

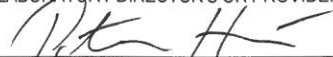
State of Virginia

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: VA0199	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 09/02/2021
NAME OF PROVIDER OR SUPPLIER WATERVIEW HEALTH & REHAB CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 414 ALGONQUIN RD HAMPTON, VA 23661		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
F 000	Initial Comments An unannounced biennial State Licensure Inspection was conducted 8/31/21 through 9/2/21. The facility was not in compliance with the Virginia Rules and Regulations for the Licensure of Nursing Facilities. Three complaints were investigated during the survey. The census in this 130 certified bed facility was 94 at the time of the survey. The survey sample consisted of 44 Resident record reviews, current/closed.	F 000	Preparation and/or execution of this plan does not constitute admission or agreement by the provider that a deficiency exists. This response is also not construed as an admission of fault by the facility, its employees, agents, or other individuals who draft or may discussed in this response and plan of correction. This plan of correction is submitted as the facility's credible allegation of compliance.	
F 001	Non Compliance The facility was out of compliance with the following state licensure requirements: This RULE: is not met as evidenced by: 12 VAC 5-371-110.B.2 (Management and Administration) cross reference to F567. 12 VAC 5-371-140.D.2 (Policies and Procedures) cross reference to F622. 12 VAC 5-371-250 (I). Resident Assessment and Care Planning cross reference to F657. 12 VAC5-371-220. (D) Nursing Services cross reference to F695, F698. 12 VAC 5-371-220 A and B. Nursing Services. Cross reference to F760 12 VAC 5-371-280 (A). Please Cross Reference to F-679. 12VAC5-371-360. Clinical Records cross reference to F842.	F 001	12 VAC 5-371-110.B.2 (Management and Administration) cross reference to F567. 12 VAC 5-371-140.D.2 (Policies and Procedures)cross reference to F622. 12 VAC 5-371-250 (I). Resident Assessment and Care Planning cross reference to F657. 12 VAC5-371-220. (D) Nursing Services cross reference to F695, F698. 12 VAC 5-371-220 A and B. Nursing Services. Cross reference to F760 12 VAC 5-371-280 (A). Please Cross Reference to F-679. 12VAC 5-371-360. Clinical Records cross reference to F842. This plan of correction is respectfully submitted as evidence of alleged compliance. The submission is not an admission that the deficiencies existed or that we are in agreement with them. It is an affirmation that corrections to the areas cited have been made and the facility is in compliance with participation requirements.	

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

TITLE

(X6) DATE



Regional Director of Operations

09/27/21

State of Virginia

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: VA0199	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 09/02/2021
NAME OF PROVIDER OR SUPPLIER WATERVIEW HEALTH & REHAB CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 414 ALGONQUIN RD HAMPTON, VA 23661		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
F 001	<p>Continued From page 1</p> <p>12 VAC5-371-220. B.3 Nursing Services cross reference to F726.</p> <p>12 VAC 5-371-220 (F). Quality of Life. ADL Care Provided for Dependent Residents Under Section (F). Each resident shall receive tub or shower baths as often as needed, but not less than twice weekly.</p> <p>The findings included:</p> <p>Resident #62 was admitted to the facility on 7/9/21 with diagnoses that included but were not limited to stroke, atrial fibrillation, heart failure, diabetes mellitus, and renal insufficiency. Resident #62's most recent Minimum Data Set (MDS) assessment was an admission assessment with an assessment reference date (ARD) of 7/14/21. Resident #62 was coded as being moderately impaired in cognitive function scoring 12 out of possible 15 on the Brief Interview For Mental Status (BIMS) exam. Resident #62 was coded as requiring total dependence on two plus persons with transfers and bathing.</p> <p>On 8/31/21 at 2:03 p.m., an interview was conducted with Resident #62. When asked if she had received showers while at the nursing facility, Resident #62 stated that she had been at the facility for approximately 5 weeks and had yet to receive a shower. Resident #62 stated that she only received bed baths and was not sure why she hasn't been offered a shower. Resident #62 stated that it may have been due to two reasons; she was extensive assistance with bathing or that staff did not want her to get her right central line dressing (used for dialysis) wet. When asked if the facility shower rooms had shower chairs, Resident #62 stated that she was not sure.</p>	F 001	<ol style="list-style-type: none"> 1. A criminal background checks for employee #21 was completed at time and copies are maintained in the facility. Results employee #21 criminal background check was found to meet the regulations required for employment. 2. The Administrator/Designee has verified that criminal background checks were performed on all employees of Waterview Health and Rehab. Results of all criminal background checks were found to meet the regulations required for employment. Copies of criminal background checks are kept on file and available in the facility. 3. The Administrator/Designee will verify that all potential employees pass a criminal background check prior to beginning employment at Waterview Health and Rehab. Copies of pre-employment criminal background checks will be kept on file and available in the facility. 4. The Administrator/Designee will review the files of all potential employees to ensure that criminal background checks are performed, and the results meet the requirement for employment, prior to any potential beginning a position at Waterview Health and Rehab. The Administrator/Designee will prohibit any employees not passing a criminal background check from being employed by Waterview Health and Rehab. The Administrator/Designee will identify any patterns or trends and report to the Quality Assurance and Performance Improvement Committee quarterly. 5. Date of Compliance: 10/15/2021 	

State of Virginia

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: VA0199	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 09/02/2021
NAME OF PROVIDER OR SUPPLIER WATERVIEW HEALTH & REHAB CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 414 ALGONQUIN RD HAMPTON, VA 23661			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
F 001	<p>Continued From page 2</p> <p>Resident #62 stated that she would love a shower to feel the water the on her back and to wash her hair. Resident #62 stated that she did not get her hair washed with bed baths. Resident #62 stated that she was not aware that she could request showers.</p> <p>Review of the facility's shower schedule revealed that Resident #62 was to receive showers on Wednesdays and Saturdays day shift; with Wednesday also being Resident #62's dialysis day with a chair time of 6 a.m.</p> <p>Review of Resident #62's care plan dated 7/22/21 documented the following for Activities of Daily Living (ADL) care: "(Name of Resident #62) has an ADL self-care performance deficit r/t (related to) CVA (Cerebrovascular Accident) (Stroke)/Hemiplegia (one sided weakness/paralysis), Impaired respiratory status, Impaired balance, Limited Mobility, Pain...(Name of Resident #62) requires extensive assistance and is sometimes dependent on staff for bathing/showering...Provide sponge bath when a full bath or shower cannot be tolerated."</p> <p>There was no evidence that Resident #62 was non-complaint or frequently refused showers on her care plan.</p> <p>Review of Resident #62's August 2021 ADL tracker for bathing failed to evidence that a shower was provided for the month of August. There was no evidence that Resident #62 had refused showers.</p> <p>On 9/1/21 at 9:38 a.m., observation was made of the shower room on the North Unit. There were approximately two shower chairs located in the shower room.</p>	F 001			

State of Virginia

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: VA0199	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 09/02/2021
NAME OF PROVIDER OR SUPPLIER WATERVIEW HEALTH & REHAB CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 414 ALGONQUIN RD HAMPTON, VA 23661			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
F 001	<p>Continued From page 3</p> <p>On 9/2/21 at 10:07 a.m., an interview was conducted with Licensed Practical Nurse (LPN) #3, the Unit manager. When asked if Resident #62 was able to receive a shower, LPN #3 stated that she was able to go to the shower room. When asked why there was no evidence on her ADL tracker that she had ever received a shower for the month of August, LPN #3 stated that the resident frequently refused showers due to dialysis and feeling tired after dialysis. When asked if it made sense to change her shower schedule so that she could receive her showers, LPN #3 stated, "Yes." LPN #3 stated that in point in August Resident #62 also had Shingles and was on precautions but that had ended on the 5th or 6th. LPN #3 stated that Resident #62 also refused showers due to residual pain from her shingles. When asked if all shower refusals should be documented, LPN #3 stated that it should. LPN #3 stated that there was an area on the ADL tracker to document refusals. When asked if shower refusals should be care planned if they are frequent, LPN #3 stated that it should be on the care plan. LPN #3 was made aware that there was no evidence of shower refusals in Resident #3's clinical record. When asked if hair can be washed while given a bed bath, LPN #3 stated that the facility utilized no rinse caps that released a cleansing solution to the hair and that the staff should be using those if a resident requests their hair to be washed.</p> <p>On 9/2/21 at 11:42 a.m., further interview was conducted with LPN #3. LPN #3 that she also did not see anything regarding Resident #62 refusing showers.</p> <p>On 9/2/21 at 11:51 a.m., an interview was conducted with Certified Nursing Assistant (CNA)</p>	F 001			

State of Virginia

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: VA0199	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 09/02/2021
NAME OF PROVIDER OR SUPPLIER WATERVIEW HEALTH & REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 414 ALGONQUIN RD HAMPTON, VA 23661		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
F 001	<p>Continued From page 4</p> <p>#5, a CNA who frequently works with Resident #62. When asked how often showers were offered to residents, CNA #5 stated generally twice weekly. When asked the process if a resident refuses a shower, CNA #5 stated that she will document refusals on the assignment sheets. When asked if Resident #62 received showers, CNA #5 stated, "She hasn't been taking them." When asked why Resident #62 has not been taking her showers, CNA #5 stated, "She has been refusing them." When asked if refusals should also be documented on the ADL tracker in the computer system, CNA #5 stated that she only documented on the assignment or the shower sheets. When asked why Resident #5 had been refusing her showers, CNA #5 stated that sometimes Resident #62's showers were also on her dialysis days and that the resident was given bed baths prior to dialysis on the 11 p.m. to 7 a.m. shift and then she felt too weak and tired to take a shower after dialysis. When asked if anyone had thought to change Resident #62's shower schedule around to ensure she received showers on non-dialysis days, CNA #5 stated that there were no changes to her shower schedule. CNA #5 stated that the resident "never voiced ever really wanting a shower." CNA #5 denied using shower caps to wash Resident #62's hair.</p> <p>On 9/2/21 Resident #62's shower skin sheets and shower assignment sheets could not be presented prior to exit.</p> <p>On 9/2/21 at 6:30 p.m., Administrative Staff Member (ASM) #1, the Administrator, ASM #2, the acting Director of Nursing (DON), ASM #3 the Assistant Director of Nursing (ADON) and ASM #4 the Regional Director of Compliance were made aware of the above concerns.</p>	F 001			

State of Virginia

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: VA0199	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 09/02/2021
NAME OF PROVIDER OR SUPPLIER WATERVIEW HEALTH & REHAB CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 414 ALGONQUIN RD HAMPTON, VA 23661		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
F 001	<p>Continued From page 5</p> <p>12 VAC 5-371-140. Policies an Procedures E-3-B Criminal Record Check:</p> <p>Based on clinical record review, and staff interview and facility documentation the facility staff failed to ensure 1 of 25 staff employees had their criminal background check completed prior to starting employment at the facility.</p> <p>The facility staff failed to ensure Criminal Records Check Employee #21 had her criminal record check completed with in 30 days of starting employment at the nursing facility.</p> <p>The findings included:</p> <p>During the Criminal Records Check review on 09/02/21 indicated Criminal Records Check Employee #21 was hired on 03/22/21 and the criminal background check report was received back on 05/07/21.</p> <p>An interview was conducted with the Payroll/Human Resource Manager at 4:45 P.M. on 09/02/21, she stated, " I really can't tell you what happened. I know I ran her criminal background check report but I can't tell what happened.</p> <p>Policy: The Personnel/Human Resources Director, or other designee, will conduct employment back ground checks, reference checks and criminal conviction checks (including fingerprint as may be required by state law) on persons making application for employment with this facility. Such investigation will be initiated within two days of employment or offer of employment.</p>	F 001		