PRINTED: 01/19/2023 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION		` ′	(X3) DATE SURVEY COMPLETED	
		495403	B. WING			08/	/30/2022	
NAME OF P	PROVIDER OR SUPPLIER	l			CITY, STATE, ZIP CODE	, 50,		
LAKEWO	OD MANOR			1900 LAUDERDALE RICHMOND, VA 2				
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E 000	Initial Comments		E	00				
F 000 F 880 SS=F	Survey was conducted 08/30/2022. The facility compliance with 42 Compliance with 42 Compliance with 42 Compliance with 42 Complemented The Cemergency prepared implemented The Cemergency prepared implemented The Cemergency prepared COVID-19. INITIAL COMMENTS A COVID-19 Focuse was conducted onsite 08/30/2022. Signification for compliance with 4 control regulations, for Centers for Medicare Centers for Disease Complaints were investigated of 20 reside employee reviews. Infection Prevention 6 CFR(s): 483.80 (a)(1) §483.80 Infection Control The facility must estatinfection prevention and designed to provide a comfortable environmed evelopment and train diseases and infection	cFR Part 483.73(b)(6) ness regulations, and has nters for Medicare & nd Centers for Disease d practices to prepare for d Infection Control Survey e 08/24/2022 through nt corrections are required 2 CFR Part 483.80 infection or the implementation of The & Medicaid Services and Control recommended for COVID-19. No stigated during the survey. d certified bed facility was 73 vey. The survey sample ent reviews and 14 d Control (2)(4)(e)(f) ntrol blish and maintain an and control program a safe, sanitary and nent and to help prevent the ensmission of communicable ns.		80			10/17/22	
I ARODATODY		prevention and control SUPPLIER REPRESENTATIVE'S SIGNATURE			TITLE		(X6) DATE	

Electronically Signed 09/22/2022

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.

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
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	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1900 LAUDERDALE DRIVE RICHMOND, VA 23238	1 00.00.2022
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F 880	and control program a minimum, the follow §483.80(a)(1) A syst reporting, investigati and communicable of staff, volunteers, visi providing services un arrangement based conducted according accepted national staff (ii) When and to who communicable communicable disease reported; (iii) Standard and traff to be followed to pre (iv)When and how is resident; including be (A) The type and dure depending upon the involved, and (B) A requirement the least restrictive possicircumstances. (v) The circumstance must prohibit employ disease or infected s	ablish an infection prevention (IPCP) that must include, at wing elements: em for preventing, identifying, and, and controlling infections iseases for all residents, tors, and other individuals ander a contractual upon the facility assessment to §483.70(e) and following andards; In standards, policies, and rogram, which must include, it is illiance designed to identify ble diseases or y can spread to other (r); Impossible incidents of se or infections should be used for a	F 8	80	

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED
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	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1900 LAUDERDALE DRIVE RICHMOND, VA 23238	,
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F 880	by staff involved in di §483.80(a)(4) A syste identified under the facorrective actions take §483.80(e) Linens. Personnel must hand transport linens so as infection. §483.80(f) Annual re The facility will conduling a line of the facility of the facility of the facility staff failed control practices and (personal protective of the facility, on the facility, on the facility, on the facility of the facil	the disease; and a procedures to be followed arect resident contact. The for recording incidents acility's IPCP and the sen by the facility. The foreign process, and a set to prevent the spread of and prevention and a set to prevent to a set t	F8	Disclaimer: This Plan of Correction submitted under Federal and State regulations and state application to term care providers. This Plan of Correction does not constitute an admission of liability on the part of facility and such liability is hereby of The submission of this plan does not constitute agreement by the facility surveyor finding or conclusions accurate, that the findings constitute deficiency, or that the scope and se regarding any of the deficiencies and correctly. Please accept this plan acceptable allegation of compliance. 1.All residents (as noted in the 256 5 resident care hallways), including affected residents identified, begand cared for with proper PPE (N95 respirators and eye protection) on	the lenied. ot that are e a everity re cited as our

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F 880	was observed to exit CNA B was not weari There was signage or Resident #1 was on Twith personal protection of the room. When as she was feeding Residery protection she sain the rooms of COVII washed it off and was B confirmed that Reside COVID infection. On 8/25/22 at 9:55 All enter the room of Reson the exterior of the TBP. CNA H was we observed to enter with protection, isolation goten back out into with gloves in her har she is supposed to wishe stated, gloves, goten when asked why she wearing those items is to get gloves. When the gloves on the cart said she didn't see the of gloves observed and top of the cart that co CNA H then put on an eye protection and re	imately 12:50 PM, CNA B the room of Resident #1. Ing any eye protection. In the door to indicate TBP and a station was set-up we equipment (PPE) outside liked, CNA B confirmed that dent #1. When asked about id she usually does wear it D Residents but "I had swaiting for it to dry". CNA ident #1 has an active M, CNA H was observed to sident #20, who had signage room that they were on aring a KN-95 only, she was mout putting on an N-95, eye own or gloves. CNA H The hallway a moment later Ind. When asked what PPE ear when entering the room own, and eye protection. In had entered without she stated she had gone in asked what was wrong with to outside of the room, she oose. There were two boxes and pointed out that were on intained isolation gowns. In isolation gown, gloves and entered the room. illity policies were requested.	F 880	,	for ints d d ill d ing fon tive.
	•	s submitted/provided, did not PE (personal protective		All residents have the potential to be affected by the deficient practice. All	pe

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LAKEWOO	JD WANOK		1	RICHMOND, VA 23238	
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F 880	titled, "Interim Infection Recommendations to Spread in Nursing Hodocument read, "Ma Suspected or Confirm HCP [healthcare perswith suspected or corinfection should use f protection, and a NIO equivalent or higher-leonline at: https://www.cdc.gov/cong-term-care.html#a During an end of day facility Administrator, Preventionist were man findings. They confirm wear an N-95 mask, i protection and gloves of a Resident on TBP No further information 2. The facility staff fai when providing direct facility was located in transmission and during suspense of the state of the sta	uidance in the document on Prevention and Control Prevent SARS-CoV-2 omes" was conducted. This anage Residents with ned SARS-CoV-2 Infection: connel] caring for residents offirmed SARS-CoV-2 ull PPE (gowns, gloves, eye ISH-approved N95 or evel respirator)" Accessed coronavirus/2019-ncov/hcp/lanchor_1631031561398 1/11 meeting on 8/24/22, the DON and Infection ade aware of the above med they expect staff to solation gown, eye a prior to entering the room	F 880	residents are at risk for transmission of COVID-19. All residents are being cared for using proper PPE both for substantial/hight transmission rates and for TBP this be 8/26/22. An audit of all residents vaccination status was done and all residents who were not up to date with COVID vaccination were placed on TBP this was completed by 8/29/2022. Resider TBP were discontinued after the require 10 days of isolation. All residents were tested for COVID-19/8/25/22 and 8/27/2022 and proper protocol followed based on test results (NOTE: appropriate outbreak testing we carried out per facility policy and procedure for residents and team members and the outbreak concluded 9/12/2022). Beginning 8/26/2022, the process of COVID testing all new admissions upon admission and 5 days after admission began. Any resident with a positive te	the gan set on on on
	CDC COVID Data Tra	am's entry to the facility the acker was reviewed and it located in an area with a		3. Beginning on 8/27/2022 and ongoir all team members were educated on the proper use of PPE (N95 respirators and eye protection) by the Director of Nurs (DON), Staff Development Coordinato (SDC), and other designees for both	ne d ing

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On 8/24/22 at app entrance conferen Administrator, Dire Infection Prevention they currently were required to woursing units. The protection being reached to the protection being reached to the protection being reached to the facility submit COVID transmissing facility had remain high COVID transmissing the facility was confused to th	proximately 11:30 AM, during an acce with the facility ector of Nursing (DON), and conist (IP) they identified that e in a COVID outbreak and staff wear a KN-95 mask on the ey made no mention of eye equired. Ited tracking of the community's bility rates which indicated the led in an area of substantial or mission since December 2021. Proximately 12 Noon, a tour of inducted by Surveyor B. Pursing assistants, therapy staff, g employees were all observed rooms wearing no eye of the Resident care hallways dent rooms to provide direct	F 8	counties in substantial/high and for residents who are CO On 8/26/2022 the VP of Clire-educated the DON, IP, a facility COVID testing portion testing portion of the Covid CMS guidance. The Infection Preventionist, Nursing, Interim Administration were educated on 8/28/202 CMS guidelines for COVID documents Interim Infection and Control Recommendat SARS-CoV-2 Spread in Nu and Interim Infection Preve Control Recommendations Personnel During the COVID Pandemic. Also reviewed to policies and procedures whon the CDC and CMS guidaleducation included proper of the countries of the countries of the countries are countries and procedures whon the CDC and CMS guidaleducation included proper of the countries of the countr	transmission COVID positive. nical Services and SDC on the olicy and on CDC and , Director of ttor, and SDC 22 on CDC and using the two n Prevention ions to Prevent trising Homes ntion and for HC ID-19 were facility nich are based ance. This conduction of	
the third floor: a. Employee F wa Resident wearing the staff vaccination up to date with CO b. LPN C entered wearing no eye pr date with COVID i c. CNA C was pus to their room, wea was not up to date the staff vaccination d. Employee E was	s in a room providing care to a no eye protection. According to on matrix, Employee F was not DVID immunizations. a room to provide medication otection. LPN C was not up to mmunizations. The hallway ring a Resident in the hallway ring no eye protection. CNA C with COVID immunization per on matrix.		case is identified in a team resident. On 8/26/2022 LifeSpire VP Services developed a policy PPE use in counties with substantial or High Transmission titled Use Facilities Located in Counti Substantial or High Transmis policy was adopted by facili incorporated into the 8/28/2 described above. On 8/29/2022 LifeSpire VP	of Clinical y specific to ubstantial or e of PPE in es with ussion. This ity and 2022 training	
	CORRECTION ROVIDER OR SUPPLIER OD MANOR SUMMAR' (EACH DEFICI) REGULATORY Continued From p On 8/24/22 at app entrance conferen Administrator, Dire Infection Preventic they currently wer were required to w nursing units. The protection being re The facility submit COVID transmissi facility had remain high COVID trans On 8/24/22 at app the facility was con Nurses, certified in and housekeeping entering Resident protection on all 5 and housekeeping entering Resident protection on all 5 and housekeeping entering Resident protection on all 5 and housekeeping entering Resident protection being re entering Resident protec	A95403 ROVIDER OR SUPPLIER OD MANOR SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 5 On 8/24/22 at approximately 11:30 AM, during an entrance conference with the facility Administrator, Director of Nursing (DON), and Infection Preventionist (IP) they identified that they currently were in a COVID outbreak and staff were required to wear a KN-95 mask on the nursing units. They made no mention of eye protection being required. The facility submitted tracking of the community's COVID transmissibility rates which indicated the facility had remained in an area of substantial or high COVID transmission since December 2021. On 8/24/22 at approximately 12 Noon, a tour of the facility was conducted by Surveyor B. Nurses, certified nursing assistants, therapy staff, and housekeeping employees were all observed entering Resident rooms wearing no eye protection on all 5 of the Resident care hallways and entering Resident rooms to provide direct care or be within a few feet of the Residents. The following specific observations were noted on	ROVIDER OR SUPPLIER OD MANOR SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 5 On 8/24/22 at approximately 11:30 AM, during an entrance conference with the facility Administrator, Director of Nursing (DON), and Infection Preventionist (IP) they identified that they currently were in a COVID outbreak and staff were required to wear a KN-95 mask on the nursing units. They made no mention of eye protection being required. The facility submitted tracking of the community's COVID transmissibility rates which indicated the facility had remained in an area of substantial or high COVID transmission since December 2021. On 8/24/22 at approximately 12 Noon, a tour of the facility was conducted by Surveyor B. Nurses, certified nursing assistants, therapy staff, and housekeeping employees were all observed entering Resident rooms wearing no eye protection on all 5 of the Resident care hallways and entering Resident rooms to provide direct care or be within a few feet of the Residents. The following specific observations were noted on the third floor: a. Employee F was in a room providing care to a Resident wearing no eye protection. According to the staff vaccination matrix, Employee F was not up to date with COVID immunizations. b. LPN C entered a room to provide medication wearing no eye protection. LPN C was not up to date with COVID immunizations. c. CNA C was pushing a Resident in the hallway to their room, wearing no eye protection. CNA C was not up to date with COVID immunizations. c. CNA C was pushing a Resident in the hallway to their room, wearing no eye protection. CNA C was not up to date with COVID immunization per the staff vaccination matrix. d. Employee E was ambulating a Resident in the	ROVIDER OR SUPPLIER OD MANOR SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 5 On 8/24/22 at approximately 11:30 AM, during an entrance conference with the facility Administrator, Director of Nursing (DON), and Infection Preventionist (IP) they identified that they currently were in a COVID outbreak and staff were required to wear a KN-95 mask on the rursing units. They made no mention of eye protection being required. The facility submitted tracking of the community's COVID transmissibility rates which indicated the facility had remained in an area of substantial or high COVID transmission since December 2021. On 8/24/22 at approximately 12 Noon, a tour of the facility was conducted by Surveyor B. Nurses, certified nursing assistants, therapy staff, and housekeping employees were all observed entering Resident rooms to provide direct care or be within a few feet of the Residents. The following specific observations were noted on the third floor: a. Employee F was in a room providing care to a Resident wearing no eye protection. LPN C was not up to date with COVID immunizations. b. LPN C entered a room to provide medication wearing no eye protection. LPN C was not up to date with COVID immunizations. c. CNA C was pushing a Resident in the hallway to their room, wearing no eye protection. CNA C was not up to date with COVID immunizations. d. Employee E was ambulating a Resident in the contact tracing when a near a second on the third floor: a. Employee F was in a room provide medication wearing no eye protection. LPN C was not up to date with COVID immunizations. b. LPN C entered a room to provide medication wearing no eye protection. According to the staff vaccination matrix. d. Employee E was ambulating a Resident in the contact tracing when a near a case is identified in a team resident. Con 8/28/2022 LifeSpire VP Services developed a polic incorporated into the 8/28/2 described above.	A BUILDING A STREET ADDRESS, CITY, STATE, JIP CODE 1990 LAUDEROLE BRIVE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 5 Continued From page 6 Continued From page 6 Continued From page 5 Continued From page 7 Continued From page 6 Continued From page 7 Continued From page 7 Continued From page 8 Continued From page 8 Continued From page 8 Continued From page 8 Continued From page 9 FROWDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) FROWDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) FROWDERS PLAN OF CORRECTION (EACH OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) FROWDERS PLAN OF CORRECTION (EACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) FROWDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY ON 8/26/2022 the VP of Clinical Services re-educated the DON, IP, and SDC on the facility COVID testing policy and procedure which is based on CDC and CMS guidelines for COVID using the two documents Interim Infection Prevention and Control Recommendations to Prevent SARS-COV-2 Spread in Nursing Homes and Interim Infection Prevention and Control Recommendations to Prevent SARS-COV-2 Spread in Nursing Homes and Interim Infection Prevention and Control Recommendations to Prevent SARS-COV-2 Spread in Nursing Homes and Interim Infection Prevention and Control Recommendations to Prevent SARS-COV-2 Spread in Nursing Homes and Interim Infection Prevention Control Recommendations to Prevent SARS-COV-2 Spread in Nursing Homes and Interim Infection Prevention Control Recommendations to Prevent SARS-COV-2 Spread in Nursing Homes and Interim Infect

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F 880	e. CNA D was distril Residents, setting up the meal and had now was up to date with On 8/24/22 at approfollowing specific obsecond floor: a. CNA E was distril and was wearing now b. CNA F was sitting them with no eye proceed. LPN B was admir Resident wearing now the up to date with Od. CNA B was feeding protection on. e. CNA K entered at the Resident in an extended the Resident in an extended the Resident wearing eye protection on all of the Resider were again made or rooms to provide cathey included, but wand LPN D. On 8/25/22 at 9:10 on each of the Reside E was observed in a medications and did on. Eye protection on Eye protection Eye	with COVID immunizations. buting meal trays to various p the Resident and food for deepe protection on. CNA D COVID immunizations. eximately 12:30 PM, the deservations were made on the deepervation to a deservation on. Deservations were made on the deservations were made on	F8	Based Precautions include specific for COVID-19 to in specific instructions around COVID-19. This revised predopted by facility and clinical educated. On 8/29/2022 to were educated regarding the policy. Infection Preventionist has new processes in place: "tracking all residents status and is maintaining at this log includes resident to ensure TBP are implement vaccination status is not up weekly documentation transmission rate "educate all new team proper use of PPE and CO (vaccination, testing) during employee orientation and conservice sessions. "make rounds daily to employee orientation and conservice sessions. "make rounds daily to employee orientation and conservice sessions. "contract tracing form to contact tracing is being impall positive cases (within a team member, including age 4. DON, or designee, will revaccination log, weekly documentation log,	aclude more d PPE use for olicy was ical leadership eam members his revised the following vaccination current log - esting, and ent admissions ented if COVID to to date of county members on oVID practices g new during annual ensure team properly and o show proper olemented for resident or gency staff) eview resident cumentation of d daily PPE round weeks, then months and then		

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F 880	On 8/25/22 at 9:14 Athe door of Resident door observed a the room providing treat any eye protection. On 8/25/22 at 9:25 Aconducted with LPN necessary and the pwon't transmit infection. All COVID related fareview of the policie address the use of Fequipment). The CDC guidance of Infection Prevention Recommendations of during the Coronavir Pandemic", with a resident of the part of the policie address the use of Fequipment).	AM, Surveyor B knocked on a #7 and upon opening the rapy staff member in the ment who was not wearing AM, an interview was E. When asked why PPE is surpose, LPN E said, "So you ion". acility policies were requested. The submitted provided, did not PPE (personal protective document titled, "Interim	F	380	designee, will review the new resident admission log daily for 2 weeks, the monthly for 2 months. Identified areas of concerbe corrected as appropriate and feeds provided to IP. All completed contact tracing forms wireviewed by the Administrator and VP Clinical Services for each positive CO case within a team member or resider. This will be done for each new for 2 months. Identified area of concerwill be corrected and IP re-educated. Results of all audits will be reviewed a reported at the next scheduled QAPI meeting for recommendations. Varian will be investigated and staff will be re-educated and/or counseled as indicated. 5. Date of compliance: 10/17/2022	hen 2 rn will back Il be of VID at. case rn	
	for HCP [health care HCP working in facil substantial or high tr PPE as described by goggles or a face sh sides of the face) sh patient care encount https://www.cdc.gov.nfection-control-reco	an end of day meeting, the , Director of Nursing and IP f the above referenced CDC					

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F 880	Administrator, DOI follow CDC guidan references were pound they were made observations. No further information of the facility staff (Resident #5, 6, 7, were not up-to-dat and had a COVID based precautions on 8/24/22, the list immunization status provided was revied 12 current Resider COVID immunization currently on transman active COVID in Residents, (Residents, (Residents) and 16) rooms well	roximately 9:15 AM, the facility N and IP confirmed that they ace. The above CDC guidance binted out to the facility staff de aware of Surveyor B's	F 88	<u>'</u>	
	On 8/25/22 at 9 AN with special attenti 6, 7, 9, 10, 12, 13, was still no indicat TBP. Review of the facil listing/infection rep	M, a facility tour was conducted on being made to Resident #5, 14, and 16's rooms. There ion that the Residents were on ity submitted COVID line port revealed that each of the owere not up-to-date with			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
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	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP COD 1900 LAUDERDALE DRIVE RICHMOND, VA 23238	•	
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F 880	during their contact to Resident #14 was poon 8/14/22 and 8/15/ for COVID-19 on 8/1 Residents #5, #6, and exposed to COVID betested positive for CO 8/19/22, LPN G care 16. LPN G then test after her shift on 8/15/ Resident #7 and #12/ CNA L on 8/16/22. COVID-19 on 8/19/2/ Resident #13 was call and 8/17/22. CNA B COVID-19 on 8/18/2/ Residents #9 and #1 on 8/17/22. LPN H in symptoms on 8/17/2/ COVID-19 on 8/18/2/ Residents #7, #9, #1 for by LPN F on 8/17/2/ Residents #7, #9, #1 for by LPN F on 8/17/2/ Residents #7, #9, #1 for by LPN F on 8/17/2/ Residents #7, #9, #1 for by LPN F on 8/17/2/ Residents #7, #9, #1 for by LPN F on 8/17/2/ Residents #7, #9, #1 for by LPN F on 8/17/2/ Residents #7, #9, #1 for by LPN F on 8/17/2/ Residents #7, #9, #1 for by LPN F on 8/17/2/ Residents #7, #9, #1 for by LPN F on 8/17/2/ Residents #7, #9, #1 for by LPN F on 8/17/2/ Residents #7, #9, #1 for by LPN F on 8/17/2/ Residents #7, #9, #1 for by LPN F on 8/17/2/ Residents #7, #9, #1 for by LPN F on 8/17/2/ Residents #7, #9, #1 for by LPN F on 8/17/2/ Residents #7, #9, #1 for by LPN F on 8/17/2/ Residents #7, #9, #1 for by LPN F on 8/17/2/ Residents #7, #9, #1 for by LPN F on 8/17/2/ Residents #7, #9, #1 for by LPN F on 8/17/2/ Residents #7 for By LPN F on 8/17/2/ Resident	lity had not identified this tracing. Interest of the property of the propert	F 88			
	conducted with the factor of the IP stated that not to conduct contact trought two days for possible two days for possible covid having an incomplete the conducted with the factor of the IP state of the IP	AM, an interview was acility Infection Preventionist. o one had trained her on how acing but she knew to look otential exposures due to cubation period. When the IP said, "That is when				

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		495403	B. WING			08/30/2022	
	ROVIDER OR SUPPLIER	,		STREET ADDRESS, CITY, STATE, ZIP COD 1900 LAUDERDALE DRIVE RICHMOND, VA 23238	•		
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F 880			F 88	30			
	Review of the policie address the use of P equipment).	cility policies were requested. s submitted/provided, did not PE (personal protective					
	Recommendations to Spread in Nursing Ho document read, "Ei Transmission-Based recommended for res	Precautions (quarantine) is sidents who have had meone with SARS-CoV-2 ot up to date with all					
	Contact with Someor Infection. Residents all recommended CC who have had close SARS-CoV-2 infection quarantine after their testing is negative.	who are not up to date with DVID-19 vaccine doses and contact with someone with an should be placed in exposure, even if viral HCP caring for them should gloves, eye protection, and					
	following the exposur develop symptoms. A infection is low, healt consider testing for S	Precautions after day 10 re (day 0) if they do not Although the residual risk of hcare providers could 6ARS-CoV-2 within 48 hours anned discontinuation of					

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	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP 1900 LAUDERDALE DRIVE RICHMOND, VA 23238	CODE	
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F 880	Continued From pag	e 11	F 8	380		
	following the exposure negative for SARS-C develop symptoms. To collected and tested time of planned disconstruction of planned disconstruction of planned disconstruction. Transmission-Based online at: https://www.cdc.gov/ong-term-care.html#6 CDC also provides a facility is in a COVID found in the above redocument and read, Healthcare Personne a Newly Identified SARS-ident. Because of infection among resides SARS-CoV-2 infection home-onset SARS-CoV-2 infection home-onset sarks-Coshould be evaluated outbreakResidents date with all recomm doses: These residents shout their rooms, even if to for by HCP using an respirator, eye protects in the planned of the same planned as described that covers the gloves and gown. The group activities. Close managed as described that sarks-CoV-2 Interest in the sar	Precautions after day 7 re (day 0) if a viral test is oV-2 and they do not The specimen should be within 48 hours before the ontinuation of Precautions" Accessed coronavirus/2019-ncov/hcp/l anchor_1631031561398 1/11 dditional guidance when the outbreak. This guidance is eferenced guidance "New Infection in el or Residents: Respond to ARS-CoV-2-infected HCP or of the risk of unrecognized dents, a single new case of on in any HCP or a nursing eoV-2 infection in a resident as a potential s and HCP who are not up to ended COVID-19 vaccine uld generally be restricted to esting is negative, and cared N95 or higher-level ction (goggles or a face e front and sides of the face), ey should not participate in se contacts, if known, should ribed in Section: Manage Close Contact with Someone				

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F 883 SS=E	were given a copy of guidance document. On 8/26/22 at approx Administrator, DON a follow CDC guidance references were point and they were made a observations. No further information Influenza and Pneum CFR(s): 483.80(d)(1) influenza immunizations §483.80(d)(1) Influenza immunizations (i) Before offering the each resident or the receives education repotential side effects (ii) Each resident is of immunization Octobe annually, unless the incontraindicated or the immunized during this (iii) The resident or the has the opportunity to (iv)The resident's med documentation that in following: (A) That the resident was provided education and potential side effects of the side	Director of Nursing and IP the above referenced CDC imately 9:15 AM, the facility and IP confirmed that they The above CDC guidance ted out to the facility staff aware of Surveyor B's a was provided. accoccal Immunizations (2) and pneumococcal za. The facility must develop tes to ensure that- influenza immunization, esident's representative garding the benefits and of the immunization; ffered an influenza of through March 31 mmunization is medically the resident has already been to time period; the resident's representative to refuse immunization; and dical record includes and i		380	DEFICIENCY)		10/17/22
	immunization; and	either received the influenza					

PRINTED: 01/19/2023 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

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F 883	immunization due to refusal. §483.80(d)(2) Pneum must develop policies that- (i) Before offering the immunization, each rerepresentative receive benefits and potential immunization; (ii) Each resident is orimmunization, unless medically contraindical ready been immunization already been immunization that infollowing: (iii) The resident or the has the opportunity to (iv) The resident or the hast he opportunity to (iv) The resident infollowing: (A) That the resident was provided education and potential side effection immunization; and (B) That the resident pneumococcal immunitation or rethis REQUIREMENT by: Based on staff intervive review, and clinical refailed to implement the	ococcal disease. The facility and procedures to ensure pneumococcal esident or the resident's es education regarding the side effects of the esident's representative or resident's representative or resident's representative or regarding the benefits est of pneumococcal includes inc	F	383	1. Residents #2 was offered the pneumonia vaccine on 9/21/2022 and education was mailed to the RR on 9/22/2022. Resident #4 was discharge on 9/3/2022. Residents #6 was	d	
	immunizations to 3 R	esidents (Resident #2, #3, of 5 Residents reviewed for			discharged on 8/26/2022. All residents will be educated on and		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	•		
LAKEWO	OD MANOR			1900 LAUDERDALE DRIVE			
LAKEWO	UD MANOR			RICHMOND, VA 23238			
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F 883	Continued From pag	e 14	F 88	33			
	The findings included	1:		offered an influenza vaccine facility⊡s flu vaccination clinic.	during the		
	On 8/25/22, clinical re						
		mpled Residents in the		2. All residents have the potential			
		ction Preventionist (IP). The		affected by the deficient prac	ctice. An		
	immunizations for flu	following with regard to		audit of all residents□ pneumococcal vaccination s	tatus will bo		
	IIIIIIIuiiizalions ioi iiu	and priedmonia.		done by the DON or designe			
	1. Resident #2 had b	een admitted to the facility		resident found to have not be			
	on 6/7/22. On the imi	•		and offered the pneumococo			
	electronic health reco	ord (EHR) no information		will be educated and offered			
		monia vaccination status was					
	found. The Infection			All residents will be educated			
	_	al record and indicated there		offered an influenza vaccine	-		
	was no information a	vallable.		facility⊡s flu vaccination clin	IC.		
	2. Resident #3 had b	een admitted to the facility		3. Facility policies titled Vaco	cine 🗆		
		viewed the clinical record of		Pneumococcal Vaccine and			
		ed no information was		Vaccine Policy were reviewe			
		esident #3's immunization		facility Infection Preventionis			
	status with regard to	ilu or pneumonia.		9/16/2022 by the Administra Clinical Services.	tor and VP of		
	3. Resident #6 had b	een admitted to the facility					
	on 8/11/22. Review o	of the clinical record for		IP, or designee, will re-educate	ate nurses on		
	Resident #6 revealed			offering the flu and pneumod			
		Resident #6's vaccination		vaccines to all newly admitte			
	status for flu or pneu	monia.		education on the benefits of			
	Additionally there we	as no svidence that		vaccination and document a	• •		
	Additionally, there wa	d #6, were educated or		the resident s medical reco			
	offered vaccination for			applicable.	ieciii lation ii		
	The Infection Preven	tionist stated that it is the		4. IP, or designee, will audit	the medical		
		admitting nurse to document		charts of all new residents of	•	 	
		and offer immunizations		basis for the education, offer		 	
	upon admission.			administration and documen			
	During the above inte	erview with the IP accessed		flu and pneumococcal vaccin declination if applicable). The			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED				
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F 883	the EHR for Resident observed and confirm had no data recorded remainder of the recono information for the that no information for the that no information was had been educated o immunizations. On 8/25/22 at 10:37 A conducted with the fa Preventionist (IP). The important for the immedocumented?" The II their immunizations we should be the doctor and other primmunization status of "Yes". When asked we for that information, the immunization status of	s #2, #3 and #6. She led the immunization tab . She reviewed the rd and confirmed there was missing immunizations and as available to indicate they n or offered the AM, an interview was cility's Infection le IP was asked, "Why is it unization status to be led stated, "We should know letus, if they don't have the lould offer it". When asked if croviders should know the lef Residents, the IP said, where the doctor would look lef IP said, "In the chart". Inview, the IP was asked if lus of a Resident affects the lot othem, she said, "Yes". Ipolicy titled, "Vaccine- lef" was conducted. This lor to or upon admission, left was defended in the resident has left the vaccine series within left in the resident has left the vaccine series within left in the resident has left the vaccine series within left in the resident has left the vaccine of the resident h	F8	883	audit will occur for 4 weeks, then twice month for two months, then quarterly for two quarters. Identified areas of conce will be corrected as appropriate and feedback provided to staff nurses. Results of all audits will be reviewed ar reported at the next scheduled QAPI meeting for recommendations. Variance will be investigated and staff will be re-educated and/or counseled as indicated. 5. Date of compliance: 10/17/2022	or rn nd	

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F 883	was reviewed. This part of the except those with a previous severe react Director of Nursing of coordinating the admits and except those with a previous severe react Director of Nursing of coordinating the admits and explain vaccinationsProce current educations in residents, and explain responsible party will before any vaccine is refusal will become a permanent medical will be obtained prior vaccine. 4. Document the resident's medical of vaccination given, name and title of the the vaccination."	ed, "Influenza Vaccine Policy" colicy was noted to read, " co be offered vaccination, history of egg allergy, ction to vaccination 3. The or designee is responsible for hinistration of dure: 1. Prior to vaccination, haterials will be offered to ined as necessary by the	F 88:	3		
F 885 SS=C	CFR(s): 483.80(g)(3 §483.80(g) COVID-1 must— §483.80(g)(3) Inform	e,Representatives&Families)(i)-(iii) 9 reporting. The facility	F 88	5	10/17/22	

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F 885	Continued From pag		F 8	385		
	the occurrence of eit infection of COVID-1 or staff with new-ons occurring within 72 h information must—	the next calendar day following ther a single confirmed 19, or three or more residents set of respiratory symptoms nours of each other. This				
	(ii) Include information implemented to prevent transmission, including facility will be altered (iii) Include any cump their representatives or by 5 p.m. the next subsequent occurrence confirmed infection of whenever three or many onset of respiration 72 hours of each other transmissions.	ulative updates for residents, s, and families at least weekly t calendar day following the nce of either: each time a of COVID-19 is identified, or nore residents or staff with tory symptoms occur within				
	by: Based on Resident interviews, and facilif facility staff failed to when new cases of	and family interviews, staff ty documentation review, the notify Residents and families COVID-19 were identified in all 73 Residents residing in		1. Resident □s #2, #4, #6, were noted as not having on file for COVID-19 repor #4 was discharged on 9/3/#6 was discharged on 8/2€ Families of residents 2, 8 a contacted via phone for Coreporting.	email addresses ting. Resident /2022. Resident 6/2022. and 15 are to be	
	and family notification outbreaks and mitigation implemented prior to On 8/24/22 at 11:30 and family notification	no evidence of any Resident ons of the facility's COVID ating strategies being the current outbreak. A.M., evidence of Resident ons of COVID cases and the on for the last 6 months,		2. An audit was conducted residents on 9/15/22 by Adnewly admitted residents shad email addresses in the addresses were added to distribution list. The list will when there are new admissactivities Director or designation.	dministrator and since 8/30/22 eir records and the email ill be updated ssions by the	

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F 885	Continued From page	e 18	F 88	5		
	February-August, 202 On 8/24/22 at 3:00 Piclerk, provided Surve 8/18/22, 8/19/22, and she had emailed to R of the email list she ureviewed and identific facility had no email a Residents with no embut was not limited to #15, which were part asked if she placed a she stated, "No". Emhad made any notification in the said "No". On 8/24/22 and 8/25/health record (EHR) for the said she stated in the said she stated in the said she stated in the said "No".			residents who do not have an en address on file will be called by Activities Director or designee. resident representative (RR) do have an email address to provid copy of notifications will be maile and a phone call made. All residents have the potential traffected by the deficient practices.	the If the es not le, then a ed to RR to be e. The cluded on vere and via adate. by the to nursing nts and esses via	
	the clinical record of the being notified of the find	the Resident or families accilities COVID outbreak. imately 1:00 PM, an acted with the spouse of go this interview, the spouse is made aware of COVID aty. The spouse of Resident down and an email last week." The had received any to last week and she said, and interim Administrator,		electronic medical record. For all new cases of COVID-19 team member or resident, a notification/phone call will be progresidents and residents response representatives. The notification include information regarding the case/outbreak (no personally ide information), mitigating strategie implemented to prevent or reduct of transmission (including if nor operations of the facility will be fand cumulative updates at least by 5 p.m. the next calendar day the subsequent occurrence of eitime a confirmed infection of CO identified or whenever three or residents or staff with new onse	within a ovided to nsible n will e positive entifiable es being ce the risk mal followed), weekly or following ither: each oVID-19 is more	

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NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	•	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
LAKEWO	OD MANOD			1900 LAUDERDALE DRIVE			
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F 885	progress notes dated attempted to call Resemail address on file On 8/26/22 at 9:55 A conducted with Residuho was at the beds some confusion and The daughter reported COVID verbally by staked if this community. When asked if shwriting, she stated, "I Review of the COVID facility had a COVID in May and again stated, June, July, and Aug., for COVID-19. The file	the DON provided copies of 8/25/22, where she sident families who had no	F 88	<u> </u>	inistrator, or for ensuring nd provided. dit resident OVID-19 ting the I addresses eks, then and entified area nd esignee, will be do by the 30 days. If be viewed and di QAPI so Variances		
	Testing- Routine, Syr (Revised 3/14/22)", v read, "5. Residents members will be noti and advised as to the taking to mitigate the Communities will ma communication with and families for upda On 8/26/2022, the into f Nursing, and Infections	policy titled, "COVID-19 mptomatic and Outbreak, vas conducted. This policy s, family members and team fied of the outbreak promptly e measures the community is spread of infection. 6. intain frequent, ongoing team members, residents tes and facility actions" terim administrator, Director tion Preventionist, were bove findings and that no		re-educated and/or counseled indicated. 5. Date of Compliance: Octob			

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F 885	Continued From page additional information No further information end of survey.		F	885			
F 886 SS=F	COVID-19 Testing-Re CFR(s): 483.80 (h)(1 §483.80 (h) COVID-1 must test residents a individuals providing and volunteers, for C for all residents and f individuals providing and volunteers, the L §483.80 (h)((1) Cond parameters set forth but not limited to: (i) Testing frequency; (ii) The identification this paragraph diagne COVID-19 in the facil (iii) The identification this paragraph with sconsistent with COVI suspected exposure (iv) The criteria for coasymptomatic individ paragraph, such as the COVID-19 in a count (v) The response time (vi) Other factors special testing the covid testing testing testing the covid testing tes	9 Testing. The LTC facility and facility staff, including services under arrangement OVID-19. At a minimum, acility staff, including services under arrangement TC facility must: uct testing based on by the Secretary, including of any individual specified in posed with ity; of any individual specified in symptoms D-19 or with known or to COVID-19; anducting testing of uals specified in this ne positivity rate of y; et for test results; and cified by the Secretary that went the	F	886			10/17/22

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	ROVIDER OR SUPPLIER		•	19	TREET ADDRESS, CITY, STATE, ZIP CODE 900 LAUDERDALE DRIVE ICHMOND, VA 23238		
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F 886	(i) Document that test results of each staff to (ii) Document in the rowas offered, complete to the resident's testine each test. §483.80 (h)((4) Upon individual specified in symptoms consistent with COVII for COVID-19, take attransmission of COVI §483.80 (h)((5) Have residents and staff, in services under arranger fuse testing or are used to the contact state and local health department of the Requirement of the facility staff failed testing in accordance Disease Control) and & Medicaid Services)	ach instance of testing: ting was completed and the est; and esident records that testing ed (as appropriate ng status), and the results of the identification of an this paragraph with D-19, or who tests positive ctions to prevent the D-19. procedures for addressing icluding individuals providing gement and volunteers, who unable to be tested. In necessary, such as in esting supply shortages, irtments to assist in testing ning testing supplies or is. is not met as evidenced n, staff interview, clinical cility documentation review, to conduct COVID-19 with CDC (Centers for CMS (Centers for Medicare guidance/requirements agency staff and Staff #2,	F	886	1. All residents were tested for COVID on 8/25/22, 8/27/22, 8/31/22, and 9/7/2 The results of their COVID-19 test were documented in the resident selectron medical record. Any residents testing positive for COVID-19 had transmission-based precautions implemented based on the facilities policies and procedures and CMS	2. e	

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		\ /	(X3) DATE SURVEY COMPLETED	
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NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO		130/2022	
				1900 LAUDERDALE DRIVE			
LAKEWO	OD MANOR			RICHMOND, VA 23238			
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F 886	Continued From pa	ge 22	F 88	86			
	The findings include	ed:		guidelines.			
	outbreak COVID-19	aff who worked in the facility		All staff members, including began being tested for COV CMS guidance. Twice a webegan the week of 8/29/2025 continues.	ID-19 per ek testing		
	schedule and staff	or B used the as-worked vaccination matrix to select a was reviewed for COVID esting.		Outbreak status concluded 9 Staff continue to be tested to due to the high county tra and will continue while the c	wice weekly nsmission rate		
	met with the facility IP confirmed she w records of all of the the name of Staff # dates of COVID tes have her, I don't thi	oximately 10 AM, Surveyor B 's infection preventionist. The as the person that maintained staff testing. She was given 1 and asked to provide the sting. The IP stated, "I don't nk she works here". The IP		transmission rate remains high. All testing is being recorded member testing log and a re log by the IP.	substantial or on a team sident testing		
		n agency staff person, and the do not conduct COVID-19 taff unless they are		All residents have the potential affected by the deficient practice.			
	symptomatic. The IP was then given	ven the name of Staff #7. The re her". She was told she was		Resident testing and staff moves started and carried out above.			
	another agency sta	ff member and the IP said, "If omatic, they screen when they aren't symptomatic we don't		Since 8/29/2022 all new adn been COVID tested upon ad days after admission. Appro transmission-based precauti implemented based on facili	lmission and 5 priate ions were		
	Human Resources Employee H was gi Employee H confirr	AM, Surveyor B met with the Director, Employee H. ven Staff #1's name and ned that Employee H had		Residents will have appropri orders to test for COVID-19.	iate physician		
		mployee H confirmed that y and worked 6/29/22, 7/9/22,		3. On 8/26/2022 the VP of C Services re-educated the DC SDC on the facility COVID to and procedure which is base	ON, IP, and esting policy		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		495403	B. WING		08/30/2022
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1900 LAUDERDALE DRIVE RICHMOND, VA 23238	,
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	OULD BE COMPLETION
F 886	confirmed that she COVID immunization identified that Employee G, the set was given the name asked to obtain her information. Employee G and #7 had receive series, but were not up-to-date to routine testing. Employee G provide agency staff that had the months of June worked at the facility Infection Presented in the strength of the agency staff were untinely and she had testing of the agency staff of the agency staff were untinely and she had testing of the agency staff were untinely and she had testing of the agency staff were untinely and she had testing of the agency staff were untinely and she had testing of the agency staff of the agency staff were untinely and she had testing of the agency staff were untinely and she had testing of the agency staff were untinely and she had testing of the agency staff were staff of the agency staff of the agency staff were staff of the agency staff of the agency staff of the agency staff of the agency staff were staff of the agency staff	R Director looked and didn't maintain record of the on status for agency staff, she loyee G kept that information. afternoon, Surveyor B met with cheduling coordinator. She e of Staff #1 and #7 and was COVID vaccination by Ed Italian with cheduling coordinator. She e of Staff #1 and #7 and was COVID vaccination by Ed Italian with E	F 886	and CMS guidance. The Infection Preventionist, Direct Nursing, Interim Administrator, an were educated on August 28, 202 CDC and CMS guidelines for COV using the two documents Interim Prevention and Control Recommendations to Prevent SARS-CoV-2 Spread in Nursing Hand Interim Infection Prevention at Control Recommendations for HC Personnel During the COVID-19 Pandemic. Also reviewed were fapolicies and procedures which are on the CDC and CMS guidance. education included proper conductonact tracing when a new COVI case is identified in a team membresident. The Infection Preventionist or deswill educate admissions and nursi the criteria for testing newly admitresidents and on appropriate documentation in the resident since testing results, and RR notification. Human Resources Director will mocurrent team member vaccination log and will include all agency stated in the colonical leading possible to clinical leading possible possible to clinical leading possible to clinical leading possible possible to clinical leading possible possible possible to clinical leading possible p	nd SDC 22 on VID Infection Homes and C acility e based This ction of ID-19 per or signee ing on tted medical er to test, n. maintain a n status off. This through
	Services, CMS. The team member testing	ment of Health & Human nis applies to resident and ng, including providing angement and volunteers for		transmission rate weekly on the w	veekly

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495403	B. WING _			08/30/2022	
NAME OF P	ROVIDER OR SUPPLIER	1		ST	TREET ADDRESS, CITY, STATE, ZIP CODE	,	<u> </u>
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F 886	1) Routine testing of up-to-date, is based the community- using transmission level for member testing frequency guidelinesIII. Who included in the testing consultants, contract caregivers who proveresidents on behalf of training programs or institutions" The CDC document Prevention and Context Prevention of asymptom Personnel] should be homes, HCP who arrecommended COVI expanded screening community transmission and transmission are testing of asymptomic community transmission and context prevention and context pre	Testing of Team Members: team members, who are not on the extent of the virus in g the most recent community r the trigger for team uency per CMS should be tested: Individuals g include employees, ors, volunteers, and de care and services to of the facility, and students in from affiliated academic entitled, "Interim Infection rol Recommendations to 2 Spread in Nursing Homes", 2022, page 4, subheading, d, "Expanded screening atic HCP [Healthcare e as follows:In nursing e not up to date with all D-19 doses should continue testing based on the level of sion as follows: In nursing unties with substantial to high sion, these HCP should have eekIf these HCP work	F	386	IP will maintain resident testing log dail Monday through Friday when resident outbreak testing is being conducted. IP will maintain team member testing log daily Monday through Friday. 4. The Infection Preventionist or design will audit resident medical records for COVID-19 testing per facility policy once per week for 4 weeks, then twice a most for two months and quarterly for two quarters. Identified areas of concern where addressed and responsible staff re-educated. DON, or designee, will review resident testing log, weekly documentation of transmission rate, and team member testing log week once a week for 4 week then twice a month for two months and then quarterly for two quarters. DON, of designee, will review the new resident admission log daily for 2 weeks, then weekly for 2 weeks, then monthly for 2 months. Identified areas of concern will be corrected as appropriate and feedbarents.	og nee ce nth vill	
		facilities, they should ideally 3 days before their shift the shift)".			reported at the next scheduled QAPI	nd	
	Medicaid Services) Medicaid Services) Medicaid Services) Tevision date 3/10/20 "Documentation of Tevision of Tevision Services"	esting, page 10, item 3 read, ting, document the facility's			meeting for recommendations. Variand will be investigated and staff will be re-educated and/or counseled as indicated. 5. Date of compliance: 10/17/2022	ces	
	1	g frequency indicated (e.g.,			,		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
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F 886	community transmist document the date of the staff, who are not of each test" and pain dividuals providing and volunteers, the results in a secure of the staff of the staff of the staff revealed that Staff of the	are date each level of sistent was collected. Also, so that testing was performed to up-to-date, and the results age 11, "For staff, including g services under arrangement facility must document testing manner". Tailed to conduct routine of staff who were not up to date dizations for Staff #2, #3, #6, Waccination matrix submitted #2, 6 and 8, were noted to not covid immunizations, as they booster dose. Staff #3 had emption from COVID Tor B met with the facility hist (IP) to review testing staff sample. The following his review: Sted twice weekly based as a #2 was not up to date with one and the facility was located community transmission of 2 was tested 8/5/22, and was til 8/12/22. Review of Staff	F8	86		
	from COVID immur testing occurrences	een granted an exemption nization, was reviewed for Staff #3 was tested on the ne months of June-August:				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 1900 LAUDERDALE DRIVE RICHMOND, VA 23238			
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F 886	6/9/22, 6/28/22, 6/2 8/11/22, 8/12/22, 8/ Staff #3's timecard worked 17 shifts, in August, Staff #3 wo Staff #6 was tested again until 6/29/22. revealed she worke frame. When the Intervelope she worke frame when the Intervelope she worke frame when the Intervelope she worke frame. When the Intervelope she worke frame when the Intervelope she worke frame when the Intervelope she worke frame. When the Intervelope she worke frame when the facilit community transmis revealed they had revealed they	9/22, 7/27/22, 7/29/22, 18/22, and 8/19/22. Review of revealed in June, she had July she worked 21 shifts. In rked 15 shifts. 6/9/22, and was not tested Review of Staff #6's timecard d 13 shifts during this time fection Preventionist was during the time frame from "That's all I have for her". ing for July. When asked, the w why I don't have any July why it's missing". y submitted tracking of the saibility rate of COVID emained at a high level for all ugust. y policy titled, "COVID-19 ymptomatic, and Outbreak" of 3/14/22, was conducted. 1) Routine testing of team not up-to-date, is based on us in the community- using the inity transmission level for the mber testing frequency per Table 2: Routine testing COVID-19 Level of ission: High (red), Minimum is staff who are not up-to-date:	F 88			
	Medicaid Services) revision date 3/10/2	Memo Ref: QSO-20-38-NH, 2022, subheading				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI	TIPLE CONSTRUCTION NG		ATE SURVEY DMPLETED
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F 886	"For staff routine tee level of community corresponding testine every week), and the community transmist document the date (for staff, who are not of each test" and paindividuals providing and volunteers, the results in a secure of the CDC document Prevention and Corprevent SARS-Covupdated February 2 "Testing", item 7, retesting of asymptom Personnel] should be homes, HCP who a recommended COvexpanded screening community transmist homes located in community transmist a viral test twice a winfrequently at these bete tested within the (including the day of the CON 8/25/22, Survey Infection Prevention	Testing, page 10, item 3 read, sting, document the facility's transmission, the ag frequency indicated (e.g., e date each level of ssion was collected. Also, s) that testing was performed at up-to-date, and the results age 11, "For staff, including g services under arrangement facility must document testing manner". It entitled, "Interim Infection atrol Recommendations to -2 Spread in Nursing Homes", 2022, page 4, subheading, ad, "Expanded screening matic HCP [Healthcare are as follows:In nursing are not up to date with all "ID-19 doses should continue green as follows: In nursing the sion as follows: In nursing the sion, these HCP should have be facilities, they should ideally 3 days before their shift fithe shift)".	F	386		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION	, ,	(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 1900 LAUDERDALE DRIVE RICHMOND, VA 23238	•	0.00.2022	
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F 886	find COVID-19 testin clinical record. The I listing of the Resident testing book that only documented in the clinical charts. Review of the testing revealed a Resident test date with a minu name to indicate they no indication as to will and no testing inform clinical charts. The facility policy title Routine, Symptomati revision date of 3/14/policy read, " VII. DC. Resident testing residents' medical re The CMS (Centers for Services) issued QS date of 03/10/2022. instance of testing records that testing wappropriate to the results of each testing of Residents was exposed to COVID-1. Review of the testing	know she was not able to g occurrences within the P said that she keeps a ts who were tested in her positive results are inical charts. logs the IP had available listing that would indicate the sign beside a Resident's petited the testing lation was noted in the sed, "COVID-19 Testing-c, and Outbreak" with a 22, was reviewed. This locumentation of Testing: will be documented in the cord" or Medicare and Medicaid O-20-38-NH with a revision at read, " (3) For each (ii) Document in the resident was offered, completed (as sident's testing status), and st"	F 88	36			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
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F 886	Continued From page	e 29	F 88	36			
F 886	the Residents on the was a census sheet of the third floor but no being conducted. Review of the COVID numerous staff had to in August. Review of revealed the following. Residents on the sector were exposed on 8/1 as the only nurse for positive for COVID 19. Residents on the sector additional possible explained by the sector of the sector additional exposure of worked 8/16/22, and on 8/18/22. Residents on the sector additional exposure of worked 8/16/22, and on 8/18/22. Residents on the thirm 8/14/22 and 8/15/22, days and then tested 8/16/22. Residents on the thirm 8/17/22, by CNA L, we then tested positive for the sector of the sec	2nd floor third hall. There of the Residents residing on indication of any testing D line listing revealed ested positive for COVID-19 if the assignment sheets g: cond floor halls 1, 2 and 3 7/22, by LPN F who worked the second floor and tested	F 88	36			
		n 8/18/22 and 8/19/22, by ositive for COVID-19 on					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
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F 886	preventionist (IP), the tracing is conducted her on how to condusaid, "No one, but I I because of the incut When asked to definindicated this is whe infectious and not be to show evidence of above noted staff me F, LPN G, and LPN assignment sheet". back to the two days positive she said sheet the two days positive she said sheet to the two days positive sheet to the two days pos	e IP confirmed that contact . When asked who trained of contact tracing, the IP know to go back 2 days pation period of COVID". The incubation period, she in a person could be exymptomatic. When asked ther contact tracing for the embers, CNA L, CNA M, LPN H, she said, "I look at the When asked if she went apprior to the staff testing endid not. The incubation period, she in a person could be exymptomatic. When asked ther contact tracing for the embers, CNA L, CNA M, LPN H, she said, "I look at the When asked if she went apprior to the staff testing endid not. The incurrence of th	F8	86		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
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	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP CODE 1900 LAUDERDALE DRIVE RICHMOND, VA 23238	•	
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F 886	Continued From pag	ne 31	F8	86		
	COVID-19 infection staff and residents, is status, should be test and residents that the retested every 3 day identifies no new cast among staff or resident 14 days since the machines section Normal symptomatic resident suspected exposure SARS-CoV-2"	If a single new case of in any staff or residents, all regardless of vaccination sted immediately, and all staff sted negative should be is to 7 days until testing sees of COVID-19 infection ents for a period of at least cost recent positive result. See ing Guidelines for Nursing adiagnostic testing of ents without known or to an individual infected with				
	Prevention and Comprevent SARS-CoV-updated February 2, "Manage Resident Manage Residents v Someone with SARS who are not up to da COVID-19 vaccine of close contact with so infection should be putheir exposure, even HCP caring for them gloves, eye protection respirator). Resident Transmission-Based following the exposure develop symptoms. Infection is low, heal consider testing for Stefore the time of plants.	trol Recommendations to 2 Spread in Nursing Homes", 2022, was reviewed. It read, is with Close Contact: who had Close Contact with 3-CoV-2 Infection. Residents at the with all recommended loses and who have had be meone with SARS-CoV-2 placed in quarantine after a fi viral testing is negative. It is should use full PPE (gowns, on, and N95 or higher-level to the testing is negative. In the precautions after day 10 are (day 0) if they do not all though the residual risk of the the testing is negative. It is can be removed from the precautions after day 10 are (day 0) if they do not all though the residual risk of the the testing is negative. The providers could sarks-CoV-2 within 48 hours anned discontinuation of the precautions. Residents can				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED				
		495403	B. WING		08/30/2022	
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 1900 LAUDERDALE DRIVE RICHMOND, VA 23238			
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMPLETION	
F 886	(day 0) if a viral test and they do not despecimen should be 48 hours before the discontinuation of The Precautions. Residents who are recommended COV residents who have infection in the prioducint of the prioducing the contact with some contact	ay 7 following the exposure t is negative for SARS-CoV-2 velop symptoms. The e collected and tested within e time of planned Transmission-Based up to date with all vID-19 vaccine doses and e recovered from SARS-CoV-2 r 90 days who have had close one with SARS-CoV-2 infection e control and be tested as	F 88	6		
	order prior to conduct Resident, (Resident Resident, (Resident Review of the clinic revealed the follow AM, "Resident note confusion. Resident [medical doctor], note [medical doctor], note [responsible party] On 8/25/22 at 3:54 Infection Prevention testing. Resident # conducted and the physician order for clinical record and order, but clearly note in the physician order and order, but clearly note in the physician order for clinical record and order, but clearly note in the physician order and order, but clearly note in the physician order and order.	cal chart of Resident #1 ing note dated 8/18/22 at 9:50 ed very lethargic and increased int tested + for COVID-19, MD ursing supervisor & RP				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		495403	B. WING			08/	30/2022
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F 886	Routine, Symptomatic revision date of 3/14/2 policy read, "Reside physician/practitioner acceptable) will be obta administration of test. Review of the Center Services (CMS) Mem DATE: August 26, 20 was conducted. This "Conducting Testing CFR § 483.50(a)(2)(i) order from a physicial practitioner, or clinical accordance with State practice laws to proviservices for a resident testing (see F773). Through the use of physicial forms and the second policy" 6. The facility staff fail new admissions, for 2 #4 and #5) reviewed On 8/25/22 at 3:54 Pl Infection Preventionist testing. The IP confirmed Resident of the facility on 6/24/2 more acceptable of the facility of facility on 6/24/2 more acceptable of the facility of facility of	d, "COVID-19 Testing- c, and Outbreak" with a 22, was reviewed. This ents: 1) A order (standing order is btained prior to" s for Medicare and Medicaid o titled, "QSO-20-38-NH 20, REVISED 04/27/2021", memo stated, g: In accordance with 42 h, the facility must obtain an n, physician assistant, nurse I nurse specialist in e law, including scope of de or obtain laboratory t, which includes COVID-19 nis may be accomplished ysician approved policies), or other means as practice laws and facility	F	386			

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII		STRUCTION		E SURVEY PLETED
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F 886	Continued From pag	ge 34	F 8	886			
	Resident #4 had no 6/24/22, to the date	testing revealed that testing occurrences from of review, 8/25/22. mitted to the facility on					
		ested on 8/17/22, and had no					
		with the IP, she stated tested upon admission and ter.					
	Routine, Symptoma revision date of 3/14 policy references re QSO-20-38 and QS "Communities will fo "Interim Infection Pr Recommendations to During the Coronavi for residents3) b)	led, "COVID-19 Testing- tic, and Outbreak" with a k/22, was reviewed. This gulatory references from O-20-29. It also read, follow the CDC guidance evention and Control for Healthcare Personnel frus Disease 2019 Pandemic" Communities will follow nes based on the outcome of"					
	Prevention and Con Prevent SARS-CoV updated February 2 "Testing", item 3, rea and residents who h (greater than) 24 ho status, should have SARS-CoV2 infection	entitled, "Interim Infection trol Recommendations to -2 Spread in Nursing Homes", 2022, page 4, subheading, ad, "Newly-admitted residents have left the facility for urs, regardless of vaccination a series of two viral tests for on; immediately and, if days after their admission".					
	of day meetings, the	in on 8/26/22, during the end e facility Administrator, and Infection Preventionist					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495403	B. WING			08/	30/2022
	ROVIDER OR SUPPLIER		•	1	TREET ADDRESS, CITY, STATE, ZIP CODE 900 LAUDERDALE DRIVE RICHMOND, VA 23238		
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F 886	Continued From page were made aware of COVID testing finding No further information	all of the above noted gs.	F	886			
F 887 SS=E	COVID-19 Immunization CFR(s): 483.80(d)(3) §483.80(d) (3) COVID LTC facility must developed and procedures to endition (i) When COVID-19 voluments offered the COVID-19 immunization is medial resident or staff memiamunized; (ii) Before offering COMEMBERS are provided regarding the benefits effects associated with (iii) Before offering COMEMBERS and potential side the COVID-19 vaccination (iv) In situations where requires multiple dose resident representation provided with current additional doses, included the composition of the composition of the opportunity to accovaccine, and change	cion (i)-(vii) D-19 immunizations. The elop and implement policies sure all the following: accine is available to the and staff member -19 vaccine unless the cally contraindicated or the ber has already been DVID-19 vaccine, all staff d with education and risks and potential side the the vaccine; DVID-19 vaccine, each not representative garding the benefits and the effects associated with es; the resident, we, or staff member is information regarding those uding any changes in the potential side effects DVID-19 vaccine, before and aministration of any	F	887			10/17/22

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F 887	requirements of 483 under IFC-5 [CMS-3 and (vi) The resident's m documentation that it the following: (A) That the resident was provided educate benefits and potential COVID-19 vaccine; (B) Each dose of CO to the resident; or (C) If the resident did vaccine due to medicontraindications or (vii) The facility main to staff COVID-19 vaccined at a minimum (A) That staff were pure the benefits and potential sacciated with COV (B) Staff were offere information on obtain (C) The COVID-19 vaccined information and Healthcare Safety Northis REQUIREMENTH by: Based on staff interreview, and clinical resident #2, 3, and Residents reviewed facility staff failed to who are eligible for the covince of the staff failed to who are eligible for the covince of the staff failed to who are eligible for the covince of the staff failed to who are eligible for the covince of the staff failed to who are eligible for the covince of the staff failed to who are eligible for the covince of the staff failed to who are eligible for the covince of the staff failed to who are eligible for the covince of the staff failed to who are eligible for the covince of the staff failed to who are eligible for the covince of the staff failed to who are eligible for the covince of the staff failed to who are eligible for the covince of the staff failed to who are eligible for the covince of the staff failed to who are eligible for the covince of the staff failed to who are eligible for the covince of the staff failed to who are eligible for the covince of the staff failed to who are eligible for the covince of the staff failed to who are eligible for the covince of the covince of the covince of the staff failed to who are eligible for the covince of the covinc	a3415-IFC], must comply with .80(d)(3)(v) that apply to staff 414-IFC] edical record includes ndicates, at a minimum, to resident representative tion regarding the al risks associated with and .0VID-19 vaccine administered do not receive the COVID-19 cal refusal; and stains documentation related accination that tim, the following: provided education regarding ential risks .7ID-19 vaccine; do the COVID-19 vaccine; do the COVID-19 vaccine; and vaccine status of staff and as indicated by the Centers for I Prevention's National etwork (NHSN). To is not met as evidenced view, facility documentation record review, the facility staff covID immunization status imunizations to 3 Residents	F 8	1. Resident #2 will have her Covaccination status verified. The COVID-19 vaccine (primary set updated booster) will be offered has not received the vaccine. Resident #3 was discharged or 8/22/2022. Resident #6 was dion 8/26/2022.	e ries or d if resident		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		CONSTRUCTION	(X3	B) DATE SURVEY COMPLETED
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F 887	Continued From pag	e 37	F 8	387			
	#2, 6, and 8) in a sar	nple of 14 staff.					
	The findings included	d:			Staff# 2, 6, and 8 were vaccinated b included on the team member vaccilog. Staff #2 was vaccinated on 1/1-	nation	
	COVID immunization immunizations to 3 F	iled to failed to document in status and failed to offer Residents (Resident #2, 3, of 5 Residents reviewed for			and 2/4/21, Staff #6 was vaccinated 1/14/21 and 2/4/21, and Staff #8 wa vaccinated on 2/4/21 and 2/25/21. Vaccinations for these team membe have been confirmed and these team members are now included on the team.	on s rs m	
	presence of the Infective review revealed the	mpled Residents in the ction Preventionist (IP). The following with regard to			member vaccination log maintained Human Resources Director daily Mo through Friday.	by onday	
	on 6/7/22. On the im electronic health rec with regards to COV Infection Preventioni clinical record and in information available	been admitted to the facility munization tab of the ord (EHR) no information ID immunization status. The st looked throughout the dicated there was no			2. An audit of 100% of resident recomplete will be done by the IP or designee a resident found to not be COVID-19 vaccinated will be educated and offer the primary series or declination will documented. Administration will be documented in resident record. All residents will be educated and of the updated COVID-19 bivalent boo	nd an ered be fered ster	y
	on 6/6/22. Surveyor clinical record of Resinformation was presimmunization status 1c. Resident #6 had on 8/11/22. Review of Resident #6 revealed.	been admitted to the facility B and the IP reviewed the sident #3 and noted no eent to indicate Resident #3's with regards to COVID. been admitted to the facility of the clinical record for d no information was Resident #6's vaccination			and appropriate documentation doneresidents record. Administration of updated booster will be documented appropriately. Human Resources is maintaining a member vaccination log and reconcitis log daily Monday through Friday scheduler to ensure agency staff are included and with current team memorster.	e in If the If Iteam Iteam Ites If with	
	Additionally, there we Residents #2, 3 and vaccination for COV	6, were educated or offered			3. The Vice President of Clinical set educated the Infection Preventionist Director of Human Resources on		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION		TE SURVEY
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F 887	the responsibility of document all of this immunizations upon how the Resident's and able to be repo Healthcare Safety Nooks it up in VIIS (Nooks it up in V	entionist (IP) stated that it is the admitting nurse to information and offer admission. When asked vaccination status was known red in NHSN (National Network), the IP stated she Virginia Immunization). When asked if she puts the clinical record of the ed, "No". Iterview with the IP accessed ants #2, 3 and 6. She amed the immunization tab and She reviewed the cord and confirmed there was are missing immunizations and was available to indicate they on or offered the	F	8/28/2022 regarding the COVID-19 vaccination is boosters, of all team medocumenting education or approved exemption immunization and placin personnel file as appropriate as a covid-19 vaccination and/or do appropriate appropr	status, including embers, as well as and declination, of the COVID-19 in including agency on status including agency on status ing. All new team to be COVID olicy and if not in approved to starting. Human maintain a current on status log and taff. This log will are through Friday leadership. Inist or designee staff on offering to all newly cation on the on and the including th	

F 887 Continued From page 39 isolate for 10 days if they haven't had their second booster". Review of the facility policy titled, "COVID-19 Vaccination- Federal CDC LTCF (Long Term Care Facility) Pharmacy Partnership and Independent Pharmacy Partnership, Revised 3/15/21", was conducted. This policy read, "[Company name redacted] is committed to protecting the health and safety of residents and team members and to taking necessary action to ensure the appropriate mitigation of the spread and impact of COVID-19 on residents, team members, and the general public. [Company name redacted] will offer, or arrange for the offering of, the COVID-19 vaccination to residents and team members to minimize the risk of acquiring, transmitting, or experiencing complications from COVID-19" TAG F 887 4. The IP or designee will audit residents □ medical records for offering the COVID-19 immunization to all newly admitted residents, education on the benefits and documentation in the electronic medical record of declination or administration once per week for 4 weeks, then twice a month for two months and quarterly for two quarters. Identified areas of concern will be corrected as appropriate and feedback provided to responsible staff. The Administrator or designee will audit the team member vaccination log for up to date COVID-19 immunization information or appropriate and feedback provided to responsible staff. The Administrator or designee will audit the team member vaccination log for up to date COVID-19 immunization information or approved exemption for team members and agency staff once per week for 4 weeks, then twice a month for two	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` /	1 ` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		
ANAME OF PROVIDER OR SUPPLIER LAKEWOOD MANOR (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 887 Continued From page 39 isolate for 10 days if they haven't had their second booster". Review of the facility policy titled, "COVID-19 Vaccination- Federal CDC LTCF (Long Term Care Facility) Pharmacy Partnership and Independent Pharmacy Partnership, Revised 3/15/21", was conducted. This policy read, "(Company name redacted) is committed to protecting the health and safety of residents and team members and to taking necessary action to ensure the appropriate mitigation of the spread and impact of COVID-19 on residents, team members, and the general public. [Company name redacted] will offer, or arrange for the offering of, the COVID-19 vaccination to residents and team members to minimize the risk of acquiring, transmitting, or experiencing complications from COVID-19" STREET ADDRESS, CITY, STATE, ZIP CODE 1900 LAUDERDALE DRIVE RICHMOND, VA 23238 D PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) 4. The IP or designee will audit residents — medical records for offering the COVID-19 immunization in the electronic medical record of declination or administration once per week for 4 weeks, then twice a month for two on the benefits and documentation in the electronic medical record of declination or administration once per week for 4 weeks, then twice a month for two quarters. Identified areas of concern will be corrected as appropriate and feedback provided to responsible staff. The Administrator or designee will audit the team member vaccination log for up to date COVID-19 immunization information or approved exemption fo			495403	B. WING		08/30/2022	
F 887 Continued From page 39 isolate for 10 days if they haven't had their second booster". Review of the facility policy titled, "COVID-19 Vaccination- Federal CDC LTCF (Long Term Care Facility) Pharmacy Partnership, Revised 3/15/21", was conducted. This policy read, "[Company name redacted] is committed to protecting the health and safety of residents and team members and to taking necessary action to ensure the appropriate mitigation of the spread and impact of COVID-19 on residents, team members, and the general public. [Company name redacted] will offer, or arrange for the offering of, the COVID-19 vaccination to residents and team members to minimize the risk of acquiring, transmitting, or experiencing complications from COVID-19" PREFIX TAG CROSS-REFERENCE TO THE APPROPRIATE DEFICIENCY) 4. The IP or designee will audit residents — dudit residents, education to all newly admitted residents, education on the benefits and documentation in the electronic medical records for offering the COVID-19 immunization to all newly admitted residents, education on the benefits and documentation in the electronic medical record of declination or admitted residents, education on the benefits and documentation in the electronic medical record of declination or admitted residents, education on the benefits and documentation in the electronic medical record of declination or admitted residents, education on the benefits and documentation in the electronic medical record of declination or admitted residents, education on the benefits and documentation in the electronic medical record of declination or admitted residents, education on the benefits and documentation in the electronic medical records for offering the COVID-19 immunization to all newly admitted residents, education on the benefits and documentation in the electronic medical records for offering the COVID-19 immunization to all newly admitted residents, education on the benefits and documentation in the electronic medical records for offering the COVID-19				1	1900 LAUDERDALE DRIVE	,	
isolate for 10 days if they haven't had their second booster". Review of the facility policy titled, "COVID-19 Vaccination- Federal CDC LTCF (Long Term Care Facility) Pharmacy Partnership and Independent Pharmacy Partnership, Revised 3/15/21", was conducted. This policy read, "[Company name redacted] is committed to protecting the health and safety of residents and team members and to taking necessary action to ensure the appropriate mitigation of the spread and impact of COVID-19 on residents, team members, and the general public. [Company name redacted] will offer, or arrange for the offering of, the COVID-19 vaccination to residents and team members to minimize the risk of acquiring, transmitting, or experiencing complications from COVID-19" 4. The IP or designee will audit residents □ medical records for offering the COVID-19 immunization to all newly admitted residents, education on the benefits and documentation in the electronic medical record of declination or administration once per week for 4 weeks, then twice a month for two months and quarterly for two quarters. Identified areas of concern will be corrected as appropriate and feedback provided to responsible staff. The Administrator or designee will audit residents □ medical records for offering the COVID-19 immunization to all newly admitted residents □ medical records for offering the COVID-19 immunization or admitted residents □ medical records for offering the COVID-19 immunization to all newly admitted residents □ medical records for offering the COVID-19 immunization to all newly admitted residents □ medical records for offering the COVID-19 indunitation to all newly admitted residents □ medical record of declination or administration once per week for 4 weeks, then twice a month for two months and quarterly for two quarters. Identified areas of concern will be corrected as appropriate and feedback provided to responsible staff. The Administration once per week for 4 weeks, then twice a month for two duarterly for two quarters. Identif	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF	D BE COMPLETION	
Administrator, Director of Nursing and Infection Preventionist were made aware of the above findings. No further information was provided. No further information was provided. 2. The facility staff failed to document that employees who were eligible for COVID vaccine doses were educated on the benefits of vaccination and were offered vaccination (s) for Staff #2, 6, and 8, in a sample of 14 staff. Review of the staff vaccination matrix submitted revealed that Staff #2, 6 and 8, were noted to not be up to date with COVID immunizations, as they had not received a booster dose. On 8/25/22, the facility Infection Preventionist months, and quarterly for two quarters. Identified areas of concern will be corrected as appropriate and feedback provided to HR Director. Results of all audits will be reviewed and reported at the next scheduled QAPI meeting for recommendations. Variances will be investigated and staff will be re-educated and/or counseled as indicated. 5. Date of compliance: 10/17/2022	F 887	isolate for 10 days if the second booster". Review of the facility Vaccination- Federal Facility) Pharmacy Partnershic conducted. This policy redacted] is committed and safety of resident taking necessary actimitigation of the spreador on residents, team in public. [Company na arrange for the offering vaccination to resider minimize the risk of a experiencing complication of the spreador on 8/25/22 and again Administrator, Director Preventionist were infindings. No further information 2. The facility staff fair employees who were doses were educated vaccination and were Staff #2, 6, and 8, in a Review of the staff varevealed that Staff #2 be up to date with Company in the staff was revealed that Staff #2 be up to date with Company in the staff was revealed that Staff #2 be up to date with Company in the staff was revealed that Staff #2 be up to date with Company in the staff was revealed that Staff #2 be up to date with Company in the staff was revealed that Staff #2 be up to date with Company in the staff was revealed that Staff #2 be up to date with Company in the staff was revealed that Staff #2 be up to date with Company in the staff was revealed that Staff #2 be up to date with Company in the staff was revealed that Staff #2 be up to date with Company in the staff was revealed that Staff #2 be up to date with Company in the staff was revealed that Staff #2 be up to date with Company in the staff was revealed that Staff #2 be up to date with Company in the staff was revealed that Staff #2 be up to date with Company in the staff was revealed that Staff #2 be up to date with Company in the staff was revealed that Staff #2 be up to date with Company in the staff was revealed that Staff #2 be up to date with Company in the staff was revealed that Staff #2 be up to date with Company in the staff was revealed that Staff #2 be up to date with Company in the staff was revealed that Staff #2 be up to date with Company in the staff was revealed that Staff #2 be up to date with Company in the staff was revealed that	policy titled, "COVID-19 CDC LTCF (Long Term Care artnership and Independent p, Revised 3/15/21", was by read, "[Company name and to protecting the health are and team members and to on to ensure the appropriate and impact of COVID-19 embers, and the general arme redacted] will offer, or any of, the COVID-19 and team members to cquiring, transmitting, or ations from COVID-19" In 8/26/22, the facility interim or of Nursing and Infection and aware of the above In was provided. Iled to document that eligible for COVID vaccine in the benefits of offered vaccination (s) for a sample of 14 staff. In ccination matrix submitted and 8, were noted to not ovid immunizations, as they poster dose.	F 887	4. The IP or designee will audit residents medical records for offer the COVID-19 immunization to all neadmitted residents, education on the benefits and documentation in the electronic medical record of declinat administration once per week for 4 verthen twice a month for two months a quarterly for two quarters. Identified of concern will be corrected as appropriate and feedback provided to responsible staff. The Administrator or designee will at the team member vaccination log for date COVID-19 immunization inform or approved exemption for team memand agency staff once per week for weeks, then twice a month for two months, and quarterly for two quarter Identified areas of concern will be corrected as appropriate and feedback provided to HR Director. Results of all audits will be reviewed reported at the next scheduled QAP meeting for recommendations. Varia will be investigated and staff will be re-educated and/or counseled as indicated.	ewly estion or veeks, and lareas to udit r up to nation mbers 4 ers. ack	

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		495403	B. WING			08/30/2022	
	ROVIDER OR SUPPLIER		•	1	TREET ADDRESS, CITY, STATE, ZIP CODE 900 LAUDERDALE DRIVE RICHMOND, VA 23238		
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F 888 F 888 SS=G	On 8/25/22, a meeting Employee H, the HR was given the names Surveyor B explained staff vaccination reco booster dose. Employees had On 8/26/22 at 9:31 Al Preventionist stated sprovide that would indicate the COVID immunizar meeting was held we vaccinations and that On 8/26/22, during the facility Administrator a made aware of the above the covidence of the above the covidence of the procedure of the procedure of the covidence	sources maintains the rds to employee vaccination. g was conducted with Director. The HR Director of Staff #2, 6, and 8. I that they were listed on the rd as not receiving the yee H had no evidence that I been offered and declined. M, the Infection she had no evidence to dicate the staff were offered tions. She said an all staff re she discussed if they wanted it to see her. e end of day meeting, the and Director of Nursing were pove findings. In was provided. In of Facility Staff (3)(i)-(x) In of facility staff. The facility plement policies and that all staff are fully 10-19. For purposes of this sidered fully vaccinated if it more since they completed series for COVID-19. The arry vaccination series for here as the administration of all		887			10/17/22

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		\ \ \ \ \ \	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
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F 888	or resident contact, the must apply to the foll provide any care, treathe facility and/or its (i) Facility employee (ii) Licensed practitic (iii) Students, trainee (iv) Individuals who other services for the under contract or by \$483.80(i)(2) The posection do not apply (i) Staff who exclusive telemedicine services and who do not have residents and other services and who do not have residents and other services and who provides facility that are performed the facility setting and contact with resident paragraph (i)(1) of the \$483.80(i)(3) The position of the facility setting and contact with resident paragraph (i)(1) of the staff who have pendibeen granted, exemprequirements of this services.	dless of clinical responsibility ne policies and procedures owing facility staff, who atment, or other services for residents: s; oners; s, and volunteers; and provide care, treatment, or a facility and/or its residents, other arrangement. Dicies and procedures of this to the following facility staff: ely provide telehealth or so outside of the facility setting any direct contact with staff specified in paragraph (i) descriptions and one have any direct so and other staff specified in	F 88	38		
	clinical precautions a	ended by the CDC, due to nd considerations) have um, a single-dose COVID-19 ose of the primary				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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F 888	vaccine prior to staff treatment, or other sits residents; (iii) A process for er additional precautior transmission and sp who are not fully vac (iv) A process for tradocumenting the CO all staff specified in psection; (v) A process for tradocumenting the CO any staff who have consumenting the CO any staff who have consumented by (vi) A process by whe exemption from the requirements based (vii) A process for tradocumenting information from the requirements based (viii) A process for tradocumenting information have requested has granted, an exe COVID-19 vaccination (viii) A process for endocumentation, which clinical contraindicate and which supports exemptions from vacand dated by a licen the individual requesis acting within their as defined by, and in applicable State and ensuring that such di (A) All information spauthorized COVID-1	providing any care, ervices for the facility and/or assuring the implementation of as, intended to mitigate the read of COVID-19, for all staff acinated for COVID-19; cking and securely avoid by a secure and a securely avoid by a secure and a	F	388				

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	(X3) DATE SURVEY COMPLETED	
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F 888	recommending that the exempted from the favaccination requirement recognized clinical control (ix) A process for ensignature of the process for the process for ensignature of the process for the process for ensignature of the process for exempting the process for ensignature of the process for ensignature of the process for ensignature of the process for exempting t	inical reasons for the december of the eauthenticating practitioner the staff member be cility's COVID-19 tents for staff based on the intraindications; turing the tracking and the of the vaccination status of the vaccination must be as recommended by the precautions and ting, but not limited to, illness secondary to duals who received as or convalescent plasma tent; and tent of the vaccination must be as recommended by the precautions and ting, but not limited to, illness secondary to duals who received as or convalescent plasma tent; and tent of the second tent of the process for ensuring that all the graph (i)(1) of this section or COVID-19, except for the been granted exemptions to rements of this section, or COVID-19 vaccination must and, as recommended by the	F 888		n
	the facility staff failed control policies and p COVID-19, including record of staff's COV	to implement their infection		COVID-19, was discharged from the hospital to her daughter's home approximately 1 week after hospital admission per the resident #3's daught As of 9/20/22 this resident remains at h	

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				1900 LAUDERDALE DRIVE	
LAKEWO	OD MANOR			RICHMOND, VA 23238	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETION
F 888	Continued From pag	e 44	F 88	3	
	outbreak, which resu positive for COVID-1 #3) being hospitalize	e facility had a COVID-19 Ited in 14 residents testing 9 and one resident (Resident d, which is harm. This ted residents on all 5 facility.		daughter's home and is receiving health services for therapy. All residents (as noted in the 256 resident care hallways), including affected residents identified, bega	7 as all 5 the 11
	The findings include The facility staff failed control policies and p COVID-19, as evider	d to implement their infection procedures regarding		cared for with proper PPE (N95 respirators and eye protection) or 26, 2022 per CDCs recommenda healthcare workers in counties wi substantial or high transmission or resident care encounters.	tions for th
	regards to employee 9 was noted on the s having completed the vaccination series andose; however, her in indicated she had on	te documentation with s' vaccination status. Staff # taff vaccination matrix as e COVID-19 primary d had received a booster mmunization record on-file ly received one of a		Residents who were on transmission-based precautions (confirmed COVID-19 infection (R #1 and #20) began being cared for August 26, 2022 with PPE that is for TBP (gloves, gown, N95 respirand eye protection).	esidents or on required rator,
	rooms of residents (F transmission based p	were made of staff entering Residents #1 and #20) on precautions (TBP) with , without wearing proper		Beginning on August 27, 2022 an ongoing all team members were on the proper use of PPE (N95 re and eye protection) by the Direct Nursing (DON), Staff Developmed Coordinator (SDC), and other destoration and for positions and for registrate with transmission and for registrate with the staff of the staff	educated espirators or of nt signees gh
	providing direct resid eye protection. Due t high level of commur protection was to be encounters;	ed on all 5 nursing units/halls ent care without wearing any o being in an area with a nity transmissibility, eye worn during all patient care		transmission and for residents whe COVID positive. The nine residents identified (Results, 6, 7, 9, 10, 12, 13, 14, and 16) were not up to date with their COVID exposure during an outbressed on TRP on August 26, 200	sidents) who VID ced a eak were
		esidents #5, 6, 7, 9, 10, 12, were exposed to COVID-19 ate with COVID-19		placed on TBP on August 26, 202 All residents were tested for COV	

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION	I . ,	(X3) DATE SURVEY COMPLETED	
		495403	B. WING _	-	08/3	30/2022	
NAME OF PI	ROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP (•		
LAKEWO	20 1441/20			1900 LAUDERDALE DRIVE			
LAKEWO	OD MANOR			RICHMOND, VA 23238			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO' DEFICIENT	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 888	Continued From pa	ge 45	F 8	388			
	immunizations were CDC guidance.	not placed on quarantine per		8/25/22, 8/27/22, 8/31/22, The results of their COVID documented in the resider medical record. Any resid	l-19 test were lt⊟s electronic ents testing		
		nas failed to maintain ate documentation with		positive for COVID-19 had transmission-based precal implemented based on the	utions		
	regards to employed	es' vaccination status. Staff#		policies and procedures ar	nd CMS		
	having completed th	staff vaccination matrix as ne COVID-19 primary nd had received a booster		guidelines. All staff memb for COVID-19 per CMS gu			
		immunization record on-file nly received one of a		All staff members, includin began being tested for CO			
	two-dose vaccinatio	n series.		CMS guidance. Twice a w began the week of 8/29/20	eek testing		
	with the facility Adm	ing the entrance conference inistrator, Director of Nursing		continues. Staff #1 was tested 8/29/2.			
		ntionist, they identified that (HR) tracks the staff		and will continue to be test policy.	ted per facility		
	On 08/25/2022 at 1	1:34 a.m., a meeting was held		Staff #7 was tested 8/29/2 continue to be tested per f			
	with the HR Director staff members' nam	r, Employee H. She was given es of Staff #1 and Staff #7.		Staff #3 who had been gra			
	, ,	vaccination status, Employee uling Coordinator keeps		exemption was COVID tes 8/30/22, 9/1/22, 9/8/22, 9/ and will continue to be test	13/22, 9/15/22		
		erview on 08/25/022 at 11:34		policy which is in accordar CDC/CMS guidance.			
	a.m., Employee H c	onfirmed the staff vaccination sted Staff #9 as having		On August 26, 2022 a broa	ad based facility		
	completed the prima	ary vaccination series and had dose. When Employee H		wide testing approach was	initiated (and		
	pulled the vaccination	on information for Staff #9, it e Virginia Immunization		COVID-19 is identified) so contact tracing could be le	that proper		
	Information System dose of the primary	that noted Staff #9 only had 1 series of a Pfizer vaccine. ned the findings and stated		implemented appropriately community Infection Preven	by the		
	the matrix was inac			Outbreak status concluded	d 9/12/22. Staff		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495403	B. WING			08.	/30/2022
NAME OF PI	ROVIDER OR SUPPLIER			S ⁻	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00/	00/2022
					900 LAUDERDALE DRIVE		
LAKEWO	OD MANOR				RICHMOND, VA 23238		
0	CUMMA DV C	CATEMENT OF DEFICIENCIES	- 15		 T		0/5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL 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 888	Continued From pag	e 46	F	888			
					continue to be tested twice weekly due	to	
	On 08/25/2022 at 2:0	00 p.m., Employee H			the high county transmission rate and		
		with a copy of Staff #9's			continue while the county transmission		
	vaccine card. Employ	yee H said, "She works the			rate remains substantial or high.		
	11:00 p.m. to 7:00 a.	m. shift, so we called and					
	woke her up and she	took a picture and sent it to			All testing is being recorded on a team		
		firmed that prior to this, they			member testing log and a resident test	ing	
		ne had completed her			log by the IP.		
	ļ ·	e vaccination matrix was					
	inaccurate.				Staff #9's COVID immunization docum	ent	
	0 00/05/0000 / 40	10 0 5 1			was obtained by Human Resources		
		:18 p.m., Surveyor B met			Director, placed in personnel file	and	
		e Scheduling Coordinator.			reflects the information on the staff		
		ked if she keeps any record vaccination status. Employee			vaccination log. Staff member was vaccinated on 1/14/21, 2/4/21, and		
		e everyone be vaccinated			10/27/21.		
		s they can't send us anyone			10/2//21.		
	who isn't vaccinated.	-			Staff # 2, 6, and 8 were vaccinated but	not	
	Wile left vaccinated.				included on the team member vaccinate		
	On 08/26/2022 at 9:1	0 a.m., Surveyor B met with			log. Staff #2 was vaccinated on 1/14/2		
		Vhen asked about agency			and 2/4/21, Staff #6 was vaccinated or		
		atus, she said she just knows			1/14/21 and 2/4/21, and Staff #8 was		
	the facility requires e	veryone be vaccinated, so			vaccinated on 2/4/21 and 2/25/21.		
	when the agency ser	nds her information, she just			Vaccinations for these team members		
	•	confirmed she does not			have been confirmed and these team		
	, ,	of their immunization status.			members are now included on the tear		
		her desk drawer and pulled			member vaccination log maintained by		
	-	pies of various agency staff's			Human Resources Director daily Mond	ay	
		ards. Review of this file			through Friday.		
		s who indicated they they					
		2-dose primary series. nis, Employee G said she			2. All residents have the notential to be		
	would have to call the				All residents have the potential to be affected by the deficient practices. All		
	would have to call the	c agonoles.			residents are at risk for transmission of		
	On 08/26/2022 at 2.0	00 p.m., Employee H, the			COVID-19.	•	
		irector, was conducting an					
		e vaccination matrix. She			All residents are being cared for using	the	
		of the review completed and			proper PPE □ both for substantial/high		
		that she had identified 14			transmission rates and for TBP ☐ this		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495403	B. WING		08/30/2022	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1900 LAUDERDALE DRIVE RICHMOND, VA 23238	,	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE COMPLETION	
F 888	2. Two observations rooms of residents (#20) on transmissio with confirmed COV PPE. On 08/24/2022 at all B was observed exic CNA B was not weat was signage on the was on TBP and a spersonal protective the room. When ask she was feeding Releve protection, she it in the rooms of CO washed it off and with confirmed that Resic COVID-19 infection On 8/25/22 at 9:55 entering the room of signage on the extet they were on TBP. mask and she was resident's room with protection, isolation stepped back out in with gloves in her hashe is supposed to the supposed	accination status was gracination status was gracination status was gracination status was gracination status was gracinated from the state of	F 888	began August 26, 2022. An audit of all residents vaccination status was done and all residents who were not up to date with COVID-19 vaccination were placed on TBP this was completed by August 29, 2022. Residents TBP were discontinued af the required 10 days of isolation. All residents were tested for COVID-19 8/25/22 and 8/27/22 and proper protoc followed based on test results. (NOTE appropriate outbreak testing was carriout per facility policy and procedure for residents and team members and the outbreak concluded on September 12, 2022). Since August 29, 2022, all new admissions have been COVID tested upon admission and 5 days after admission. Appropriate transmission-based precautions were implemented based on facility policy. Resident testing and staff member test (including agency staff) was started are carried out as described above in #1. An audit of 100% of resident records we be done by the IP or designee and any resident found to not be COVID-19	ting nd	
	she stated, gloves, When asked why sh wearing those items to get gloves. When the gloves on the ca	gown, and eye protection. The had entered without is she stated she had gone in a sked what was wrong with art outside of the room, she those. There were two boxes		vaccinated will be educated and offered the primary series or declination will documented. Documentation of administration will be documented in resident record.	ed ill be	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495403	B. WING			Of	3/30/2022
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	<u>, , , , , , , , , , , , , , , , , , , </u>	
LAKEWO	OD MANOD			19	900 LAUDERDALE DRIVE		
LAKEWO	OD MANOR			R	RICHMOND, VA 23238		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(X5) COMPLETION DATE
F 888	Continued From page	e 48	F	888			
	· -	nd pointed out that were on			All residents will be educated and offer	red	
		ontained isolation gowns.			the updated COVID-19 bivalent booste		
		n isolation gown, gloves, and			and appropriate documentation de		
	eye protection and re				in residents□ record. Administration o		
					the updated booster will be documented	∍d	
	On 08/25/2022, durin	ig an end of day meeting			appropriately.		
		ninistrator and Director of					
	Nursing, they confirm				The Vice President of Clinical services		
	guidance with regard	s to COVID-19.			educated the Infection Preventionist a		
	0.01.5				Director of Human Resources on Augu	ist	
	3. Staff were observed, on all 5 nursing units/halls, providing direct resident care without				28, 2022 regarding the tracking of	~	
				COVID-19 vaccination status, including boosters, of all team members and	J		
	area with a high level	ection. Due to being in an			residents, as well as documenting		
	_	rotection was to be worn			education and declination, or approved	Ł	
	during all patient care				exemption of the COVID-19 immunizar		
					and placing in their personnel file or		
	On 08/24/2022 at app	proximately 12:00 p.m., a			resident electronic medical record as		
	tour of the facility was	s conducted by Surveyor B.			appropriate.		
		sing assistants (CNA),					
		usekeeping employees were			An audit was done of 100% personnel		
		residents' rooms wearing no			files by Human Resources to confirm a		
		5 of the resident care			team members have been fully vaccing		
	-	g resident rooms to provide			or received an exemption as required	эу	
	direct care or be with	in a few feet of the residents.			CMS and to confirm the required		
	The following specific	c observations were noted on			documentation is present in personnel files. HR is maintaining a team memb		
	the third floor:	o observations were noted on			vaccination log and reconciles this log		
	and annual noon.				daily Monday through Friday with		
	a. Employee F was ir	n a room providing care to a			scheduler to ensure agency staff are		
		protection. According to the			included and with current team member	er	
	staff vaccination matr	rix, Employee F was not			roster.		
	up-to-date with COVI						
		oom to provide medication					
		ction. LPN C was not			3. Beginning on August 27, 2022 and		
	up-to-date with COVI				through August 29, 2022 all team		
		ng a resident in the hallway to			members were educated on the prope	r	
	_	io eye protection. CNA C			use of PPE (N95 respirators and eye		
	⊢was not up-to-date w	ith COVID-19 immunization			protection) by the Director of Nursing		1

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495403	B. WING _	· · · · · · · · · · · · · · · · · · ·	1	08/30/2022	
	NAME OF PROVIDER OR SUPPLIER LAKEWOOD MANOR			STREET ADDRESS, CITY, STATE, ZIP CO 1900 LAUDERDALE DRIVE RICHMOND, VA 23238	•		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 888	hallway wearing no was not up-to-date wimmunizations. e. CNA D was distril residents, setting up meal and had no ey up-to-date with COV. On 08/24/2022 at ap following specific obsecond floor: a. CNA E was distrit and was wearing no b. CNA F was sitting them with no eye proc. LPN B was admir resident wearing no not up-to-date with 0 d. CNA B was feeding protection on. e. CNA K entered a the resident in an ef the resident's clothir not have on eye prof. CNA K entered the beside them to start eye protection. On 08/24/2022 at 4:	tion matrix. ambulating a resident in the eye protection. Employee E with COVID-19 Duting meal trays to various the resident and food for the e protection on. CNA D was VID-19 immunizations. Deproximately 12:30 p.m., the servations were made on the servations were made on the servations were made on the outing meal trays to residents eye protection. In beside a resident feeding objection on. Distering eye drops to a eye protection. LPN B was COVID-19 immunizations. Deproximately 12:30 p.m., the servations were residents and had no eye eye protection. LPN B was COVID-19 immunizations. Deproximately 12:30 p.m., the servations were resident and had no eye are sident and had no eye room to put a towel around fort to provide protection to not while they ate. CNA K did tection. Deproximately 12:30 p.m., the servations were	F 8	(DON), Staff Development O (SDC), and other designees counties in substantial/high tand for residents who are Compared to the process of the	Coordinator for both transmission OVID positive. of Clinical DN, IP, and I9 testing is based on Director of or, and SDC B, 2022 on or COVID terim Infection or HC D-19 vere facility ch are based nce. This onduction of COVID-19 member or al services entionist and		
	made on all of the resident care halls and staff were entering rooms to provide care without any eye protection. They included, but were not limited to, CNA G and LPN D. On 08/25/2022 at 9:10 a.m., observations were made on each of the resident care units/hallways.			Director of Human Resource 28, 2022 regarding the track COVID-19 vaccination status boosters, of all team member documenting education and or approved exemption of the immunization and placing in	king of s, including ers, as well as declination, le COVID-19		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		l l	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495403	B. WING _			08/	/30/2022
	NAME OF PROVIDER OR SUPPLIER LAKEWOOD MANOR			19	TREET ADDRESS, CITY, STATE, ZIP CODE 1000 LAUDERDALE DRIVE ICHMOND, VA 23238		
(X4) ID PREFIX TAG			ID PREFI) TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ON SHOULD BE HE APPROPRIATE	
F 888	Continued From page	e 50	F 8	888			
	LPN E was observed administering medical eye protection. Eye put top of her medication the hallway while she on 08/25/2022 at 9:10 on the door of Reside door, a therapy staff room providing treatrice protection. On 08/25/2022, during with the facility's Adm Nursing, they confirm guidance with regard 4. Nine Residents (R 13, 14 and 16) who wand were not up-to-dimmunizations were CDC guidance. On 08/24/2022, a reversidents' COVID-19 conducted. This revieresidents are not up-immunizations. Three currently on transmis (TBP) for an active Cother 9 Residents (R 13, 14, and 16) room was no identified signon TBP.	in a resident room ations and did not have on protection was observed on a cart, which had been left in the entered the resident room. 4 a.m., Surveyor B knocked and #7. Upon opening the member was observed in the ment and not wearing eye ag an end of day meeting ministrator and Director of med they follow CDC as to COVID-19. esidents #5, 6, 7, 9, 10, 12, were exposed to COVID-19 and placed on quarantine per riew of the listing of immunization status was ew revealed that 12 current to-date with COVID-19 as (3) of the 12 residents were sion based precautions are (3) of the 12 residents were sion based precautions are (3) of the 12 residents were sion based precautions are (3) of the 12 residents were sion based precautions are (3) of the 12 residents were sion based precautions are (3) of the 12 residents were sion based precautions are (3) of the 12 residents were sion based precautions are (3) of the 12 residents were sion based precautions are (3) of the 12 residents were sion based precautions are (3) of the 12 residents were sion based precautions are (3) of the 12 residents were sion based precautions are (3) of the 12 residents were sion based precautions are (3) of the 12 residents were sion based precautions are (4) of the 12 residents were sion based precautions are (4) of the 12 residents were sion based precautions are (4) of the 12 residents were sion based precautions are (4) of the 12 residents were sion based precautions are (4) of the 12 residents were sion based precautions are (4) of the 12 residents were sion based precautions are (4) of the 12 residents were sion based precautions are (4) of the 12 residents were sion based precautions are (4) of the 12 residents were sion based precautions are (4) of the 12 residents were sion based precautions are (4) of the 12 residents were sion based precautions			On August 26, 2022 LifeSpire VP of Clinical Services developed a policy specific to PPE use in counties with substantial or high transmission titled of PPE in Facilities Located in Countie with Substantial or High Transmission. This policy was adopted by facility and incorporated into the August 28, 2022 training described above. On August 29, 2022 LifeSpire VP of Clinical Services revised policy titled Transmission Based Precautions including TBP specific for COVID-19 to include more specific instructions arou PPE use for COVID-19. This revised policy was adopted by facility and clinic leadership educated. On August 29, 2 team members were educated regardithis revised policy. The Infection Preventionist or designed will educate the nursing staff on offering the COVID-19 vaccine to all newly admitted residents, education on the benefits of the vaccination and documentation of declination or administration in the residents electromedical record. The Vice President of Clinical services educated the Infection Preventionist and Director of Human Resources on August 28, 2022 regard the tracking of COVID-19 vaccination status, including boosters, of all team	o nd cal 0222 ng e g	
	On 08/25/2022 at 9:00 a.m., a facility tour was conducted with special attention being made to Residents #5, 6, 7, 9, 10, 12, 13, 14, and 16's rooms. There was still no indication the residents				status, including boosters, of all team members, as well as documenting education and declination, or approved exemption of the COVID-19 immunization		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G	, ,	(X3) DATE SURVEY COMPLETED	
		495403	B. WING _)8/30/2022	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	•	0.00,2022	
				1900 LAUDERDALE DRIVE			
LAKEWO	OD MANOR			RICHMOND, VA 23238			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF C	ORRECTION	(X5)	
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F 888	Continued From page	age 51	F 8	88			
	were on TBP.			and placing in their personne appropriate.	el file as		
	In review of the CO	OVID-19 line listing/infection					
	report submitted by	y the facility, it was revealed		Infection Preventionist has the	he following		
	that each of the nir	ne residents who were not		new processes in place:			
	•	munizations had a possible		" tracking all residents va			
	'	D-19. The facility had not		status and is maintaining a c			
	identified this durin	ng their contact tracing.		this log includes resident tes	iting, and		
				resident isolation			
		potentially exposed to CNA M		" tracking all new residen			
		d 08/15/2022. CNA M tested		to ensure TBP are implemen			
		0-19 on 08/16/2022.		COVID-19 vaccination status date	s is not up to		
		nd 16 were potentially exposed		" weekly documentation of	of county		
		NA L on 08/17/2022. CNA L		transmission rate			
		COVID-19 on 08/19/2022. On		" educate all new team m			
		G cared for Residents #5, 6,		proper use of PPE and COV			
		en tested positive for COVID-19		practices (vaccination, testin			
	after her shift on 0	8/19/2022.		employee orientation and du	iring annual		
	D : 1 (#7)	#40		in-service sessions.			
		#12 were potentially exposed to		" make rounds daily to er			
		022. CNA L tested positive for		members are utilizing PPE p	properly and		
	COVID-19 on 08/1	9/2022.		use an audit form " contract tracing form to	ahaw proper		
	Posidont #13 was	cared for by CNA B on		contact tracing is being imple			
		8/17/2022. CNA B tested		all positive cases (within a re			
		0-19 on 08/18/2022.		team member, including age			
	positive for GOVID	7-19-011-00/10/2022.		team member, moldding age	noy stair)		
	Residents #9 and	#10 were cared for by LPN H		The Infection Preventionist of	or designee		
		N H reported having COVID-19		will educate admissions and			
		7/2022 and then tested positive		the criteria for testing newly			
	for COVID-19 on 0	•		residents and on appropriate			
				documentation in the resider	nt□s medical		
	Residents #7, 9, 1	0, 12, and 13 were cared for by		record including physician□s	s order to test,		
	LPN F on 08/17/20	022. LPN F had COVID-19		testing results, and RR notifi	ication.		
	symptoms on 08/1	7/2022, then tested positive for					
	COVID-19 on 08/1	8/2022.		Human Resources Director	will maintain a		
				current team member vaccir	nation status		
	On 08/25/2022 at	10:21 a.m., an interview was		log and will include all agend	cy staff. This		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	MULTIPLE CONSTRUCTION ILDING		(X3) DATE SURVEY COMPLETED	
		495403	B. WING _			08/30/2022	
NAME OF PROVIDER OR SUPPLIER LAKEWOOD MANOR		•		STREET ADDRESS, CITY, STATE, ZIP CO 1900 LAUDERDALE DRIVE RICHMOND, VA 23238)DE		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 888	(IP). The IP stated no how to conduct conta look back two days to COVID-19 having an asked to explain this, they may be infectiousymptoms." When as	acility Infection Preventionist obody had trained her on act tracing, but she knew to be prevential exposures due to incubation period. When the IP said, "That is when as prior to exhibiting sked if she looked at who the re to in the two days prior to	F8	log will be updated daily Mo Friday and available to clinic IP will document facility coutransmission rate weekly on transmission rate log. IP will maintain resident test Monday through Friday whe outbreak testing is being could be will maintain team members at the members are required to be vaccinated per facility policy vaccinated must have an appexemption on file prior to start Resources Director will must be updated daily Mo Friday and available to clinic The Infection Preventionist will educate the nursing staff the COVID-19 vaccine to all admitted residents, education and documentation of declination and documentation of declination and in the residents of the vaccination and documentation of declination and record. IP will follow up with any residents a COVID-19 vaccination.	cal leadership nty ting log daily en resident nducted. er testing log y. uding agency status All new team e COVID y and if poproved arting. Human aintain a nation status cy staff. This enday through cal leadership or designee eff on offering I newly on on the and nation or ints electronic	not n	

	MENT OF DEFICIENCIES LAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING A. BUILDING			(X3) DATE SURVEY COMPLETED				
		495403	B. WING _		08	3/30/2022		
NAME OF PROVIDER OR SUPPLIER LAKEWOOD MANOR				STREET ADDRESS, CITY, STATE, ZIP CODE 1900 LAUDERDALE DRIVE RICHMOND, VA 23238				
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	EFIX (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION DATE		
F 888	Continued From pag	e 53	F8	record. All residents will have the COVID-19 booster offere offering, administrati documented appropriatel 4.DON, or designee, will vaccination log, weekly d transmission rate, ar audit form every week for twice a month for two quarterly for two quarters designee, will review the admission log daily f weekly for 2 weeks, then	d (educated, ion will be y). review resident ocumentation of and daily PPE round at 4 weeks, then months and then at DON, or new resident for 2 weeks, then monthly for 2 eas of concern will ate and feedback or resident. In the case for 2 of concern will be attention at the case for 2 of concern will be attention at the case for 2 of concern will be attention to the case for 2 of concern will be attention to the case for 2 of concern will be attention to the case for case at the case for the case for case at the case for case for case at the case for c			

, ,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495403	B. WING		08/30/2022	
NAME OF PROVIDER OR SUPPLIER LAKEWOOD MANOR		STREET ADDRESS, CITY, STATE, ZIP CODE 1900 LAUDERDALE DRIVE RICHMOND, VA 23238		, 03.00.2022		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE COMPLETION	
F 888	Continued From page	e 54	F 88	transmission rate, and team membresting log week for 4 weeks, then month for two months and then quarter two quarters. DON, or designed review the new resident admis daily for 2 weeks, then weekly weeks, then monthly for 2 months. Identified areas of concern will be corrected as appropriate and feedb provided to IP. The Infection Preventionist or designed will audit residents medical record offering the COVID-19 immunization newly admitted residents, education the benefits and documentation in the electronic medical record of declinate administration once per week for 4 then twice a month for two months quarterly for two quarters. Identified of concern will be corrected as appropriate and feedback provided responsible staff. The Administrator or designee will at the team member vaccination log for date COVID-19 immunization inform or approved exemption for team meand agency staff once per week for weeks, then twice a month for two months, and quarterly for two quart Identified areas of concern will corrected as appropriate and feedback provided to HR Director. Results of all audits will be reviewed reported at the next scheduled QAF meeting for recommendations. Var will be investigated, and staff will be	twice a sarterly e, will sion log for 2 sack space ds for on to all on on the sation or weeks, and ed areas state or up to mation embers or 4 sters. It be back space dand Pl riances	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l l	PLE CONSTRUCTION G	(X3) DA	(X3) DATE SURVEY COMPLETED	
		495403	B. WING		 	08/30/2022	
NAME OF P	ROVIDER OR SUPPLIER	ı		STREET ADDRESS, CITY, STATE, ZIP CODE		<u> </u>	
LAKEWO	OD MANOR			1900 LAUDERDALE DRIVE			
				RICHMOND, VA 23238			
(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 CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 888	Continued From page	e 55	F 8	re-educated and/or counseled indicated. 5. Date of compliance: 10/17/3			