	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION		E SURVEY IPLETED
						С
		495147	B. WING			1/03/2022
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	CODE	
RIVER ED	RIVER EDGE REHABILITATION AND NURSING			1221 ROSSER AVE WAYNESBORO, VA 22980		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE) THE APPROPRIATE	(X5) COMPLETION DATE
E 000	Initial Comments		EO	00		
E 039	survey was conducted 11/3/2022. Correction compliance with 42 C	ns are required for FR Part 483.73, g-Term Care Facilities.	E0	39		12/5/22
	§460.84(d)(2), §482.1 §483.475(d)(2), §484 §485.542(d)(2), §485	113(d)(2), §441.184(d)(2), 15(d)(2), §483.73(d)(2), .102(d)(2), §485.68(d)(2), .625(d)(2), §485.727(d)(2), .12(d)(2), §494.62(d)(2).				
	at §485.542, OPO, "C	§485.920, RHCs/FQHCs at				
	., .	ty] must conduct exercises plan annually. The [facility] pwing:				
	community-based eve (A) When a commun accessible, conduct a exercise every 2 year (B) If the [facility]	ity-based exercise is not facility-based functional s; or experiences an actual				
	activation of the emer exempt from engagin community-based or	emergency that requires rgency plan, the [facility] is g in its next required individual, facility-based llowing the onset of the				
		onal exercise at least every 2 ear the full-scale or				

Electronically Signed

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

11/25/2022

		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 01/26/20 FORM APPROVE OMB NO. 0938-039
TATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
495147		B. WING _		C 11/03/2022	
	ROVIDER OR SUPPLIER	ND NURSING		STREET ADDRESS, CITY, STATE, 1221 ROSSER AVE	-
				WAYNESBORO, VA 22980	1
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORRECTIVE CROSS-REFERENCEE	IN OF CORRECTION (X5) E ACTION SHOULD BE COMPLETIO D TO THE APPROPRIATE CIENCY)
E 039	functional exercise un this section is conduct not limited to the follo (A) A second full-scal community-based or functional exercise; of (B) A mock disaster of (C) A tabletop exercise a facilitator and include a narrated, clinically- scenario, and a set of directed messages, of designed to challeng (iii) Analyze the [facility maintain documentate exercises, and emerge [facility's] emergency *[For Hospices at 418 (2) Testing for hospice patient's home. The exercises to test the annually. The hospice (i) Participate in a full community based even (A) When a community accessible, conduct at functional exercise even (B) If the hospice expression the emergency plan, engaging in its next r community-based function onset of the emerger (ii) Conduct an addition opposite the year the	nder paragraph (d)(2)(i) of cted, that may include, but is owing: le exercise that is individual, facility-based or drill; or se or workshop that is led by des a group discussion using relevant emergency of problem statements, or prepared questions e an emergency plan. ity's] response to and ion of all drills, tabletop gency events, and revise the plan, as needed. 8.113(d):] ces that provide care in the hospice must conduct emergency plan at least ce must do the following: Il-scale exercise that is ery 2 years; or ity based exercise is not an individual facility based very 2 years; or periences a natural or cy that requires activation of the hospital is exempt from equired full scale ercise or individual nal exercise following the	E	039	

Facility ID: VA0019

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		ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 01/26/2 FORM APPRO OMB NO. 0938-0
TATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495147	B. WING		C 11/03/2022
NAME OF P	ROVIDER OR SUPPLIER		ST	REET ADDRESS, CITY, STATE, ZIP CODE	
RIVER ED	RIVER EDGE REHABILITATION AND NURSING			21 ROSSER AVE AYNESBORO, VA 22980	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE COMPLET
E 039	 is conducted, that matter to the following: (A) A second full-scatter of the following: (A) A second full-scatter of the following: (A) A second full-scatter of the following: (B) A mock disaster of the following the	ale exercise that is a facility based functional drill; or se or workshop that is led by des a group discussion using relevant emergency f problem statements, or prepared questions e an emergency plan. es that provide inpatient spice must conduct emergency plan twice per ust do the following: innual full-scale exercise that or ity-based exercise is not an annual individual hal exercise; or ereiences a natural or by that requires activation of the hospice is exempt from equired full-scale community ad functional exercise if the emergency event. ional annual exercise that of limited to the following: a facility based functional drill; or se or workshop led by a is a group discussion using a levant emergency scenario,	E 039		

Facility ID: VA0019

If continuation sheet Page 3 of 71

		ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 01/26/20 FORM APPROVE OMB NO. 0938-03
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495147		(X1) PROVIDER/SUPPLIER/CLIA	· ,	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
		B. WING		C 11/03/2022	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C	
RIVER ED	GE REHABILITATION A	ND NURSING		WAYNESBORO, VA 22980	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE COMPLETION THE APPROPRIATE DATE
E 039	messages, or prepare challenge an emerge (iii) Analyze the hosp maintain documentat exercises, and emerge hospice's emergency *[For PRFTs at §441. §482.15(d), CAHs at (2) Testing. The [PRT conduct exercises to twice per year. The [do the following: (i) Participate in an a is community-based; (A) When a communi accessible, conduct a facility-based function (B) If the [PRTF, Hos actual natural or man requires activation of [facility] is exempt fro required full-scale co facility-based function (ii) Conduct an [and that may include following: (A) A second full-sca community-based or functional exercise; o (B) A mock of (C) A tabletop ex led by a facilitator and discussion, using a n emergency scenario,	ed questions designed to ncy plan. bice's response to and ion of all drills, tabletop gency events and revise the plan, as needed. 184(d), Hospitals at §485.625(d):] 'F, Hospital, CAH] must test the emergency plan 'PRTF, Hospital, CAH] must innual full-scale exercise that or ity-based exercise is not an annual individual, hal exercise; or pital, CAH] experiences an immunity based or individual, hal exercise following the mengaging in its next mmunity based or individual, hal exercise following the acy event. additional] annual exercise or , but is not limited to the ale exercise that is individual, a facility-based or disaster drill; or tercise or workshop that is	E O	39	

Facility ID: VA0019

If continuation sheet Page 4 of 71

	MENT OF HEALTH AN S FOR MEDICARE & I	D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495147	B. WING				C 03/2022
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
RIVER ED	GE REHABILITATION AN	ID NURSING			221 ROSSER AVE VAYNESBORO, VA 22980		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
E 039	questions designed to plan. (iii) Analyze the [maintain documentati exercises, and emerg [facility's] emergency *[For PACE at §460.8 (2) Testing. The PACE exercises to test the e annually. The PACE of following: (i) Participate in an a is community-based; (A) When a community accessible, conduct at facility-based function (B) If the PACE experi- man-made emergency the emergency plan, f engaging in its next re based or individual, fa exercise following the event. (ii) Conduct an ac years opposite the ye exercise under parag is conducted that may the following: (A) A second full-sca community-based or if functional exercise; of (B) A mock disaster of (C) A tabletop exercise a facilitator and inclust	a challenge an emergency facility's] response to and on of all drills, tabletop ency events and revise the plan, as needed. 4(d):] E organization must conduct emergency plan at least organization must do the nnual full-scale exercise that or ty-based exercise is not n annual individual, al exercise; or iences an actual natural or y that requires activation of the PACE is exempt from equired full-scale community acility-based functional onset of the emergency dditional exercise every 2 ar the full-scale or functional raph (d)(2)(i) of this section y include, but is not limited to le exercise that is ndividual, a facility based full; or se or workshop that is led by les a group discussion, cally-relevant emergency problem statements,	E	039			

Facility ID: VA0019

If continuation sheet Page 5 of 71

	MENT OF HEALTH AN S FOR MEDICARE & I	D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		495147	B. WING				C 03/2022
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
RIVER ED	GE REHABILITATION AN	ID NURSING			1221 ROSSER AVE WAYNESBORO, VA 22980		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI. DEFICIENCY)		(X5) COMPLETION DATE
E 039	designed to challenge (iii) Analyze the PACI maintain documentati exercises, and emerg PACE's emergency pl *[For LTC Facilities at (2) The [LTC facility] r test the emergency pl including unannounce emergency procedure ICF/IID] must do the f (i) Participate in an a is community-based; (A) When a communit accessible, conduct a facility-based function (B) If the [LTC facility] actual natural or man- requires activation of LTC facility is exempt required a full-scale c individual, facility-bass following the onset of (ii) Conduct an additi may include, but is no (A) A second full-sca community-based or a functional exercise; of (C) A tabletop exercise a facilitator includes a narrated, clinically-rel- and a set of problem s messages, or prepare challenge an emerger (iii) Analyze the [LTC	a an emergency plan. E's response to and on of all drills, tabletop ency events and revise the an, as needed. §483.73(d):] must conduct exercises to an at least twice per year, ed staff drills using the es. The [LTC facility, ollowing: mual full-scale exercise that or ty-based exercise is not n annual individual, al exercise. facility experiences an made emergency that the emergency plan, the from engaging its next ommunity-based or ed functional exercise that ot limited to the following: le exercise that is an individual, facility based full; or se or workshop that is led by group discussion, using a evant emergency scenario, statements, directed ed questions designed to	E	03	9		

Facility ID: VA0019

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		ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 01/26/20 FORM APPROVE OMB NO. 0938-03
TATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING	(X3) DATE SURVEY COMPLETED	
495147		B. WING		C 11/03/2022	
NAME OF PF	ROVIDER OR SUPPLIER	•	STF	REET ADDRESS, CITY, STATE, ZIP COL	
RIVER ED	RIVER EDGE REHABILITATION AND NURSING			1 ROSSER AVE AYNESBORO, VA 22980	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO) CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE COMPLETIO E APPROPRIATE DATE
E 039	[LTC facility] facility's *[For ICF/IIDs at §483 (2) Testing. The ICF/I to test the emergency The ICF/IID must do (i) Participate in an ar- is community-based; (A) When a communi- accessible, conduct a facility-based function (B) If the ICF/IID exper- man-made emergency the emergency plan, engaging in its next re- community-based or functional exercise for emergency event. (ii) Conduct an addition may include, but is no (A) A second full-scal community-based or functional exercise; o (B) A mock disaster of (C) A tabletop exercise a facilitator and include using a narrated, clin scenario, and a set o directed messages, o designed to challenge (iii) Analyze the ICF/I maintain documentat	gency events, and revise the emergency plan, as needed. 3.475(d)]: IID must conduct exercises y plan at least twice per year. the following: nnual full-scale exercise that or ity-based exercise is not an annual individual, nal exercise; or. eriences an actual natural or cy that requires activation of the ICF/IID is exempt from equired full-scale individual, facility-based illowing the onset of the onal annual exercise that ot limited to the following: le exercise that is an individual, facility-based iff is or se or workshop that is led by des a group discussion, ically-relevant emergency f problem statements, or prepared questions e an emergency plan. ID's response to and ion of all drills, tabletop gency events, and revise the plan, as needed.	E 039		
		l02] HA must conduct exercises			

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		ND HUMAN SERVICES MEDICAID SERVICES			FOF	ED: 01/26/202 RM APPROVE IO. 0938-039
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING		TE SURVEY IPLETED	
495147		B. WING		1'	C 1/03/2022	
NAME OF P	ROVIDER OR SUPPLIER		STF	REET ADDRESS, CITY, STATE, ZIP COD	DE	
RIVER EDGE REHABILITATION AND NURSING				1 ROSSER AVE YNESBORO, VA 22980		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETIO DATE
E 039	 (i) Participate in a full community-based; or (A) When a com accessible, conduct a facility-based function or. (B) If the HHA e or man-made emerge of the emergency pla engaging in its next m community-based or functional exercise for emergency event. (ii) Conduct an addition opposite the year the exercise under parage is conducted, that limited to the followin (A) A second full community-based or functional exercise; on (B) A mock disase (C) A tabletop exercise, or statements, directed questions designed to plan. (iii) Analyze the HHA documentation of all emergency events, a emergency plan, as manual systems. 	y plan at IHA must do the following: I-scale exercise that is munity-based exercise is not an annual individual, hal exercise every 2 years; experiences an actual natural ency that requires activation in, the HHA is exempt from equired full-scale individual, facility based blowing the onset of the onal exercise every 2 years, full-scale or functional graph (d)(2)(i) of this section at may include, but is not g: -scale exercise that is an individual, facility-based or ster drill; or kercise or workshop that is d includes a group arrated, clinically-relevant and a set of problem messages, or prepared o challenge an emergency 's response to and maintain drills, tabletop exercises, and nd revise the HHA's heeded.	E 039			

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 01/26/202 M APPROVE D. 0938-039
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
	495147		B. WING				C / 03/2022
NAME OF PI	ROVIDER OR SUPPLIER			STR	EET ADDRESS, CITY, STATE, ZIP CODE		
RIVER ED	GE REHABILITATION AI	ND NURSING			1 ROSSER AVE YNESBORO, VA 22980		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETIO DATE
E 039	Continued From page	e 8	É E	039			
		y plan. The OPO must do the					
	(i) Conduct a paper-b	ased, tabletop exercise or nually. A tabletop exercise is d includes a group					
	discussion, using a n emergency scenario,	arrated, clinically relevant and a set of problem					
	questions designed to plan. If the OPO expe	messages, or prepared o challenge an emergency eriences an actual natural or					
	the emergency plan,	by that requires activation of the OPO is exempt from equired testing exercise					
	following the onset of	the emergency event. s response to and maintain					
		tabletop exercises, and nd revise the [RNHCI's and lan, as needed.					
	*[RNCHIs at §403.74 (d)(2) Testing. The R exercises to test the c	-					
	least annually. A table	ased, tabletop exercise at etop exercise is a group					
	clinically-relevant em	acilitator, using a narrated, ergency scenario, and a set s, directed messages, or					
	prepared questions d emergency plan.	esigned to challenge an					
	and emergency even	ion of all tabletop exercises, ts, and revise the RNHCI's					
	emergency plan, as r This REQUIREMENT by:	needed. is not met as evidenced					
	Based on staff interv review, the facility sta				1. The Administrator held tabletop exercise including a group discussion		
	exercises to test the	emergency preparedness			using a narrated, clinically relevant		

Facility ID: VA0019

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AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			· · /			(X3) DATE SURVEY COMPLETED	
		495147	B. WING		1	C 1/03/2022	
IAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO			
				1221 ROSSER AVE			
RIVER EDGE REHABILITATION AND NURSING			WAYNESBORO, VA 22980				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BE E APPROPRIATE	(X5) COMPLETIO DATE	
E 039	Continued From page	e 9	E 03	9			
F 000	plan. There was no c of an annual table-top drill, attempts to partic community-based exc emergency plan. The findings include: The facility's current B Plan (09/2022) was re a.m. The plan docum regarding an annual f emergency exercise, disaster drill or docum emergency plan had actual event. On 11/3/22 at 8:30 a. interviewed about any plan activations or ex and evaluate the eme The administrator sta facility for approximat find anything about te plan. The administratif if and/or when a table exercise had been co stated he did not find emergency prepared previous administrator	documentation or evidence o exercise, mock disaster cipate in a full-scale ercise or activation of the Emergency Preparedness eviewed on 11/3/22 at 8:00 nented no evidence full-scale community-based a table-top exercise, a mock nentation that the been activated due to an m., the administrator was y disaster drills, emergency ercises conducted to test ergency preparedness plan. ted he had worked at the tely three months and did not ests/drills of the emergency tor stated he was not aware e-top or community-based onducted. The administrator any information about the ness exercises from the or.	F 00	emergency scenario, and a s statements, directed message prepared questions designed an emergency plan for Winte Alert on 11/22/2022. 2. No other full-scale exerce community based or facility & functional exercise is due at 3. The Regional of Operati conduct education with the A Maintenance Director and th Nursing on Emergency prepa- conducting tabletop exercise 4. The administrator or des a monthly audit to determine next full-scale exercise is due Audit findings will be reporter facility QAPI Committee mor months to review the need for intervention or amendment of	ges, and d to challenge er Weather cise that is a based this time. ion will administrator, e Director of aredness and es. signee will do when the e. d to the hthly for three or continued		
				Č			

Facility ID: VA0019

If continuation sheet Page 10 of 71

		ID HUMAN SERVICES MEDICAID SERVICES			FOR	ED: 01/26/202 MAPPROVE O. 0938-039
TATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
495147		B. WING		11	C / /03/2022	
NAME OF P	ROVIDER OR SUPPLIER	1	STF	REET ADDRESS, CITY, STATE, ZIP CO	•	
RIVER ED	RIVER EDGE REHABILITATION AND NURSING			21 ROSSER AVE AYNESBORO, VA 22980		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 000 F 580 SS=E	11/03/2022. Significat for compliance with 4 Long Term Care requined Code survey/report with Three complaints were survey: VA00054201 with three unsubstantiated. VA00056045 with three substantiated with de and F684. VA00054405 with one unsubstantiated. The census in this 10 84 at the time of the size consisted of eighteen reviews and three (3) Notify of Changes (In CFR(s): 483.10(g)(14) S483.10(g)(14) Notified (i) A facility must immer consult with the resid consistent with his or representative(s) whee (A) An accident involver results in injury and hephysician intervention (B) A significant chan mental, or psychosood deterioration in health	d 11/01/2022 through ant Corrections are required 2 CFR Part 483 Federal irrements. The Life Safety vill follow. re investigated during the ee allegations was ficient practice cited at F580 e allegation was 9 certified bed facility was survey. The survey sample o (18) current Resident o closed record reviews. jury/Decline/Room, etc.) e)(i)-(iv)(15) cation of Changes. nediately inform the resident; ent's physician; and notify, her authority, the resident en there is- ving the resident which has the potential for requiring n; ge in the resident's physical, tial status (that is, a n, mental, or psychosocial reatening conditions or);	F 000			12/5/22

Event ID:08B311

Facility ID: VA0019

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	-	ND HUMAN SERVICES				FO	ED: 01/26/202 RM APPROVE NO: 0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
495147		B. WING			1	C 1/03/2022	
NAME OF PF	ROVIDER OR SUPPLIER			STR	EET ADDRESS, CITY, STATE, ZIP CODE		
RIVER ED	GE REHABILITATION A	ND NURSING			ROSSER AVE		
				WA	YNESBORO, VA 22980		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETIOI DATE
F 580	Continued From page	e 11	E 4	580			
		erse consequences, or to		000			
	commence a new for						
		sfer or discharge the					
	resident from the faci	lity as specified in					
	§483.15(c)(1)(ii). (ii) When making not	ification under paragraph (g)					
		the facility must ensure that					
	all pertinent informati						
	-	ided upon request to the					
	physician. (iii) The facility must :	also promptly notify the					
		dent representative, if any,					
	when there is-						
		or roommate assignment					
	as specified in §483.	10(e)(6); or ent rights under Federal or					
		ons as specified in paragraph					
	(e)(10) of this section	I					
		record and periodically					
	phone number of the	mailing and email) and					
	representative(s).	resident					
	§483.10(g)(15)						
		osite distinct part. A facility					
		istinct part (as defined in e in its admission agreement					
	- ,	tion, including the various					
	locations that comprise	se the composite distinct					
		y the policies that apply to					
	room changes betwe under §483.15(c)(9).	en its different locations					
		Γ is not met as evidenced					
	by:						
	-	ailed to notify the physician			1. Facility staff notified resident	#34's RP	
	of a delay in the treat infection) for Resider	ment of a UTI (urinary tract			of wound on 8/8/2022. Facility staff notified resident #78	s NP of	
		IL <i>π</i> ∠ 0.			resident's pain and/or that the res		
	Findings were:				pain medication was not administ		

Facility ID: VA0019

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STATEMENT	CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				(X3) DATE COMP		
		495147	B. WING		C 11/03/2022		
NAME OF P	ROVIDER OR SUPPLIER	I		STREET ADDRESS, CITY, STATE, ZIP CODE			
				1221 ROSSER AVE			
RIVER ED	GE REHABILITATION AN	ND NURSING		WAYNESBORO, VA 22980			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE	
F 580	Continued From page	e 12	F 58				
	following diagnoses in Diabetes mellitus, qua- left hand, UTI, and ch An annual MDS (mini- assessment tool), dat the BIMS (Brief Interv- of "15" (out of 15), inc function for daily deci The clinical record wa beginning at approxim progress notes with th "10/29/2022 22:20 (10 Spoke with (Name); p ertapenem 1 GM (gra "10/31/2022 (Note fro 10/31/2022 at 7:51 p. inflammatory reaction catheterurine cultur and Pseudomonas. S mg daily for UTI prop developed a UTI agai ertapenem 1 g daily u should be performed should be changed et "11/01/2022 01:27 (a. Reconstituted 1 GM U one time a day for UT begin tomorrow 11-1 change in (computer Written by the unit ma nurse) #1, a change i	as reviewed on 11/01/2022 nately 3:00 p.m, noting the he following entries: 0:22 p.m.) Positive for UTI. blace PICC line begin am) q (every) 24 hours." om nurse practitioner signed .m.)Infection and n due to indwelling urethral e came back with E. Coli She is on trimethoprim 50 hylaxis, however, she has in. She should continue until 11/4/2022. Foley care every shift and the catheter very 28 days" .m.) Ertapenem Sodium Jse 1 gram intravenously II over 4 days. IV therapy to @1700 per MD order, noted system) as well."		 ordered on 11/2/2022 and resident seen by provider. Facility staff notified resident #28's a delay in the treatment of a UTI (tract infection). 2. The wound care nurse will con 100% audit of all RP notification of non-pressure areas. The DON/designee will complete a audit of MD/NP notification of pain medications not administered as o The DON/designee will complete a audit of MD/NP notification for dela treatments for current antibiotic ord treat UTI's. 3. The ADON will complete educ with licensed nursing staff in regar notification of wounds, MD/NP not of pain medication not administere ordered and MD/NP notification of treatment for UTI's. 4. The DON/designee will do an two times weekly times six weeks monthly times two months. Audit findings will be reported to the facility QAPI Committee monthly for months to review the need for committee intervention or amendment of the pain for the pain for the pain for the pain for the pain the pain for the pain the pain	NP of urinary mplete a f all a 100% rdered. a 100% ay of ders to cation d to RP ification ed as delay in audit then ne or three tinued		

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	`, ´		E CONSTRUCTION	(X3) DATE	
		495147	B. WING				C 03/2022
NAME OF P	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE		
				1	1221 ROSSER AVE		
RIVER ED	GE REHABILITATION AN	ID NURSING		١	WAYNESBORO, VA 22980		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)				(X5) COMPLETION DATE
F 580	"11/02/2022 08:56 (a. Conditionnursing ob recommendations are UTI, Foley catheter in Ertapenem 1 Gm IV X On 11/02/2022 at app was interviewed. In m change in condition m RN #1 was asked if st antibiotics for Resider started. She looked a stated, "Yes, it starts f referred back to the p 10/29/2022, 10/31/20 regarding Resident #2 antibiotic. At approximately 11:3 conference room and order was written by t weekend. It looks like written on October 29 discontinue it when th That order was discor order written on Octob be given for four days rewritten to start on N was discontinued on I on the order was wait pharmacy and they w todayI don't know w notes say we were was say waiting on IV sup ordered the medicine have that antibiotic h startedI spoke with	m.)Change in pervations, evaluation, and e: Resident presents with place. Treatment with ((times) 4 days" proximately 9:30 a.m., RN #1 eference to the 11/02/2022 ote, written earlier that day, he was aware that the nt #28 had not yet been t the physician orders and this evening." She was rogress notes from 22, and 11/01/2022 28's orders for an IV 40 a.m., RN #1 came to the stated, "The antibiotic he on-call physician over the original order was to place a PICC line and the antibiotics were complete. ntinued. There was also an ber 29 for the antibiotics to sthat was discontinued and ovember firstthat order November 1st, the reason ing on IV supplies from the ere suppose to be here that happenedsome of the aiting on the medicine, some	F	580			

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		ID HUMAN SERVICES MEDICAID SERVICES				_	FORM	01/26/2023 APPROVED 0938-0391
STATEMENT O	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA ID PLAN OF CORRECTION IDENTIFICATION NUMBER:		· /		ONSTRUCTION		SURVEY ETED	
		495147	B. WING_				C 11/0	3/2022
NAME OF PI	ROVIDER OR SUPPLIER			STR	EET ADDRESS, CITY, STATE, ZIP CODE		-	
				122	1 ROSSER AVE			
RIVERED	GE REHABILITATION AN	ND NURSING		WA	YNESBORO, VA 22980			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	Ē	(X5) COMPLETION DATE
F 580	that the medication hat today. She stated, "Ti that notification occur happened." She was changed/canceled the of the antibiotic witho physician or the nurse "Yes, that is what I thi should have been not On 11/02/2022 at app nurse practitioner was asked if she was awa not received any dose the IM injection earlie "I was told on Monday an IV and that it had in nurses name who told weren't any needles f would have to come fi thought she had gotte resume the next day today that none had b route to IM so it could On 11/02/2022 at app was asked if other that was any place the nu documented that the the physician/nurse p stated, "There is a ph the nurse's station an stated, "There's not a about that."	actitioner had been notified ad not been given before here isn't any documentation red, I don't feel like that asked if the nurses had e orders and the start dates ut speaking with the e practitioner. She stated, ink happenedthe physician tified." broximately 3:30 p.m., the s interviewed. She was are that Resident #28 had es of her antibiotics prior to r on 11/02/2022. She stated, y (10/31/2022) that she had infiltratedI can't tell you the d me that, but she said there here to restart it and they from the pharmacyI en one dose and it would (11/01/2022). I found out been given, we changed the d start as soon as possible."	F	580				
	DON, the administrat	or, the ADON (assistant nd three members of the				If continue		

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DEPART	MENT OF HEALTH AN	D HUMAN SERVICES					I APPROVED
		MEDICAID SERVICES					0. 0938-0391
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
							C
		495147	B. WING			11/	03/2022
NAME OF PI	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
RIVER ED	GE REHABILITATION AN	ID NURSING			1221 ROSSER AVE		
					WAYNESBORO, VA 22980		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	PREFI	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) COMPLETION DATE
F 580	antibiotic had been or four doses and the m until 11/02/2022. The physician or Nurse pr of the delay in treatme see what she could fin On 11/03/2022 at 9:30 conference room. She clarify if the physician delay in treatment for "I've not been able to nursesI don't know or not, or if the proble had the meds or if the weren't availableeith have been notifiedI that." The facility policy "Un contained the followin "Medications may be reasons. Staff shall ta it is known that the m unavailable:Notify p medication upon notif medication is not ava scheduled dose of the follow procedures for physician/family notifi	erns were voiced that an IV dered on 10/29/2022 for edication was not started DON was asked if the actitioner had been notified ent. She stated she would nd out. D a.m., the DON came to the e was asked if she could had been notified of the Resident #28. She stated, get in touch with the if the physician was notified m was they didn't know we ey thought the IV supplies her way the physician should don't see any record of available Medications" og information: unavailable for a number of ake immediate action when edication is hysician of inability to obtain fication or awareness that ilableIf a resident misses a e medication errors, including cation"	F	580			
	clinical record review	erview, staff interview, and in the course of a n, the facility staff failed to					

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	
		495147	B. WING				C 03/2022
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
RIVER ED	GE REHABILITATION AN	ID NURSING			1221 ROSSER AVE WAYNESBORO, VA 22980		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)					(X5) COMPLETION DATE
F 580	 notify the physician are of a change in condition in the survey sample #78 and Resident #28 1. The facility staff far RP of a wound. 2. The facility staff far physician of the resident's pain mere for administration. 3. The facility staff far a delay in the treatmere infection) for Resident Findings include: 1. Resident #34's dia not limited to: HTN (h (congestive heart failut Parkinson's disease, polyneuropathy, obestimated the resident's resident in factor of the resident in the resident in the treatmere infection) for Resident The most current MD quarterly review (this discovery of the resident assessed the resident 12, indicating the resident was also assestentsive to full assis of daily living) with as The resident's most residen	nd/or RP (responsible party) on for three of 21 residents (Resident #34, Resident 3). iled to notify Resident #34's iled to notify Resident #78's ent being in pain and/or that edication was not available iled to notify the physician of ent of a UTI (urinary tract t #28. ingnoses included, but were high blood pressure), CHF ure), schizophrenia, asthma, anxiety disorder, ity, and depression. S (minimum data set) was a MDS was prior to the ent's wound). This MDS t with a cognitive score of dent had moderate ecision making skills. The pessed as requiring tance with ADL's (activities	F	580			

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-		ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	
		495147	B. WING				C 03/2022
NAME OF PROVIDER OR SUF	PLIER		•	5	STREET ADDRESS, CITY, STATE, ZIP CODE		
RIVER EDGE REHABILIT		ID NURSING			1221 ROSSER AVE WAYNESBORO, VA 22980		
PREFIX (EACH	DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE
A complaint 11/01/22 the the resident 11/01/22 the the complaint 11/01/22 the the complain Resident #3 the resident" The resident" According to resident was to the dorsal resident to wa 07/29/22). The resident did not evide been notified On 11/02/22 administrato corporate nu complaint all team. The E no informatic this incident resident's re in locating a The DON sta did not notify	wound di dated 12 with a co e residen king skills ection of f investiga bugh 11/(at alleged 4 was no s wound 's clinical the resid s found w area of t eekly skir 's record ence that d of the a at appro r, DON (of urse were legation i DON and on was fo to the resid on was fo to the resid at dappro r, DON (of urse were legation i DON and on was fo to the resid at dappro r, DON (of urse were legation i DON and on was fo to the resid at dappro r, don was fo to the resid at dappro r, don was fo to the resid on was fo to the resid at dappro r, don was fo to the resid at dappro r, don was fo to the resid on was fo to the resid at dappro r, don was fo to the resid on was for to the resid at dappro	scovery) was an annual //20/21. The MDS assessed gnitive score of 14, t was intact for daily s. The resident triggered in this MDS for pressure tion was completed on 03/22. An allegation within that the RP/family of t notified of the discovery of on 07/29/22. I records were reviewed. dent's clinical records, the ith bilateral 'friction' wounds both feet on 07/29/22 per the n assessment (dated s were further reviewed and the resident's RP/family had bove information. ximately 6:15 PM, the director of nursing), and made aware of the above n a meeting with the survey staff were made aware that und regarding notification of sident's RP/family in the d was asked for assistance	F	580	,		

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		ID HUMAN SERVICES				FORM	M APPROVED
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN OF	FCORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING			PLETED
		495147	B. WING				03/2022
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
RIVER ED	GE REHABILITATION AN	ND NURSING			1221 ROSSER AVE WAYNESBORO, VA 22980		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE				(X5) COMPLETION DATE
F 580	resident's wounds that 07/29/22. The DON stated that notification as probler policy on wound care "notification to phys party regarding woun No further information presented prior to the at 11:30 AM to evider	at were discovered on they had recognized m. According to the facility , the policy states, ician and/or responsible d or treatment changes" n and/or documentation was exit conference on 11/03/22 nce that Resident #34's d of a change in condition t's skin.	F	580			
	not limited: diverticuli depression, muscle w abnormal gait, polyne and musculoskeletal The resident's most re- set) was an admission 08/23/22. This MDS cognitive score of 15, intact for daily decision The resident was ass supervision with limite person for ADL's (action	veakness, dysphagia, europathy, history of falls, mastoid bone pain. ecent MDS (minimum data n assessment dated assessed the resident with a indicating the resident was on making skills. essed as requiring ed assistance of one staff					

Facility ID: VA0019

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		D HUMAN SERVICES MEDICAID SERVICES				FORM): 01/26/2023 MAPPROVED). 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í		E CONSTRUCTION	(X3) DATE	
AND I LAN OI	CONNECTION	IDENTIFICATION NOWDER.	A. BUILD	ING		C	
		495147	B. WING				03/2022
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
RIVER ED	GE REHABILITATION AN	ID NURSING			1221 ROSSER AVE WAYNESBORO, VA 22980		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 580	#78 was interviewed i was sitting on the side stated that she had a had not slept due to the that she had asked the ordered pain medicat stated that the nurse of facility) didn't have an nurse told her they die was asked what her p moment and the resid a 7 on a scale of 1-10 and 10 being the worst that they were suppose medication order from and that the nurse tole order and had not arri The resident stated the stated that she hoped from it. At approximately 8:05 Practical Nurse) #1 (ti made aware of Resid and not getting any pa before, as the night sl medication was not ar LPN #1 looked in the the resident had an o 10/31/22 10:32 am] Hydrocodone-Acetarm mg/5 ml (milligrams/m at bedtime for mastoid 10/31/22" The LPN looked furth resident did not get the resident she resident he resident she resident he resident she resident she resident she resident she resident she r	n her room. The resident e of the bed. The resident rough night, was in pain and he pain. The resident stated e night nurse for her ion (hydrocodone) and told her that they (the y. The resident stated the dn't have it. The resident vain was at the present lent stated that her pain was 0 (one being minimal pain st pain). The resident stated sed to change the n a pill form to liquid form d her that it was still on ived from the pharmacy. hat she was hurting and d she wouldn't start crying 5 AM, LPN (Licensed he resident's day nurse) was ent #78's complaints of pain ain medication the night hift nurse had told her the vailable. system and confirmed that rder for: "[order date: hinophen solution 2.5 -108 hilliliter) Give 5 ml by mouth d bone pain Start Date:	F	580			

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	0: 01/26/2023 APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		495147	B. WING		_		C 03/2022
NAME OF P	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STA	ATE, ZIP CODE		
RIVER ED	GE REHABILITATION AN	ID NURSING		221 ROSSER AVE VAYNESBORO, VA 2298	80		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BE ICED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE
F 580	nursing/EMAR (electr administration record) nurse. The LPN stated that if a medication to get he ordered on 10/31/22.' The LPN was asked t cart to see if the medi began looking for the found the bottle of me at the bottle and state the resident's name a 10/31/22. The LPN s sense" and went on to understand why the n the medication was he look at the narcotic sh see if any had been s the narcotic sheet for documented the date received as 10/31/22. as administered. The look to see if the resid medication at bedtime looked and stated tha received pain medica At approximately 9:30 records were reviewe (medication administr and November 2022 of 10/31/22 and 11/01/2 MAR documented a 'S	as on order according to the onic medication) note written by the night t shouldn't take that long for ere and stated, "it was ' o look on the medication ication was there. The LPN ordered medication and edication. The LPN looked ed, "this is it." The bottle had nd the date dispensed as tated, "that doesn't make o say that the she didn't nedication was not given if ere. The LPN was asked to neet for this medication to igned out. The LPN pulled this medication. The sheet the medication was No doses were signed off e LPN was then asked to dent had received pain e on 10/31/22. The LPN t the resident had not tion on that night either.	F 580				

Facility ID: VA0019

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FC	TED: 01/26/2023 DRM APPROVED NO. 0938-0391	
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495147	B. WING				C 11/03/2022	
NAME OF P	ROVIDER OR SUPPLIER		•	S	STREET ADDRESS, CITY, STATE, ZIP CODE	•		
RIVER ED	GE REHABILITATION A	ND NURSING			I221 ROSSER AVE NAYNESBORO, VA 22980			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
F 580	The resident's nursin On 10/31/22 the nursin "10/31/2022 5:00 PM Noteyou have enter HYDROcodone-Acet MG/5ML Give 5 ml by mouth a pain" On 11/1/2022 an EM "1:35 AM - Medicat HYDROcodone-Acet On 11/2/2022 an EM "12:17 AM - Medicat HYDROcodone-Acet	g notes were reviewed. ing note documented, Orders - General red aminophen Solution 2.5-108 It bedtime for mastoid bone AR note documented, ion Administration Note etaminophen Solution e 5 ml by mouth at bedtime n Pending pharmacy delivery diation RX" AR note documented, ation Administration Note aminophen Solution 2.5-108	F	580				
	mastoid bone pain M this time. Res resting There were no notes resident's physician w medication was not g medication was not a On 11/02/22 at 3:10 F Practitioner) was mad information regarding about being in pain la to sleep and stating ti The NP stated that the arthritis and that this the resident's daught have tried several thi	vailable.						

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING (X3) DATE SURVEY COMPLETED C		S FOR MEDICARE & I	ID HUMAN SERVICES MEDICAID SERVICES					APPROVED 0. 0938-0391	
	()						COMP	LETED	
495147 B. WING 11/03/2023			495147	B. WING					
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	NAME OF PR	ROVIDER OR SUPPLIER		- · [ST	REET ADDRESS, CITY, STATE, ZIP CODE	•		
RIVER EDGE REHABILITATION AND NURSING 1221 ROSSER AVE WAYNESBORO, VA 22980	RIVER EDC	GE REHABILITATION AN	ND NURSING						
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPL	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE			(X5) COMPLETION DATE	
F 580 Continued From page 22 The NP stated that she did increase it that and that the resident is now on a low dose of Norco (the medication that was not administered on 10/31/22 and 11/01/22). The NP stated that other medications were tried, but stated that the Norco 2.5 mg seemed to do better for this resident. The NP was asked what would the expectation be for a situation like Resident #78's, if the resident doesn't have pain medication or the medication is not available to administer. The NP stated that with someone like her (Resident #78) she would have told the nurse to give the resident a one time dose of an alternate medication that was actually on hand. The NP stated that she was not on call and that she was not made aware. The NP stated that her regarding this pain." The NP stated that her regarding this pain." The NP stated that here regident does have an upcoming appointment. The NP stated that when any resident is in pain and their pain medication of the runse to call the provider. The NP stated that for this resident toes have an upcoming appointment. The NP stated that when any resident tis in pain and their pain medication of something preferably in house and stated that statef could have crushed a pill (after contacting the provider and obtained an order to give an alternative pain medication of something preferably in house and stated the stated the nurse should have contacted the provider. On 11/02/22 at approximately 6:15 PM, the administrator, DON (director of nursing) and the corporete nurse were meda aware that the		The NP stated that sh that the resident is no (the medication that w 10/31/22 and 11/01/2 medications were trie 2.5 mg seemed to do The NP was asked w be for a situation like resident doesn't have medication is not avai stated that with some she would have told th a one time dose of an was actually on hand, was not on call and th aware. The NP stated something is going or pain." The NP stated an upcoming appoint. The NP stated that wh and their pain medica don't have pain medica don't have pain medica don't have pain medica to give, whatever they prevent a delay in trea The NP again stated to contacted the provide to give, whatever they prevent a delay in trea The NP again stated to contacted the provide	he did increase it that and w on a low dose of Norco vas not administered on 2). The NP stated that other d, but stated that the Norco better for this resident. hat would the expectation Resident #78's, if the pain medication or the ilable to administer. The NP one like her (Resident #78) he nurse to give the resident a alternate medication that . The NP stated that she hat she was not made d, "I do feel bad, I do think n with her regarding this that the resident does have ment. hen any resident is in pain tion is not available or they cation ordered her (the NP) for the nurse to call the ted that for this resident the tacted the provider and give an alternative pain ing preferably in house and have crushed a pill (after er) and put it in applesauce y needed to do, in order to ating the resident's pain. the nurse should have er.	F	580				

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		495147	B. WING				C 103/2022
NAME OF PI	ROVIDER OR SUPPLIER		•		STREET ADDRESS, CITY, STATE, ZIP CODE	•	
RIVER ED	GE REHABILITATION AN	ID NURSING			1221 ROSSER AVE WAYNESBORO, VA 22980		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)				(X5) COMPLETION DATE
F 580 F 584 SS=D	resident's pain medica cart and was found the that according to the li- bottle and the narcotia delivered on 10/31/22 had been administerer were made aware that information and the res (MARs/TARs) the res medication for two nig provider had not been On 11/02/22 at 6:35 F expectation would be the provider had not been On 11/02/22 at 6:35 F expectation would be the provider to get an No other information a provided prior to the e Safe/Clean/Comfortal CFR(s): 483.10(i)(1)-(§483.10(i) Safe Envire The resident has a rig comfortable and home but not limited to rece supports for daily livin The facility must prov §483.10(i)(1) A safe, the homelike environment use his or her persona possible. (i) This includes ensure physical layout of the independence and do (ii) The facility shall ex-	ation was on the medication is morning by LPN #1 and abel on the medication c sheet the medication was and no medication doses ad from it. The facility staff it according to the above esident's clinical records ident had not received the ghts and the resident's in contacted either night. PM, the DON stated that the and is for the nurse to notify order for something pain. and/or documentation was exit conference on 11/03/22. ble/Homelike Environment (7) onment. ght to a safe, clean, elike environment, including iving treatment and ig safely.		580			12/5/22

Facility ID: VA0019

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	-	ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 01/26/2023 FORM APPROVED OMB NO. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _	(X3) DATE SURVEY COMPLETED	
		495147	B. WING		C 11/03/2022
NAME OF P	ROVIDER OR SUPPLIER		s	STREET ADDRESS, CITY, STATE, ZIP CODE	
	GE REHABILITATION A		1	221 ROSSER AVE	
			v	VAYNESBORO, VA 22980	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION
F 584	Continued From page or theft.	e 24	F 584		
		eeping and maintenance o maintain a sanitary, orderly, ior;			
	§483.10(i)(3) Clean bed and bath linens that are in good condition;				
	§483.10(i)(4) Private resident room, as spe	closet space in each ecified in §483.90 (e)(2)(iv);			
	§483.10(i)(5) Adequa levels in all areas;	te and comfortable lighting			
	levels. Facilities initia	table and safe temperature Ily certified after October 1, a temperature range of 71 to			
	sound levels. This REQUIREMENT	maintenance of comfortable is not met as evidenced			
	interview and facility staff failed to ensure	n, resident interview, staff document review, the facility a clean, comfortable and		1. Resident #34's bedside commod was cleaned immediately. CNA educa on emptying and cleaning the bedside	ated e
		It in two resident rooms on a ecifically known as the		commode after each use. Built-close cabinet has been painted. Resident # sink has been replaced due to stains ceramic sink bowl and flange ring	#34's
	Findings include:			repaired. Top cabinet doors have bee replaced resident #34's room. Reside	ent
	#34 was interviewed	ximately 11:15 AM, Resident in his room, which had a sed by Resident #34) sitting		#335's sink has replaced due to stain ceramic sink bowl. The resident's flor around the heating unit (attached to t	or
	at the end of the bed. had a dry, smeared b	The bedside commode rown substance on the		wall) has been cleaned. The power of has been repaired and cleaned as we	outlet ell.
	inside and around the	e sides of the bucket. The		2. DON/Designee will complete a 1	00%

Event ID:08B311

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA		LE CONSTRUCTION	(X3) DATE	
	CORRECTION	IDENTIFICATION NUMBER:			· · ·	LETED
						С
		495147	B. WING		11/	03/2022
NAME OF P	ROVIDER OR SUPPLIER		•	STREET ADDRESS, CITY, STATE, ZIP CODE	•	
				1221 ROSSER AVE		
	GE REHABILITATION AN	ND NURSING		WAYNESBORO, VA 22980		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRI		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SE CROSS-REFERENCED TO THE AP DEFICIENCY)		COMPLETIO DATE
F 584	Continued From page	e 25	F 58	34		
	toilet seat also had a	dry, brown substance that		audit of bedside commodes.		
		When asked if staff clean the		The Maintenance Director will co		
		esident #34 replied, "Yes."		an 100% audit/inspection of buil		
		ns in the room included the		closets and cabinets, sinks with		
		closet had paint chipped off		sink flange rings, missing cabine		
		on the front and sides; the		and rust around outlets in reside	nt's	
		aped, indented areas in the sand sides; the resident's		rooms for repair. (Built-in closet/cabinet doors hav	ia haan	
		nish stain around the drain		ordered for replacement.)	e been	
	-	iameter; the pipe under the		Housekeeping Manager will com	nplete an	
		detached from the wall and		100% inspection of resident's flo		
		and the top cabinet of the		around the heating unit for clear		
	closet had an entire d	loor missing. No hinges or		3. ADON will conduct education	on with	
		present. When asked how		nursing staff on emptying and cl		
	-	een without a door, Resident		bedside commodes after each u		
		een like that for quite a		The Administrator will conduct e		
		what happened to the door to		with the housekeeping director r		
	Ine closel, Resident #	#34 stated, "It got gone."		cleaning the floors and walls are heating unit and maintenance di		
	On 11/01/22 at appro	ximately 11:40 AM, Resident		regard to built-in closets/cabinet		
		ed in her room, along with		with stains, repairs to sink flange		
		as present. Resident #335's		replacement of cabinet doors, a	-	
	-	he resident's sink was dirty		cleaning/repairing outlets in resi		
	and she had asked so	omeone to clean it, but it had		rooms.		
		he sink had some soiled		4. Audits of resident's bedside		
		The resident's floor around		commodes, room floors/walls ar		
		ched to the wall) was soiled		heating unit, sink stains, sink fla	•	
		up around the edges of the		electrical outlets and built- close		
		the heating unit and around e power outlet had dirt		needing paint and/or verification replacements will be conducted		
	· ·	nd the casing of the outlet.		weekly times six weeks then mo		
		ghter stated that it had been		times two months.	·····	
		ident arrived on 10/12/22.		Audit findings will be reported to	the	
				facility QAPI Committee monthly		
		were observed in the same		months to review the need for co		
		d above multiple times each		intervention or amendment of the	e plan.	
		process from November 1,				
	2022 through Novem	ber 3, 2022.				

Facility ID: VA0019

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		ID HUMAN SERVICES MEDICAID SERVICES				F	NTED: 01/26/2023 ORM APPROVED 3 NO. 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		ONSTRUCTION	(X3)	DATE SURVEY COMPLETED
		495147	B. WING				C 11/03/2022
NAME OF PF	ROVIDER OR SUPPLIER		•	STR	REET ADDRESS, CITY, STATE, ZIP CODE	•	
RIVER ED	GE REHABILITATION A	ND NURSING			1 ROSSER AVE YNESBORO, VA 22980		
		ATEMENT OF DEFICIENCIES	ID	VVA	PROVIDER'S PLAN OF CORRI		(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI		(EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE	COMPLETION DATE
F 584	Continued From page	e 26	F	584			
		2 at approximately 7:30 AM,					
		ere again observed in the					
		cribed above, except the					
	sink in Resident #335 and/or cleaned.	5's room had been wiped					
	On 11/03/22 at 7:45 /	AM, LPN (Licensed Practical					
		ewed and asked who is					
		bed side commodes. The					
		he CNA's responsibility and					
	takes care of that.	pathroom that housekeeping					
		ximately 7:50 AM, CNA					
	(certified nursing assi	-					
		d if she was working with The CNA stated that she					
		ked on that hall, with that					
		y before. The CNA was					
	5	om with the soiled bedside					
		stated that they (CNA's) are em after each use. The					
		esident didn't use the					
		esterday, he only used the					
		she didn't notice the day de commode was soiled/dirty					
	and therefore, didn't	,					
	On 11/03/22 at 8:03 A	AM, The Maintenance					
	Supervisor (MS) was	asked how does the					
		nent go about checking on					
		nay need repairs. The MS / thing and that they (he and					
	-	and check on things. The					
	MS stated that they a	re constantly painting and					
		MS stated that they make					
	-	I the nurse's should be The MS observed Resident					
		ded the resident's stained					

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If continuation sheet Page 27 of 71

		ID HUMAN SERVICES MEDICAID SERVICES					FORM	: 01/26/2023 APPROVED . 0938-0391
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		CONSTRUCTION	¢	(X3) DATE SURV COMPLETE	
		495147	B. WING					, 3/2022
NAME OF PI	ROVIDER OR SUPPLIER	I		ST	TREET ADDRESS, CITY, STATE, ZIP CODE			
	GE REHABILITATION AN			12	221 ROSSER AVE			
				W	AYNESBORO, VA 22980			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	E	(X5) COMPLETION DATE
F 584	from resident's closet didn't just get like that any explanation and/o items observed had r addressed. On 11/03/22 at appro- was again asked how issues/concerns logg replacement. The MS assistant make round constantly looking for The MS also stated th book at the nurse's st in items of concern for department to check, then stated that, a lot tell him in passing of to be fixed and he will remembers and has to time if possible, but s sometimes those thin MS looked in the log stated that he did not related to the issues p two resident rooms all The MS was asked for how repairs are to be tracked for completion was for general reside The MS stated that he in writing. On 11/03/22 at appro-	he sink and the door missing The MS stated, "Yea, that t." The MS did not provide for knowledge of why those not been fixed and/or ximately 8:50 AM, the MS v are maintenance ed and tracked for repair or S stated that he and his ls every day, all day and are items in need of repair. nat the nurse's have a log tation where they can write or the maintenance repair or replace. The MS of times the facility staff will concerns or things that need I write it down, if he time, or may try to fix at that tated that if he is busy gs could be missed. The book for the B-wing and see anything in the book pointed out regarding the	F	584				
	information and aske	d for a policy/protocol on the tions for resident rooms.						

Facility ID: VA0019

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM): 01/26/2023 // APPROVED). 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION		LETED
		495147	B. WING				C 03/2022
NAME OF PF	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
	GE REHABILITATION AN			1	221 ROSSER AVE		
				V	VAYNESBORO, VA 22980		
(X4) ID PREFIX TAG	IX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORI		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE		
F 584	Continued From page	28	F	584			
	developed and impler provision of a safe, fu comfortable environm the publicmaintain a servicesshall assess plant to determine if p requiredmay be deter request, grand rounds or experiencedecide completed and how o	enance Programshall be mented to ensure the nctional, sanitary, and ent for residents, staff and a schedule of maintenance s all aspects of the physical preventative maintenance is ermined by maintenance s, life safety requirements, e what tasks need to be ften to complete ndar to assist with keeping cumentation shall be sTels is the cument and schedule					
	administrator, DON (c (assistant director of r	ximately 10:30 AM, the director of nursing), ADON nursing) and corporate are in a meeting with the nove findings.					
F 641 SS=D	presented prior to the	oms.	F	641			12/5/22
	resident's status.	of Assessments. t accurately reflect the is not met as evidenced					

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Facility ID: VA0019

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ATEMPNIT A				PLE CONSTRUCTION		
	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	G	· · · ·	OATE SURVEY OMPLETED
						С
		495147	B. WING			11/03/2022
NAME OF PR	OVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP (CODE	
RIVER EDO	GE REHABILITATION AN	ND NURSING		1221 ROSSER AVE WAYNESBORO, VA 22980		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 641	Continued From page	e 29	F 64	41		
		investigation, clinical record		1. Facility staff corrected		
4 ((1 i		rview, the facility failed to		resident #82 who was disc	0	
	ensure an accurate Minimum Data Set (MDS - a cms assessment tool) for one of 21 residents (Resident # 82) in the survey sample. Resident #			2. MDS Coordinator will audit of MDS on residents	•	
				home in the past 30 days t	-	
	82, who was discharg	ged to home, was incorrectly		accuracy.		
		scharged to an acute care		3. The Administrator will	•	
		Home Discharge Minimum		education with MDS Coord		
	Data Set.			accuracy of MDS assessm resident's discharged hom		
	The findings include:			4. The MDS Coordinator		
	····			of resident's discharge ME		
	Resident # 82 was ac	dmitted to the facility with		weekly times six weeks the	en monthly	
		ed a left wrist fracture,		times two months.		
	cancer, hypertension	-		Audit findings will be repor		
		valking, right below the knee bromhidrosis, frequency of		facility QAPI Committee m months to review the need		
		ry urgency. According to a		intervention or amendmen		
		arge Minimum Data Set with			· · · · · · · · · · · · · · ·	
		rence Date of 8/19/2022, the				
	resident was assesse					
	(Cognitive Patterns) a with a Summary Scor	as being cognitively intact, re of 15 out of 15.				
	Under Section A (Ider	ntification Information), at				
	Item A2100, Discharg	ge Status, Resident # 82 was				
	identified as being dis hospital.	scharged to an acute				
	Review of the Progre	ss Notes in Resident # 82's				
	-	Ith record revealed the				
		I from facility to home. All				
	personal items packe walked out of facility of	d by resident. Resident on own"				
	At approximately 0.20) a.m. on 11/2/2022, the				

Facility ID: VA0019

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		ID HUMAN SERVICES MEDICAID SERVICES			FOR	D: 01/26/202 MAPPROVE O. 0938-039	
TATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING		(X3) DAT	E SURVEY PLETED	
		495147	B. WING		C 11/03/2022		
NAME OF P	ROVIDER OR SUPPLIER	l	STR	EET ADDRESS, CITY, STATE, ZIP COL			
RIVER ED	GE REHABILITATION AN	ND NURSING		I ROSSER AVE YNESBORO, VA 22980			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETIO DATE	
	Planner, was intervie Social Worker, the dis was a planned discha Coordinator is made Social Worker explain is held daily that inclu- discharges. "The MD that meeting," the So The MDS Coordinato interviewed due to an During a meeting at 4 included the Administ Assistant Director of 1 Consultant, and the so of Resident # 82's dis discussed. No additional docume to exit conference. Develop/Implement C CFR(s): 483.21(b)(1) §483.21(b) Comprehe §483.21(b)(1) The fac implement a compreh care plan for each res resident rights set for §483.10(c)(3), that in objectives and timefra medical, nursing, and needs that are identiff assessment. The con describe the following (i) The services that a	Iso serves as the Discharge wed. According to the scharge of Resident # 82 arge. Asked how the MDS aware of discharges, the ned that a Utilization Meeting ides a discussion of OS Coordinator is present at cial Worker said. r was unable to be n extended illness. 1:00 p.m. on 11/2/2022, that trator, Director of Nursing, Nursing, Corporate Nurse survey team, the inaccuracy scharge assessment was entation was provided prior Comprehensive Care Plan ensive Care Plans cility must develop and hensive person-centered sident, consistent with the th at §483.10(c)(2) and cludes measurable ames to meet a resident's I mental and psychosocial ied in the comprehensive inprehensive care plan must	F 641			12/5/22	

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		ND HUMAN SERVICES MEDICAID SERVICES				FOF	ED: 01/26/202 RM APPROVE O. 0938-039
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		INSTRUCTION	(X3) DATE SURV COMPLETE	
		495147	B. WING _			1	C 1/03/2022
NAME OF PF	ROVIDER OR SUPPLIER		1	STRE	ET ADDRESS, CITY, STATE, ZIP CODE	•	
	GE REHABILITATION A			1221	ROSSER AVE		
	GE REHABIEITATION A			WAY	NESBORO, VA 22980		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 656	Continued From Dear	o 91					
F 050	- 15		Ft	656			
		l psychosocial well-being as					
		24, §483.25 or §483.40; and would otherwise be required					
		.25 or §483.40 but are not					
		esident's exercise of rights					
		ding the right to refuse					
	treatment under §483	. .					
	(iii) Any specialized s	ervices or specialized					
		s the nursing facility will					
	provide as a result of						
		a facility disagrees with the					
	rationale in the reside	RR, it must indicate its					
		the resident and the					
	resident's representa						
	-	als for admission and					
	desired outcomes.						
	(B) The resident's pre	eference and potential for					
		ilities must document					
		s desire to return to the					
	-	ssed and any referrals to					
		s and/or other appropriate					
	entities, for this purpo						
		in the comprehensive care in accordance with the					
		h in paragraph (c) of this					
	section.						
	This REQUIREMENT	「 is not met as evidenced					
	by:						
		view, clinical record review			1. Resident #23 Careplan entered	for	
	, , , , , , , , , , , , , , , , , , ,	t review, the facility staff			anticoagulant medication and DM		
		omprehensive care plan			nanagement. Resident #78 Carepl		
		idents in the survey sample			entered for pain management. Resi		
		#80, and #81). Resident #23 or anticoagulant (AC)			#80 Careplan entered for anticoagu		
	-	etic management, including			nedication. Resident #81 Careplan entered for anticoagulant medicatior		
		. Resident #78 had no plan			2. The MDS coordinator will condu		
	of care developed/im	plemented for pain		1	100% audit of residents on Eliquis a	nd	

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Facility ID: VA0019

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	DF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DATE	D. 0938-039 SURVEY PLETED
	CONNECTION	IDENTIFICATION NUMBER.	A. BUILDING	G		C
		495147	B. WING			03/2022
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZI	P CODE	
RIVER ED	GE REHABILITATION AN	ND NURSING		1221 ROSSER AVE WAYNESBORO, VA 22980		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED TI DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETIOI DATE
F 656	1.0		F 65	56 conduct an 100% audit c	f all racidants for	
	had no plan of care for medication.) medication. Resident #81 or anticoagulant (AC)		Pain management Carep 3. The Regional Direct Services will conduct edu	blan. or of Clinical	
	The findings include: 1. The facility staff fai	led to develop and		Director of Nursing, Unit the MDS coordinator on residents who receives a	Managers and care planning	
	implement a compreh anticoagulant therapy	nensive care plan for / and diabetic management,		therapy, insulin, and pair 4. Audits of Eliquis and	n management I Insulin therapy	
	admitted to the facility included COVID 19, I	apy. Resident #23 was y with diagnoses that nemiplegia/hemiparesis, cognitive communication		orders and Careplan for therapy and DM will be c times weekly times six w monthly times two month	conducted two reeks then	
	deficit, and aphasia.	The MDS (minimum data tool) dated 09/05/22 was		management will be con and readmissions two tin six weeks then monthly t	ducted on all new nes weekly times	
	documented Residen impaired cognitively f a score of 8 out of 15	t #23 as moderately or daily decision making with		Audit findings will be repo facility QAPI Committee months to review the new intervention or amendme	orted to the monthly for three ed for continued	
	#23 received insulin a					
	11/01/2022. Observer report were the follow	•				
	by mouth two times a Order Date 10/5/2022	g (milligrams) Give 1 tablet day for DVT prevention. 2" 10 Unit/ML Solution				
	Pen-injector. Inject 30 time a day for DM 2. "Insulin Lispro (1 Unit) unit subcutaneously one Order Date 10/12/2022." t Dial) Solution Pen-injector				
	-	unit subcutaneously four tes Order Date 10/25/2022."				
		cation administration records nd November 2022 were				

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		D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		495147	B. WING				03/2022
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
RIVER ED	GE REHABILITATION AN	ID NURSING			1221 ROSSER AVE WAYNESBORO, VA 22980		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD BE			(X5) COMPLETION DATE
F 656	reviewed and docume the anticoagulant, Api (Glargine-yfgn & Lisp) Resident #23's comprise was reviewed, but had care for anticoagulant management, includin On 11/02/2022 at 11:2 practical nurse (LPN a care for Resident #23 the resident's medicar #2 reviewed Resident stated the resident was the anticoagulant and these serious medica the care plan, LPN #2 manager was respons On 11/02/2022 at 11:3 (LPN #3) was intervie of high risk medication reviewed the clinical r there should be care anticoagulant and ins sure why they were n On 11/02/2022 at 5:39 were reviewed during administrator, DON, A No further information that the facility had pr either of the high risk management. 2. The facility failed to need for anticoagulant	ented the resident received ixaban and both insulin ro) as ordered/scheduled. rehensive care plan (CCP) d no individualized plan of t (AC) medication or diabetic ng insulin administration. 25 a.m., the licensed #2) who routinely provided was interviewed regarding tions and care plans. LPN t #23's clinical record and as currently receiving both insulin. When asked why tions were not included in 2 stated that the unit sible for the care plans. 30 a.m., the unit manager wed regarding the inclusion ns in the care plan. LPN #3 record and stated, "Yes, plans for both the ulin medications. I'm not ot included."	F	656			

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	-	ID HUMAN SERVICES				FORM	APPROVED
	DF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	FIPLE	E CONSTRUCTION	(X3) DATE	0. 0938-0391 SURVEY
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG _			LETED
		495147	B. WING				C 03/2022
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
RIVER ED	GE REHABILITATION AN	ID NURSING			1221 ROSSER AVE WAYNESBORO, VA 22980		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 656	 #80 was admitted to the DM2, hemiplegia/hemic weakness, and dyspheset (MDS) dated 09/2 admission assessmere Resident #80 with sevel daily decision making Interview for Mental SUnder Section N - Medidocumented Residen medication, which has Resident #80's clinication, which has Resident #80's medication, which has responsible for the anticoagulant medication of the anticoagulant medication of the resident's medication of the resident was anticoagulant. LPN # was responsible for the On 11/02/2022 at 11:3 	he facility with hypertension, hiparesis, AFIB, muscle hagia. The minimum data 3/2022 was the 5-day ht, which documented verely impaired cognition for , with a BIMS (Brief Status) score of 6 out 15. edications, the MDS t #80 received anticoagulant is increased risk of bleeding. Al record was reviewed on l on the the order summary ng order: "Apixaban Tablet 5 1 tablet via J-Tube two a peg tube. Order Date ation administration records h November 2022 were ented the resident received dication, Apixaban as blans were reviewed, but had ticoagulant (AC) medication. 25 a.m., the licensed #2) who routinely provided was interviewed regarding tions and care plans. LPN t #80's clinical record and as currently receiving the H2 stated the unit manager	F	656			

If continuation sheet Page 35 of 71

	MENT OF HEALTH AN	ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	
		495147	B. WING				C 03/2022
NAME OF P	ROVIDER OR SUPPLIER		•		STREET ADDRESS, CITY, STATE, ZIP CODE	-	
RIVER ED	GE REHABILITATION AN	ID NURSING			1221 ROSSER AVE WAYNESBORO, VA 22980		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 656	 plans. LPN #3 review stated, "Yes, there sh anticoagulant medica was not included." On 11/02/2022 at 5:39 were reviewed during administrator, DON, A No other information of planning had been de accordance with the N resident-centered need medication. The facility staff fa ordered anticoagulant #81's comprehensive was admitted to the fa included pneumonia, failure, DM2, perforati heart failure and hype data set (MDS - cms at 10/03/2022 was the 5 and assessed Reside for daily decision mak 15. Under Section N documented Resider anticoagulant medica risk of bleeding. Resident #81's clinica 11/01/022. Observed report was the followi 2.5 MG (milligrams) G times a day for a-fib. 0 	ved the clinical record and ould be a care plan for the tions. I'm not sure why it 9 p.m., the above findings a meeting with the ADON, and corporate staff. was provided that care eveloped/implemented, in MDS, to address the ed for anticoagulant iled to include the physician t medication in Resident care plan. Resident #81 acility with diagnoses that hypoxia, acute kidney ion of intestine, congestive ertension. The minimum assessment tool) dated -day admission assessment int #81 as cognitively intact ting with a score of 13 out of - Medications, the MDS it #81 received tion, which has increased al record was reviewed on on the the order summary ng order: "Apixaban Tablet Give 2.5 mg by mouth two Order Date 10/20/2022."	F	650	6		

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	SURVEY PLETED
		495147	B. WING				C /03/2022
NAME OF PI	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
RIVER ED	GE REHABILITATION AN	ID NURSING			1221 ROSSER AVE		
					WAYNESBORO, VA 22980		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 656	Continued From page anticoagulant medica ordered/scheduled. Resident #81's compl reviewed, but had no individualized need for medication or the ass physician ordered the On 11/02/2022 at 11:2 practical nurse (LPN scare for Resident #81 the resident's medica #2 reviewed Resident stated the resident wa anticoagulant. When for this high risk medi unit manager was res On 11/02/2022 at 11:3 (LPN #3) was intervie plans for the high-risk reviewed the clinical r there should be a car medications. I'm not s included." On 11/02/2022 at 5:33 were reviewed during administrator, DON, A No other evidence wa care for anticoagulant developed or implement 4. The facility staff fa	e 36 tion, Apixaban as rehensive care plans were plan of care to address the or anticoagulant (AC) ociated risk factors of this rapy. 25 a.m., the licensed #2) who routinely provided was interviewed regarding tions and care plans. LPN #81's clinical record and as currently receiving the asked about care planning cation, LPN #2 stated the ponsible for the care plans. 30 a.m., the unit manager wed regarding the care medications. LPN #3 record and stated, "Yes, e plan for the anticoagulant sure why it was not 9 p.m., the above findings a meeting with the ADON, and corporate staff. as presented that a plan of a medication had been ented for Resident #81.		656	DEFICIENCY)		
	include measurable o	mprehensive care plan) to bjectives and timeframes e area of pain management.					

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 01/26/2023 MAPPROVED D. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE	
		495147	B. WING			C 11/03/2022	
NAME OF P	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE	<u>,</u>	
				1	1221 ROSSER AVE		
RIVER ED	GE REHABILITATION AN	ID NORSING		۱	WAYNESBORO, VA 22980		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 656	Continued From page	9 37	F	656	3		
	Resident #78's diagno limited: diverticulitis, muscle weakness, dy polyneuropathy, histo musculoskeletal mast The resident #78's mo data set - cms assess admission assessmen MDS assessed the re Interview for Mental S indicating the residen decision making skills This MDS did not ass pain and pain was no	oses included, but were not atrial fibrillation, depression, sphagia, abnormal gait, ry of falls, and coid bone pain. ost recent MDS (minimum sment tool) was an nt dated 08/23/22. This sident with a BIMS (Brief Status) score of 15 out of 15, t was intact for daily		000			
	approximately 7:55 A Resident #78 had sta had not slept the nigh Resident #78 stated t pain and has schedul not get the pain media Resident #78's clinica included the following "Observation: Pain-o date: 08/21/22" Further review of Res revealed that a lidoca was started on 10/11/ 10/17/22, and the nar	hat she has been having ed pain medications, but did cation as ordered. Il record was reviewed and physician's order: observe every shiftstart ident #78's physician orders ine pain patch for hip pain 22, Tylenol was started on cotic pain medication					
	(indicated for modera hydrocodone-acetam	te to severe pain) inophen 5-325 for mastoid					

Facility ID: VA0019

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	-	ID HUMAN SERVICES				FORM	/ APPROVED
	S FOR MEDICARE & I	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUI		E CONSTRUCTION	(X3) DATE	0. 0938-0391
	CORRECTION	IDENTIFICATION NUMBER:					LETED
						(C
		495147	B. WING			11/	03/2022
NAME OF PF	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
RIVER ED	GE REHABILITATION AN	ND NURSING			1221 ROSSER AVE WAYNESBORO, VA 22980		
(X4) ID		ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI		COMPLETION DATE
_					DEFICIENCY)		
			1				
F 656	Continued From page		F	656	5		
	bone pain was started	d on 10/17/22.					
	Resident #78's currer	nt CCP (comprehensive care					
	plan) was reviewed a	nd revealed that the resident					
		are plan developed until e resident was experiencing					
	· •	reatments, and had been					
	admitted with pain dia						
	The CCD desuments	d " Dain Managamant					
		d, "Pain Management 22 resident will demonstrate					
		dge of strategies for pain					
		nanagement date initiated:					
	11/01/22Medication 1/01/22Resident will	management date initiated:					
	non-pharmacological						
	including distraction,	entertainment/activity, food					
	and fluids offered and	l/or repositioning date					
	initiated: 11/01/22"						
	There was no evidence	ce in the resident's clinical					
		#78 had any other care plan					
	related to pain prior to	0 11/01/22.					
	On 11/02/22 at approx	ximately 6:15 PM, the					
		director of nursing), ADON					
		nursing) and the corporate are in a meeting with the					
		DN was asked why was					
	Resident #78's pain c	are plan just added on					
		eplied that she did not					
	update or review the	care plan and wasn't sure.					
	No further information	n and/or documentation was					
		exit conference to evidence					
	that a pain care plan #78 prior to 11/01/22.	was developed for Resident					
F 657	Care Plan Timing and		F	657	,		12/5/22
SS=D	J						

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	-	ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 01/26/20 FORM APPROV OMB NO. 0938-03		
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495147	B. WING		C 11/03/2022		
NAME OF PI	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP			
RIVER ED	GE REHABILITATION AI	ND NURSING		1221 ROSSER AVE WAYNESBORO, VA 22980			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE COMPLETION THE APPROPRIATE DATE		
F 657	Continued From page CFR(s): 483.21(b)(2)		F 6	57			
	§483.21(b) Compreh §483.21(b)(2) A com be-	ensive Care Plans orehensive care plan must					
	the comprehensive a	7 days after completion of ssessment. terdisciplinary team, that					
	includes but is not lim (A) The attending phy	nited to vsician.					
	 (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the 						
	resident.	and nutrition services staff.					
	(E) To the extent prac the resident and the	cticable, the participation of resident's representative(s).					
	medical record if the	be included in a resident's participation of the resident resentative is determined					
	not practicable for the resident's care plan.						
		staff or professionals in ined by the resident's needs e resident.					
	(iii)Reviewed and rev team after each asse	ised by the interdisciplinary ssment, including both the					
	comprehensive and c assessments. This REQUIREMENT	uarterly review					
		n, resident interview, staff record review, the facility		1. Careplan was update self-colostomy care on 11			
	staff failed to review a	•		resident #17. Careplan w physician ordered interver	as updated for		
	residents in the surve #62). Resident #17's	ey sample (Resident #17 & Comprehensive Care Plan d regarding the provision of		therapeutic support hose. 2. The MDS Coordinato an 100% audit of all resid	or will complete		
		ident #62's plan of care was		self-care of the colostomy			

Facility ID: VA0019

		ID HUMAN SERVICES MEDICAID SERVICES			FOR	ED: 01/26/2023 RM APPROVED O. 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	IPLE CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
		495147	B. WING _		11	C / 03/2022
NAME OF PF	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, 2	ZIP CODE	
	GE REHABILITATION AN			1221 ROSSER AVE		
				WAYNESBORO, VA 22980		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	((EACH CORRECTIVE CROSS-REFERENCED	N OF CORRECTION ACTION SHOULD BE TO THE APPROPRIATE CIENCY)	(X5) COMPLETION DATE
F 657	intervention of theraphose). The findings include: 1. The Comprehensive #17 was not revised to colostomy care by the Resident #17 was add diagnoses that include disease with colostom cerebral infarction, di hypothyroidism, depri- and chronic respiratoric data set (MDS - cms 9/9/22 assessed Res- intact for daily decision On 11/1/22 at 12:06 pri- interviewed about quarks Resident #17 stated of provided her own colority twice weekly flange of stated the aides assission colostomy site during further about the speak Resident #17 stated to colostomy bag daily, made sure the skin arity and notified the nurses Resident #17's CCP of that the resident had mention that the resident had mention that the resident had mention that the resident had mention the the resident had menti	e the physician ordered eutic support hose (TED ve Care Plan for Resident to address the provision of e resident. mitted to the facility with led inflammatory bowel ny, asthma, history of verticulosis, atrial fibrillation, ession, anxiety, hypertension ry failure. The minimum asssessment tool) dated ident #17 as cognitively on making. o.m., Resident #17 was ality of care in the facility. during this interview that she ostomy care that included thanges. Resident #17 sted her to clean around the showers. When asked cifics of her colostomy care, that she emptied the changed the bag/flange, round the site was clean, es of any problems. (revised 7/6/22) documented a colostomy but made no dent provided her own care. tain function of the	F 6	 ordered intervention of 3. The Regional Director of Nursing, Unthe MDS coordinator or residents for self-care of and physician ordered those. 4. Audit of residents to colostomy care, TED hichanges in self-care twitimes six weeks then minonths. Audit findings will be refacility QAPI Committee months to review the nointervention or amendmine the second second	ctor of Clinical ducation with the it Managers and n care planning of the colostomy intervention of TED with new orders for ose and/or any ro times weekly nonthly times two eported to the e monthly for three eed for continued	
	mention that the resid Interventions to main colostomy and preven	lent provided her own care.				

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		ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 01/26/2023 MAPPROVED 0. 0938-0391	
STATEMENT O	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		ONSTRUCTION	(X3) DAT	E SURVEY PLETED	
		495147	B. WING			C 11/03/2022		
NAME OF P	ROVIDER OR SUPPLIER	I		STR	EET ADDRESS, CITY, STATE, ZIP CODE			
RIVER ED	GE REHABILITATION AN	ND NURSING			1 ROSSER AVE			
				WA	YNESBORO, VA 22980			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE	
F 657	leaking or burstsNo is passed each shift ostomy site, around s [signs/symptoms] of i #17's] dignity when p There were no revision part of the CCP since documentation that the interventions were be problems, goals and/a regarding the residen colostomy. On 11/2/22 at 2:37 p. nurse (LPN #2) caring interviewed. LPN #2 performed her own co stated Resident #17 v care was done and us facility. When question being included in the that the unit manager plans. On 11/2/22 at 3:10 p. #3) was interviewed a stated she was respo- updates/revisions. LB routinely performed h LPN #3 reviewed the stated there was noth- resident performing c stated, "It definitely sh that she does her own	stomy bag per MD d prn [as needed] if bag is tify Charge nurse if no stool .skin will be inspected at stoma for s/s rritationrespect [Resident roviding ostomy care" ons to the colostomy care e 9/24/20, but there was no he identified care eing followed. Also, no or interventions were listed t #17's self-care of the m., the licensed practical g for Resident #17 was stated the resident olostomy care. LPN #2 was specific about how the sed supplies provided by the oned about the self-care not care plan, LPN #2 stated t took care of updating care m., the unit manager (LPN about Resident #17. LPN #3 insible for care plan PN #3 stated Resident #17 ier own colostomy care. current plan of care and hing on the plan about the olostomy self-care. LPN #3 hould have been on there in care."	F	657				
	These findings were a administrator, directo	reviewed with the r of nursing and regional						

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		495147	B. WING				C 03/2022
NAME OF P	ROVIDER OR SUPPLIER	I		:	STREET ADDRESS, CITY, STATE, ZIP CODE		
RIVER ED	GE REHABILITATION AN	ND NURSING			1221 ROSSER AVE WAYNESBORO, VA 22980		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) COMPLETION DATE	
F 657	director of clinical ser 11/2/22 at 5:40 p.m. No further information exit conference on 11 the Comprehensive C	vices during a meeting on n was obtained prior to the /03/2022 that indicated that Care Plan had been mented to address the	F	657	7		
	revised to include the (thrombo- embolic de hose to be applied da Resident #62 was ad hypertension, arthero sinus syndrome, pres	e plan was not reviewed and physician orders for TED terrent/therapeutic support) illy for edema. mitted to the facility with sclerotic heart disease, sick sence of cardiac pacemaker, gnitive impairment, and a					
	(assessment reference assessed Resident # Interview for Mental S						
	11/01/2022 at approx of the physician order orders, which were be "Apply TED hose dail extremities). Nursing task, one time a day f "Remove TED hose (

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	-	D HUMAN SERVICES				FORM	APPROVED
		MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPL	E CONSTRUCTION	(X3) DATE	0. 0938-0391 SURVEY
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG .			LETED
		495147	B. WING				C 03/2022
NAME OF PI	ROVIDER OR SUPPLIER			:	STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	05/2022
RIVER ED	GE REHABILITATION AN	ID NURSING			1221 ROSSER AVE		
					PROVIDER'S PLAN OF CORRECTION		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 657	Continued From page	e 43	F	657			
	On 11/02/2022 at app Resident #62 was obs for the day. No TED r asked if she had white her put on in the morr evening, Resident #60 that." When asked if her drawers, Residen and stated, "No, I dor CNA (certified nursing hallway and confirmer Resident #62. When a ordered TED hose, C know if she is suppos or not." When asked Resident #62's karde: caring for her, CNA # it recentlythe nurses supposed to do" The CCP and the kard approximately 10:15 a observed on either. At approximately 11:3 conference room. Sh knew to apply TED h resident's kardex. She nurse's MAR (medica record)the nurse tel	proximately 9:30 a.m., served in her room, dressed hose were observed. When e stockings that staff helped hings and took off in the 2 stated, "No, I don't have she had any stockings in t #62 opened her drawers i't have any." g assistant) #1 was in the d that she was assigned to asked about the physician NA #1 stated, "I don't ed to be wearing TED hose if she had reviewed x (daily care guide) prior to 1 stated, "I haven't looked at s tell us what we are dex were reviewed at a.m., the TED hose were not to 0 a.m., RN #1 came to the e was asked how CNAs ose if they were not on a e stated, "It was on the					
	Kardex. The above information administrator, the DO ADON (assistant direct	n was discussed with the N (director of nursing), the ctor of nursing) and three an end of the day meeting					

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CENTERS FOR MEDICARE & MEDICAID SERVICES TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA ND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MUL	TIPLE	OMB NO. 0938-039 (X3) DATE SURVEY			
		IDENTIFICATION NUMBER:	A. BUILD		COMPLETED			
		495147	B. WING			C 11/03/2022		
NAME OF P	ROVIDER OR SUPPLIER	1		s	TREET ADDRESS, CITY, STATE, ZIP CODE			
RIVER ED	GE REHABILITATION A	ND NURSING			221 ROSSER AVE			
		ATEMENT OF DEFICIENCIES	ID	WAYNESBORO, VA 22980			(X5)	
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREF		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		COMPLETION DATE	
F 657	Continued From page	e 44	F	657				
	on 11/02/2022 at app			001				
	No further information	n was obtained prior to the						
	exit conference on 11	1/03/2022 that indicated that						
		essed the individualized n ordered therapeutic hose						
		mprehensive care plan.						
F 684 SS=E	Quality of Care CFR(s): 483.25		F	684			12/5/22	
	§ 483.25 Quality of ca	are						
		Indamental principle that nt and care provided to						
		sed on the comprehensive						
	assessment of a resid	dent, the facility must ensure						
		e treatment and care in						
		essional standards of nensive person-centered						
	care plan, and the res This REQUIREMENT	•						
	by: 2. Facility staff failed	d to assist Resident #62 with			1. Resident #62's TED Hose are app	olied		
	wearing the physiciar				daily as resident will allow. Resident			
		terrent) hose. On 11/02/2022			#62's Kardex has been updated for			
) a.m., Resident #62 was n. She was dressed for the			resident wearing TED hose. Resident #34's wound documentation	was		
	day. No TED hose we	ere observed. She was			completed on return from the hospital a			
		te stockings that staff helped			ongoing weekly until wound resolved.			
	-	nings and took off in the I, "No, I don't have that." She			2. DON/Designee will conduct 100% audit of all residents with TED hose to			
	was asked if she had				assure the resident is wearing TED Ho	se		
	drawers. She opened	her drawers and stated,			and the Kardex is accurate.			
	"No, I don't have any				The Wound Nurse will conduct 100% audit of all residents with non-pressure	•		
	CNA (certified nursing	g assistant) #1 was in the			areas to assure a current weekly			
	hallway. She confirm	ed that she was assigned to			non-pressure tool is in place.			
		as asked about the physician			3. The Assistant Director of Nursing conduct education with all license nurs			
	ordered IED Hose. S	she stated, "I didn't help her			Conduct education with all license hurs	62	1	

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TATEMENT (OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION	(X3) D.	ATE SURVEY
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING) CC	OMPLETED
		495147	B. WING			C 11/03/2022
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		11/05/2022
RIVER ED	GE REHABILITATION AN	ND NURSING		1221 ROSSER AVE WAYNESBORO, VA 22980		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
F 684	get dressed today, the she is supposed to be She was asked if she #62's kardex (daily ca her. She stated, "I ha recentlythe nurses to supposed to doI thin residents anyway." Resident #62 was add hypertension, arthero sinus syndrome, pres diabetes mellitus, cog history of falls. A quarterly MDS (min assessment tool), wit reference date) of 10/ Resident #62 having Mentals Status) score moderately impaired making. Resident #62's clinical	e nurse did. I don't know if e wearing TED hose or not." had reviewed Resident are guide) prior to caring for ven't looked at it tell us what we are nk they put those on the mitted to the facility with sclerotic heart disease, sick sence of cardiac pacemaker, gnitive impairment, and a imum data set - cms h an ARD (assessment /07/2022, assessed a BIMS (Brief Interview for	F 68	 on TED hose application, follow Kardex and completing non-preassessment tools on residents identified areas. The Director of Nursing or will audit all residents with TED assure the resident is wearing the Kardex is accurate and nor assessment tools are complete times weekly times six weeks t monthly times two months. Audit findings will be reported t facility QAPI Committee month months to review the need for eintervention or amendment of the second second	essure with newly Designee hose to TED Hose, p-pressure ed two hen o the ly for three continued	
	orders written on 09/1 "Apply TED hose dail extremities). Nursing task, one time a day f "Remove TED hose (Nursing staff to assist day for edema." The unit manager, RM	y to BLE (bilateral lower staff to assist her with this for edema.				

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE	
		495147	B. WING				C 03/2022
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	<u>1 11/</u>	03/2022
					1221 ROSSER AVE		
RIVER ED	GE REHABILITATION AN	ID NURSING		, I	WAYNESBORO, VA 22980		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 684	her TED hose on, nor that the resident could may be in the laundry spare pair in the room The comprehensive of were reviewed at app TED hose were not o At approximately 11:3 conference room and TED hose did go to th there should have bee RN #1 was asked how apply the TED hose s resident's kardex. RN nurse's MAR (medica it should have been o administration record assist the resident, bu plan and the Kardex.' The above informatio administrator, the DO ADON (assistant dire corporate staff during on 11/02/2022 at app	were there any in her room d find, RN #1 stated, "They y, but there should be a n." are plan and the kardex roximately 10:15 a.m., the bserved on either. 30 a.m., RN #1 came to the stated, "[Resident #62's] ne laundry this morning, but en a spare in there for her." w the CNA would know to ince they were not on the #1 stated, "It was on the tion administration record), n the TAR (treatment)the nurse tells the CNA to ut it should be on the care " n was discussed with the N (director of nursing), the ctor of nursing) and three an end of the day meeting roximately 5:30 p.m.	F	684	4		

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 01/26/2023 MAPPROVED
STATEMENT O	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLI	E CONSTRUCTION	OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED	
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING _			
		495147	B. WING				C 03/2022
NAME OF PI	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE		
	GE REHABILITATION AN			1	1221 ROSSER AVE		
	GE REHABILITATION AN	ID NORSING		۱ I	WAYNESBORO, VA 22980		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 684	Continued From page	÷ 47	F	684	L I		
	clinical record review, the facility staff failed assessments to moni of 21 residents in the #34) and failed to follo	erview, staff interview, facility document review, to provide ongoing wound tor healing progress for one survey sample (Resident ow physician's orders for or one of 21 residents in the lent #62).					
	11/01/22 through 11/0 the complaint alleged monitor for appropriat #34's diagnoses inclu HTN (high blood press heart failure), schizop disease, anxiety dison obesity, and depressi The most current MD						
	prior to the discovery 07/29/22. This MDS Interview for Mental 15, indicating Residen cognitive impairment skills. Resident #34's assessed as non-amb	of the resident's wound on documented the BIMS (brief Status) score of 12 out of nt #34 had moderate in daily decision making s physical function was					

Facility ID: VA0019

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	0: 01/26/2023 APPROVED 0. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	-	(X3) DATE SURVEY COMPLETED		
		495147	B. WING				C 03/2022
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, S	TATE, ZIP CODE		
				1221 ROSSER AVE			
RIVER ED	GE REHABILITATION AN	D NURSING		WAYNESBORO, VA 22	980		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION ECTIVE ACTION SHOULD BE ENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
TAG F 684	Continued From page (activities of daily livin Resident #34's most r data set - cms assess an annual assessmer triggered in the CAAS summary) section for the need for care plan Resident #34's clinica and revealed that bila dorsal area of both fer documented on a 07/2 assessment. A physician progress following: "08/01/22 reports that he has at of his feet with odor. staff reports that his s of his feetrubbed the offnursing staff have nonstick piece of gaus nursing staff reports th odorous. Resident de concerns regarding th socks instead of shoe starteddorsal aspect of skin sloughed off d	48 g). ecent full MDS (minimum ment tool) assessment was it dated 12/20/21, which (care area assessment pressure ulcers, indicating development in this area. I records were reviewed teral 'friction' wounds to the et (from shoes) were 29/22 weekly skin note documented the 2seeing the resident for prasions to the tops of both Over the weekend, nursing hoes were rubbing the tops e first layer of skin e been covering with ze and tape however nat today it is drainingand enies pain or any other acute is todaywearing nonskid s since these abrasions ts of both feet with 1st layer	F 6			ΤΕ	DATE
	small amount of drain ordered for nursing st with DWC (dermal wo (topical antibiotic ointu gauze, and tape/wrap drainage and odor, I h 500 mg (milligrams) 3	age on dressingI have aff to cleanse the wounds und cleanser), apply TAO nent), cover with nonstick until healed. Due to yellow nave ordered cephalexin times daily for 7 p shoes offuntil wounds					

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE	
		495147	B. WING _				C 03/2022
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
RIVER ED	GE REHABILITATION AN	ID NURSING			221 ROSSER AVE /AYNESBORO, VA 22980		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	ĸ	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 684	Continued From page	9 49	F6	684			
	the following: "Clea	cian's orders were revealed nsewith DWC, apply TAO, auze until healed (order					
	following: "Cleanse apply collagen and ca kerlix, Change QD [ev	changed on 08/03/22 to the ebilateral feet with DWC, alcium alginate, wrap with very day] every day shift for (start date: 08/03/22)."					
	administration records reviewed and reveale receive the above treat	TARs (medication/treatment s) for August 2022 were d that the resident did atments as ordered, but no ed wound monitoring or					
	interviewed regarding was asked what had wounds. Resident #3 what happened to eith doesn't walk. When of care, Resident #34 st and dressing it once a dreaded them doing i When asked if he refu #34 stated that he did wounds on his feet ar care of them. When of problems with his fee in August, Resident # know.	t, but he did let them do it. used care at times, Resident I not refuse care to the hd that the staff was taking uestioned if he had any t before going to the hospital 34 stated that he didn't					
		PM, an interview was P, regarding the wound atment for Resident # 34.					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING (X3) DATE SURVEY COMPLETED AND PLAN OF CORRECTION 10ENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING (X3) DATE SURVEY COMPLETED NAME OF PROVIDER OR SUPPLIER 495147 B. WING 11/03/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1221 ROSSER AVE WAYNESBORO, VA 22980 1221 ROSSER AVE WAYNESBORO, VA 22980 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5)		-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
11/03/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1212 ROSSER AVE WAYNESBORO, VA 22980 WAYNESBORO, VA 22980 WAYNE DEGE REHABILITATION AND NURSING Difference WIRE EDGE REHABILITATION AND NURSING SUMMARY STATEMENT OF DEFICIENCIES WAYNESBORO, VA 22980 0%). VIEW (EACH OPERCIENCOV MUST BE PRECEDED BY FULL TAG PRETX CACCORRECTIVE ACTION PHOLD BE (EACH OPERCETVE ACTION PHOLD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COMMENTION) F 684 Continued From page 50 F 684 The NP stated that the resident started out with friction wounds from his shoes, for which she stated that she treated the resident with Keflex and wound care. The NP stated that the wounds seemed fine unli one of the nurse's had notified another provider when magogots were found in the wound assessments could be found or any evidence that the wound progress or treatment effective was being monitored. The NP was made aware that according to documentation, the wound treatments were coupleted, but there were no assessments documenting what the wound slooked like, during the dressing changes, on any of the days leading up to resident #34's transfer to the hospital on 08/08/22. The NP replied that she would expect them (nursing staff) to look at it and document would deped them (here sing staff) to look at it and document what they saw, not necessarily measure each time, but would expect them to document wound frainage, dor, and to document specifically what they did and of what they saw during the dressing change each day.	STATEMENT C	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	, í		CONSTRUCTION	(X3) DATE	SURVEY
1221 ROSSER AVE WAYNESBORO, VA 22980 Image: CMU join PREPIX TAG SUMMARY STATEMENT OF DEFICIENCIES USED CONTROL TO A DUBLE OF CONTROL TO STOLLD BE (EACH DEFICIENCY WAIE PROFECTED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREPIX TAG PROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD BE (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) C(%) DATE F 684 Continued From page 50 The NP stated that the resident started out with friction wounds from his shoes, for which she stated that she treated the resident with Keflex and wound care. The NP stated that the wounds seemed fine until one of the nurse's had notified another provider when magots were found in the wound and the resident had been sent out to the hospital. The NP was then made aware that no wound assessments could be found or any evidence that the wound progress or treatment effective was being monitored. The NP was made aware that according to documentation, the wounds looked like, during the dressing changes, on any of the days leading up to resident #34's transfer to the hospital on 08/08/22. The NP replied that she would expect them (nursing staff) to look at it and document what they saw, not necessarily measure each time, but would expect them to document wound drainage, dor, and to document specifically what they did and of what they saw during the dressing change each day. Image: Note State Add State Ad			495147	B. WING				-
RVER EDGE REHABILITATION AND NURSING WAYNESBORO, VA 22980 (M) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH ORDERCTION REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREVX TAG PROVIDER'S PLAN OF CORRECTION (EACH ORDERCTION TAG (00) PRETATION (EACH ORDERCTION TAG (00) PRETATION (EACH ORDERCTION TAG (00) PRETATION (EACH ORDERCTION (EACH ORDERCTION DEFICIENCY) (00) PRETATION (EACH ORDERCTION (EACH ORDERCTION (E	NAME OF PR	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
(M4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID ID PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH ORRECTIVE ACTION SHOLD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (20) COMPLETION DATE F 684 Continued From page 50 The NP stated that the resident started out with friction wounds from his shoes, for which she stated that she treated the resident with Keflex and wound care. The NP stated that the wounds seemed fine until one of the nurse's had notified another provider when magagots were found in the wound and the resident had been sent out to the hospital. The NP was then made aware that no wound assessments could be found or any evidence that the wound progress or treatment effective was being monitored. The NP was made aware that according to documentation, the wounds looked like, during the dressing changes, on any of the days leading up to resident #34's transfer to the hospital on 08/08/22. The NP repied that she would expect them (nursing staff) to look at it and document what they saw, not necessarily measure each time, but would expect them to document wound drainage, door, and to document specifically what they did and of what they saw during the dressing change each day. ID					1:	221 ROSSER AVE		
Prefrix TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) comment DEFICIENCY F 684 Continued From page 50 F 684 The NP stated that the resident started out with friction wounds from his shoes, for which she stated that she treated the resident with Keflex and wound care. The NP stated that the wounds seemed fine until one of the nurse's had notified another provider when maggots were found in the wound and the resident had been sent out to the hospital. The NP was then made aware that no wound assessments could be found or any evidence that the wound progress or treatment effective was being monitored. The NP was made aware that according to documentation, the wounds looked like, during the dressing changes, on any of the days leading up to resident #34's transfer to the hospital on 08/08/22. The NP replied that she would expect them (nursing staff) to look at it and document what they saw, not necessarily measure each time, but would expect them to document wound drainage, odor, and to document specifically what they did and of what they saw during the dressing change each day.		GE REHABILITATION AN	ND NORSING		v	VAYNESBORO, VA 22980		
The NP stated that the resident started out with friction wounds from his shoes, for which she stated that she treated the resident with Keflex and wound care. The NP stated that the wounds seemed fine until one of the nurse's had notified another provider when maggots were found in the wound and the resident had been sent out to the hospital. The NP was then made aware that no wound assessments could be found or any evidence that the wound progress or treatment effective was being monitored. The NP was made aware that according to documentation, the wound treatments were completed, but there were no assessments documenting what the wounds looked like, during the dressing changes, on any of the days leading up to resident #34's transfer to the hospital on 08/08/22. The NP replied that she would expect them (nursing staff) to look at it and document what they saw, not necessarily measure each time, but would expect them to document wound drainage, dor, and to document specifically what they did and of what they saw during the dressing change each day.	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFI		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA		COMPLETION
administrator, DON (director of nursing), and corporate nurse were made aware of the complaint allegations regarding Resident #34 and that no wound assessments to monitor wound progress could be found after the initial wound assessment by the NP, which was completed on 08/01/22. Their assistance was requested in locating any ongoing wound assessments, since that date. A policy on wound care and assessments was also requested at that time. On 11/03/22 at approximately 8:15 AM, the DON presented wound policy and procedure documents. The policy documented,	F 684	The NP stated that the friction wounds from the stated that she treater and wound care. The seemed fine until one another provider whe wound and the reside hospital. The NP was wound assessments of evidence that the would effective was being m made aware that accor wound treatments we were no assessments wounds looked like, d on any of the days leas transfer to the hospitar replied that she would to look at it and docur necessarily measure them to document wo document specifically they saw during the d On 11/02/22 at approx administrator, DON (of corporate nurse were complaint allegations that no wound assess progress could be fou assessment by the NI 08/01/22. Their assis locating any ongoing that date. A policy on assessments was als On 11/03/22 at approx	e resident started out with his shoes, for which she d the resident with Keflex e NP stated that the wounds of the nurse's had notified n maggots were found in the ent had been sent out to the s then made aware that no could be found or any und progress or treatment nonitored. The NP was ording to documentation, the ere completed, but there s documenting what the during the dressing changes, ading up to resident #34's al on 08/08/22. The NP d expect them (nursing staff) ment what they saw, not each time, but would expect bund drainage, odor, and to what they did and of what tressing change each day. ximately 6:15 PM, the director of nursing), and made aware of the regarding Resident #34 and sments to monitor wound and after the initial wound P, which was completed on stance was requested in wound assessments, since wound care and to requested at that time.	F	684			

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	-	ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 0 FORM AP OMB NO. 09	PROVED
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		495147	B. WING		C 11/03/2	2022
NAME OF P	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP	· · · · · · · · · · · · · · · · · · ·	-
RIVER ED	GE REHABILITATION AI	ND NURSING		1221 ROSSER AVE WAYNESBORO, VA 22980		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN O		(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG		TION SHOULD BE CC	DMPLETION DATE
F 684	Continued From page	e 51	F 68	84		
	e e contrace a contrace parge	Wound Treatmentsthe				
		curate documentation of				
		and treatments, including				
	changes in treatment	it, change in condition and				
	woundlocationsta					
	non-pressure (partial	or full				
		mentsdescription of wound				
	amount, and character	type of tissuepresence, eristics of wound				
	drainagepresence					
	-	osence of painnotification				
		esponsible party regarding				
		hanges" The DON also vound assessment dated				
	07/29/22, which only					
	-	area that was abraded to				
	both feet from shoes.	I he other wound 3/08/22 only documented				
		an open area. No other				
	information was on th	nis assessment, now were				
	any other wound ass	essments presented.				
	No further information	n and/or documentation was				
		e exit conference on 11/03/22				
		nce that the facility staff				
		ound assessments to Resident #34's wound				
	healing.					
	This is a complaint de	eficiency.				
F 689 SS=D	Free of Accident Haz	ards/Supervision/Devices	F 68	89	12/	5/22
	§483.25(d) Accidents	6.				
	The facility must ensu	ure that -				
		sident environment remains				
	as nee of accident ha	azards as is possible; and				
L				1		

Event ID:08B311

Facility ID: VA0019

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		ID HUMAN SERVICES MEDICAID SERVICES			FOR	D: 01/26/2023 M APPROVED O. 0938-0391
STATEMENT (DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495147	B. WING		11	C / 03/2022
NAME OF P	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE		
				1221 ROSSER AVE		
RIVERED	GE REHABILITATION AN	ND NURSING		WAYNESBORO, VA 22980		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 689	Continued From page	ə 52	F 68	9		
	supervision and assis accidents. This REQUIREMENT by: Based on observatio facility staff failed to e environment for one of #62. Findings were: Resident #62 was ad hypertension, arthero sinus syndrome, pres diabetes mellitus, cog history of falls. A quarterly MDS (min assedsment tool) with reference date) of 10, Resident #62 with a E Mental Status) score cognitive impairment Initial tour of the facili 11/01/2022 at approx Resident #62 was ob doorway of her room. discoloration was obs When asked what ha Resident #62 stated, she fell, Resident #62 slicky." Resident #62 into her room and sta was getting up and sl asked if she had calle	of 21 residents, Resident mitted to the facility with sclerotic heart disease, sick sence of cardiac pacemaker, gnitive impairment, and a numum data set - cms n an ARD (assessment /07/2022, assessed BIMS (Brief Interview for of 5/15, indicating moderate for daily decision making. ty was conducted on		 Resident #62 did not fall from the floor. Housekeeping corrected the we floor immediately on 11/2/22 while surveyor standing there. The Housekeeping Director will complete an audit of all housekeeping employees with an inspection of more floors. The Housekeeping director will complete education with housekeeping employees on not applying large and of water to the floor while mopping, leaving the floors very visibly wet. The Housekeeping director will conduct audit of wet floors for very v wet floors two times weekly times six weeks then monthly times three more Audit findings will be reported to the facility QAPI Committee monthly for months to review the need for contin- intervention or amendment of the plant 	et og opping ng ounts isibly three ued	

Facility ID: VA0019

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495147	B. WING				C 03/2022
NAME OF P	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE		
				1	1221 ROSSER AVE		
RIVERED	GE REHABILITATION AN	ID NURSING		١	WAYNESBORO, VA 22980		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 689	approximately 2:30 p. that Resident #62 had up unassisted with the subsequent injury ind around her eye. A rev care plan revealed ne included the addition On 11/02/2022 at app "Caution Wet Floor" s doorway to Resident f Resident #62's room and was very visibly w risk/hazard). Residen in her room between wetness of the floor a pointed out to Reside being careful, I've got housekeeper (other s the floor was around the hallway. When asked Resident #62's floor, a asked [name of Reside until it dried." Other s the resident was not s was up walking in her visibly very wet. When mop or something that to get up the excess w	record on 11/01/2022 at m., provided documentation d recently fallen while getting e resulting fall and icated by the discoloration view of the comprehensive ew fall interventions that of a night light in her room. proximately 9:00 a.m., a sign was observed in the #62's room. The floor in had been recently mopped wet (indicating increased fall t #62 was observed walking the bed and wall. The nd the need for caution was nt #62, who stated, "I'm emy shoes on." The taff #1) who had mopped the corner, on another if she had mopped other staff #1 stated, "YesI dent #62] to sit on the bed staff #1 was then told that sitting on her bed, that she e room, and the floor was n asked if there was a dry at could be run over the floor water, Other Staff #1 took a and ran it over the floor to	F	689			
	information: "high ris incontinence[Name	an included the following sk of falls r/t (related to) of Resident #62] needs a n even floors free from spills					

Facility ID: VA0019

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	MENT OF HEALTH AN S FOR MEDICARE & I	D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION UMBER:				E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
		495147	B. WING			C 11/03/2022	
NAME OF P	ROVIDER OR SUPPLIER		•		STREET ADDRESS, CITY, STATE, ZIP CODE	·	
RIVER ED	GE REHABILITATION AN	ID NURSING			1221 ROSSER AVE WAYNESBORO, VA 22980		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 689 F 690 SS=E	and/or clutter" The above findings we administrator, the DO ADON (assistant direct corporate staff during on 11/02/2022 at appl Concerns were voiced visibly wet in a reside resident with a known interventions to reduct administrator stated, ' her [OS #1] this morn housekeeping directo No further information exit conference on 11 Bowel/Bladder Incontt CFR(s): 483.25(e)(1)- §483.25(e) Incontiner §483.25(e)(1) The factor resident who is contin admission receives see maintain continence u condition is or becom- not possible to maintata §483.25(e)(2)For a refince incontinence, based of comprehensive assess ensure that- (i) A resident who enter indwelling catheter is resident's clinical com- catheterization was ner- (ii) A resident who enter ind of the sident who enter ind welling catheter is resident's clinical com- catheterization was ner- (ii) A resident who enter ind welling catheter is	as discussed with the N (director of nursing), the ctor of nursing), and three an end of the day meeting roximately 5:30 p.m. d that the floor had been left nt's room, especially a fall history and e fall risk. The 'I overheard you talking to ing. I went to the r and he met with his staff." was obtained prior to the /03/2022. inence, Catheter, UTI (3) nce. bility must ensure that ent of bladder and bowel on ervices and assistance to unless his or her clinical es such that continence is ain. sident with urinary on the resident's assment, the facility must ers the facility without an not catheterized unless the dition demonstrates that		689			12/5/22

Facility ID: VA0019

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		ND HUMAN SERVICES MEDICAID SERVICES				FORM	D: 01/26/202 /I APPROVE). 0938-039
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	LTIPLE CONSTRUCTION DING			SURVEY PLETED
		495147	B. WING _				C 03/2022
NAME OF P	ROVIDER OR SUPPLIER	•		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
				12	221 ROSSER AVE		
	GE REHABILITATION AI	ND NORSING		N	AYNESBORO, VA 22980		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	K	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ЗE	(X5) COMPLETION DATE
F 690	Continued From page	e 55	F 6	300			
				0.90			
		val of the catheter as soon e resident's clinical condition					
		theterization is necessary;					
	and						
	(iii) A resident who is	incontinent of bladder					
		treatment and services to					
		infections and to restore					
	continence to the exte	ent possible.					
	§483.25(e)(3) For a r	esident with fecal					
	incontinence, based						
		ssment, the facility must					
		twho is incontinent of bowel					
	receives appropriate restore as much norn	treatment and services to					
	possible.	har bower function as					
		Γ is not met as evidenced					
	by:						
	Based on observatio	on, staff interview, resident			1. Resident #28 received Ertapenen	n	
		ord review, and facility			Sodium Solution Reconstituted 1 GM	for	
		e facility staff failed to provide			UTI on 11/2/22 NP/RP made aware.		
	-	an UTI (urinary tract infection)			2. The Unit Managers will conduct a	n	
	for one of twenty-one	e residents, Resident #28.			100% audit of residents on antibiotic therapy to assure timely treatment is		
	The findings include:				provided. 3. The Assistant Director of Nursing	will	
	Resident #28 was ad	lmitted to the facility with the			conduct education with the Unit Mana		
	following diagnoses i	ncluding but not limited to:			and licensed nurses on clarification of	-	
		adriplegia, contracture of the			antibiotic orders, notifying the MD whe	en	
	left hand, UTI, and ch	nronic kidney disease.			the medication is not available and		
		inclume electre and arrest			obtaining unavailable medication.	ا :4	
	An annual MDS (min				 DON/Designee will conduct an au of antibiotic orders to assure medication 		
		ed 09/02/2022 documented view of Mental Status) score			availability and timely treatment is	ווכ	
		ating Resident #28 was			provided two times weekly times six		
		daily decision making.			weeks then monthly times three month	าร.	
	5	,			Audit findings will be reported to the		
	On 11/01/2022 begin	ning at approximately 3:00			facility QAPI Committee monthly for th	iree	
		clinical record included			months to review the need for continu	ed	

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	-	ND HUMAN SERVICES MEDICAID SERVICES				FOF	ED: 01/26/2023 RM APPROVED O. 0938-0391
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			NSTRUCTION	· · ·	E SURVEY IPLETED
		495147	B. WING _			11	C I/ 03/2022
NAME OF PI	ROVIDER OR SUPPLIER			STRE	ET ADDRESS, CITY, STATE, ZIP CODE		
RIVER ED	GE REHABILITATION AN	ND NURSING			ROSSER AVE		
				WAY	NESBORO, VA 22980		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 690	Continued From page	e 56	F 6	90			
F 090	progress notes with the "10/29/2022 22:20 (1) Spoke with [Name re- begin ertapenem 1 G hours." "10/31/2022 (Note from 10/31/2022 at 7:51 p. inflammatory reaction catheterurine cultur and Pseudomonas. Simg daily for UTI prop developed a UTI aga ertapenem 1 g daily of should be performed should be changed et "11/01/2022 01:27 (at Reconstituted 1 GM to one time a day for UTI begin tomorrow 11-1 change in (computer Resident #28 had beat during initial tour on 1 12:00 p.m. No IV line At approximately 5:00 again observed sitting	he following entries: 0:22 p.m.) Positive for UTI. dacted]; place PICC line M (gram) q (every) 24 om nurse practitioner signed m.)Infection and n due to indwelling urethral re came back with E. Coli She is on trimethoprim 50 hylaxis, however, she has in. She should continue until 11/4/2022. Foley care every shift and the catheter very 28 days" .m.) Ertapenem Sodium Use 1 gram intravenously FI over 4 days. IV therapy to @1700 per MD order, noted			ntervention or amendment of the	plan.	
	supposed to be but I said they don't have a think it was last week took it out." When as	, Resident #28 stated, "I am haven't gotten any yetthey any needlesI had one, I a, it started bleeding and they sked if she was having any					
		omfort or any symptoms esident #28 stated, "No, I'm					
	(licensed practical nu	proximately 5:10 p.m., LPN irse) #7 was in the hallway s. When asked if she was					

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT C	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPL	LE CONSTRUCTION	(X3) DATE	SURVEY
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING		COMF	LETED
		495147	B. WING				C 03/2022
NAME OF PF	ROVIDER OR SUPPLIER		I		STREET ADDRESS, CITY, STATE, ZIP CODE	,	
					1221 ROSSER AVE		
RIVER ED	GE REHABILITATION AN	ID NURSING			WAYNESBORO, VA 22980		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B) CROSS-REFERENCED TO THE APPROPRIA		(X5) COMPLETION DATE
170					DEFICIENCY)		
F 690	Continued From page taking care of Reside "Yes." When asked al antibiotics for her urin looked at the MAR (m record) and stated, "T tomorrow (11/02/2022 wasn't being started u ordered on 10/29/202 waiting for the pharma to do it." When asked by supplies, LPN #7 s antibiotic and the sup On 11/02/2022 at app review of the clinical r condition note, which was written by the uni nurse) #1: "11/02/2022 08:56 (a. Conditionnursing of recommendations are UTI, Foley catheter in Ertapenem 1 Gm IV > On 11/02/2022 at app was interviewed. Ref condition note that sh day, RN #1 was aske antibiotics for Resider started. RN #1 looked stated, "Yes, it starts to referred back to the p 10/29/2022, 10/31/20 regarding Resident #2 antibiotic and the entr PICC line insertion. R	e 57 nt #28, LPN #7 stated, bout Resident #28's IV ary tract infection, LPN #7 nedication administration The order says to start that 2). When asked why it until 11/02/2022, when it was 22, LPN #7 stated, "We are acy to send us the supplies to explain what she meant stated, "We need the plies to start the IV." proximately 9:10 a.m., a record included a change in contained the following and it manager, RN (registered m.)Change in bservations, evaluation, and a: Resident presents with place. Treatment with K (times) 4 days" proximately 9:30 a.m., RN #1 ferring to the change in e had written earlier that d if she was aware that the nt #28 had not yet been d at the physician orders and this evening." She was rogress notes from 22, and 11/01/2022,		690	DEFICIENCY)		
	a four day course of a	antibiotics she wouldn't need e a regular IV." When asked					

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DEPARTMENT OF HEALTH ANI CENTERS FOR MEDICARE & M				FOI	ED: 01/26/2023 RM APPROVED NO. 0938-0391	
			LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
	495147	B. WING		C 11/03/2022		
NAME OF PROVIDER OR SUPPLIER		•	STREET ADDRESS, CITY, STATE, ZIP CODE			
			1221 ROSSER AVE			
RIVER EDGE REHABILITATION AND	DNURSING		WAYNESBORO, VA 22980			
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
the pharmacy, since the ordered on 10/29/2022 not received a dose, R why she hasn't gotten something we have he everything we need to that she would look int to the survey team. At approximately 11:30 conference room and a order was written by the weekend. It looks like written on October 29 discontinue it when the That order was discon order written on Octob be given for four days. rewritten to start on No was discontinued on No on the order was 'waiti pharmacy', but they we todayI don't know wh notes say we were wa say waiting on IV supp ordered the medicine f have that antibiotic hell startedI spoke with the we got the order clarifi starting today at noon. physician or nurse pra that the medication ha today, RN #1 stated, " documentation that no feel like that happened nurses had changed/c start dates of the antib	nedication to arrive from ne antibiotic had been 2 and the resident had still 2N #1 stated, "I don't know her antibiotic. Ertapenem is ere in stock and we have start an IV." RN #1 stated to a few things and get back 0 a.m., RN #1 came to the stated, "The antibiotic ne on-call physician over the the original order was to place a PICC line and e antibiotics were complete. tinued. There was also an er 29 for the antibiotics to that was discontinued and ovember firstthat order lovember 1st, the reason ing on IV supplies from the ere suppose to be here nat happenedsome of the iting on the medicine, some office. It looks like we from the pharmacywe re so it could have been he nurse practitioner and ed so we can give it IM " When asked if the citiioner had been notified d not been given before There isn't any tification occurred, I don't	F 69				

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0.0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURV COMPLETED	
		495147	B. WING				C 03/2022
NAME OF PI	ROVIDER OR SUPPLIER		•		STREET ADDRESS, CITY, STATE, ZIP CODE	-	
RIVER ED	GE REHABILITATION AN	ID NURSING	1221 ROSSER AVE WAYNESBORO, VA 22980				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 690	physician should have On 11/02/2022 at app nurse practitioner (NF asked if she was awa not received any dose the IM injection order NP stated, "I was told that she had an IV an can't tell you the nurse but she said there we restart it and they word pharmacyI thought and it would resume to found out today that no changed the route to On 11/02/2022 at app was asked if other that was any place the nur documented that the the physician/nurse p #1 stated, "There is a went to the nurse's st book, but stated, "The in here about that." On 11/02/2022 at app DON (director of nurse room and stated, "He the pharmacythe ar whole timethey wer dispensed them on the they were delivered of	hat I think happenedthe e been notified." proximately 3:30 p.m., the P) was interviewed. When re that Resident #28 had es of her antibiotics prior to ed earlier on 11/02/2022, the on Monday (10/31/2022) d that it had infiltratedI es name who told me that, ren't any needles here to uld have to come from the she had gotten one dose the next day [11/01/2022]. I none had been given, so we IM." proximately 4:00 p.m., RN #1 an the clinical record there rses could have antibiotic was not given and ractitioner were notified. RN physician book." RN #1 ation and looked in the ere's not any documentation proximately 4:30 p.m., the ing) came to the conference re is the packing slip from ntibiotics have been here the e ordered and the pharmacy ie 30th [10/30/2022] and n the 31st [10/31/2022]As	F	690			
	twice. The bags are in med cart." When ask	harmacy delivered them n the bottom drawer of the red why the nurse had meds were not available,					

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	-	ID HUMAN SERVICES				FORM	APPROVED
	5 FOR MEDICARE & I	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	TIPLE	CONSTRUCTION	(X3) DATE	0. 0938-0391 SURVEY
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:					LETED
		1051.17					C
	ROVIDER OR SUPPLIER	495147	B. WING		STREET ADDRESS, CITY, STATE, ZIP CODE	11/	03/2022
NAME OF FI	CONDER OR SOFFLIER				221 ROSSER AVE		
RIVER ED	RIVER EDGE REHABILITATION AND NURSING				VAYNESBORO, VA 22980		
(X4) ID		SUMMARY STATEMENT OF DEFICIENCIES ID			PROVIDER'S PLAN OF CORRECTION		
PREFIX TAG		Y MUST BE PRECEDED BY FULL _SC IDENTIFYING INFORMATION)	PREFIZ TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA		COMPLETION DATE
					DEFICIENCY)		
Г 600							
F 690	Continued From page	9 60 n't know, she is not here	F 6	690			
		her as DNR." When asked					
		DON stated, "Do not					
	rehire."						
	The above informatio	n was discussed with the					
		or, the ADON (assistant					
		nd three members of the					
	-	erns were voiced that an IV dered on 10/29/2022 for					
		edication was not started					
		en asked if the physician or					
		been notified of the delay					
		l stated that she would find / the nurses know what					
		in the "Stat" box, the DON					
		a list in each medication					
	room.						
	On 11/03/2022 at 9:3	0 a.m., the DON entered the					
		was asked if she could					
		s were not started because e meds were in house or					
		now that IV supplies were in					
	-	bonded, "I've not been able					
		e nursesI don't know if the					
		d or not, or if the problem we had the meds or if they					
		es weren't available."The					
	DON then presented	a list of medications					
		box, on which Ertapenem 1					
	gram was listed.						
		n was obtained prior to the					
	exit conference on 11		_	·			
F 691 SS=E	Colostomy, Urostomy CFR(s): 483.25(f)	v, or lleostomy Care	F e	691			12/5/22
33-E	01 1(3). 403.23(1)						

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CENTER	S FOR MEDICARE &	MEDICAID SERVICES			OMB NO. 0938-0	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	(X3) DATE SURVEY COMPLETED		
		495147	B. WING		C 11/03/2022	
NAME OF P	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE		
RIVER ED	GE REHABILITATION AN	ND NURSING		1221 ROSSER AVE WAYNESBORO, VA 22980		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLET	
F 691	 F 691 Continued From page 61 §483.25(f) Colostomy, urostomy,, or ileostomy care. The facility must ensure that residents who require colostomy, urostomy, or ileostomy services, receive such care consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview and clinical record review, the facility staff failed to obtain physician orders to provide ongoing assessment and care for a colostomy for one of twenty residents in the survey sample. Resident #17 had no current physician orders for care the colostomy and no evidence of daily colostomy site assessments as documented in the comprehensive care plan. 		F 69'	1		
				 A MD order for colostomy care placed in PCC on 11/2/22 for the res #17, documentation shows on the T The Unit Managers will complet 100% audits of all residents with ME orders for colostomy care and reviet offs on the TAR. The Assistant Director of Nursir complete education with the Unit Managers and all Licensed Nurses 	sident AR. te) w sign ng will	
	diagnoses that includ disease with coloston cerebral infarction, di hypothyroidism, depr and chronic respirato (minimum data set - (assessment dated 9/9	CMS assessment tool) 9/22 documented the BIMS ental Status) as indicating		 placing MD orders for colostomy car Audits of residents with colostory orders will be conducted two times or times six weeks then monthly times months. Audit findings will be reported to the facility QAPI Committee monthly for months to review the need for containintervention or amendment of the place. 	my weekly three three nued	
	quality of care in the that she provided car included twice weekly #17 stated the aides	o.m., when interviewed about facility, Resident #17 stated e for her colostomy that y flange changes. Resident assisted her to clean around ring showers. Resident #17				

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE	
		495147	B. WING			C 11/03/2022	
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	,	00/2022
					1221 ROSSER AVE		
RIVERED	R EDGE REHABILITATION AND NURSING				WAYNESBORO, VA 22980		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 691	had any problems with Resident #17's clinical revealed no current p the care of the coloster treatment administration documented a previous emptying of the coloss replacement as needed discontinued on 10/7/ colostomy orders or the the TAR from 10/8/22 was no documentation and/or flange were che A nursing note dated "PT [patient] needin The remaining Nursin through 10/31/22 made resident's colostomy. Resident #17's computed 7/6/22) documented to colostomy, with goals and prevent skin breat interventions that ince make sure ostomy is stool is being diverted [physician] of any com bag per MD orders" On 11/2/22 at 2:37 p.1 nurse (LPN #2) caring interviewed about colo that the resident perfor- care. LPN #2 stated	routinely look at the formed the nurses if she h the site. Il record was reviewed and hysician orders regarding omy. The October 2022 ion record (TAR) us order dated 11/4/20 for tomy bag once per shift with ed. This order was 22. There were no current reatments documented on through 10/31/22. There n regarding when the bag hanged. 10/10/22 documented, g assistance with stoma" g notes from 10/11/22 de no further mention of the rehensive care plan (revised he resident had a to maintain proper function ukdown, along with luded, "Assess daily to functioning properly and a through ostomy. Notify MD nplicationsChange Ostomy m., the licensed practical g for Resident #17 was ostomy care. LPN #2 stated ormed her own colostomy	F	69			

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					FOF	ED: 01/26/2023 RM APPROVED IO. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING		(X3) DATE SURVEY COMPLETED C 11/03/2022	
		495147	B. WING			
NAME OF P	ROVIDER OR SUPPLIER		STRI	EET ADDRESS, CITY, STATE, ZIP CODE		
			1221	ROSSER AVE		
RIVER ED	GE REHABILITATION AN	ND NURSING	WAY	YNESBORO, VA 22980		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 691 F 697 SS=G	found no current order colostomy. LPN #2 s readmitted to the faci orders may not have readmission. LPN #2 current entries on the On 11/2/22 at 3:10 p. #3) was interviewed a colostomy care. LPN record and stated tha orders for colostomy she did not know why not initiated when the 10/10/22. LPN #3 state provided routine care usually informed the LPN #3 stated that not the colostomy site for This finding was revise director of nursing an services during a mean No further information facility exit. Pain Management CFR(s): 483.25(k) §483.25(k) Pain Mana The facility must ensu- provided to residents consistent with profes	the facility. LPN #2 record and stated that she ers about care of the tated that the resident was lity on 10/10/22 and the been restarted upon 2 stated that there were no TAR about the colostomy. m., the unit manager (LPN about Resident #17's #3 reviewed the clinical t there were no current care. LPN #3 stated that colostomy care orders were resident was readmitted on ated that the resident of the colostomy and nurses of any problems. urses should be monitoring any complications. ewed with the administrator, d regional director of clinical eting on 11/2/22 at 5:40 p.m. n was provided prior to agement. ure that pain management is who require such services, asional standards of practice, erson-centered care plan,	F 691			12/5/22

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TATEMENT	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION	(X3) DA	NO. 0938-039 TE SURVEY	
ND PLAN O	FCORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	B	co	COMPLETED C 11/03/2022	
		495147	B. WING				
NAME OF F	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	I '	1/00/2022	
RIVER ED	GE REHABILITATION AN	ID NURSING		1221 ROSSER AVE WAYNESBORO, VA 22980			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 697	Based on observatio interview, clinical reco document review, the pain management for survey sample, Resid not administered sche ordered by the physic unrelieved pain and w resulted in actual harn Findings include: Resident #78's diagna limited: diverticulitis, muscle weakness, dy polyneuropathy, histo musculoskeletal mast Resident #78's most n set - CMS assessmen assessment dated 08 the resident with a BII Mental Status) score intact cognition function skills. Physical function requiring supervision one staff person for m living). On 11/02/22 at approx #78 was observed sit facial grimacing. Upp stated that she had a and had not slept due the night nurse for he Resident #78 states t	n, resident interview, staff ord review and facility facility staff failed to ensure one of 21 residents in the lent #78. Resident #78 was eduled pain medication as tian; Resident #78 suffered vas unable to sleep, which m to the resident. oses included, but were not atrial fibrillation, depression, sphagia, abnormal gait, ry of falls, and toid bone pain. recent MDS (minimum data nt tool) was an admission /23/22. This MDS assessed MS (Brief Interview for of 15 (out of 15), indicating on for daily decision making	F 69		on 11/2/22. nplete an scheduled to assure ng ursing will ed nurses bllowing tion policy, ons and edication nduct an d two be six weeks to the y for three ontinued		

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		ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 01/26/202 FORM APPROVE OMB NO. 0938-039
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` <i>`</i>	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495147	B. WING _		C 11/03/2022
NAME OF P	ROVIDER OR SUPPLIER	•	•	STREET ADDRESS, CITY, STATE, Z	IP CODE
				1221 ROSSER AVE	
RIVER ED	GE REHABILITATION AN	ND NURSING		WAYNESBORO, VA 22980	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE / CROSS-REFERENCED T DEFICIE	ACTION SHOULD BE COMPLETION TO THE APPROPRIATE DATE
F 697	When asked if the nu any non-pharmacolog heat or ice packs or a stated, "No." When a resident #78 respond of 10, indicating seve the resident expresses start crying because of hurts." At approximately 8:05 Practical Nurse) #1 (t informed of the above #78's present compla LPN #1 looked in the the resident had an o Hydrocodone-Acetan medication for moder scheduled at bedtime a Start Date of 10/31/ (electronic medication further, LPN #1 stated not get the medication PM) and that accordin written by the LPN #7 order. Stating that it s medication to get her ordered on 10/31/22, observed, LPN #1 loo until holding a bottle a bottle was labled with medication name, and 10/31/22. When aske narcotic count sheet a medication doses we as administered on 1	anything else for her pain. rse had provided her with gical interventions, such a a back rub, etc., the resident asked to rate her pain level, ed that her pain was a 7 out re pain. In apparent distress, ed that she hoped she didn't of the pain, but stated, "it 5 AM, LPN (Licensed he day shift nurse) was e information and Resident int of pain. system and confirmed that rder for ninophen (a narcotic ate to severe pain) solution, e, for mastoid bone pain, with (22. Reviewing the EMAR n administration record) d that the resident #78 did n last night (11/01/22 at 10 ng to the nursing/note 7, the medication was on shouldn't take that long for a e, LPN #1 added, "It was it should be here." While oked thru the medication cart and said, "This is it." The n Resident # 78's name, d date dispensed as	F	397	

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	
		495147	B. WING				C 03/2022
NAME OF P	ROVIDER OR SUPPLIER		I		STREET ADDRESS, CITY, STATE, ZIP CODE	<u>. </u>	
RIVER ED	GE REHABILITATION AN	ID NURSING			1221 ROSSER AVE WAYNESBORO, VA 22980		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ЗE	(X5) COMPLETION DATE
F 697	resident had not recenight either. On 11/02/22 at appro- stated that she had of administer the resider Observed preparing t the medication to the Holding her hand to s Resident #78 appeare what her pain level waresponded that her pain (indicating very sever and stated that she had At approximately 9:30 records were reviewe physician's orders we order for: "[order da Hydrocodone-Acetam mg/5 ml (milligrams/n at bedtime for mastoi 10/31/22" The Resident #78's M administration records November 2022 were and 11/01/22 at 10:00 a '9' in the slot for the (Hydrocodone-Acetam According to the MAR 'Other/see nursing no The review of the nur following entries:	ived pain medication on that ximately 8:45 AM, LPN #1 btained a one time order to nt's pain medication. he medication, LPN #1 took Resident #78's room. ide of her head & grimacing, ed teary-eyed. When asked as at the time. Resident #78 ain was now at 8.5 out of 10 e pain), took the medication, oped it helped. 0 AM, Resident #78's clinical d. The resident's rere reviewed and included an ate: 10/31/22 10:32 am] ninophen solution 2.5 -108 nilliliter) Give 5 ml by mouth d bone pain Start Date: MAR (medication s) for October and reviewed. On 10/31/22 0 PM, the MAR documented scheduled pain medication minophen solution). R legend, a '9' means tes'. sing notes included the ing note documented, Orders - General	F	697			

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STATEMENT OF AND PLAN OF C	DEFICIENCIES ORRECTION DVIDER OR SUPPLIER E REHABILITATION AN SUMMARY STA (EACH DEFICIENCY		. ,	PLE CONSTRUCTION G STREET ADDRESS, CITY, STATE, Z	OMB NO. 0938-03 (X3) DATE SURVEY COMPLETED C 11/03/2022
(X4) ID PREFIX	E REHABILITATION AN SUMMARY STA (EACH DEFICIENCY	ID NURSING	B. WING	STREET ADDRESS, CITY, STATE, Z	-
(X4) ID PREFIX	E REHABILITATION AN SUMMARY STA (EACH DEFICIENCY			STREET ADDRESS, CITY, STATE, Z	
(X4) ID PREFIX	SUMMARY STA			, , , ,	IP CODE
PREFIX	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES		1221 ROSSER AVE WAYNESBORO, VA 22980	
PREFIX	(EACH DEFICIENC)	(X4) ID SUMMARY STATEMENT OF DEFICIENCIES		PROVIDER'S PLAN	OF CORRECTION (X5)
		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE) CROSS-REFERENCED DEFICI	ACTION SHOULD BE COMPLETION TO THE APPROPRIATE DATE
F 697 (Continued From page	67	F 69	77	
1	HYDROcodone-Aceta MG/5ML	aminophen Solution 2.5-108			
	Give 5 ml by mouth at pain"	t bedtime for mastoid bone			
"		on Administration Note			
		etaminophen Solution e 5 ml by mouth at bedtime			
f (or mastoid bone pain	Pending pharmacy delivery liation [medication] RX			
i i r	HYDROcodone-Aceta MG/5ML Give 5 ml by nastoid bone pain Me	AR note documented, tion Administration Note aminophen Solution 2.5-108 mouth at bedtime for edication pending delivery @ in bed w/ eyes closed"			
۲ r	physician was either r did not receive the ph	ordered pain medication			
((i	CCP documented, " nitiated: 11/01/22 re /erbalize knowledge o	plan) was reviewed. The Pain Management Date sident will demonstrate and of strategies for pain			
r	11/01/22Resident w non-pharmacological	interventions for			
f - -	luidsrepositioning Fhis care plan was de Fhere was no other in	ertainment/activity, food and date initiated: 11/01/22" eveloped on 11/01/22. formation on the resident's ain, including resident			

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		ID HUMAN SERVICES MEDICAID SERVICES				FC	TED: 01/26/2023 DRM APPROVED NO. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` <i>'</i>		DNSTRUCTION	(X3) D	ATE SURVEY OMPLETED
		495147	B. WING			C 11/03/2022	
NAME OF P	ROVIDER OR SUPPLIER		•	STR	EET ADDRESS, CITY, STATE, ZIP CODE		
	GE REHABILITATION AN			122 [.]	1 ROSSER AVE		
	GE REHABILITATION A	ID NORSING		WA	YNESBORO, VA 22980		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 697	reporting pain, treatmerenerging issues. Nothat the above pain merenerging calmerenerging calmerenerging. When ask Resident #78 response her pain level was " indicated moderate pain level was " indicated moderate pain level was " indicated moderate pain level was made findings regarding the with Resident #78 on resident's pain medic medication cart but he which resulted in Reserved her pain and was hopir due to the pain. In reserved medis has ma which several meds her gabapentin, "which stated that a low dose [hydrocodone-acetamer"which seemed to casked, the NP stated pain and their pain methey don't have pain methey don't have pain methey don't never a delay in the NP then stated thet the stated thet the provider to obtain pain medication of so to prevent a delay in the NP then stated the stated thet the stated pain and their pain methey don't have pain they don't have pain the stated the state	A sessment, guidelines for nent effectiveness, or documentation was found nanagement interventions ed or even offered. AM, Resident # 78 was ly in bed, without any ted if she was feeling better, ded, 'some' and stated that still at a level 5," which ain. PM, the NP (Nurse de aware of the above e observation and interview 11/02/22. Adding that the ation was found on the ad not been administered, ident stating that she had a unable to sleep due to being ng that she didn't start crying sponse, the NP stated that stoid bone arthritis, for nad been tried, including didn't really help." The NP	F	697			

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	-	ID HUMAN SERVICES				FORM	APPROVED
		MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPL	LE CONSTRUCTION	OMB NO. 0938-0391 (X3) DATE SURVEY	
	CORRECTION	IDENTIFICATION NUMBER:					LETED
						(C
		495147	B. WING			11/	03/2022
NAME OF PI	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
RIVER ED	GE REHABILITATION AN	ID NURSING			1221 ROSSER AVE WAYNESBORO, VA 22980		
		ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(ME)
(X4) ID PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFI		(EACH CORRECTIVE ACTION SHOULD B		
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)		TAG		CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΤE	DATE
			1				
F 697	Continued From page	e 69	F	697	7		
		e should have contacted the					
	provider.						
	On 11/02/22 at appro	ximately 6:15 PM, the					
		director of nursing), ADON					
		nursing) and the corporate					
		are of the serious concerns					
		ing observed in pain, after					
	•	eduled pain medication as ints of inability to sleep and					
	-	the medication was actually					
		ration. A policy on pain					
	u u u u u u u u u u u u u u u u u u u	uested at this time. At 6:35					
		hat the expectation would e to notify the provider to get					
	an order for somethin						
		ity policy titled "Pain-Clinical					
		ed, which documented,					
	"staff will identify ind pain_staff will evalua	te how pain is affecting					
		ily living, sleepquality of					
		ment program is based					
		ssmentresident choices					
	related to pain manag painverbal expressi						
	cryingfacial express						
	frowninglimitations						
	activityinsomniano						
		appropriate alone or in icationsice packs, cool or					
	warm compresses,	icationsice packs, cool of					
	-	harmacological interventions					
	be prescribed to man	age painadministering					
		he clock rather than PRN					
	[as needed]impleme as ordered"	ent the medication regimen					
	Another facility policy	, which was titled					

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	-	ID HUMAN SERVICES MEDICAID SERVICES				NTED: 01/26/2023 FORM APPROVED B NO. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3)) DATE SURVEY COMPLETED
		495147	B. WING			C 11/03/2022
NAME OF P	ROVIDER OR SUPPLIER	I		STREET ADDRESS, CITY, STATI	E, ZIP CODE	
RIVER ED	RIVER EDGE REHABILITATION AND NURSING			1221 ROSSER AVE WAYNESBORO, VA 22980	I	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTI CROSS-REFERENCI	LAN OF CORRECTION VE ACTION SHOULD BE ED TO THE APPROPRIATE FICIENCY)	(X5) COMPLETION DATE
F 697	"Unavailable Medicat "shall follow establis ensuring residents ha medicationsmay be reasonsStaff shall to it is known that the m unavailableNotify pl treatment" No further information presented prior to the to evidence that facilit management to Resid	ions", documented that staff shed procedures for we a sufficient supply of unavailable for a number of ake immediate action when edication is hysicianobtain alternate an and/or documentation was e exit conference on 11/03/22 ty staff provided timely pain dent # 78 when experiencing with the physician's orders	F 69	7		

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