurance committee. The individual designated as the IP, or at least one of the individuals if there is more than one IP, must be a member of the facility's quality assessment and assurance committee and report to the committee on the IPCP on a regular basis. This REQUIREMENT is not met as evidenced by: Based on staff interviews the facility staff failed to have a designated Infection Preventionist who had completed a specialized training in infection prevention and control oversee the COVID-19 infection program. The findings included: On 7/6/22 at approximately 10:40 a.m., an interview was conducted with the Infection Preventionist who had completed a specialized training in infection prevention and control to review the COVID-19 infection program. The Infection preventionist stated she oversaw all of the infection control program except the COVID-19 program because the previous Director of Nursing (DON) managed the program and now the new DON was managing the COVID-19 infection program. An interview was conducted with the DON on 7/7/22 at approximately 1:20 p.m. The DON stated she was the designated person to oversee the COVID-19 infection program but she hadn't completed specialized training in infection prevention and control. The DON further stated	F 882	1.There is a certified Infection Preventionist currently in facility 2.All residents may be impact by this practice. 3.Infection Prevention nurse was in serviced regarding COVID19 Policies and procedures and role of Infection Prevention nurse. 4.Director of Nursing to audit COVID19 protocol weekly for 4 weeks to ensure compliance. The results of these audits will be reported by the Director of Nursing to the QAPI team monthly to ensure on going compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495247	A. BUILDING _____ B. WING _____	C 07/12/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NANS POINTE REHABILITATION AND NURSING	200 WEST CONSTANCE ROAD SUFFOLK, VA 23434

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 882	Continued From page 66 her role as the COVID-19 Infection Preventionist would cease and the plan was for the current in-house Infection Preventionist to take over the program. On 7/12/22 at approximately 8:00 p.m., the above findings were shared with the Administrator, Director of Nursing and Corporate Consultant. An opportunity was offered to the facility's staff to present additional information but no additional information was provided and no further concerns were voiced.	F 882		
F 883 SS=E	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and	F 883		8/19/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495247	A. BUILDING _____ B. WING _____	C 07/12/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NANS POINTE REHABILITATION AND NURSING	200 WEST CONSTANCE ROAD SUFFOLK, VA 23434

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 883	Continued From page 67 (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review the facility staff failed to administer the pneumococcal immunization to 3 of 5 residents (Resident #5, 7 and 68) reviewed for the pneumococcal immunization protocol. The findings included:	F 883	1.Residents 5, 7 and 68 are being offered pneumococcal and influenza immunization. 2.All residents eligible for these two vaccinations may be impacted by this practice. 3.100% of residents are being reviewed to	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495247	A. BUILDING _____ B. WING _____	C 07/12/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NANS POINTE REHABILITATION AND NURSING	200 WEST CONSTANCE ROAD SUFFOLK, VA 23434

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 883	Continued From page 68 1. Resident #5 was originally admitted to the facility 07/14/2021 and had never been discharged from the facility. The current diagnoses included a stroke and diabetes. The annual Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 6/24/22 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 8 out of a possible 15. This indicated Resident #5's cognitive abilities for daily were moderately impaired. Review of the clinical record for immunizations revealed on 10/7/21 Resident #5's representative gave consent for the resident to receive the pneumococcal immunization but it hadn't been administered by 7/12/22. An interview was conducted with the Infection Preventionist on 07/11/22 at approximately 10:30 a.m. The Infection Preventionist stated the previous Director Of Nursing stated she was acquiring the pneumococcal immunization from the pharmacy but it was never acquired for reasons unknown to her therefore the immunization wasn't administered to Resident #5. 2. Resident #7 was originally admitted to the facility 02/12/2019 and readmitted 7/15/2022 after an acute care hospital stay. The current diagnoses included a stroke, heart failure, end-stage renal disease requiring dialysis, and an anxiety disorder. The quarterly Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 6/29/22 coded the resident as	F 883	determine eligibility for the pneumococcal and influenza immunizations. Infection preventionist and clinical staff were in-serviced on the regulation for offering pneumococcal and influenza immunization to residents (and gaining consent) at Staff education Day July 29, 2022. Infection preventionist conducted a review of residents. 4.Clinical managers/designees will audit new residents weekly for 4 weeks to ensure compliance. Director of nursing/designee will review weekly with clinical managers. DON will ensure existing residents will be evaluated annually to assess eligibility for vaccinations and then offered as needed. Results of these audits will be reported to QAPI committee for on going compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495247	A. BUILDING _____ B. WING _____	C 07/12/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NANS POINTE REHABILITATION AND NURSING	200 WEST CONSTANCE ROAD SUFFOLK, VA 23434

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 883	Continued From page 69	F 883		

completing the Brief Interview for Mental Status (BIMS) and scoring 13 out of a possible 15. This indicated Resident #7's cognitive abilities for daily were intact.

Review of the clinical record for immunizations revealed no evidence the resident and/or resident representative had been offered the immunization or provided with education or about the pneumococcal immunization as of 7/12/22.

The resident wasn't available for an interview on 7/12/22 because she was admitted to the hospital on 7/10/22 for diminished lung sounds, a new onset of cough, lethargy and shortness of breath.

An interview was conducted with the Infection Preventionist on 07/11/22 at approximately 10:30 a.m. The Infection Preventionist stated upon the resident's return from the hospital the pneumococcal immunization would be offered to the resident.

3. Resident #68 was originally admitted to the facility 3/6/2020 and readmitted 5/26/22 after an acute care hospital stay. The current diagnoses included a stroke and a seizure disorder.

The annual Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 6/27/22 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 12 out of a possible 15. This indicated Resident #68's cognitive abilities for daily were moderately impaired.

A review of the clinical record for immunizations revealed on 8/22/16 Resident #68 received the Pneumococcal PPSV23 immunization but

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495247	A. BUILDING _____ B. WING _____	C 07/12/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NANS POINTE REHABILITATION AND NURSING	200 WEST CONSTANCE ROAD SUFFOLK, VA 23434

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 883	Continued From page 70 revaccination wasn't offered every 5 years as recommended for an individual not 65 years old when the first Pneumococcal PPSV23 immunization was administered. As of 7/12/22 the clinical record had no evidence that the resident and/or representative was provided with education on revaccination with the Pneumococcal PPSV23 immunization because the previous vaccination was received greater than 5 years ago and the resident was 43 years old at the time. Another Pneumococcal PPSV23 immunization was recommended after 8/22/2021. An interview was conducted with the Infection Preventionist on 07/11/22 at approximately 10:30 a.m. The Infection Preventionist stated there was no additional information available regarding Resident #68's pneumococcal immunization status. On 7/12/22 at approximately 8:00 p.m., the above findings were shared with the Administrator, Director of Nursing and Corporate Consultant. The Director of Nursing stated arrangements had been made with the pharmacy and the pneumococcal immunization would be available for administration to all who desired to receive it before the end of the week.	F 883		
F 885 SS=D	Reporting-Residents,Representatives&Families CFR(s): 483.80(g)(3)(i)-(iii) §483.80(g) COVID-19 reporting. The facility must— §483.80(g)(3) Inform residents, their representatives, and families of those residing in facilities by 5 p.m. the next calendar day following the occurrence of either a single confirmed	F 885		8/19/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495247	A. BUILDING _____ B. WING _____	C 07/12/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NANS POINTE REHABILITATION AND NURSING	200 WEST CONSTANCE ROAD SUFFOLK, VA 23434

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 885	Continued From page 71 infection of COVID-19, or three or more residents or staff with new-onset of respiratory symptoms occurring within 72 hours of each other. This information must— (i) Not include personally identifiable information; (ii) Include information on mitigating actions implemented to prevent or reduce the risk of transmission, including if normal operations of the facility will be altered; and (iii) Include any cumulative updates for residents, their representatives, and families at least weekly or by 5 p.m. the next calendar day following the subsequent occurrence of either: each time a confirmed infection of COVID-19 is identified, or whenever three or more residents or staff with new onset of respiratory symptoms occur within 72 hours of each other. This REQUIREMENT is not met as evidenced by: Based on staff interviews clinical record review, and review of facility documents, the facility staff failed to inform residents, their representatives, and families of those residing in the facility by 5 p.m., the next calendar day or at least weekly following the occurrence of a single confirmed infection of COVID-19. The findings included: A review was conducted of the number of resident and staff COVID-19 cases over the last 4 weeks (6/7/22 - 7/6/22); it revealed Licensed Practical Nurse (LPN) #9 reported to work on 7/3/22 with a headache and expressed not feeling well. LPN #10 completed a Rapid COVID-19 test of LPN #9. The results identified LPN #9 as positive for a COVID-19 infection. LPN #10 stated the LPN #9 didn't enter the resident living	F 885	1.The facility will ensure all residents and their representative are notified of any positive Covid cases as they occur. 2.All residents may be impacted by this practice. 3.Facility purchased DIALACALLS service which will send immediate notifications via phone or email to all resident families and responsible parties. Information is added by Admissions Coordinator upon admission and contacts removed by Social Work upon discharge. Education was conducted with Administrator, Admissions coordinator, and Social Work on utilizing the communication system. 4.Administrator to audit COVID19 communication logbook weekly for 8 week for compliance. The results of the audits will be reported by the Administrator to the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495247	A. BUILDING _____ B. WING _____	C 07/12/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NANS POINTE REHABILITATION AND NURSING	200 WEST CONSTANCE ROAD SUFFOLK, VA 23434

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 885	Continued From page 72 area and was sent home after the positive results were confirmed. An interview was conducted with the Director of Nursing (DON) on 7/7/22 at approximately 1:20 p.m. The DON stated the facility staff began to inform resident representatives, and families of those residing in the facility of the COVID-19 positive staff member's case but they cease the notifications because the facility's owner stated it wasn't necessary therefore they didn't notify all applicable persons. The DON stated it had been their practice to divide the calls between various staff member and make the calls by 5 p.m., the following day neither were they informed weekly. On 7/12/22 at approximately 8:00 p.m., the above findings were shared with the Administrator, Director of Nursing and Corporate Consultant. An opportunity was offered to the facility's staff to present additional information but no additional information was provided and no further concerns were voiced.	F 885	QAPI team to ensure on going compliance.	
F 886 SS=E	COVID-19 Testing-Residents & Staff CFR(s): 483.80 (h)(1)-(6) §483.80 (h) COVID-19 Testing. The LTC facility must test residents and facility staff, including individuals providing services under arrangement and volunteers, for COVID-19. At a minimum, for all residents and facility staff, including individuals providing services under arrangement and volunteers, the LTC facility must: §483.80 (h)((1) Conduct testing based on parameters set forth by the Secretary, including but not limited to:	F 886		8/19/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495247	A. BUILDING _____ B. WING _____	C 07/12/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NANS POINTE REHABILITATION AND NURSING	200 WEST CONSTANCE ROAD SUFFOLK, VA 23434

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 886	Continued From page 73 (i) Testing frequency; (ii) The identification of any individual specified in this paragraph diagnosed with COVID-19 in the facility; (iii) The identification of any individual specified in this paragraph with symptoms consistent with COVID-19 or with known or suspected exposure to COVID-19; (iv) The criteria for conducting testing of asymptomatic individuals specified in this paragraph, such as the positivity rate of COVID-19 in a county; (v) The response time for test results; and (vi) Other factors specified by the Secretary that help identify and prevent the transmission of COVID-19. §483.80 (h)((2) Conduct testing in a manner that is consistent with current standards of practice for conducting COVID-19 tests; §483.80 (h)((3) For each instance of testing: (i) Document that testing was completed and the results of each staff test; and (ii) Document in the resident records that testing was offered, completed (as appropriate to the resident's testing status), and the results of each test. §483.80 (h)((4) Upon the identification of an individual specified in this paragraph with symptoms consistent with COVID-19, or who tests positive for COVID-19, take actions to prevent the transmission of COVID-19. §483.80 (h)((5) Have procedures for addressing residents and staff, including individuals providing	F 886		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495247	A. BUILDING _____ B. WING _____	C 07/12/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NANS POINTE REHABILITATION AND NURSING	200 WEST CONSTANCE ROAD SUFFOLK, VA 23434

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 886	Continued From page 74 services under arrangement and volunteers, who refuse testing or are unable to be tested. §483.80 (h)((6) When necessary, such as in emergencies due to testing supply shortages, contact state and local health departments to assist in testing efforts, such as obtaining testing supplies or processing test results. This REQUIREMENT is not met as evidenced by: Based on staff interviews and review of facility documents, the facility staff failed to reduce the risk of COVID-19 transmission from unvaccinated staff by testing staff at least weekly for exempted staff regardless of whether the facility is located in a county with low to moderate community transmission, The findings included: A review was conducted of the twelve staff granted exemption from the COVID-19 vaccination. The review revealed the unvaccinated staff wasn't tested at least weekly for greater than 30 days. An interview was conducted with the Director of Nursing (DON) on 7/7/22 at approximately 1:20 p.m. The DON stated the testing was missed but they will begin testing. On 7/12/22 at approximately 8:00 p.m., the above findings were shared with the Administrator, Director of Nursing and Corporate Consultant. An opportunity was offered to the facility's staff to present additional information but no additional information was provided and no further concerns were voiced.	F 886	1.All unvaccinated staff have been tested per CDC guidelines. 2.All residents may be impacted by this practice. 3.Infection Preventionist has been educated on the requirement for weekly testing of all unvaccinated and exempt staff members. Infection Preventionist will provide testing per the community transmission rate of area by way of checking he Covid Tracker weekly and follow cadence accordingly. The Infection Preventionist will maintain a log of all tested employees. 4.Administrator/Director of Nursing will audit logbook weekly for 4 weeks for compliance. The results of the audits will be reported by the Administrator to the QAPI team monthly to ensure on going compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495247	A. BUILDING _____ B. WING _____	C 07/12/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NANS POINTE REHABILITATION AND NURSING	200 WEST CONSTANCE ROAD SUFFOLK, VA 23434

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 908 SS=E	Essential Equipment, Safe Operating Condition CFR(s): 483.90(d)(2) §483.90(d)(2) Maintain all mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews, and review of facility documents, the facility staff failed to maintain cleaning equipment in good operational condition to ensure the necessary equipment was available to keep the facility clean, sanitary and homelike. The findings included: On 7/6/22 resident rooms 119, 103, and 115 were observed with many stains and heavily soiled floors. On 7/11/22 the corridors were heavily soiled and paths of wetness throughout the resident care areas and evidence of wheels rolling through the wetness and tracking it throughout the building were obvious. An interview was conducted with the Director of Environmental Services on 7/11/22 at approximately 4:28 p.m. The Director of Environmental Services stated two staff member quit before the weekend of 7/9/22 - 7/10/22 therefore the manpower needed to provide facility services wasn't available and they are with needed equipment to keep the floors clean. The Director of Environmental Services stated the scrubber has been out of order for approximately a month and they have one buffer but the electrical cord has been broken for 2.5 weeks and the Maintenance Director has been attempting to obtain a replacement cord. The Director of Environmental Services also stated	F 908	1.Facility ordered new floor buffer and scrubber 2.All residents may be impacted by this practice. 3.New Floor scrubber arrived and was operational July 2022 A side by side is currently operational. A new floor buffer was ordered July 2022 and is expected to arrive and be operational August 2022. 4.Director of Environmental Services will inspect floor equipment monthly for 3 months to ensure equipment is operational. The results of the audits will be reported by the Director of Environmental Services to the QAPI team to ensure on going compliance.	8/19/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495247	A. BUILDING _____ B. WING _____	C 07/12/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NANS POINTE REHABILITATION AND NURSING	200 WEST CONSTANCE ROAD SUFFOLK, VA 23434

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 908	Continued From page 76 she provides the manpower which is three housekeepers and two floor techs daily and the scrubber is utilized to maintain the floors based on the number of staff allowed on a daily basis and her staffing pattern doesn't include sufficient staff to physically mop the floors and neither would physical mopping the floor remove the scuff marks caused by the wheel chairs. The Director of Environmental Services stated the cleaning equipment is owned by the facility and she had notified the appropriate personnel of the needed equipment but the owner hadn't obtained it at the time of our interview. On 7/12/22 at approximately 8:00 p.m., the above findings were shared with the Administrator, Director of Nursing and Corporate Consultant. The Administrator in Training stated on 7/7/22 the walk behind scrubber was ordered and she had no estimated date of delivery and the Interim Administrator stated the owner stated the buffer would be ordered tonight 7/12/22.	F 908		
F 925 SS=E	Maintains Effective Pest Control Program CFR(s): 483.90(i)(4) §483.90(i)(4) Maintain an effective pest control program so that the facility is free of pests and rodents. This REQUIREMENT is not met as evidenced by: Based on observations and staff interview the facility staff failed to maintain an effective pest control program. The findings included: During the kitchen observation at 11:07 a.m. on 07/07/22, live roaches (numerous) were	F 925	1.Contracted pest control company completed on site visit to facility on 7/15/22. 2.All residents had the potential to be impacted by this practice. 3.All staff were educated regarding the use of new pest control logs. Contracted pest control company has begun regularly	8/19/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495247	A. BUILDING _____ B. WING _____	C 07/12/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NANS POINTE REHABILITATION AND NURSING	200 WEST CONSTANCE ROAD SUFFOLK, VA 23434

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 925	Continued From page 77 observed on the wall at the beginning of the serving line were spices were observed stored. Live roaches were observed at the drain line behind the two door oven. Live roaches were observed coming in and out of the left side wall where an eight inch by three inch hole was observed. A pest control tech was observed removing a 4 by 4 tile block off of the wall at the floor drain line hole. Live roaches were observed coming in and out of the hole as well as from behind the tile block. A 7/5/22 pest control service report indicated: "Found live cockroaches in kitchen. Inspected and treated. Kitchen- treated area food covered or removed. Rooms - treated- Rooms, 116, 117, 118, 119, 124, 125, dietitian office, hallway to dining room, kitchen dinning room." A 6/1/22 pest control service report indicated: "Treated MDS coordinator office, Activities office, Holiday Hall nursing station, clean utility room, soiled/dirty utility room, rooms 100, 320, 321, 322 and 323." A 5/23/22 pest control service report indicated: "Inspected room 16 for concern of mouse. Rooms 115, 117, 204, 218, and 227 serviced for mice." A 5/20/22 pest control service report indicated: "Inspected treated select rooms for customer call of bugs: Kitchen, Dining Room, rooms 204, 206, 211, 216, 218, 220, 322, 323, social service office, dietitian office, Joyner Hall nursing station."	F 925	scheduled, every 2 weeks, on site treatments in and around facility. 4.Maintenance director/designee will audit the pest control logs weekly for 4 weeks to maintain effective pest control program as well as monthly audits that will be reported to QAPI committee for on going compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495247	A. BUILDING _____ B. WING _____	C 07/12/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NANS POINTE REHABILITATION AND NURSING	200 WEST CONSTANCE ROAD SUFFOLK, VA 23434

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 925	Continued From page 78	F 925		

A 5/13/22 pest control service report indicated: "Inspected and treated select rooms and hallways for customer concern of ants and cockroaches. Rooms serviced: 118, 122, 123, 124, 323, 324, 326, shower area, Assistant Director of Nursing office, janitor closet, and select hallways."

A 5/2-3/22 pest control service report dated indicated: "This report is provided to identify sanitation deficiencies, structural defects, and improper storage practices contributing to pest infestations: Kitchen Area-interior - Finding- cockroaches noted during service live activity found along wall and baseboards of wall where grill is. Action needed."

Location: "Kitchen- Finding- hole/gap noted FRP Board in dish room of kitchen is loose. Action needed: seal to prevent pest entry or harborage. Exclusion measures here will reduce the number of pests entering the area."

Location: "Kitchen- Finding- floor tiles or baseboards loose/missing many areas but most are in dish area behind machine. Action needed: Please repair to eliminate potential pest harborage/breeding site."

Location: "Kitchen- Finding- floor tiles or baseboards loose/missing. many areas where titles is pulling away from wall or grout is missing creating openings. Action needed: Please repair to eliminate potential pest harborage/breeding site."

During an interview on 07/07/22 at 2:54 p.m. with the Maintenance Director he stated, the pest

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495247	A. BUILDING _____ B. WING _____	C 07/12/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NANS POINTE REHABILITATION AND NURSING	**200 WEST CONSTANCE ROAD SUFFOLK, VA 23434**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 925	Continued From page 79 control company comes out when the facility calls them regarding pest sightings. A request for a pest control policy was requested but was not provided during the survey. Complaint Deficiency	F 925		