	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	PLE CONSTRUCTION		TE SURVEY MPLETED
			A. BUILDIN			С
		495391	B. WING		0	2/08/2023
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIF	P CODE	
GLENBUR	NIE REHAB & NURSIN	IG CENTER		1901 LIBBIE AVE RICHMOND, VA 23226		
(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 ((EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE D THE APPROPRIATE	(X5) COMPLETION DATE
E 000	Initial Comments		EO	00		
	survey was conduct 02/08/2023. Correc compliance with 42 Requirement for Lor	ng-Term Care Facilities. No dness complaints were the survey n	EO	37		3/21/23
	§441.184(d)(1), §46 §483.73(d)(1), §483 §485.68(d)(1), §483	6.54(d)(1), §418.113(d)(1), 0.84(d)(1), §482.15(d)(1), .475(d)(1), §484.102(d)(1), 5.542(d)(1), §485.625(d)(1), 5.920(d)(1), §486.360(d)(1),				
	Hospitals at §482.15 at §484.102, REHs under §485.727, OF RHC/FQHCs at §49 (1) Training program the following: (i) Initial training in e policies and procedu staff, individuals pro arrangement, and we expected roles.					
	least every 2 years. (iii) Maintain docum preparedness trainin (iv) Demonstrate sta procedures. (v) If the emergency	entation of all emergency				

Electronically Signed

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

03/03/2023

	OR MEDICARE & N	D HUMAN SERVICES IEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE			FORM	03/14/2023 1APPROVED 0.0938-0391 SURVEY
AND PLAN OF CO		IDENTIFICATION NUMBER:	. ,				· · /	LETED
		495391	B. WING			_		08/2023
NAME OF PROV	IDER OR SUPPLIER				TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
GLENBURNIE	E REHAB & NURSING	CENTER			901 LIBBIE AVE RICHMOND, VA 23226			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORREC CROSS-REFEREN	B PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
m pr *[[ho (i) po ho se ex (ii) pr (iii) lea (iv) er sp pr ot (v pr (v pr (v pr (v pr (v pr (v pr (v pr (v) (v) pr (v) pr (v) (v) pr (v) pr (v) (v) pr (v) (v) pr (v) (v) pr (v) (v) pr (v) (v) (v) (v) (v) (v) (v) (v) (v) (v)	For Hospices at §418 popice must do all of Initial training in em plicies and procedure popice employees, and ervices under arrange (pected roles.) Demonstrate staff H ocedures. i) Provide emergence ast every 2 years. cocedures. i) Periodically review mergency prepared nployees (including pecial emphasis plac ocedures necessary hers.) Maintain document eparedness training ocedures are signific ust conduct training ocedures. For PRTFs at §441.1 ogram. The PRTF m Initial training in em plicies and procedures aff, individuals provid rangement, and volu (pected roles.) After initial training, eparedness training	on the updated policies and B.113(d):] (1) Training. The the following: ergency preparedness es to all new and existing nd individuals providing ement, consistent with their knowledge of emergency y preparedness training at and rehearse its ess plan with hospice nonemployee staff), with ed on carrying out the to protect patients and tation of all emergency preparedness policies and cation of all emergency to reparedness policies and cation of all of the hospice on the updated policies and (B4(d):] (1) Training hust do all of the following: ergency preparedness es to all new and existing ding services under inteers, consistent with their	E	037				

Facility ID: VA0392

If continuation sheet Page 2 of 213

ID PLAN OF	F DEFICIENCIES CORRECTION ROVIDER OR SUPPLIER	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN		NSTRUCTION	· · ·	TE SURVEY MPLETED
GLENBUR	ROVIDER OR SUPPLIER		A. BUILDIN				
GLENBUR	ROVIDER OR SUPPLIER			NG			С
GLENBUR	ROVIDER OR SUPPLIER	495391	B. WING				2/08/2023
GLENBUR				STRE	ET ADDRESS, CITY, STATE, ZIP CODE		2/00/2023
					LIBBIE AVE		
(X4) ID	NIE REHAB & NURSING	CENTER			IMOND, VA 23226		
	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF COR	RECTION	(X5)
PREFIX TAG	•	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	<	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)		COMPLETIO
E 037	Continued From page	2	E 0)37			
		ntation of all emergency					
	preparedness training].					
		preparedness policies and					
		icantly updated, the PRTF					
	-	on the updated policies and					
	procedures.						
	*[For PACE at §460.8	4(d)·1(1) The PACE					
	organization must do	· / - · /					
	-	nergency preparedness					
	policies and procedur	es to all new and existing					
	-	iding on-site services under					
	arrangement, contrac	· · · ·					
		t with their expected roles. y preparedness training at					
	least every 2 years.	y preparedness training at					
		knowledge of emergency					
	· · /	informing participants of					
	what to do, where to g	go, and whom to contact in					
	case of an emergency						
	(iv) Maintain documer	-					
		preparedness policies and					
		icantly updated, the PACE on the updated policies and					
	procedures.	on the updated policies and					
	-	\$483.73(d):] (1) Training					
	-	cility must do all of the					
	following: (i) Initial training in em	nergency preparedness					
	., _	es to all new and existing					
	staff, individuals provi						
		unteers, consistent with their					
	(ii) Provide emergenc	y preparedness training at					
	least annually.						
	(iii) Maintain documer preparedness training	ntation of all emergency					

Facility ID: VA0392

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM): 03/14/2023 APPROVED 0. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		495391	B. WING		_		C 08/2023
NAME OF PF	ROVIDER OR SUPPLIER		5	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
GLENBUR	NIE REHAB & NURSING	CENTER		901 LIBBIE AVE RICHMOND, VA 23226			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREI	EPLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
E 037	procedures. *[For CORFs at §485. CORF must do all of t (i) Provide initial training preparedness policies and existing staff, indi- under arrangement, at with their expected ro (ii) Provide emergence least every 2 years. (iii) Maintain documer (iv) Demonstrate staff procedures. All new p and assigned specific the CORF's emergency their first workday. The include instruction in the alarm systems and signed equipment. (v) If the emergency procedures are signified must conduct training procedures. *[For CAHs at §485.6 The CAH must do all (i) Initial training in em- policies and procedur reporting and extinguia and where necessary personnel, and guests cooperation with firefia authorities, to all new- individuals providing signed and volunteers, consistent	knowledge of emergency 68(d):](1) Training. The he following: ng in emergency and procedures to all new viduals providing services nd volunteers, consistent les. y preparedness training at tation of the training. knowledge of emergency ersonnel must be oriented responsibilities regarding cy plan within 2 weeks of e training program must he location and use of gnals and firefighting preparedness policies and cantly updated, the CORF on the updated policies and 25(d):] (1) Training program. of the following: hergency preparedness es, including prompt shing of fires, protection, , evacuation of patients, s, fire prevention, and ghting and disaster	E 037				
	and volunteers, consi roles.	stent with their expected					

Facility ID: VA0392

If continuation sheet Page 4 of 213

STATEMENT (OF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION		TE SURVEY MPLETED	
		495391	B. WING			C		
	ROVIDER OR SUPPLIER	495591	D. WING -		TREET ADDRESS, CITY, STATE, ZIP CODE		2/08/2023	
NAME OF FI	ROVIDER OR SUFFLIER				901 LIBBIE AVE			
GLENBUR	RNIE REHAB & NURSING	G CENTER			RICHMOND, VA 23226			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	ILD BE	(X5) COMPLETION DATE	
E 037	least every 2 years. (iii) Maintain document (iv) Demonstrate staff procedures. (v) If the emergency procedures are signiff must conduct training procedures. *[For CMHCs at §485 CMHC must provide preparedness policies and existing staff, ind under arrangement, a with their expected ro documentation of the demonstrate staff knop procedures. Thereaff emergency prepared years. This REQUIREMENT by: Based on staff intervor review the facility staff emergency prepared training and document The findings include: Facility staff failed to	cy preparedness training at intation of the training. If knowledge of emergency of preparedness policies and icantly updated, the CAH of on the updated policies and 5.920(d):] (1) Training. The initial training in emergency is and procedures to all new lividuals providing services and volunteers, consistent oles, and maintain training. The CMHC must powledge of emergency ter, the CMHC must provide ness training at least every 2 is not met as evidenced iew and facility document ff failed to have a complete ness plan related to annual ntation.	E	037	The facility sets forth the following correction to remain in compliance federal and state regulations. The has taken or will take the actions s in the plan of correction. The follow plan of correction constitutes the fa allegation of compliance. All allega deficiencies cited have been or wil corrected by the date or dates indi	with all facility et forth wing acility⊡s ed l be		
	documentation that fa annual emergency pr On 02/07/2023 at app facility's emergency p	acility staff have received			E037 EP Training Program 1-The Administrator has completed in-house emergency preparedness as well as completed staff training maintenance director or designee ensure the management software	plan The will		

Event ID: V8T511

Facility ID: VA0392

If continuation sheet Page 5 of 213

	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	ECONSTRUCTION	(X3) DATE SURVEY COMPLETED
			A. BUILDING		C
		495391	B. WING		02/08/2023
NAME OF P	ROVIDER OR SUPPLIER		S	STREET ADDRESS, CITY, STATE, ZIP CODE	
GLENBUF	RNIE REHAB & NURSING	CENTER		1901 LIBBIE AVE RICHMOND, VA 23226	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
E 037	Continued From page	e 5	E 037		
	preparedness plan fa	iled to evidence		updated to include all documentation ar	nd
		facility's annual emergency		conducting of drills.	
	preparedness training			2-Maintenance Director and safety	
	annual emergency pr	acility staff have received		committee has reviewed all training materials and has educated all staff on	
		oparoarioos training.		annual facility-based emergency	
	On 02/08/2023 appro			preparedness drills.	
		ted with ASM (administrative		3-An audit will be completed monthly X	
		ministrator. When asked		months to ensure that required drills are	e
		ning regarding the facility's ness ASM #1 stated that		completed and annual emergency preparedness drills and training have	
		dence of annual emergency		occurred. Any variances will be corrected	ed
	preparedness training	g offerings and		with additional training.	
		acility staff have received		4-On-going compliance will be monitore	ed
	annual emergency pr	eparedness training.		and reviewed at the QAPI meeting process. The results of the review will b	
	No further informatior	n was provided prior to exit.		discussed at the monthly QAPI meeting Once the QAPI committee determines to problem no longer exists, the reviews we be completed on a random basis. The Administrator or Director of Nursing are responsible for implementation of the pro- of correction.	ı. he ill
E 030	EP Testing Requirem	ents	E 039	5-Date of Completion 3/21/23	3/21/23
	CFR(s): 483.73(d)(2)				0/2 1/20
	§460.84(d)(2), §482.1 §483.475(d)(2), §484 §485.542(d)(2), §485	113(d)(2), §441.184(d)(2), 15(d)(2), §483.73(d)(2), .102(d)(2), §485.68(d)(2), .625(d)(2), §485.727(d)(2), .12(d)(2), §494.62(d)(2).			
	at §485.542, OPO, "C	§485.920, RHCs/FQHCs at			

Facility ID: VA0392

If continuation sheet Page 6 of 213

DEPARTMENT OF HEALTH AN CENTERS FOR MEDICARE & I						FORM): 03/14/2023 MAPPROVED). 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>í</i>		CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
	495391	B. WING			_		C 08/2023
NAME OF PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STA	ATE, ZIP CODE		
GLENBURNIE REHAB & NURSING	CENTER		19	901 LIBBIE AVE			
	BERTER		R	RICHMOND, VA 23226			
PREFIX (EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BE ICED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE
to test the emergency must do all of the follo (i) Participate in a full- community-based eve	ty] must conduct exercises plan annually. The [facility] owing: -scale exercise that is	E	039				
accessible, conduct a exercise every 2 year (B) If the [facility] natural or man-made activation of the emer exempt from engaging community-based or if functional exercise for actual event. (ii) Conduct an addition years, opposite the year functional exercise un this section is conduct not limited to the follor (A) A second full-scale community-based or if functional exercise; of (B) A mock disaster d (C) A tabletop exercise a facilitator and include a narrated, clinically-r scenario, and a set of directed messages, of designed to challenge (iii) Analyze the [facility maintain documentatii exercises, and emerg [facility's] emergency *[For Hospices at 418	facility-based functional s; or experiences an actual emergency that requires gency plan, the [facility] is g in its next required individual, facility-based lowing the onset of the onal exercise at least every 2 ear the full-scale or oder paragraph (d)(2)(i) of ted, that may include, but is wing: e exercise that is individual, facility-based r rill; or we or workshop that is led by les a group discussion using elevant emergency problem statements, r prepared questions e an emergency plan. ty's] response to and on of all drills, tabletop ency events, and revise the plan, as needed.						

Facility ID: VA0392

If continuation sheet Page 7 of 213

	MENT OF HEALTH AN S FOR MEDICARE & I	D HUMAN SERVICES					FORM): 03/14/2023 APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í				(X3) DATE COMP	SURVEY LETED
		495391	B. WING			_		C 08/2023
NAME OF PI	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
GLENBUF	NIE REHAB & NURSING	CENTER			901 LIBBIE AVE RICHMOND, VA 23226			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD B ICED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
E 039	 annually. The hospice (i) Participate in a full community based ever (A) When a community accessible, conduct a functional exercise event (B) If the hospice exponent man-made emergency the emergency plan, the engaging in its next re- community-based event facility-based function onset of the emergency (ii) Conduct an additional opposite the year the exercise under paragon is conducted, that mat to the following: (A) A second full-scal community-based or a exercise; or (B) A mock disaster or (C) A tabletop exercise a facilitator and include a narrated, clinically-re- scenario, and a set of directed messages, on designed to challenge (3) Testing for hospice care directly. The hospice exercises to test the ex- year. The hospice mutical is community-based; 	anospice must conduct mergency plan at least e must do the following: -scale exercise that is ary 2 years; or y based exercise is not in individual facility based ery 2 years; or eriences a natural or y that requires activation of he hospital is exempt from equired full scale ercise or individual al exercise following the cy event. onal exercise every 2 years, full-scale or functional raph (d)(2)(i) of this section y include, but is not limited the exercise that is a facility based functional frill; or se or workshop that is led by es a group discussion using elevant emergency problem statements, r prepared questions e an emergency plan. es that provide inpatient spice must conduct mergency plan twice per ust do the following: nnual full-scale exercise that	E	039				

Facility ID: VA0392

If continuation sheet Page 8 of 213

CENTER STATEMENT (MENT OF HEALTH AN S FOR MEDICARE & I DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE			FORM OMB NC (X3) DATE	
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING _		Ĩ	COMP	LETED
		495391	B. WING			_		C 08/2023
NAME OF PI	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STA	ATE, ZIP CODE	-	
GLENBUR	RNIE REHAB & NURSING	CENTER			901 LIBBIE AVE RICHMOND, VA 23226			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BE ICED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
E 039	accessible, conduct a facility-based function (B) If the hospice expr man-made emergence the emergency plan, te engaging in its next re based or facility-based following the onset of (ii) Conduct an addition may include, but is no (A) A second full-scal community-based or a exercise; or (B) A mock disaster of (C) A tabletop exercise facilitator that includes narrated, clinically-releand a set of problem s messages, or prepare challenge an emergen (iii) Analyze the hosp maintain documentatii exercises, and emergen (iii) Analyze the hosp maintain documentatii exercises, and emergen (iii) Analyze the hosp maintain documentatii exercises, and emergen (iii) Analyze the hosp maintain documentatii exercises and emergen (i) Participate in an an is community-based; of (A) When a community accessible, conduct a facility-based function	n annual individual al exercise; or eriences a natural or y that requires activation of he hospice is exempt from equired full-scale community d functional exercise the emergency event. onal annual exercise that it limited to the following: le exercise that is a facility based functional drill; or se or workshop led by a s a group discussion using a evant emergency scenario, statements, directed ed questions designed to ncy plan. ice's response to and on of all drills, tabletop ency events and revise the plan, as needed. 184(d), Hospitals at §485.625(d):] F, Hospital, CAH] must test the emergency plan PRTF, Hospital, CAH] must nnual full-scale exercise that or cy-based exercise is not n annual individual,	E	039				

Facility ID: VA0392

If continuation sheet Page 9 of 213

	-	D HUMAN SERVICES MEDICAID SERVICES				FORM): 03/14/2023 MAPPROVED). 0938-0391
STATEMENT C	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		495391	B. WING		_		C 08/2023
NAME OF PF	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
GLENBUR	NIE REHAB & NURSING	CENTER		901 LIBBIE AVE CHMOND, VA 23226			
			I	-			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	S PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
E 039	Continued From page	9	E 039				
		made emergency that					
		the emergency plan, the					
	[facility] is exempt from						
	required full-scale cor	nmunity based or individual,					
	-	al exercise following the					
	onset of the emergen	•					
		additional] annual exercise or					
	following:	but is not limited to the					
	(A) A second full-sca	le exercise that is					
		ndividual, a facility-based					
	functional exercise; or						
		lisaster drill; or					
	(C) A tabletop ex	ercise or workshop that is					
	led by a facilitator and	÷ .					
		arrated, clinically-relevant					
	emergency scenario,	-					
		nessages, or prepared o challenge an emergency					
	plan.	challenge an emergency					
		facility's] response to and					
	.,	on of all drills, tabletop					
		ency events and revise the					
	[facility's] emergency	plan, as needed.					
	*[For PACE at §460.8	4(d):]					
	(2) Testing. The PACE	E organization must conduct					
		emergency plan at least					
	•	organization must do the					
	following:						
	 (i) Participate in an all is community-based; 	nnual full-scale exercise that					
	•	y-based exercise is not					
	accessible, conduct a						
	facility-based function						
	-	iences an actual natural or					
		y that requires activation of					
	the emergency plan, t	he PACE is exempt from					

Facility ID: VA0392

If continuation sheet Page 10 of 213

	-	D HUMAN SERVICES MEDICAID SERVICES					FORM): 03/14/2023 APPROVED 0. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /				(X3) DATE COMP	SURVEY LETED
		495391	B. WING			_		C 08/2023
NAME OF PF	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
GLENBUR	NIE REHAB & NURSING	CENTER			901 LIBBIE AVE RICHMOND, VA 23226			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BE ICED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
E 039	based or individual, fa exercise following the event. (ii) Conduct an ad years opposite the ye exercise under paragu is conducted that may the following: (A) A second full-scal community-based or i functional exercise; or (B) A mock disaster of (C) A tabletop exercise a facilitator and includ using a narrated, clini scenario, and a set of directed messages, o designed to challenge (iii) Analyze the PACI maintain documentati exercises, and emerg PACE's emergency pl *[For LTC Facilities at (2) The [LTC facility] r test the emergency pl	equired full-scale community acility-based functional onset of the emergency dditional exercise every 2 ar the full-scale or functional raph (d)(2)(i) of this section r include, but is not limited to de exercise that is ndividual, a facility based drill; or se or workshop that is led by des a group discussion, cally-relevant emergency problem statements, r prepared questions an emergency plan. E's response to and on of all drills, tabletop ency events and revise the an, as needed. §483.73(d):] nust conduct exercises to an at least twice per year,	E	039				
	is community-based; (A) When a communit accessible, conduct a facility-based function (B) If the [LTC facility] actual natural or man-	es. The [LTC facility, ollowing: nnual full-scale exercise that or cy-based exercise is not n annual individual,						

Facility ID: VA0392

If continuation sheet Page 11 of 213

	MENT OF HEALTH AN S FOR MEDICARE & I		_				FORM): 03/14/2023 1 APPROVED 0. 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		E CONSTRUCTION			LETED
		495391	B. WING			-	(02/	08/2023
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STA	ATE, ZIP CODE		
GLENBUR	NIE REHAB & NURSING	CENTER			901 LIBBIE AVE RICHMOND, VA 23226			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BI ICED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE
E 039	required a full-scale c individual, facility-base following the onset of (ii) Conduct an addition may include, but is not (A) A second full-scal community-based or a functional exercise; of (B) A mock disaster of (C) A tabletop exercise a facilitator includes a narrated, clinically-rele and a set of problem s messages, or prepare challenge an emerger (iii) Analyze the [LTC and maintain docume exercises, and emerg [LTC facility] facility's of *[For ICF/IIDs at §483 (2) Testing. The ICF/II to test the emergency The ICF/IID must do t (i) Participate in an ar- is community-based; (A) When a community accessible, conduct a facility-based function (B) If the ICF/IID exper man-made emergency the emergency plan, t engaging in its next re community-based or i functional exercise fol emergency event.	from engaging its next ommunity-based or ed functional exercise the emergency event. onal annual exercise that it limited to the following: le exercise that is an individual, facility based drill; or se or workshop that is led by group discussion, using a evant emergency scenario, statements, directed ed questions designed to ncy plan. facility] facility's response to ntation of all drills, tabletop ency events, and revise the emergency plan, as needed. 8.475(d)]: ID must conduct exercises plan at least twice per year. he following: nual full-scale exercise that or cy-based exercise is not n annual individual, al exercise; or. eriences an actual natural or y that requires activation of he ICF/IID is exempt from	E	039				

Facility ID: VA0392

If continuation sheet Page 12 of 213

		ND HUMAN SERVICES			PRINTED: 03/14/20 FORM APPROVE OMB NO. 0938-039
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495391	B. WING		C 02/08/2023
NAME OF P	DDE				
GLENBUF	RNIE REHAB & NURSING	GCENTER		901 LIBBIE AVE RICHMOND, VA 23226	
(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 C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE COMPLETION THE APPROPRIATE DATE
E 039	may include, but is no (A) A second full-sca community-based or functional exercise; o (B) A mock disaster o (C) A tabletop exercise a facilitator and includu using a narrated, clin scenario, and a set o directed messages, o designed to challengy (iii) Analyze the ICF/I maintain documentate exercises, and emergy ICF/IID's emergency *[For HHAs at §484.1 (d)(2) Testing. The H to test the emergency least annually. The H (i) Participate in a full community-based; or (A) When a com accessible, conduct a facility-based function or. (B) If the HHA e or man-made emerge of the emergency platent engaging in its next r community-based or functional exercise for emergency event. (ii) Conduct an addition opposite the year the exercise under parage	ot limited to the following: le exercise that is an individual, facility-based or drill; or se or workshop that is led by des a group discussion, ically-relevant emergency f problem statements, or prepared questions e an emergency plan. ID's response to and ion of all drills, tabletop gency events, and revise the plan, as needed. 102] HA must conduct exercises y plan at IHA must do the following: I-scale exercise that is munity-based exercise is not an annual individual, nal exercise every 2 years; experiences an actual natural ency that requires activation in, the HHA is exempt from equired full-scale individual, facility based ollowing the onset of the onal exercise every 2 years, e full-scale or functional graph (d)(2)(i) of this section at may include, but is not	E 039		

Facility ID: VA0392

If continuation sheet Page 13 of 213

DEPARTMENT OF HEA CENTERS FOR MEDIC/							FORM	D: 03/14/2023 MAPPROVED D. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		E CONSTRUCTION			LETED
		495391	B. WING					C 08/2023
NAME OF PROVIDER OR SUPPL	IER.			s	STREET ADDRESS, CITY, STAT	TE, ZIP CODE	-	
GLENBURNIE REHAB & N	URSING	CENTER			901 LIBBIE AVE RICHMOND, VA 23226			
PREFIX (EACH DE	FICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORRECT CROSS-REFERENC	PLAN OF CORRECTION TIVE ACTION SHOULD B CED TO THE APPROPRIA FFICIENCY)		(X5) COMPLETION DATE
community-ba functional exer (B) A mod (C) A tabl led by a facilita discussion, us emergency sc statements, di questions desi plan. (iii) Analyze th documentation emergency ev emergency ev emergency pla *[For OPOs at (d)(2) Testing. to test the emer following: (i) Conduct a p workshop at le led by a facilita discussion, us emergency sc statements, di questions desi plan. If the OP man-made em the emergency engaging in its following the o (ii) Analyze the documentation emergency ev	ond full sed or rcise; o k disas etop ex- ator and ing a n- enario, rected gned to e HHA' o of all o ents, a in, as r §486.3 The Ol ergency baper-b ast and ator and ing a n- extern set of o expe- ergency / plan, next ro next ro ne	-scale exercise that is an individual, facility-based r ster drill; or ercise or workshop that is d includes a group arrated, clinically-relevant and a set of problem messages, or prepared o challenge an emergency s response to and maintain drills, tabletop exercises, and nd revise the HHA's needed. 360] PO must conduct exercises y plan. The OPO must do the ased, tabletop exercise or nually. A tabletop exercise is d includes a group arrated, clinically relevant and a set of problem messages, or prepared o challenge an emergency eriences an actual natural or by that requires activation of the OPO is exempt from equired testing exercise the emergency event. s response to and maintain tabletop exercises, and nd revise the [RNHCI's and an, as needed.	E	039				

If continuation sheet Page 14 of 213

TATEMENT (DF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		E CONSTRUCTION	(X3) DATE COMF	SURVEY	
		495391	B. WING				-	
NAME OF PI	ROVIDER OR SUPPLIER		•	s	STREET ADDRESS, CITY, STATE, ZIP CODE	ments a has n-house drills. blished for in 6 months or n the annual Administrator Il facility staff on process and designee will to ensure that for Emergency lemented. Any with additional ill be monitored meeting review will be		
GLENBUF	NIE REHAB & NURSING	GCENTER			1901 LIBBIE AVE RICHMOND, VA 23226			
		ATEMENT OF DEFICIENCIES	10		PROVIDER'S PLAN OF CORRECTION		(25)	
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	COMPLETION	
E 039	Continued From page	e 14	F	039				
	(d)(2) Testing. The R			000				
		emergency plan. The RNHCI						
	must do the following							
		, based, tabletop exercise at						
		etop exercise is a group						
	discussion led by a fa	acilitator, using a narrated,						
	-	ergency scenario, and a set						
		ts, directed messages, or						
		lesigned to challenge an						
	emergency plan.							
	(ii) Analyze the RNH							
		ion of all tabletop exercises, ts, and revise the RNHCI's						
	emergency plan, as r							
		is not met as evidenced						
	by:							
	-	view and facility document			E039 EP Testing Requirements			
		ined that the facility staff			1-The life safety committee has			
	failed to have a comp	blete emergency			completed the first of two in-house			
	preparedness plan re	elated to emergency			emergency preparedness drills.			
	preparedness training	g exercises.			2-Schedule has been established for			
					completion of second drill in 6 months			
	The findings include:				the facility will participate in the annua			
		munide evidence of			VAHHS Tabletop exercise. Administra			
	Facility staff failed to	e annual tabletop and full			or designee will educate all facility sta			
		cility's efforts to identify a full			Emergency preparedness process ar annual requirements.	u		
		ise analysis, response and			3- Maintenance director or designee	will		
		ted its emergency program			audit monthly X 3 months to ensure th			
	based on the exercis				required training and drills for Emerge			
					preparedness is being implemented.	-		
	On 02/07/2023 at ap	proximately 2:00 p.m., the			variances will be corrected with additi			
		preparedness plan was			training.			
		the facility's emergency			4. On-going compliance will be monit	ored		
	preparedness plan fa				and reviewed at the QAPI meeting			
		annual tabletop and full			process. The results of the review wil			
		cility's efforts to identify a full			discussed at the monthly QAPI meeti	-		
		ise analysis, response and ted its emergency program			Once the QAPI committee determined problem no longer exists, the reviews			
	bout the teallity undet	a lite amarganey program	1		proplem no longer eviete the reviewe	14/111		

Facility ID: VA0392

If continuation sheet Page 15 of 213

	DF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DA	NO. 0938-039 TE SURVEY MPLETED
		495391	B. WING		0	C 2/08/2023
NAME OF PR	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODI		
GLENBUR	NIE REHAB & NURSING	GCENTER	1	901 LIBBIE AVE		
			R	RICHMOND, VA 23226		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION X (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
E 039	Continued From page	e 15	E 039			
	based on the exercis			be completed on a random ba Administrator or Director of Nu	ursing are	
	interview was conduct staff member) #1, ad about the annual tab the facility's efforts to exercise analysis, result updated its emergent	eximately 10:30 a.m., cted with ASM (administrative ministrator. When asked letop and full scale exercise, or identify a full scale exercise, sponse and how the facility cy program based on the M #1 stated that they did not		responsible for implementation of correction. 5-Date of Completion 3/21/23	n of the plan	
F 000	No further informatio	n was provided prior to exit. S	F 000			
	survey was conducted 2/8/2023. Correction compliance with 42 C Term Care requirement survey/report will folk investigated during the Substantiated with de Substantiated with de					
	115 at the time of the	25 certified bed facility was survey. The survey sample int resident reviews and 15 s.				

Event ID: V8T511

Facility ID: VA0392

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	-	D HUMAN SERVICES MEDICAID SERVICES					FORM): 03/14/2023 1 APPROVED 0. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ì í		CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		495391	B. WING _			_	(02/) 08/2023
NAME OF PF	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STA	ATE, ZIP CODE		
GLENBUR	NIE REHAB & NURSING	CENTER			901 LIBBIE AVE ICHMOND, VA 23226			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	K	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BE ICED TO THE APPROPRIA IEFICIENCY)		(X5) COMPLETION DATE
F 550 SS=D	Continued From page CFR(s): 483.10(a)(1)(F	550				
	self-determination, an access to persons an outside the facility, ind this section.	ht to a dignified existence, d communication with and d services inside and cluding those specified in						
	with respect and dign resident in a manner promotes maintenance	and in an environment that e or enhancement of his or ognizing each resident's ity must protect and						
	access to quality care severity of condition, must establish and m practices regarding tra	ility must provide equal regardless of diagnosis, or payment source. A facility aintain identical policies and ansfer, discharge, and the under the State plan for all of payment source.						
		ight to exercise his or her the facility and as a citizen						
	resident can exercise	ility must ensure that the his or her rights without , discrimination, or reprisal						
	free of interference, c	ident has the right to be oercion, discrimination, and ty in exercising his or her						

Facility ID: VA0392

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	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	IPLE CON	STRUCTION	OMB NO	
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	. ,			COMPI	LETED
)
		495391	B. WING			02/0	08/2023
NAME OF PI	ROVIDER OR SUPPLIER			STREE	T ADDRESS, CITY, STATE, ZIP CODE		
	NIE REHAB & NURSIN	GCENTER		1901 L	IBBIE AVE		
022.1201		0 0 - 11 - 21		RICH	MOND, VA 23226		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT 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 APPROPRIA DEFICIENCY)		(X5) COMPLETIO DATE
F 550	Continued From pag	e 17	F	550			
		oorted by the facility in the					
		rights as required under this					
	subpart.						
	•	T is not met as evidenced					
	by:						
		on, resident interview, staff			550-Resident Rights/Exercise of Rig		
	· · ·	ument review, and clinical			Resident # 128 is provided clean and		
		cility staff failed to provide a dignified manner for two of			propriate clothing. All current residents have the potenti		
		urvey sample, Residents			be affected. The Interdisciplinary tea		
	#128 and #96.	arrey campie, reclaeme			designees will complete an audit of a		
					sidents to ensure that they are weari		
	The findings include:			cle	ean and appropriate clothing and ins	-	
				re	sident rooms to ensure that they are		
		8 (R128), the facility staff			ean and sanitary.		
		sident's soiled sock, failed to			The ADON, or designee will educate	all	
	dress in street clothe	vacy, and failed to help him to			ertified Nursing Aides and Licensed		
	aress in street clothe	S.			urses on the provisions of providing spectful and dignified care, to include		
	On the most recent N	/IDS (minimum data set), an			ean and appropriate clothing and		
		ent with an ARD (assessment			porting resident rooms that need		
		22/23, R128 was coded as			eaning to the appropriate Departmen	t.	
	being severely cogni	tively impaired for making		T	he Housekeeping director or designe	e	
		ng scored three out of 15 on			Il educate all housekeeping staff on t	he	
		view for mental status). The			ocess of room cleanliness		
		as requiring the extensive			The Unit Manager, or designee will		
	assistance of staff fo grooming, and dress				mplete observations of residents to sure that they are dressed in clean a	and	
	9:0011119, and 01655				propriate clothing on a weekly basis		
	On each of the follow	ving dates and times, R128			beeks, then monthly $x 2$. The		
		spital gown, and was in a			ousekeeping Director, or designee wi	ill	
		itors and staff: 2/5/23 at 3:18			mplete resident room inspections on		
		5:12 p.m.; 2/6/23 at 8:16			eekly basis x 8 weeks, then monthly	x 2	
		p.m.; 2/7/23 at 12:10 p.m.			check for cleanliness.		
		n. and 9:40 a.m., R128 was			The results of the audits will be	a	
		gown, and sitting on the side ay from the door. The			scussed at the monthly QAPI meeting ne committee will determine the need	-	
		own was tied at the neck, and			rther audits and/or action.		
		down to the resident's			ne Administrator or Director of Nursin		

Facility ID: VA0392

		MEDICAID SERVICES		LE CONSTRUCTION		10. 0938-039
	CORRECTION	IDENTIFICATION NUMBER:	. ,		. ,	MPLETED
			A. DOILDING	·		С
		495391	B. WING		0	2/08/2023
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE,		
				1901 LIBBIE AVE		
GLENBUR	RNIE REHAB & NURSING	GENTER		RICHMOND, VA 23226		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE CROSS-REFERENCED	N OF CORRECTION E ACTION SHOULD BE TO THE APPROPRIATE CIENCY)	(X5) COMPLETIO DATE
F 550	Continued From page	e 18	F 55	0		
		nt's back was exposed to the		are responsible for imp	lementation of the	
	view of anyone who I	ooked into the room from the		plan of correction.		
		different staff members		6-Date of Compliance 3	3/21/23	
	passed by the resider passing out meal tray	nt's door while they were /s during this time.				
	On the following date	es and times, R128 was				
		oodstained sock: 2/5/23 at				
		and 5:12 p.m.; 2/6/23 at				
	8:16 a.m., 9:40 a.m.,					
		n., LPN (licensed practical				
		11 were asked what types of				
		hould receive with morning				
		y living) care each day. LPN re includes washing a				
		ands, changing incontinence				
		oileting, repositioning a				
		, and getting a resident				
	dressed for the day.					
	•	resident to be dressed all				
		n, or to still be wearing				
		rom over 24 hours before				
		it is not." LPNs #11 and #2 g up in the bed, still dressed				
	in a hospital gown, ar					
		PN #11 stated: "This is not				
		. I will get [R128] changed."				
	When asked what sh	e would do if she observed a				
		outtocks were visible from				
	-	ed she would give the				
		piece of clothing to cover d a resident "deserves their				
		d if R128 had been treated in				
	a dignified manner by	y the facility staff, both LPN ed the resident had not.				
	On 2/7/23 at 5:05 p.n	n., ASM (administrative staff				

Facility ID: VA0392

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							FORM	
STATEMENT C	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>í</i>				(X3) DATE COMP	SURVEY LETED
	ND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING 495391 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 1901 LIBBIE AVE RICHMOND, VA 23226 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF COR (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF COR (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF COR		_					
NAME OF PF	ROVIDER OR SUPPLIER		1	S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
GLENBUR	NIE REHAB & NURSING	CENTER						
PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREF		(EACH CORREC CROSS-REFEREN	CTIVE ACTION SHOULD BINCED TO THE APPROPRIA		(X5) COMPLETION DATE
F 550	Continued From page	e 19	CES FORM APPRC LERCLA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY LINDER: A BUILDING (X3) DATE SURVEY at B. WING C D STREET ADDRESS, CITY, STATE, ZIP CODE C 1901 LIBBIE AVE RICHMOND, VA 23226 VES D PROVIDER'S PLAN OF CORRECTION COMPLETED VENUL PREFIX CROSS-REFERENCED TO THE APPROPRIATE DOM/LETED VENUL PREFIX CROSS-REFERENCED TO THE APPROPRIATE DOM/LETED Ional F 550 COMPRES PLAN OF CORRECTION COMPLETED ional F 550 COMPRES PLAN OF CORRECTION COMPLETED ional F 550 CONSS-REFERENCED TO THE APPROPRIATE DOM/LETED ional F 550 COMPLETED COMPLETED ional a Stetl, a Stetl, a Stetl, a ssed in tr dignity Spital Stetl, a Stetl, a a rs, he Stetl, a Stetl, a Stetl, a Stetl, a sseth, a Stetl, a Stetl, a Stetl, a Stetl, a arctartartartartartartartartartartartartart					
	director of clinical serv							
	assistant) #5 was inter ADL resident care corr up, washing their face combing their hair, an regular clothes. When is preserved if the res gown during the day, bloodstained sock for stated: "No. That is no A review of the facility revealed no information resident personal care	erviewed. He stated morning hists of getting a resident e, brushing their teeth ind getting them dressed in h asked if a resident's dignity bident is left in a hospital and is left wearing a more than 24 hours, he but dignified at all." I policy labeled "Dignity," on relevant to dignity in e.						
	2. For (R96), the facil the bathroom in a clea	lity staff failed to maintain						
	quarterly assessment reference date) of 12/ out of 15 on the BIMS status), indicating the	with an ARD (assessment /20/2022, (R96) scored 13 6 (brief interview for mental resident is cognitively intact						
	on 02/06/2023 at app observation of (R96's) feces in and on the to side of the toilet bowl, toilet to the bathroom	roximately 8:30 a.m., an) bathroom revealed loose ilet seat, down the front and , on the floor trailing from the						

Facility ID: VA0392

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	MENT OF HEALTH AN S FOR MEDICARE & I					FORM): 03/14/2023 APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE COMP	SURVEY LETED
		495391	B. WING	_	C 02/08/2023		
NAME OF P	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STA	ATE, ZIP CODE	-	
GLENBU	RNIE REHAB & NURSING	CENTER		901 LIBBIE AVE RICHMOND, VA 23226			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BE ICED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE
F 550	interview was conduct asked how long the b condition as described wasn't cleaned in the they kept the bathrood odor. When asked if about the condition of that they told facility s they told or when. On 02/06/2023 at 9:04 (R96's) room revealed (other staff member) at in the doorway looking #1, housekeeping ma room, cleaning the bat the dark substance we bathroom out into the stated that the substa On 02/06/2023 at 9:14 conducted with OSM housekeeping. When they were cleaning in seat, down the front at the floor trailing from the door and extending of OSM #1 stated it was describe what their de schedule should be C housekeepers on eac through 3:00 p.m. eve asked how many hou working in the facility Sunday 02/05/2023 C two housekeepers on the weekend was fully	roximately 8:45 a.m. an ted with (R96). When athroom was in the d above (R96) stated that it past couple of days and that m door closed due to the they notified any facility staff their bathroom (R96) stated taff but could not recall who 4 a.m. an observation of d housekeeping staff OSM #2, housekeeper, standing g into the room and OSM nager, who was in the throom. When asked what as trailing from the resident's room OSM #2 nce looked like feces. D a.m., an interview was #1, director of a asked about the substance the bathroom on the toilet nd side of the toilet bowl, on the toilet to the bathroom ut into the (R96's) room, feces. When asked to epartment's staffing ISM #1 stated three h unit from 7:00 a.m. ery day of the week. When	F 550				

Facility ID: VA0392

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-		ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT OF DEFICIE AND PLAN OF CORRECT	NCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			ONSTRUCTION	(X3) DATE COMF	
		495391	B. WING				08/2023
NAME OF PROVIDER C	R SUPPLIER			STR	EET ADDRESS, CITY, STATE, ZIP CODE		
GLENBURNIE REH	AB & NURSING	CENTER			1 LIBBIE AVE HMOND, VA 23226		
	EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
 requires shift to bathrood When a bathrood OSM # have be constant of the second of the seco	check all the r oms, pick up an asked if it was om to be in the 1 stated no an een cleaned in 07/2022 at app strative staff n 2, interim dired director of clion of the above fill her information nt/Family Grout : 483.10(f)(5)(f) 0(f)(5) The res- ticipate in resi- facility must pr f one exists, we able steps, wite e residents and ng meetings in f, visitors, or o t group or fam- bective group's facility must pr who is approv- and the facility must pr statility must pr f on exists, we able steps, wite e residents and ng meetings in f, visitors, or o t group or fam- bective group's facility must pr who is approv- and the facility must of t or family grou- vances and re- concerning iss	A-through' at the end of their esident's rooms and by trash, clean any spills. dignified for a resident's condition described above d that the bathroom should mediately. broximately 5:00 p.m., ASM member) #1, administrator, ctor of nursing and ASM # 3, nical services, were made ndings. a was provided prior to exit. up and Response D-(iv)(6)(7) ident has a right to organize dent groups in the facility. rovide a resident or family <i>v</i> ith private space; and take h the approval of the group, d family members aware of n a timely manner. ther guests may attend ily group meetings only at	F 5				3/21/23

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		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 03/14/2023 FORM APPROVED OMB NO. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495391	B. WING		C 02/08/2023
NAME OF P	ROVIDER OR SUPPLIER	•	S	STREET ADDRESS, CITY, STATE, ZIP CODE	•
GLENBU	RNIE REHAB & NURSING	G CENTER		1901 LIBBIE AVE RICHMOND, VA 23226	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION
F 565	 (A) The facility must heresponse and rational (B) This should not be facility must impleme request of the resider §483.10(f)(6) The resident sparticipate in family gi §483.10(f)(7) The resident in family gi §483.10(f)(7) The resident for representative(s) mean families or resident residents in the facility This REQUIREMENT by: Based on staff interving review, the facility staff state council concerts council meetings; the The findings include: The facility staff failed November 2022 resident council concerts revealed the for "(Name of a resident) expressed a concern They are not being and Grievance form will be review of the November 2022 grievances failed regarding the resident council concerts form will be review of the November 2022 grievances failed the regarding the resident council councerts form will be review of the November 2022 grievances failed the regarding the resident councerts failed the resident councerts form will be review of the November 2022 grievances failed the resident councerts failed the r	 be able to demonstrate their lie for such response. e construed to mean that the nt as recommended every nt or family group. bident has a right to groups. bident has a right to have other resident et in the facility with the epresentative(s) of other ry. T is not met as evidenced riew and facility document aff failed to respond to a ern for one of one resident et November 2022 meeting. 	F 565	F565-Resident/Family Group and response 1-Any concerns mentioned from the r recent Resident Council meeting have been addressed and feedback provid the residents. 2-All residents have the potential to b affected by resident concerns mention in the Resident council meeting not b addressed. The Administrator will rev the most recent Resident council meet minutes and ensure that any noted concerns will be addressed. 3-The Administrator, or designee will educate the Activities Director and the Interdisciplinary Team on communica resident council meeting to the Administrator and ensuring feedback resolution of the concerns to the Residents. 4-The Administrator, or designee will review the Resident council minutes of	e ed to e ned eing iew eting of

Facility ID: VA0392

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	S FOR MEDICARE &	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPI	E CONSTRUCTION	(X3) DATE SURVE	8-039 Y
	CORRECTION	IDENTIFICATION NUMBER:	. ,		COMPLETED	
					С	
		495391	B. WING		02/08/202	23
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
GLENBUR	NIE REHAB & NURSING	G CENTER		1901 LIBBIE AVE RICHMOND, VA 23226		
(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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMP	(X5) PLETIOI DATE
F 565	Continued From page	e 23	F 56	5		
	member) #1 (the adm	ninistrator) was asked to		monthly basis x 2 and ensure that a	any	
	provide evidence that	t the November 2022		concerns are addressed appropriat		
		ern regarding call bells was		5-The results of the audits will be		
	addressed. No furthe provided. A review o	er documentation was		discussed at the monthly QAPI meet The committee will determine the n	•	
	meeting notes for 1/2			further audits and/or action.		
		arding call bell response.		The Administrator or Director of Nu	rsing	
	5	5		are responsible for implementation	-	
	On 2/7/23 at 10:53 a.			plan of correction.		
		(other staff member) #5 (the		6- Date of compliance 3/21/23		
	director of activities).					
	• •	es a grievance form when biced at the resident council				
		tated she provides the				
	-	director of social services				
	who distributes the g	rievance to the department				
	•	oncern. OSM #5 stated				
	there should have be					
	concern regarding ca	28/22 resident council Il bells.				
		n., ASM #1 and ASM #2 (the ere made aware of the				
	The facility policy title	d, "Resident Council"				
		Administrator is responsible				
	for reviewing and sign	ning the (name of company)				
	Resident Council Me					
		to concerns presented by ministrative Response to				
	Resident Council For					
F 580	-	jury/Decline/Room, etc.)	F 580		3/21/2	/23
SS=E						
	§483.10(g)(14) Notifi					
	(i) A facility must imm consult with the resid	ediately inform the resident;				

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	MENT OF HEALTH AN S FOR MEDICARE & I					FORM	: 03/14/2023 APPROVED . 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		495391	B. WING			(02/	C 08/2023
NAME OF P	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STA	TE, ZIP CODE		
GLENBU	RNIE REHAB & NURSING	CENTER		901 LIBBIE AVE RICHMOND, VA 23226			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECT CROSS-REFERENC	PLAN OF CORRECTION TIVE ACTION SHOULD BE CED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE
F 580	consistent with his or representative(s) whe (A) An accident involve results in injury and has physician intervention (B) A significant change mental, or psychosocid deterioration in healthe status in either life-the clinical complications) (C) A need to alter tre a need to discontinue treatment due to advect commence a new form (D) A decision to trans- resident from the facil §483.15(c)(1)(ii). (ii) When making notif (14)(i) of this section, all pertinent information is available and provide physician. (iii) The facility must a resident and the reside when there is- (A) A change in room as specified in §483.1 (B) A change in resided State law or regulation (e)(10) of this section. (iv) The facility must re- update the address (re- phone number of the representative(s). §483.10(g)(15) Admission to a compo-	her authority, the resident n there is- ring the resident which as the potential for requiring ; ge in the resident's physical, ial status (that is, a , mental, or psychosocial eatening conditions or ; atment significantly (that is, an existing form of erse consequences, or to n of treatment); or sfer or discharge the ity as specified in fication under paragraph (g) the facility must ensure that on specified in §483.15(c)(2) ded upon request to the also promptly notify the ent representative, if any, or roommate assignment 0(e)(6); or ent rights under Federal or ns as specified in paragraph fecord and periodically nailing and email) and	F 580				

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		MEDICAID SERVICES			OMB NO. 0938-03
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED
		495391	B. WING		C 02/08/2023
NAME OF P	ROVIDER OR SUPPLIER	•	S	TREET ADDRESS, CITY, STATE, ZIP CODE	•
	RNIE REHAB & NURSING	CENTER	1	901 LIBBIE AVE	
GLENDUP		CENTER	F	RICHMOND, VA 23226	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETIC
F 580	§483.5) must disclose its physical configura locations that compris part, and must specif room changes betwe under §483.15(c)(9). This REQUIREMENT by: Based on staff interv and clinical record re- to notify the physiciar party) of a need to all	e 25 e in its admission agreement tion, including the various se the composite distinct y the policies that apply to en its different locations is not met as evidenced iew, facility document review view, the facility staff failed n and/or the RP (responsible ter treatment for four of 58 ey sample, Residents #114,	F 580	F580 Notify of Changes 1-Resident # 6, #112, #114 and #114 longer reside in the facility. 2-All current residents have the pote to be affected by the RP or MD not b notified of changes in condition or m medication administration.	ential being issed
	failed to notify the phy ordered medications resident on multiple of A review of R114's cli following physician's 6/9/22- omeprazole (capsule by mouth one gastroesophageal ref 6/10/22-mupirocin oir sacrum/buttocks rash days (scheduled at 9: 6/21/22-calcium with 1 tablet by mouth one 6/21/22-melatonin 3 r bedtime for COVID; 6/21/22-vitamin C 500 day for COVID 6/21/22 (12:32 a.m.)- (milligrams)- 1 capsu	s include:3-The ADON, or designee w licensed nurses on the prod notification to MD/RP upon condition, and notification to medications were not administered to the multiple dates in June 2022.3-The ADON, or designee w licensed nurses on the prod notification to MD/RP upon condition, and notification to medications not available for administration.R114's clinical record revealed the nysician's orders: eprazole (1) 20 mg (milligrams)- 1 mouth one time a day for hageal reflux disease; pirocin ointment (2) 2%- apply to ocks rash two times a day for ten duled at 9:00 a.m. and 9:00 p.m.); cium with vitamin D 600 mg/200 units- nouth one time a day for COVID; latonin 3 mg- 1 tablet by mouth at COVID; min C 500 mg by mouth one time a3-The ADON, or designee w licensed nurses on the prod notification to MD/RP upon condition, and notification to medications not available for administration.4-The Unit Manager, or designee w review Resident medication and resident changes in composition of the review discussed at the monthly Q for determination of further action. The Administrator or Director are responsible for implement plan of correction. 6-Date of compliance: 3/21/		 4-The Unit Manager, or designee wirreview Resident medication availabies and resident changes in condition for proper MD/RP notification on a weel basis x 8 weeks, then monthly x 2 months. 5-The results of the review will be discussed at the monthly QAPI mee for determination of further audits arr action. The Administrator or Director of Nurse are responsible for implementation of complementation of complementatic complementatic complementation of complementation of complemen	n of II lity r kly ting nd/or sing

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	-	ID HUMAN SERVICES				FORM	APPROVED
	DF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	ING .			LETED
		495391	B. WING				C 08/2023
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	02/	00/2020
GLENBU	NIE REHAB & NURSING	CENTER			1901 LIBBIE AVE		
					RICHMOND, VA 23226		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 580	Continued From page	26	F	580			
	A review of R114's Ju administration record administration record the following medicati the following dates (a spaces on the MAR a Omeprazole 20 mg of Mupirocin 2% on 6/15 Calcium with vitamin 6/21/22; Melatonin 3 mg on 6/15 Vitamin C 500 mg on Zinc sulfate 220 mg of Further review of R11 June 2022 nurses' no facility staff notified R above medications we On 2/7/23 at 12:00 p. conducted with LPN (LPN #3 stated resider notified when a physic not administered, "to something or new ord should document whe On 2/8/23 at 9:50 a.m member) #1 (the adm director of nursing) we above concern. The facility policy title Management/Medicati documented, "3. If me	 and TAR (treatment) and TAR (treatment) failed to reveal evidence ions were administered on s evidenced by blank and TAR): n 6/10/22; 5/22 (9:00 p.m.); D 600 mg/200 units on 21/22; 6/21/22; n 6/21/22. 4's clinical record, including tes, failed to reveal the 114's physician when the ere not administered. m., an interview was licensed practical nurse) #3. nts' physicians should be cian ordered medication is see if they want to change lers." LPN #3 stated nurses on the physician is notified. n., ASM (administrative staff the physician is notified. n., ASM (administrative staff the physician is notified. d, "Medication tion Unavailability" edications are determined to ministration, licensed nurse 					

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED 0. 0938-0391	
STATEMENT O	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED	
		495391	B. WING			C 02/08/2023		
NAME OF PI	ROVIDER OR SUPPLIER			:	STREET ADDRESS, CITY, STATE, ZIP CODE			
GLENBUR	RNIE REHAB & NURSING	CENTER			1901 LIBBIE AVE RICHMOND, VA 23226			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 580	the stomach. This inf the website: https://medlineplus.go tml (2) Mupirocin ointmer treat skin infections. obtained from the we https://medlineplus.go tml 2. For Resident #118 failed to notify the phy ordered medication g administered to the re A review of R118's cli physician's order date Gabapentin 100 mg (mouth three times a co osteoarthritis. The m 6:00 a.m., 2:00 p.m. a R118's November 20 administration record medication was admi p.m. A nurse's note co "Awaiting order from of R118's clinical record and the November 20	ilability in the medical eases the amount of acid in formation was obtained from ov/druginfo/meds/a617014.h at is an antibiotic used to This information was bsite: ov/druginfo/meds/a688004.h (R118), the facility staff ysician when the physician abapentin (1) was not esident on 11/5/21. nical record revealed a ed 11/5/21 (2:42 p.m.) for milligrams)- 1 capsule by day for right hip edication was scheduled at and 10:00 p.m. A review of 21 MAR (medication) failed to reveal the nistered on 11/5/21 at 10:00 dated 11/5/21 documented, pharmacy." Further review ord (including progress notes 021 MAR) failed to reveal the given and failed to reveal	F	580				
		m., an interview was licensed practical nurse) #3. nts' physicians should be						

Facility ID: VA0392

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		495391	B. WING				C 108/2023
NAME OF PF	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
GLENBUR	NIE REHAB & NURSING	CENTER			1901 LIBBIE AVE RICHMOND, VA 23226		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 580	not administered, "to something or new ord should document whe On 2/7/23 at 5:02 p.m member) #1 (the adm director of nursing) we above concern. Reference: (1) Gabapentin is use information was obtain https://medlineplus.go tml 3. For Resident #112 failed to notify the phy ordered medication co antibiotic, was not add A review of R112's cli physician's order date sodium solution recor intravenously every 2 Days. A review of R1 (medication administr evidence that ceftriax administered to the re- nurse's note dated 1/2 order." Further review (including progress no MAR) failed to reveal given and failed to revea	cian ordered medication is see if they want to change lers." LPN #3 stated nurses en the physician is notified. , ASM (administrative staff ninistrator) and ASM #2 (the ere made aware of the ere made aware of the end to treat pain. This ned from the website: by/druginfo/meds/a694007.h (R112), the facility staff ysician when the physician eftriaxone sodium (1), an ministered on 1/26/23. nical record revealed a ed 1/12/23 for ceftriaxone hstituted 2 grams 4 hours for infection for 25 12's January 2023 MAR ation record) failed to reveal one sodium was esident on 1/26/23. A 26/23 documented, "On w of R112's clinical record otes and the January 2023 the scheduled dose was weal R112's physician was licensed practical nurse) #3.	F	580			
	conducted with LPN (

Facility ID: VA0392

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
	495391						C 08/2023
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	·	
GLENBUF	RNIE REHAB & NURSING	CENTER			901 LIBBIE AVE RICHMOND, VA 23226		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 580	notified when a physic not administered, "to something or new ord should document whe On 2/7/23 at 5:02 p.m member) #1 (the adm director of nursing) we above concern. Reference: (1) Ceftriaxone sodium This information was https://medlineplus.go tml 4. For Resident #6 (F notify the responsible treatment/condition at On the most recent M admission assessmen reference date) of 11/ scored 1 out of 15 on mental status) assess resident was severely decisions. On 2/5/2023 at 4:38 p conducted with R6's r RP voiced concerns r consistent communica regarding R6's care. regarding having to ca information regarding were missed, medicar for COVID-19 isolatio (intravenous) access	cian ordered medication is see if they want to change lers." LPN #3 stated nurses en the physician is notified. , ASM (administrative staff inistrator) and ASM #2 (the ere made aware of the m is used to treat infection. obtained from the website: ov/druginfo/meds/a685032.h R6), the facility staff failed to party of changes in nd refusals of care. IDS (minimum data set), an nt with an ARD (assessment '11/2022, the resident the BIMS (brief interview for sment, indicating the or impaired for making daily o.m., an interview was responsible party (RP). The egarding the lack of ation with facility staff R6's RP voiced concerns ome to the facility to get recent antibiotic doses that tion refusals, a room change n and multiple IV problems that were not e RP stated that they were	F	580			

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		ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 03/14/202 FORM APPROVE OMB NO. 0938-039
TATEMENT (OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C		(X3) DATE SURVEY COMPLETED
		495391	B. WING		C 02/08/2023
NAME OF P	ROVIDER OR SUPPLIER	I	STR	EET ADDRESS, CITY, STATE, ZIP CC	
GLENBUF	RNIE REHAB & NURSING	CENTER		1 LIBBIE AVE CHMOND, VA 23226	
(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 C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE COMPLETION TE APPROPRIATE DATE
F 580	positive for COVID-19 room change until the check on them and the moved and started or concerns that some of been able to have be been called and were come in to encourage provide the treatment The progress notes fe - "12/28/2022 01:27 (is alert and responsive touch. no ss (signs/sy distress noted patient normal (intravenous fluid fluid usually subcutant peripheral live [sic] to is not patent, pharma IVF (intravenous fluid fluid usually subcutant pending delivery. atta was unsuccessful. IV patients' room. patien her medications as o - "12/28/2022 14:32 (were made to start and unsuccessful. Call plat concerning Clysis kit and faxed. Awaiting a - "12/29/2022 10:42 (Abdomen infusing NS (milliliter per hour) no of complications." - "12/29/2022 18:32 ((family member) was status and start of cly - "12/29/2022 19:25 (9 but was not informed of a by came to the facility to ben found our they had been in IV fluids. R6's RP voiced of these refusals may have en prevented if they had a given the opportunity to a R6 to allow the staff to the the opportunity to a R6 to allow the staff to the theorem and the opportunity to a R6 to allow the staff to the theorem and the opportunity to the theorem and the staff to the theorem and took and clysis (infusion of theorem and took theorem and the theorem and took theorem and theorem and took theorem and theorem and took theorem and theorem and theorem and theorem and took theorem and theorem and theorem and theorem and took theorem and theorem and theorem and theorem and took theorem and theorem and theorem and took theorem and theorem and theorem and theorem and took theorem and th	F 580		

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							O. 0938-03
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	IPLE CONSTRUCTIO		· · ·	E SURVEY
			A. BUILDII	NG			
		495391	B. WING				С
		490091			S, CITY, STATE, ZIP CODE	02	2/08/2023
NAME OF P	ROVIDER OR SUPPLIER						
GLENBUF	RNIE REHAB & NURSING	CENTER		1901 LIBBIE AVE			
				RICHMOND, V			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	K (EAC	ROVIDER'S PLAN OF CORRE CH CORRECTIVE ACTION SH S-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETIC DATE
F 580	Continued From page	e 31	É f	580			
		nd if resident was moved.					
	•	dent has been moved to					
	(Room number), new orders received and noted						
		dent would be placed on					
		P vocalized understanding					
	and thanks for notification						
	- "1/8/2023 04:53 (4:5						
		removed due to infiltration.					
		to the right hand. on call NP					
		ime) was called. warm					
		e given for comfort. resident					
		ylenol for pain. will continue					
	to monitor for any cha - "1/16/2023 12:44 (1						
		[•] Multiple Fracture of ribs,					
		t encounters for fractures					
		Resident up and dressed					
		elchair). Resident is awake					
		. Resident refused to eat					
	her breakfast. Reside	ent is incontinent of bowel					
	and bladder. Residen	t voiced no complaints of					
	pain or discomfort. Re	esident ambulating earlies					
	[sic] in hallways with						
		:50 a.m.) patient is alert and					
	-	n and dry to touch, no s/s of					
		placement is still pending.					
	unable to collect urine	-					
	encouraged again too medications as order						
		ea. 0:10 p.m.) Residents IV					
		oved & [Name of Vendor] is					
		it tomorrow. MD (medical					
	doctor) notified."	(
		:41 p.m.) refused to take					
	medication."						
	- "1/23/2023 19:16 (7	:16 p.m.)Skilled Nursing					
	Focus: Resident in be	-					
	complaints of pain or						
	refused to est meale	today. MD was notified.		1			

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		ID HUMAN SERVICES MEDICAID SERVICES					RINTED: 03/14/2023 FORM APPROVED MB NO. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		ONSTRUCTION		3) DATE SURVEY COMPLETED
		495391	B. WING				C 02/08/2023
NAME OF P	ROVIDER OR SUPPLIER	•		STR	EET ADDRESS, CITY, STATE, ZIP COD)E	
GLENBUF	RNIE REHAB & NURSING	G CENTER			1 LIBBIE AVE HMOND, VA 23226		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 580	Resident ambulated y [Name of Vendor] wa access. Resident rec arm. IV access is no Vendor] has been no in this shift." - "1/24/2023 06:30 (6 Piperacillin-Tazobact Solution 2-0.25 GM (2.25 gram intravenou infection for 7 Days s intravenous access). - "1/26/2023 07:01 (7 Piperacillin-Tazobact GM/50ML, Use 2.25 hours for infection for (peripherally inserted resident refused." Review of the eMAR administration record 1/1/2023-1/31/2023 c "Piperacillin-Tazobacc GM/50ML, Use 2.25 hours for infection for Date: 01/20/2023 140 (discontinue) date: 0 The eMAR further do "Piperacillin-Tazobac GM/50ML, Use 2.25 hours for infection for Date: 01/25/2023 at 10:00 p. a.m. The eMAR furth receiving the medicat p.m., 1/21/2023 at 6:00 a.m.	with therapy this morning. s in facility to obtain an IV eived IV access to left lower longer working. [Name of tified to put a central access :30 a.m.) am (antibiotic) in Dex gram)/50ML (mililiter), Use isly every 8 hours for tart PIV (peripheral Refused." :01 a.m.) am in Dex Solution 2-0.25 gram intravenously every 8 • 4 Days via Picc central catheter) line. (electronic medication) for R6 dated locumented in part, tam in Dex Solution 2-0.25 gram intravenously every 8 • 7 Days start PIV. Order 04 (2:04 p.m.) D/C 1/25/2023 1500 (3:00 p.m.)."	F	580			

Facility ID: VA0392

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OLIVILI	3 FOR MEDICARE &	MEDICAID SERVICES				IO. 0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	· · ·	E SURVEY IPLETED
		495391	B. WING			С
	ROVIDER OR SUPPLIER	490091		STREET ADDRESS, CITY, STATE, ZIP COI	•	2/08/2023
NAME OF P	ROVIDER OR SUPPLIER				JE	
GLENBUF	NIE REHAB & NURSING	GENTER		1901 LIBBIE AVE RICHMOND, VA 23226		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETIO DATE
F 580	Continued From non					
F 360	Continued From page		F 5	80		
	1/24/2023 at 6:00 a.n 1/25/2023 at 6:00 a.n	•				
	Review of the clinical	record failed to evidence				
	RP notification for the refusals, missed					
		nges in status/treatment for				
	R6 as documented al	bove.				
	On 2/7/2023 at 4:01 r	o.m., an interview was				
		(licensed practical nurse) #8.				
	LPN #8 stated that th	ey were supposed to call the				
		en medications were not				
		red or when they were				
		ed that the notification would				
		e nurses notes. LPN #8 d not normally call the RP for				
	an IV infiltration they					
		ated that they would not				
		or an IV order or an IV				
	antibiotic but they wo	uld call for R6 because their				
	family was very involv					
		ed that R6 had refused to let				
		biotic and would not let them				
	touch the IV so they h	ed that they had not notified				
	the family at the time.	-				
	On 2/8/2023 at 8:17 a	a.m., an interview was				
		#2. LPN #2 stated that it				
	was the expectation f	or the RP to be notified prior				
		reatment being started and				
		mentation to support it. LPN				
		l very small veins and they				
		s getting and maintaining an of the IV and R6 picking at				
	them. LPN #2 stated					
		ng at the site but several				
	÷	d had to be removed. LPN				
	#2 stated that DC after	en refused their medications				

Facility ID: VA0392

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM): 03/14/2023 APPROVED 0. 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		495391	B. WING		_		C 08/2023
NAME OF P	ROVIDER OR SUPPLIER		S	STREET ADDRESS, CITY, ST	ATE, ZIP CODE		
GLENBUF	RNIE REHAB & NURSING	CENTER		901 LIBBIE AVE RICHMOND, VA 23226			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	EPLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 580	at times. LPN #2 stat notify the RP any time orders, a new order o #2 stated that the nur the RP notification in On 2/8/2023 at 9:20 a conducted with LPN # notified the RP at the treatments. LPN #1 s medications, antibiotic constitute a call to the when residents refuse they also notified the The facility policy "Do Notification" dated 11. "The Charge Nurse the Physician (MD) an (RP) whenever there care of the patient. No there is a: change in the medication in the Shir notification on the app Manager is ultimately notification of the MD, been documented acc will review the Shift R appropriate notification On 2/8/2023 at appro (administrator, ASM #3, nursing and ASM #3,	ble to get them to take them and that the nurses should the there was a change in r a order discontinued. LPN ses should be documenting the medical record. a.m., an interview was 41. LPN #1 stated that they time of new orders or new stated that any new cs or IV fluids would a RP. LPN #1 stated that the treatment or medications RP. cumentation and /01/19 documented in part, is responsible for notifying nd/or the Responsible Party is a change related to the otification will occur when the patient 's condition; tion regimen; room here is a notification of the Jurse will include this ft Report and document the oropriate forms. The Unit responsible to ensure that /RP has occurred and has curately. The Unit Manager eport daily to ensure that in has occurred"	F 580				

Facility ID: VA0392

If continuation sheet Page 35 of 213

TATEMENT	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DA	NO. 0938-039	
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		со	MPLETED	
		495391	B. WING			C 12/08/2023	
NAME OF P	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE		2/00/2020	
GLENBUF	RNIE REHAB & NURSING	CENTER		901 LIBBIE AVE ICHMOND, VA 23226			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 580	Continued From page	e 35	F 580				
F 583 SS=D	Personal Privacy/Cor	•	F 583			3/21/23	
		nd Confidentiality. ght to personal privacy and or her personal and medical					
	§483.10(h)(I) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.						
	right to privacy in his written, and electronic the right to send and mail and other letters materials delivered to	sonal privacy, including the or her oral (that is, spoken), c communications, including promptly receive unopened , packages and other the facility for the resident, ered through a means other					
	and confidential perso (i) The resident has the of personal and medi provided at §483.70(if federal or state laws. (ii) The facility must a Office of the State Lo to examine a resident	sident has a right to secure onal and medical records. ne right to refuse the release cal records except as)(2) or other applicable llow representatives of the ng-Term Care Ombudsman t's medical, social, and s in accordance with State					

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TATEMENT (DF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	PLE CONSTRUCTION		TE SURVEY MPLETED
		495391	B. WING		0	C 2/08/2023
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP		2/00/2020
GLENBUR	NIE REHAB & NURSING	GCENTER		1901 LIBBIE AVE RICHMOND, VA 23226		
		ATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF		0(5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 583	Continued From page	e 36 Γ is not met as evidenced	F 5	83		
	interview, facility doct record review, it was staff failed to provide 58 residents in the su #128 and #98 The findings include: 1. For Resident #128 cover exposed body on 2/6/23. On the most recent M admission assessme reference date) of 1/2 being severely cognit daily decisions, havin the BIMS (brief interv resident was coded a assistance of staff for grooming, and dressi On 2/6/23 from 8:16 a was dressed in a hos side of the bed facing resident's hospital go open from the neck d buttocks. The resider view of anyone who I hallway. At least six of	ADS (minimum data set), an nt with an ARD (assessment 22/23, R128 was coded as tively impaired for making ng scored three out of 15 on riew for mental status). The as requiring the extensive r personal hygiene, ing. a.m. until 9:40 a.m., R128 spital gown, and sitting on the g away from the door. The two was tied at the neck, and lown to the resident's nt's back was exposed to the ooked into the room from the different staff members nt's door while they were		 F583 Personal Privacy/Cerrectors □ 1-Residents # 128 no long the facility. Resident #98 h curtain in place. 2-All residents have the peraffected. All resident room inspected by the Houseker or designee to ensure a perplace. The Interdisciplinary all residents during room r that resident dignity is prof 3-The ADON, or designee licensed nurses and CNAs residents to have personal care and/or when not dress appropriately. The Housekeeping Director will educate housekeeping requirements of having priplace for each resident. 4-The Unit Manager, or deformed to the sum privacy and dignity weekly x 8, then monthly 0. 5- The results of the audits discussed at the monthly 0. The Administrator or Director are responsible for implem plan of correction. 6-Date of Compliance 3/2* 	per resides in has a privacy obtential to be eping Director, rivacy curtain in y Team will audit rounds to ensure vided. will educate all s on the Right of I privacy during sed or, or designee y staff on the ivacy curtains in esignee will residents to v is provided k2. s will be QAPI meeting. hine the need for n. ctor of Nursing hentation of the	
	nurse) #11 was interv	n., LPN (licensed practical ⁄iewed. When asked what bserved a resident's back				

Facility ID: VA0392

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM): 03/14/2023 APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /			(X3) DATE COMP	SURVEY LETED
		495391	B. WING		-		C 08/2023
NAME OF P	ROVIDER OR SUPPLIER		s	STREET ADDRESS, CITY, STA	ATE, ZIP CODE		
GLENBUR	RNIE REHAB & NURSING	CENTER		901 LIBBIE AVE RICHMOND, VA 23226			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BE CED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE
F 583	and buttocks were vis stated she would give piece of clothing to co resident "deserves the On 2/7/23 at 5:05 p.m member) #1, the adm director of nursing, ar director of clinical ser- these concerns. On 2/8/23 at 10:18 a. assistant) #5 was inte he would do if he obs- buttocks were visible "I would find somethir He stated a resident s and should not be allo part exposed to visito A review of the facility revealed, in part: "The Center promotes the of the legal rights of all p informed before and/o and in writing in a lang of their legal rightsF the Center in a public No further information 2. For Resident #98 (f promote privacy. R98 curtain in place to sep roommates bed. On the most recent M assessment, an admi assessment reference	sible from the hallway, she the resident a blanket or over their back. She stated a eir privacy." A., ASM (administrative staff inistrator, ASM #2, the hd ASM #3, the regional vices, were informed of m., CNA (certified nursing erviewed. When asked what erved a resident's back and from the hallway, he stated: ng and help them cover up." should be provided privacy, owed to sit with any body rs, staff, or other residents. Policy, "Patient Rights," e Health and Rehabilitation education and exercising of patientsPatients are or on admission both orally guage he/she understands Patient Rights are posted in	F 583				

Facility ID: VA0392

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM): 03/14/2023 APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		495391	B. WING		_		C 08/2023
NAME OF P	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
				901 LIBBIE AVE			
GLENBUF	RNIE REHAB & NURSING	CENTER		ICHMOND, VA 23226			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BI ICED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 583	interview for mental si indicating they were of daily decisions. On 2/5/2023 at 4:05 p made of R98's room. to be semi-private wit resident was observed doorway and R98 was closest to the window beds contained a ceili curtain in place. At th conducted with R98. curtain, R98 stated th down about two week never put it back up. curtain on the other si but it did not extend p roommates bed so the to use it when providin that they would like to have privacy when the wanted to have it pulle Additional observation and 4:10 p.m. revealed between the two beds On 2/8/2023 at 9:08 at conducted with OSM director of housekeep stated that all privacy to new admissions co observed daily for beit that if privacy curtains	tatus) assessment, cognitively intact for make o.m., an observation was R98's room was observed h two beds in place. A d to be in bed closest to the s observed lying in bed . The area between the two ing track with hooks but no that time, an interview was When asked about the at the staff had taken it is before to wash it and had R98 stated that there was a ide of their roommates bed the foot of the ere was no way for the staff ing care to them. R98 stated the have a curtain in place to ey were washing up or just ed. has on 2/6/2023 at 8:10 a.m. ed no curtain in place s. a.m., an interview was (other staff member) #1, the bing and laundry. OSM #1 curtains were washed prior ming into the room and ing soiled. OSM #1 stated is were found to be soiled	F 583)EFICIENCY)		
	back up the same day were extra privacy cu	nd washed and brought y. OSM #1 stated that there rtains available for use if served R98's room without a					

Facility ID: VA0392

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		ID HUMAN SERVICES MEDICAID SERVICES			FORI	M APPROVED D. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	(X3) DATE COMF	E SURVEY PLETED C
		495391	B. WING			/08/2023
NAME OF P	ROVIDER OR SUPPLIER		_ _	STREET ADDRESS, CITY, STATE, ZIP CODE		
GLENBUF	RNIE REHAB & NURSING	CENTER		1901 LIBBIE AVE RICHMOND, VA 23226		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 583 F 584 SS=E	privacy curtain betwee that there should be a stated that they thoug add some hooks but v curtain right away to r privacy. On 2/08/2023 at 11:00 conducted with CNA (#3. CNA #3 stated th during care by pulling closing the door. CNA no curtain in place the resident to the bathro other resident out of t #3 stated that they re housekeeping to repla On 2/8/2023 at appro (administrative staff m administrator, ASM #3, clinical services were No further information Safe/Clean/Comfortal CFR(s): 483.10(i)(1)-(§483.10(i) Safe Envin The resident has a rig comfortable and hom- but not limited to rece supports for daily livin The facility must prov §483.10(i)(1) A safe, for homelike environmen	en the two beds and stated a curtain in place. OSM #1 that maintenance had to would check and replace the maintain the residents 6 a.m., an interview was (certified nursing assistant) at privacy was provided the privacy curtain and A #3 stated that if there was ey would try to take the om for care or move the he room during care. CNA port any missing curtains to ace them. ximately 11:30 a.m., ASM nember) #1, the 2, the interim director of the regional director of made aware of the concern. was provided prior to exit. ble/Homelike Environment (7) onment. ght to a safe, clean, elike environment, including iving treatment and ig safely.	F 5			3/21/23

Facility ID: VA0392

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		E CONSTRUCTION	(X3) DATE COMP	
		495391	B. WING				。 08/2023
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
GLENBUR	RNIE REHAB & NURSING	CENTER			901 LIBBIE AVE RICHMOND, VA 23226		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 584	receive care and serv physical layout of the independence and do (ii) The facility shall ex- the protection of the r or theft. §483.10(i)(2) Housek services necessary to and comfortable interr §483.10(i)(3) Clean b in good condition; §483.10(i)(4) Private r resident room, as spe §483.10(i)(5) Adequa levels in all areas; §483.10(i)(6) Comfort levels. Facilities initial 1990 must maintain a 81°F; and §483.10(i)(7) For the sound levels. This REQUIREMENT by: Based on observatio determined that facilit resident's rooms in go	ring that the resident can rices safely and that the facility maximizes resident bes not pose a safety risk. xercise reasonable care for esident's property from loss eeping and maintenance o maintain a sanitary, orderly, ior; ed and bath linens that are	F	584	F584 Safe/Clean/Comfortable/Homelil Environment 1- Resident rooms #211, #217, # 219 a being maintained in good repair and properly cleaned. 2-All current resident rooms have the potential to be affected. The Maintenar Director, or designee will inspect all	are	

Event ID: V8T511

Facility ID: VA0392

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	PLE CONSTRUCTION	· · · ·	DATE SURVEY
ND PLAN OF	FCORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	G		COMPLETED
		495391	B. WING			C 02/08/2023
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	CODE	02/00/2023
GLENBU	RNIE REHAB & NURSING	CENTER		1901 LIBBIE AVE RICHMOND, VA 23226		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLETIO DATE
F 584	Continued From page	e 41	F 58	84		
	1a. For resident room to maintain the bathro feces. On 02/05/2023 at app on 02/06/2023 at app observation of reside revealed loose feces down the front and si floor trailing from the and extending out int On 02/06/2023 at 9:0 resident room #219 m OSM (other staff men standing in the doorw OSM #1, housekeepi room, cleaning the bat the dark substance w bathroom out into the stated that the substan	 a #219, the facility staff failed for and the bedroom free of boom and the toilet seat, and on the toilet seat, de of the toilet bowl, on the toilet to the bathroom door of the room. 4 a.m. an observation of evealed housekeeping staff nber) #2, housekeeper, vay looking into the room and ng manager, who was in the athroom. When asked what was trailing from the eresident's room OSM #2 ance looked like feces. 		 resident rooms to ensure properly cleaned and in g 3-The Administrator, or de educate housekeeping ar staff on proper cleaning a of resident rooms. 4-The Administrator, or de complete audits of resider weekly basis x8 and mon rooms are properly cleaned maintained. 5- The results of the audit discussed at the monthly The committee will determ further audits and/or actio The Administrator or Direct are responsible for impler plan of correction. 6-Date of compliance 3/2 	ood repair. esignee will nd maintenance nd maintenance esignee will nt rooms on a thly x2 to ensure ed and ts will be QAPI meeting. nine the need for on. ctor of Nursing mentation of the	
	conducted with OSM housekeeping. When they were cleaning in seat, down the front a the floor trailing from door and extending o OSM #1 stated it was describe what their do schedule should be C housekeepers on eac through 3:00 p.m. eve asked how many hou working in the facility Sunday 02/05/2023 C	h asked about the substance the bathroom on the toilet and side of the toilet bowl, on the toilet to the bathroom ut into the resident's room, s feces. When asked to epartment's staffing DSM #1 stated three ch unit from 7:00 a.m. ery day of the week. When				

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		495391	B. WING				C 108/2023
NAME OF P	ROVIDER OR SUPPLIER		I	S	TREET ADDRESS, CITY, STATE, ZIP CODE	•	
GLENBUR	RNIE REHAB & NURSING	CENTER			901 LIBBIE AVE RICHMOND, VA 23226		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 584	OSM #1 stated that the required to do a 'Walk shift to check all the re bathrooms, pick up and When asked if it was bathroom to be in the OSM #1 stated no and have been cleaned in The facility's policy "C Residents' Rooms" do "Purpose: The purpose provide guidelines for residents' rooms. Ge Housekeeping surfact will be cleaned on a re occur, and when thes 2. Environmental surfice cleaned) on a regular times per week) and we soiled." On 02/07/2023 at appr (administrative staff in ASM # 2, interim direct regional director of cli aware of the above fin No further information 1b. For resident room to replace the cove bay wall across from the A foot of the B-side bed the bathroom door. Observations of resid 02/05/2023 at approx	he housekeeping staff are k-through' at the end of their esident's rooms and ny trash, clean any spills. dignified for a resident's condition described above d that the bathroom should mediately. Cleaning and Disinfecting poumented in part, se of this procedure is to cleaning and disinfecting neral Guidelines: 1. es (e.g., floors, tabletops) egular basis, when spills e surfaces are visibly soiled. aces will be disinfected (or basis (e.g., daily, three when surfaces are visibly proximately 5:00 p.m., ASM nember) #1, administrator, ctor of nursing and ASM # 3, nical services, were made ndings. n was provided prior to exit. #219, the facility staff failed ase trim and repair the dry A-side bed, the wall at the , and the short wall next to ent room #219 on	F	584			

Facility ID: VA0392

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	-	D HUMAN SERVICES MEDICAID SERVICES					FORM): 03/14/2023 APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /				(X3) DATE COMP	SURVEY LETED
		495391	B. WING				(02/) 08/2023
NAME OF PI	ROVIDER OR SUPPLIER		1	S	TREET ADDRESS, CITY, STA	TE, ZIP CODE		
GLENBUR	NIE REHAB & NURSING	CENTER			901 LIBBIE AVE RICHMOND, VA 23226			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD B CED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE
F 584	approximately three fe across from the A-side base (trim) and was of approximately two-and the wall at the foot of cove base and was of approximately two-and the wall next to the bas chipped, peeling and On 02/08/2023 at app interview and observative was conducted with O #8, regional maintenand if they were the maint building OSM #8 states nursing facilities and to maintenance director observing the damage above, OSM #8 states were aware of the rep #8 further stated that was made up of main other nursing facilities repairs. When asked would receive repairs that it may take a mor conditions of resident homelike environment On 02/08/2023 at app (administrative staff m was made aware of th No further information 2. For resident rooms	23 at 2:10 p.m., revealed eet of the base of the wall e bed was missing cove hipped and peeling; and d-a-half feet of the base of the B-side bed was missing nipped and peeling; and d-a-half feet of the base of athroom door was cracked, missing cove base. Froximately 8:30 a.m., an ation of resident room #219 DSM (other staff member) ince director. When asked enance director for the ed that they cover several that they had hired a two days ago. After e to the walls and stated d that they [maintenance] wair for about a month. OSM they had a "Blitz team" that tenance personnel from a to conduct large project when resident room #219 to the walls OSM #8 stated onth. When asked if the room #219 presented a t OSM #8 stated no.	F	584				

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		MEDICAID SERVICES		E CONSTRUCTION		<u>D. 0938-039</u> E SURVEY
	CORRECTION	IDENTIFICATION NUMBER:				PLETED
						с
		495391	B. WING		02	/08/2023
NAME OF P	ROVIDER OR SUPPLIER		s	STREET ADDRESS, CITY, STATE, ZIP CODE		
		CENTER	1	901 LIBBIE AVE		
GLENDUR	RNIE REHAB & NURSING	GENTER	F	RICHMOND, VA 23226		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETIO DATE
F 584	Continued From page	e 44	F 584			
	Observations of resident room #211 on 02/05/2023 at approximately 3:40 p.m., on					
		kimately 8:20 a.m., on				
		kimately 11:00 a.m.; and on				
	02/07/2023 at approx	kimately 2:00 p.m., revealed				
		t ceiling tiles missing,				
	revealing the piping, work.	electrical wiring, and duct				
	02/06/2023 at approx 02/06/2023 at approx 02/07/2023 at approx 9 two-foot by two-foo revealing the piping, work. Further observe two-foot ceiling tiles of rust color stain cover two-foot ceiling tile di stain covering the tile ceiling tile discolored covering the tile all in Another two-foot by t	kimately 3:45 p.m., on kimately 8:25 a.m., on kimately 11:05 a.m., and on kimately 2:05 p.m., revealed t ceiling tiles missing, electrical wiring and duct vation revealed 2 two-foot by completely discolored with a ing the tile; 2 twelve-inch by scolored with a rust color e; 2 three inch by two-foot with a rust color stain dicating water damage. wo-foot ceiling tile was ed in half and partially split				
	interview and observ #211 and #217 was of After observing the m stated that the ceiling tiles should have been the stained ceiling tile					

Facility ID: VA0392

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CENTER	S FOR MEDICARE & N	D HUMAN SERVICES				RM APPROVED NO. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	(X3) DA	TE SURVEY MPLETED
		495391	B. WING)2/08/2023
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD		
GLENBUR	NIE REHAB & NURSING	CENTER		1901 LIBBIE AVE RICHMOND, VA 23226		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
F 584		proximately 10:30 a.m., ASM nember) #1, administrator,	F 5	.84		
F 585 SS=D	Grievances CFR(s): 483.10(j)(1)-(§483.10(j) Grievances §483.10(j)(1) The resi grievances to the facil that hears grievances reprisal and without fe reprisal. Such grievan respect to care and tru- furnished as well as the furnished, the behavior residents, and other of facility stay. §483.10(j)(2) The resi facility must make pro- resolve grievances the accordance with this p §483.10(j)(3) The faci- on how to file a grievan- to the resident. §483.10(j)(4) The faci- grievance policy to en- of all grievances regat	s. ident has the right to voice lity or other agency or entity without discrimination or ear of discrimination or tices include those with eatment which has been hat which has not been or of staff and of other concerns regarding their LTC ident has the right to and the ompt efforts by the facility to e resident may have, in baragraph. lity must make information ance or complaint available	F 5	85		3/21/23

Facility ID: VA0392

If continuation sheet Page 46 of 213

	S FOR MEDICARE &	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT		ISTRUCTION		<u>NO. 0938-03</u> TE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	· /			· · ·	MPLETED
							С
		495391	B. WING			0	2/08/2023
NAME OF PR	ROVIDER OR SUPPLIER	•		STREE	T ADDRESS, CITY, STATE, ZIP CODE		
	NIE REHAB & NURSING			1901 L	IBBIE AVE		
SEENBOR				RICH	MOND, VA 23226		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
F 585	Continued From page	2 46	F 5	85			
		ndividually or through					
	()	t locations throughout the					
	facility of the right to f	•					
		in writing; the right to file					
	grievances anonymo	usly; the contact information					
	of the grievance offici	ial with whom a grievance					
		iis or her name, business					
		email) and business phone					
		e expected time frame for					
		v of the grievance; the right					
		cision regarding his or her					
	grievance; and the co	with whom grievances may					
	•	ertinent State agency,					
		Organization, State Survey					
		ng-Term Care Ombudsman					
		and advocacy system;					
	(ii) Identifying a Griev	ance Official who is					
		eeing the grievance process,					
		g grievances through to their					
	•	any necessary investigations					
		ining the confidentiality of all					
		d with grievances, for					
		of the resident for those I anonymously, issuing					
		isions to the resident; and					
	5	e and federal agencies as					
	necessary in light of s						
		king immediate action to					
	prevent further poten	tial violations of any resident					
	right while the alleged	d violation is being					
	investigated;						
		483.12(c)(1), immediately					
		violations involving neglect,					
		ies of unknown source,					
	and/or misappropriati	on of resident property, by					

Facility ID: VA0392

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		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 03/14/202 FORM APPROVE OMB NO. 0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		(X3) DATE SURVEY COMPLETED
		495391	B. WING		C 02/08/2023
NAME OF PF	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE	
GLENBUR	NIE REHAB & NURSING	GCENTER		1901 LIBBIE AVE RICHMOND, VA 23226	
0(4) 15		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORREC	
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMPLETIO
F 585	Continued From page	e 47	F 58	5	
	as required by State				
		vritten grievance decisions			
		grievance was received, a			
	-	of the resident's grievance,			
	-	vestigate the grievance, a nent findings or conclusions			
		it's concerns(s), a statement			
		evance was confirmed or not			
	confirmed, any correct	ctive action taken or to be			
		s a result of the grievance,			
		en decision was issued;			
	(vi) Taking appropriat	e law if the alleged violation			
		s is confirmed by the facility			
		having jurisdiction, such as			
		ency, Quality Improvement			
		I law enforcement agency			
	rights within its area	or any of these residents'			
		ence demonstrating the			
		es for a period of no less than			
		ance of the grievance			
	decision.				
		Γ is not met as evidenced			
	by: Based on resident in	terview, staff interview and		F585-Grievances Did not provide	a
		iew, the facility staff failed to		prompt response addressing missi	
	•	to a resident grievance for		clothing grievance noted in the Re	-
	one of 58 residents in	n the survey sample,		Council meeting.	
	Resident #36.			1- The missing clothes for Resider	
	The findings include:			has been addressed by the Admin 2-All current residents have the po to be affected. The Administrator, o	otential
	For Resident #36 (R3	36), the facility staff failed to		designee will review grievances fro	
		to a grievance regarding		past 30 days to ensure that all hav	
	missing clothes.			appropriately addressed. 3-TheThe Administrator, or design	
		/IDS (minimum data set), an vith an ARD (assessment		educate the Interdisciplinary team proper procedure in addressing re-	on the

Facility ID: VA0392

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COMPLETED C 02/08/2023
E (X5) COMPLETIC DATE
I. to glee

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	
		495391	B. WING _				08/2023
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
GLENBUR	RNIE REHAB & NURSING	CENTER			001 LIBBIE AVE ICHMOND, VA 23226		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 585 F 622 SS=E	above concern. The facility policy title documented, "The pa voice/file grievances/o or anonymously) with reprisal. The Administ grievance official of th for overseeing the gri receiving and tracking Transfer and Discharg	d, "Grievances" tient has the right to complaints (orally, in writing out fear of discrimination or trator serves as the le Center and is responsible evance process and for g to their conclusion." ge Requirements		585			3/21/23
	 (A) The transfer or dis resident's welfare and cannot be met in the fill (B) The transfer or dis because the resident' sufficiently so the resident' services provided by (C) The safety of indivi- endangered due to the status of the resident; (D) The health of indivi- otherwise be endange (E) The resident has fill appropriate notice, to under Medicare or Medicare Nonpayment applies submit the necessary payment or after the to Medicare or Medicaid 	requirements- ermit each resident to and not transfer or t from the facility unless- scharge is necessary for the t he resident's needs facility; scharge is appropriate s health has improved dent no longer needs the the facility; viduals in the facility is e clinical or behavioral viduals in the facility would ered; failed, after reasonable and pay for (or to have paid edicaid) a stay at the facility. If the resident does not paperwork for third party					

Facility ID: VA0392

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0.0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		495391	B. WING				C 08/2023
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	-	
GLENBUF	GLENBURNIE REHAB & NURSING CENTER RICHMOND, VA 23226				1901 LIBBIE AVE RICHMOND, VA 23226		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 622	resident who become admission to a facility resident only allowabl or (F) The facility ceases (ii) The facility may no resident while the app § 431.230 of this char exercises his or her ri- discharge notice from 431.220(a)(3) of this of discharge or transfer or safety of the reside facility. The facility m that failure to transfer §483.15(c)(2) Docum When the facility trans- resident under any of in paragraphs (c)(1)(i) section, the facility m or discharge is docum medical record and al communicated to the institution or provider. (i) Documentation in t must include: (A) The basis for the facility attemp needs, and the servic facility to meet the ne (ii) The documentation (2)(i) of this section m (A) The resident's phy	s eligible for Medicaid after , the facility may charge a e charges under Medicaid; a to operate. of transfer or discharge the beal is pending, pursuant to oter, when a resident ght to appeal a transfer or the facility pursuant to § chapter, unless the failure to would endanger the health ent or other individuals in the ust document the danger or discharge would pose. entation. Sfers or discharges a the circumstances specified J(A) through (F) of this ust ensure that the transfer mented in the resident's opropriate information is receiving health care he resident's medical record transfer per paragraph (c)(1) agraph (c)(1)(i)(A) of this esident need(s) that cannot ots to meet the resident e available at the receiving ed(s). n required by paragraph (c)	F	62:	2		

Facility ID: VA0392

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		MEDICAID SERVICES		LE CONSTRUCTION		O. 0938-03
	F CORRECTION	IDENTIFICATION NUMBER:	· ,	3	· · ·	IPLETED
			A. DOILDING			С
		495391	B. WING		0:	2/08/2023
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD		
				1901 LIBBIE AVE		
GLENBUF	RNIE REHAB & NURSING	S CENTER		RICHMOND, VA 23226		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE APPROPRIATE	(X5) COMPLETIC DATE
F 622		- 54	F 00			
F 022			F 62	2		
	(A) or (B) of this section					
		transfer or discharge is				
	this section.	agraph (c)(1)(i)(C) or (D) of				
		led to the receiving provider				
	must include a minim					
((A) Contact information					
	responsible for the ca	•				
	· ·	ntative information including				
	contact information	-				
	(C) Advance Directive	e information				
	(D) All special instruc	tions or precautions for				
	ongoing care, as app					
	(E) Comprehensive c					
		ary information, including a				
	copy of the resident's					
	-	21(c)(2) as applicable, and				
	a safe and effective t	tion, as applicable, to ensure				
		is not met as evidenced				
	by:	is not met as evidenced				
		iew, facility document		F622□ Failed to send transfe	er documents	
	review, and clinical re	-		1-Resident #46 and #116 no		
		y staff failed to provide		in the facility. Residents #50	0	
		red transfer/discharge		not had any hospital transfers		
		harge/transfer for four of 58		2-All current residents have t	•	
		v sample, Residents #46,		to be affected. The DON, or o	-	
	#116, #50, and #79.			review residents transferred of		
				hospital in the past 14 days to		
	The findings include:			the necessary transfer docum		
				been sent at the time of the ti		
		R46) the facility staff failed		3-The ADON, or designee wi		
		any documentation to the		licensed nurses on transfer d		
	hospital for a transfer	UII 1Z/Z1/ZUZZ.		transferring a resident out to		
	On the most recent M	IDS (minimum data set)		4-The Unit Manager, or desig		
		ission assessment, with an		resident transfers weekly x 8		
	assessment referenc	e date of 12/28/2022, the		monthly X 2 months to ensure	e that the	

Facility ID: VA0392

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				LE CONSTRUCTION	OMB NO. 0938-
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DATE SURVEY COMPLETED
		495391	B. WING		C
	ROVIDER OR SUPPLIER	495591		STREET ADDRESS, CITY, STATE, ZIP CODE	02/08/2023
	NOWDER OR SOLT EIER			1901 LIBBIE AVE	
GLENBUF	RNIE REHAB & NURSING	G CENTER		RICHMOND, VA 23226	
(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 CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE COMPLE
F 622	Continued From page	e 52	F 62	2	
	interview for mental s resident is not cogniti daily decisions. The nurse's note data documented in part, " room by cna (certified writer had given resid upon entering room, y a nose bleed. Writer compress to the resid denies picking her no nose on anything. W continue to apply pres On call MD (medical given to pack nose w reentering the resider observed the resider washcloth. Writer pro- residents face and pa notified of clots and o to ED (emergency de (evaluation) and treat party) is aware and co	tatus) score, indicating the vely impaired for making ed, 12/27/2022 at 7:00 p.m., Writer called to residents d nursing assistant) after lent her 5pm medications writer observed resident with applied pressure and a cold lents (sic) nose. Resident see or hitting her face or friter instructed resident to ssure and apply cold pack. doctor) notified and order ith cotton or gauze. Upon ith cotton or gauze. Upon nts (sic) room, writer t with several blood clots in a boceeded to clean the ack nose with gauze. MD order given to send resident partment) for eval to the formation of the formation of the formation of the formation of the several blood clots in a boceeded to clean the formation of the forma		completed at the time of the hos transfer. 5 The results of the audits will be discussed at the monthly QAPI r The committee will determine the further audits and/or action. The Administrator or Director of are responsible for implementati plan of correction. 6-Compliance date 3/21/23	e neeting. e need for Nursing
	emergency departme An interview was con practical nurse) #3, th 2/7/2023 at 11:50 a.m	t with the resident to the int on 12/27/2022. ducted with LPN (licensed ne unit manager, on n. When asked what			
	resident upon transfe plan, bed hold policy, sheet. When asked w	t to the hospital with a r, LPN #3 stated, the care medication list and face /here is this documented, "Transfer Out To The computer			

Facility ID: VA0392

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	MENT OF HEALTH AN	D HUMAN SERVICES					FORM	D: 03/14/2023 MAPPROVED D. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		495391	B. WING			-		C 08/2023
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STA	ATE, ZIP CODE		
GLENBU	RNIE REHAB & NURSING	CENTER			901 LIBBIE AVE RICHMOND, VA 23226			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BE CED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE
F 622	Continued From page	\$ 53	F	522				
		clinical record failed to Out To The Hospital" form.						
	transporting to a hosp This process will prov information regarding when the patient requ and treatment. PROC order is obtained and transfer. 2. The Patien (eINTERACT) is comp when the patient is be hospital for care and a the Patient Transfer F of the current face she (medication administr TAR(treatment admin Notes for 24 hour, can notes, and DDNR (du POST form (as applic INTERACT envelope the acute care center Transfer Form (eINTE medical record. It is n the information contai Transfer form (eINTE Note." ASM (administrative s administrator, ASM #4. clinical services were concern on 2/7/2023 a	ent Transfer Form e sent with the patient when oital or acute care setting. ide a format of all pertinent the patient's medical status ires additional hospital care EDURE: 1. A physician's written for the patient nt Transfer Form pleted by a licensed nurse eing transferred to the services. 3. Place a copy of form (eINTERACT), copies eet, current MAR ation record), current istration record), Progress rable do not resuscitate) or able) in the designated and send with the patient to or hospital. 4. The Patient ERACT) is part of the ot necessary to duplicate ned within the Patient RACT) into the Progress						

Facility ID: VA0392

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	`, ´		E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		495391	B. WING _				C 108/2023
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
GLENBUF	RNIE REHAB & NURSING	G CENTER			1901 LIBBIE AVE RICHMOND, VA 23226		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 622	Continued From page	9 54	F	622			
		, the facility staff failed to y documentation to the on 3/26/2022.					
	reference date of 3/26 a 15 out of 15 indicati	IDS assessment, an nt, with an assessment 6/2022, the resident scored ing the resident was not or making daily decisions.					
	documented, "Family cursing, being aggres towards writer. Famil medical records. Wri medical records must	3/26/2022 at 4:27 p.m. of resident entered facility sive and very disrespectful ly members wanted resident ter explained to family, t be requested in writing. ed 911 to take out of facility."					
		imented the above notes byed at the facility and not /.					
	documentation of what	record failed to evidence at documents were sent with nsfer to the hospital, by					
	nurse) #2, on 2/7/202 asked if a family call a documents do you pri (emergency medical a RN #2 stated, the fac medication administra laboratory work, and sent the care plan als typically. When asked	services) when they arrive, e sheet, EMAR (electronic ation record), pertinent notes. When asked if she					

Facility ID: VA0392

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		495391	B. WING				C 08/2023
NAME OF P	ROVIDER OR SUPPLIER			Ş	STREET ADDRESS, CITY, STATE, ZIP CODE		
GLENBUR	RNIE REHAB & NURSING	CENTER			1901 LIBBIE AVE RICHMOND, VA 23226		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 622	do you send paperwo provide EMS with the them, it's not like they (against medical advia appropriate paperwor An interview was com- practical nurse) #3, th 2/7/2023 at 11:50 a.m documents were sent resident upon transfe plan, bed hold policy, sheet. When asked w LPN #3 stated on the Hospital" form in the of this changes if a resid #3 stated, "No." Further review of the evidence a "Transfer ASM (administrative s administrator, ASM #4 clinical services were concern on 2/7/2023 at No further information 3. The facility staff fa required resident info at the time of transfer #50 was transferred to Resident #50 was adu	rk, RN #2 stated, we should appropriate documents with a are signing out AMA ce), they still need k to go with them. ducted with LPN (licensed ie unit manager, on h. When asked what to the hospital with a r, LPN #3 stated, the care medication list and face there is this documented, "Transfer Out To The computer. When asked if lent's family calls 911, LPN clinical record failed to Out To The Hospital" form. staff member) #1, the 2, the interim director of the regional director of made aware of the above at 5:20 p.m. was provided prior to exit. ailed to evidence provision of rmation to a receiving facility for Resident #50. Resident to the hospital on 1/16/23. mitted to the facility on ses that included but were (chronic obstructive	F	622			

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TATEMENT	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	IPLE CO	ONSTRUCTION	(X3) DA	IO. 0938-039
ND PLAN OF	- CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG		CON	MPLETED
		495391	B. WING _				C 2/08/2023
NAME OF P	ROVIDER OR SUPPLIER	I	T	STR	EET ADDRESS, CITY, STATE, ZIP CODE	1 0	
GLENBUF	RNIE REHAB & NURSING	G CENTER			I LIBBIE AVE HMOND, VA 23226		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETIO DATE
F 622	Continued From page		F6	622			
	assessment, an annu (assessment reference the resident as scorin BIMS (brief interview	al assessment, with an ARD ce date) of 12/12/22, coded ng a 01 out of 15 on the for mental status) score, it was severely cognitively					
	There was no eviden sent with the resident						
	1/16/23, revealed "De signs/injuries if any:: by nursing staff, layin with blanket on top of underwear on left sid underwear and clothi needs, unable to stat to do, ROM (range of weakness present to neuro checks initiated resident, attempted to assistance, call bell w	It with the resident to the hospital on 1/16/23. eview of the nursing progress note dated 6/23, revealed "Description of the fall/vital ns/injuries if any:: Resident observed on floor nursing staff, laying on back, at the foot of bed, n blanket on top of her, one shoe on left foot, lerwear on left side, pants on only on left side, lerwear and clothing dry, denied toileting eds, unable to state what she was attempting lo, ROM (range of motion) assessed akness present to bilateral lower extremities, uro checks initiated, clothing placed on ident, attempted to re-orient patient to call for istance, call bell within resident reach. vsician and RP (responsible party) made are."					
	1/16/23 at 7:07 PM, r resident Xray results noted Acute intertrocl shortening, resident F made aware. On call	POA (power of attorney) I physician contacted, wants mergency room) for further					
	reduce acute care tra	ERACT (interventions to insfers) dated 1/16/23, Care Document Transfer					

Facility ID: VA0392

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	-	D HUMAN SERVICES MEDICAID SERVICES					FORM	D: 03/14/2023 MAPPROVED D. 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		495391	B. WING			_		C 08/2023
NAME OF PF	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
GLENBUR	NIE REHAB & NURSING	CENTER			901 LIBBIE AVE ICHMOND, VA 23226			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 622	Continued From page Checklist" as blank.	57	F	622				
	A request for clinical of facility with the reside 9:15 AM.	locuments sent to the nt was made on 2/7/23 at						
	member) #1, the adm director of nursing, we findings and ASM #1	, ASM (administrative staff inistrator and ASM #2, the ere made aware of the stated, we do not have any al documents sent for this						
	policy revealed, "Plac Transfer Form (eINTE current face sheet, cu administration record) administration record) hour, care plan, Physi DDNR (durable do no (physician orders for s applicable) in the desi	rrent MAR (medication), current TAR (treatment), Progress Notes for 24 ician Progress notes, and it resuscitate) or POST scope of treatment) form (as ignated INTERACT ith the patient to the acute						
	No further information	was provided prior to exit.						
	evidence that all requ	the facility staff failed to ired documentation was ing facility upon a hospital						
	Resident #79. Reside the emergency room	I record was conducted for ent #79 was transferred to on 11/27/22 for further stomy tube blockage or						

Facility ID: VA0392

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		E CONSTRUCTION	(X3) DATE COMP	
		495391	B. WING				08/2023
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
GLENBUF	RNIE REHAB & NURSING	CENTER			1901 LIBBIE AVE RICHMOND, VA 23226		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 622	forms that were comp "SNF/NF (skilled nurs Hospital Transfer Form Transfer Form V5." E demographic information, a medical information, a medication list or ca the resident. The "SNF/NF Hospita page called "Acute Ca Checklist." This page were to be sent with t and documented at th Documents Sent with that apply)" none of w being sent. One item List" was not informat anywhere else on the therefore, was not evit to the hospital since it list did not include a m comprehensive care p other evidence that th sent. In addition to the about nurse's notes failed to documents being sen were listed / identified On 2/7/23 at 9:30 AM with ASM #2 (Administ	ed two different transfer bleted. One was called sing facility / nursing facility) m" and one called "eInteract both forms contained basic tion, reason for the transfer, ind general status / basic Neither form evidenced that are plan goals were sent with al Transfer Form" included a are Transfer Document e listed several items that the resident to the hospital be top "Copies of Resident/Patient (check all which were checked off as , the "Current Medication ion that was contained transfer form, and denced as being provided t was not checked off. The equirement to send the olan goals and there was no be care plan goals were we forms, a review of the or reveal any evidence of any t to the hospital, as none i in a nurse's note. an interview was conducted strative Staff Member) the She stated that there was no umentation was sent.	F	622			

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		MEDICAID SERVICES				IO. 0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C		· · · ·	E SURVEY
			A. BUILDING			С
		495391	B. WING			2/08/2023
NAME OF P	ROVIDER OR SUPPLIER			EET ADDRESS, CITY, STATE, ZIP COD		2/00/2023
				1 LIBBIE AVE	_	
GLENBUF	RNIE REHAB & NURSIN	G CENTER	RIC	HMOND, VA 23226		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CC	RRECTION	(X5)
PRÉFIX TAG		CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)		COMPLETION
F 622	Continued From pag	je 59	F 622			
	conducted with LPN	#3 (Licensed Practical				
	, ,	d what documents are sent				
		en transferred to the hospital.				
	policy, med list and f	send the care plan, bed hold face sheet				
		N, in a follow up interview				
		ted that the documentation				
	for what items are se	transfer out to hospital				
	summary.					
		ty policy "Patient Transfer				
		ided documented, "3. Place a				
		Transfer Form (eINTERACT), t face sheet, current MAR,				
		ss Notes for 24 hour, care				
		ress notes, and DDNR or				
		icable) in the designated				
	the acute care cente	e and send with the patient to er or hospital				
		N at the end-of-day meeting,				
		tive Staff Member) the t2 the interim Director of				
		3 the Regional Director of				
		ere made aware of the				
	findings. No further the end of the surve	information was provided by v.				
F 623	Notice Requirement	s Before Transfer/Discharge	F 623			3/21/23
SS=E	CFR(s): 483.15(c)(3)-(೮)(೮)				
	§483.15(c)(3) Notice	e before transfer.				
		sfers or discharges a				
	resident, the facility					
	(i) Notify the residen	t and the resident's the transfer or discharge and				
	the reasons for the r					

Facility ID: VA0392

If continuation sheet Page 60 of 213

	MENT OF HEALTH AN S FOR MEDICARE & I	D HUMAN SERVICES					FORM): 03/14/2023 MAPPROVED). 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		495391	B. WING _			_	(02/	C 08/2023
NAME OF PI	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STA	ATE, ZIP CODE		
GLENBUR	NIE REHAB & NURSING	CENTER			001 LIBBIE AVE ICHMOND, VA 23226			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BE ICED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE
F 623	facility must send a correpresentative of the C Long-Term Care Omb (ii) Record the reason discharge in the resid accordance with para and (iii) Include in the notific paragraph (c)(5) of this §483.15(c)(4) Timing (i) Except as specified (c)(8) of this section, the discharge required un made by the facility at resident is transferred (ii) Notice must be mat before transfer or disc (A) The safety of indiv be endangered under this section; (B) The health of indiv be endangered, under this section; (C) The resident's heat allow a more immediat under paragraph (c)(1 (D) An immediate tran required by the reside under paragraph (c)(1 (E) A resident has not days. §483.15(c)(5) Content	they understand. The opy of the notice to a Office of the State udsman. s for the transfer or ent's medical record in graph (c)(2) of this section; ce the items described in s section. of the notice. In paragraphs (c)(4)(ii) and he notice of transfer or der this section must be cleast 30 days before the or discharged. de as soon as practicable charge when- riduals in the facility would paragraph (c)(1)(i)(C) of viduals in the facility would r paragraph (c)(1)(i)(D) of alth improves sufficiently to te transfer or discharge,)(i)(B) of this section; asfer or discharge is nt's urgent medical needs,)(i)(A) of this section; or resided in the facility for 30 ts of the notice. The written agraph (c)(3) of this section wing:	F 6	23				

Facility ID: VA0392

If continuation sheet Page 61 of 213

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING (X3) DATE SURVICE COMPLETED C C	FORM APPROVED OMB NO. 0938-0391
495391 B. WING 02/08/20 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1901 LIBBIE AVE	(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE GLENBURNIE REHAB & NURSING CENTER 1901 LIBBIE AVE	C 02/08/2023
GLENBURNIE REHAB & NURSING CENTER	
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COM	D BE COMPLETION
F 623 Continued From page 61 F 623 (ii) The effective date of transfer or discharge; (ii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the offic flow and assistance in completing the form and submitting the appeal hearing request; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email), and telephone number of the Offic of the State Long-Term Care Ombudsman; Conf. Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agnery responsible for the protection and advocacy of individuals with developmental disabilities assistance and Bill of Rights Act of 2000 (Pub L. 106-402, codified at 42 U.S C. 15001 te seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, set as and telephone number of the agnery responsible for the agnery responsible for the protection and advocacy for Mentally III Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the ransfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility cosure	

Facility ID: VA0392

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		ND HUMAN SERVICES MEDICAID SERVICES			FORM APPRC OMB NO. 0938-
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	(X3) DATE SURVEY COMPLETED	
	495391 B. WING			C 02/08/2023	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COL	DE
GLENBUR	NIE REHAB & NURSING	G CENTER		1901 LIBBIE AVE RICHMOND, VA 23226	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CO	DRRECTION (X5)
PREFIX TAG	(EACH DEFICIENC	LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE COMPLE E APPROPRIATE DATE
F 623	Continued From page	e 62	F 62	3	
		closure, the individual who is		-	
	the administrator of t	he facility must provide			
		ior to the impending closure			
		Agency, the Office of the re Ombudsman, residents of			
	5	esident representatives, as			
		ne transfer and adequate			
	-	dents, as required at §			
	483.70(I).				
		T is not met as evidenced			
	by: Record on staff inten	view, facility document		F623 Notice Requirements b	anforo
	review, and clinical re	-		transfer/discharge	Jeiore
		ty staff failed to give written		1-Resident #46 and #116 no	longer reside
		ident and/or responsible		in the facility. Residents #50	
		otify the Office of the State		not had any hospital transfer	
	-	budsman upon transfer from		2-All current residents have t	-
	-	58 residents in the survey 46, #116, #50 and #79.		to be affected. The Social Se Director will audit residents tr	
		+0, # 110, #00 and #75.		discharged in the past 30 day	
	The findings include:			the RP and Ombudsman rec	
				notification of the transfer.	
		(R46) the facility staff failed		3-The Administrator, or desig	
	to evidence where th	e resident and/or s given a written notification		educate Social Services staff requirements to provide writte	
		sident was being transferred		notification to the RP and On	
		ailed to notify the ombudsman		resident transfers.	
	of the transfer to the	hospital that occurred on		4-The Social Services Direct	-
	12/27/2022.			designee will audit resident ti	
	On the most recent "	IDS (minimum data act)		weekly x 8, then monthly x 2	
		MDS (minimum data set) ission assessment, with an		that written notification provid and Ombudsman.	
	•	e date of 12/28/2022, the		5-The results of the review w	vill be
		out of 15 on the BIMS (brief		discussed at the monthly QA	
	interview for mental s	status) score, indicating the		determine further audits or a	ction is
	resident is not cognit	ively impaired for making		needed. The Administrator of	r Director of

Facility ID: VA0392

If continuation sheet Page 63 of 213

		MEDICAID SERVICES	(X2) MUUTI	PLE CONSTRUCTION	OMB NO. (X3) DATE SI			
	CORRECTION	IDENTIFICATION NUMBER:		G	COMPLE			
					с			
		495391	B. WING		02/08	8/2023		
NAME OF P	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CO	DE			
GLENBUF	RNIE REHAB & NURSING	GCENTER		1901 LIBBIE AVE RICHMOND, VA 23226				
(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 C	N SHOULD BE E APPROPRIATE	(X5) COMPLETIOI DATE		
	Continued From page 63 documented in part, "Writer called to residents (sic) room by cna (certified nursing assistant) after writer had given resident her 5pm medications upon entering room, writer observed resident with a nose bleed. Writer applied pressure and a cold compress to the residents (sic) nose. Resident denies picking her nose or hitting her face or nose on anything. Writer instructed resident to continue to apply pressure		F 62	23				
	and apply cold pack. notified and order giv or gauze. Upon reent room, writer observed blood clots in a wash clean the residents fa gauze. MD notified o send resident to ED (On call MD (medical doctor) en to pack nose with cotton tering the residents (sic) d the resident with several cloth. Writer proceeded to ace and pack nose with of clots and order given to (emergency department) for treatment. RP (responsible						
	evidence any docume provided to the reside	clinical record failed to entation of a written notice ent and/or responsible party ombudsman of the transfer.						
	practical nurse) #3, th 2/7/2023 at 11:50 a.m resident and/or respo written notification of is being transferred to stated, no, they call th of the change in conc being sent out. There printed out that we we	n. When asked if the onsible party are given a the reason why the resident to the hospital, LPN #3 he family and let them know dition as to why they are e is nothing written, typed, or ould give to the resident						
	printed out that we we and/or responsible pa notification to the res	ould give to the resident arty. When asked where the ponsible party is stated in the, "Transfer Out						

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT C	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		495391	B. WING _				C 08/2023
NAME OF PF	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
GLENBUR	NIE REHAB & NURSING	CENTER			01 LIBBIE AVE CHMOND, VA 23226		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	K	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 623	Continued From page	• 64	Fe	523			
	An interview was commember) #3, the direct 2/7/2023 at 3:00 p.m. responsible for sendir notifications, OSM #3 asked if there was a rombudsman for the tr 12/27/2022. OSM #3 notification. If a reside (emergency room) and it. It wasn't an actual of I didn't report it to the The facility policy, "Not documented in part, " written notification of the patient and family me utilizing the (initials of Transfer/Discharge for copies of the complete Notice of Transfer/Dist those specified on the Ombudsman." ASM (administrative st administrator, ASM #4, clinical services were concern on 2/7/2023 at No further information 2. For Resident #116 failed to evidence that responsible party was	ducted with OSM (other staff ctor of social services, on When asked if she is ng the ombudsman stated, yes. OSM #3 was notification to the ansfer of R46 on stated, "No, there was no ent goes to the ER d comes back, I don't report discharge from the facility so ombudsman." Dice of Transfer/Discharge" Provide proper advance the transfer/discharge to the mber/legal representative corporation) Notice of rrmProvide designated ed (initials of corporation) scharge form to each of e form, which includes the staff member) #1, the 2, the interim director of the regional director of made aware of the above at 5:20 p.m. was provided prior to exit. (R116), the facility staff t the resident and/or given a written notification ident was being transferred					

Facility ID: VA0392

If continuation sheet Page 65 of 213

	MENT OF HEALTH AN S FOR MEDICARE & I	D HUMAN SERVICES					FORM	D: 03/14/2023 MAPPROVED D. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` <i>`</i>		E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		495391	B. WING			_		C 08/2023
NAME OF P	ROVIDER OR SUPPLIER		1	S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
GLENBUR	NIE REHAB & NURSING	CENTER			901 LIBBIE AVE RICHMOND, VA 23226			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BE ICED TO THE APPROPRIA IEFICIENCY)		(X5) COMPLETION DATE
F 623	reference date of 3/26 a 15 out of 15 indicati cognitively impaired for A nurse's note dated, documented, "Family cursing, being aggress towards writer. Famil medical records. Write medical records must Resident's family calle Further review of the evidence any docume provided to the reside or notification of the of An interview was com- practical nurse) #3, the	2. DS assessment, an at, with an assessment 5/2022, the resident scored ng the resident was not or making daily decisions. 3/26/2022 at 4:27 p.m. of resident entered facility sive and very disrespectful y members wanted resident er explained to family, be requested in writing. ed 911 to take out of facility." clinical record failed to entation of a written notice nt and/or responsible party mbudsman of the transfer.	F	623				
	written notification of t is being transferred to stated, no, they call th of the change in cond being sent out. There printed out that we we and/or responsible pa notification to the resp documented, LPN #3 to the Hospital" form i	he reason why the resident the reason why the resident the hospital, LPN #3 the family and let them know ition as to why they are is nothing written, typed, or build give to the resident rty. When asked where the bonsible party is stated in the "Transfer Out in the computer. ducted with OSM (other staff ctor of social services, on						

Facility ID: VA0392

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		495391	B. WING				C 08/2023
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
GLENBUF	RNIE REHAB & NURSING	CENTER			901 LIBBIE AVE RICHMOND, VA 23226		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 623	responsible for sendir notifications, OSM #3 asked if there was a r ombudsman for the tr 3/26/2022. OSM #3 s notification. At that tim did not include her in ombudsman. That was been reported to the of ASM (administrative s administrator, ASM #2 nursing, and ASM #4. clinical services were concern on 2/7/2023 a No further information 3. The facility staff fa required written RP (r notification at the time #50. Resident #50 we on 1/16/23. The most recent MDS assessment, an annu (assessment reference the resident as scorin BIMS (brief interview indicating the residen impaired. There was no evidence when the resident wa 1/16/23. A review of the nursin 1/16/23 at 7:07 PM, re	ng the ombudsman stated, yes. OSM #3 was notification to the ansfer of R116 on stated, "No, there was no ne, the assistant that I had, the report sent to the as an error, they should have ombudsman." staff member) #1, the 2, the interim director of the regional director of made aware of the above at 5:20 p.m. was provided prior to exit. iled to evidence provision of esponsible party) e of discharge for Resident as transferred to the hospital 6 (minimum data set) al assessment, with an ARD as date) of 12/12/22, coded g a 01 out of 15 on the for mental status) score, t was severely cognitively ce of written RP notification s sent to the hospital on g progress note dated evealed "Writer notes received, resident has a	F	623			

Facility ID: VA0392

If continuation sheet Page 67 of 213

	MENT OF HEALTH AN S FOR MEDICARE & I	D HUMAN SERVICES					FORM): 03/14/2023 MAPPROVED
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ì í		CONSTRUCTION		(X3) DATE COMP	LETED
		495391	B. WING			_		C 08/2023
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE	· · · ·	
				1	901 LIBBIE AVE			
GLENBUF	NIE REHAB & NURSING	CENTER		R	RICHMOND, VA 23226			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD B ICED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 623	made aware. On call patient sent to ER (en- evaluation and treatm A request for evidence was made on 2/7/23 a An interview was cone PM, with OSM (other director of social servi- nothing sent in writing to check with the DON if nursing does. On 2/7/23 at 5:15 PM member) #1, the adm director of nursing, we finding and ASM #2 si written RP notification A review of the facilitie Discharge" policy revea advance written notific transfer/discharge to the member/legal represe of Transfer/Discharge state law: i. If a transfer discharge can be coo practicable. ii. If a transfer discharge can be coo practicable. ii. If a transfer to the patient's welfar in the Center;	POA (power of attorney) physician contacted, wants nergency room) for further ent." e of written RP notification at 9:15 AM. ducted on 2/7/23 at 3:00 staff member) #3, the ces, who stated, there is to the RP, we would need N (director of nursing) to see , ASM (administrative staff inistrator and ASM #2, the ere made aware of the tated, nursing does not send es "Notice of Transfer ealed, "Provide proper cation of the the patient and family intative utilizing the Notice form. Under federal and er/discharge is voluntary a rdinated as soon as nsfer/discharge is e following reasons, ade as soon as reasonably re and needs cannot be met to has improved, and they no vices provided by the	F	623				

Facility ID: VA0392

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	
		495391	B. WING				C /08/2023
NAME OF P	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
GLENBUF	RNIE REHAB & NURSING	CENTER			1901 LIBBIE AVE RICHMOND, VA 23226		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 623	endangered; 4) The health of indivisible endangered; or 5) The patient has not thirty (30) days." No further information 4. For Resident #79, evidence that a writter transfer was provided representative upon the 12/6/22. A review of the clinical Resident #79. Resided the emergency room 12/6/22 for further evant tube blockage or disp Further review of the reveal any evidence the these hospital transferresident's legal represent On 2/7/23 at 9:30 AM with ASM #2 (Administion) Director of Nursing. Sany written notice to the that the facility had not On 2/7/2023 at 11:50 conducted with LPN # Nurse). When asked given to the resident as representative, she stand let them know the why the resident is best	iduals in the Center would t resided in the Center for a was provided prior to exit. the facility staff failed to n notice of a hospital t to the resident ransfers on 11/27/22 and al record was conducted for ent #79 was transferred to on 11/27/22 and again on aluation of a gastrostomy lacement. clinical record failed to hat a written notification for rs was provided to the sentative. an interview was conducted strative Staff Member) the She stated that there wasn't he resident representative, ot been doing that. AM, an interview was f3 (Licensed Practical if a written notification is	F	623			

Facility ID: VA0392

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	03/14/2023
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	CONSTRUCTION		(X3) DATE	0. 0938-0391 SURVEY LETED
		495391	B. WING		_		C 08/2023
NAME OF PF	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, ST	ATE, ZIP CODE	02/	00/2020
GLENBUR	NIE REHAB & NURSING	CENTER		901 LIBBIE AVE RICHMOND, VA 23226			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BE ICED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 623 F 625 SS=D	with OSM #3 (Other S Social Services. Whe written notice to the re- hospital transfers, she A review of the facility Form" that was provid requirements of writter representative. On 2/7/23 at 5:00 PM ASM #1 (Administrativ Administrator ASM #2 Nursing, and ASM #3 Clinical Services, wer- findings. No further in the end of the survey. Notice of Bed Hold Po CFR(s): 483.15(d)(1)(§483.15(d)(1) Notice of the surving facility transfer the resident goes on to nursing facility must p the resident or residen specifies- (i) The duration of the any, during which the return and resume resident	an interview was conducted Staff Member) the Director of an asked if she sends esident representative of a stated that she does not. If policy "Patient Transfer led did not address the an notification to the resident at the end-of-day meeting, ve Staff Member) the the interim Director of the Regional Director of e made aware of the aformation was provided by blicy Before/Upon Trnsfr (2) bed-hold policy and return- before transfer. Before a ers a resident to a hospital or therapeutic leave, the rovide written information to an representative that state bed-hold policy, if resident is permitted to	F 623		DEFICIENCY)		3/21/23
	facility; (ii) The reserve bed p plan, under § 447.40 c	ayment policy in the state of this chapter, if any;					

Facility ID: VA0392

If continuation sheet Page 70 of 213

		ND HUMAN SERVICES MEDICAID SERVICES			FORM APPRO OMB NO. 0938-0
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495391 B. WING			C 02/08/2023	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	i
GLENBUF	NIE REHAB & NURSING	G CENTER		1901 LIBBIE AVE	
	CUMMADY C	TATEMENT OF DEFICIENCIES		RICHMOND, VA 23226 PROVIDER'S PLAN OF CORR	
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE COMPLETI
F 625	Continued From pag	e 70	F 62	5	
1 020	10	ty's policies regarding	1 02	5	
		ly's policies regarding			
	•	nis section, permitting a			
	resident to return; an				
		specified in paragraph (e)(1)			
	of this section.				
		old notice upon transfer. At			
	the time of transfer o				
	-	rapeutic leave, a nursing to the resident and the			
		ve written notice which			
	-	n of the bed-hold policy			
		ph (d)(1) of this section.			
		T is not met as evidenced			
	by:				
	Based on staff interv	view, clinical record review		F625 Notice of Bed hold policy	
		t review, it was determined		before/upon transfer	
		to provide evidence that bed		1-Resident #50 has not been tra	Insferred
		provided when one out of 58		to the hospital.	
		ey sample was transferred to		2-All current residents have the to be affected. The DON, or des	
	the hospital; Residen	IIS #JU.		audit resident transfers to the ho	•
	The findings include:			the past 14 days to ensure that	
				hold notice was provided at the	
	The facility staff failed	d to evidence provision of		transfer.	
	•	at the time of discharge for		3-The DON, or designee will edu	ucate all
		lent #50 was transferred to		licensed nurses on the process	
	the hospital on 1/16/2	23.		transferring/discharging resident	
	Desident///50	1		bed hold policy and provided ev	Idence
		Imitted to the facility on		that this was done.	o will
	-	sis that included but were not ronic obstructive pulmonary		4-The Unit Manager, or designe conduct weekly audits x 8 weeks	
	disease), dementia a			monthly x2 to verify residents wi	
				transfers were provided the bed	
	The most recent MD	S (minimum data set)		notice at the time of the transfer	
		ual assessment, with an ARD		5-The results of the review will b	e
		ce date) of 12/12/22, coded		discussed at the monthly QAPI	-
	the resident as scorir	ng a 01 out of 15 on the		determine the need for continue	d audits

Event ID: V8T511

Facility ID: VA0392

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		MEDICAID SERVICES			OMB NO. 0938-
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495391	B. WING	C 02/08/2023	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C	
GLENBU	RNIE REHAB & NURSING	GCENTER		1901 LIBBIE AVE RICHMOND, VA 23226	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE COMPLI THE APPROPRIATE DAT
F 625	Continued From page	e 71	F 62	5	
	BIMS (brief interview indicating the residen impaired.	for mental status) score, It was severely cognitively		or action. The Administrato Nursing are responsible for implementation of the plan 6- Date of compliance 3/21	of correction.
	the resident to the ho	ce of a bed hold sent with spital on 1/16/23.			
	1/16/23 at 7:07 PM, r resident Xray results noted Acute intertrocl shortening, resident F made aware. On cal	POA (power of attorney) I physician contacted, wants mergency room) for further			
	PM, with OSM (other	ducted on 2/7/23 at 3:00 staff member) #3, the vices, who stated, there is no dent.			
	On 2/7/23 at 5:15 PM, ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing, were made aware of the findings.				
	revealed, "Hospitaliza and Medicaid program in the facility when a overnight. Conseque (regardless of payor the facility and is adm hospitalization/observa absent from the facility	y's "Bed Reserve" policy ation/Observation - Medicare ms do not pay to hold beds patient is hospitalized ntly, whenever any patient source) is transferred from nitted for overnight vation (defined as being ty for more than 24 hours), e responsible representative			
	(or hospital) must pay patient wishes to ens	y to hold the bed if the ure that he/she can return to een occupying. If the patient			

Facility ID: VA0392

If continuation sheet Page 72 of 213

CENTER	-	ID HUMAN SERVICES MEDICAID SERVICES			FORM APPRO OMB NO. 0938-
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING		(X3) DATE SURVEY COMPLETED
		495391	B. WING		C 02/08/2023
NAME OF P	ROVIDER OR SUPPLIER	·		EET ADDRESS, CITY, STATE, ZIP CO	DDE
GLENBU	RNIE REHAB & NURSING	G CENTER		I LIBBIE AVE HMOND, VA 23226	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC'	ION SHOULD BE COMPLE HE APPROPRIATE DATE
F 625 F 636 SS=D	the bed, he/she will b available bed in the fa discharge from the he safely and adequatel medical, nursing and this arrangement the representative must (sign a formal "Volunta Agreement" and (2) p the facility for the req arrangement can be or by the close of the hospitalization occurs a.m. on the day follow No further information Comprehensive Asse CFR(s): 483.20(b)(1) §483.20 Resident Ass The facility must cond a comprehensive, ac reproducible assess functional capacity. §483.20(b) Compreh §483.20(b) (1) Reside A facility must make a assessment of a resid goals, life history and resident assessment by CMS. The assess the following:	tive does not elect to hold e readmitted to the next acility following the patient's ospital and the facility can y provide appropriate support services. To make patient and/or responsible 1) promptly complete and ary Bed Retention provide private payment to uested days. This made at the time of transfer, business day on which the s, but no later than 10:00 wing the hospitalization." In was provided prior to exit. essments & Timing (2)(i)(iii) sessment duct initially and periodically curate, standardized nent of each resident's ensive Assessments ent Assessment Instrument. a comprehensive dent's needs, strengths, preferences, using the instrument (RAI) specified ament must include at least demographic information e.	F 625		3/21/23

Facility ID: VA0392

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		495391	B. WING				C 08/2023
NAME OF PI	ROVIDER OR SUPPLIER			;	STREET ADDRESS, CITY, STATE, ZIP CODE	•	
	NIE REHAB & NURSING	CENTER			1901 LIBBIE AVE		
GLENDON					RICHMOND, VA 23226		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 636	 (v) Vision. (vi) Mood and behavior (vii) Psychological we (viii) Physical function (ix) Continence. (x) Disease diagnosis (xi) Dental and nutritic (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatment (xvi) Discharge planni (xvii) Documentation or regarding the addition on the care areas trighthe Minimum Data Se (xviii) Documentation assessment. The assinclude direct observation with the resident, as with the rescribed and nonlicem members on all shifts §483.20(b)(2) When retimeframes prescribed through (iii) of this see prescribed in §413.34 apply to CAHs. (i) Within 14 calendar excluding readmission significant change in the mental condition. (For "readmission" means 	or patterns. II-being. ing and structural problems. and health conditions. onal status. Its and procedures. ing. of summary information hal assessment performed gered by the completion of it (MDS). of participation in sessment process must ation and communication well as communication with used direct care staff equired. Subject to the d in §413.343(b) of this at conduct a comprehensive lent in accordance with the in paragraphs (b)(2)(i) ction. The timeframes 3(b) of this chapter do not days after admission, ns in which there is no the resident's physical or purposes of this section,	F	636	5		

Facility ID: VA0392

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		ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 03/14 FORM APPR OMB NO: 0938	OVE
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		495391	B. WING		02/08/202	3
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	•	
GLENBUR	NIE REHAB & NURSING	CENTER		1901 LIBBIE AVE RICHMOND, VA 23226		
(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 CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPL	ETION
F 636	by: Based on staff interv review, the facility sta admission MDS (mini within the required tin residents in the surve The findings include: For Resident #112 (R to complete an admiss R112 was admitted to review of R112's clinic admission MDS asse On 2/7/23 at 3:11 p.m conducted with LPN ((a MDS coordinator). clinical record. LPN # on 1/12/23 so the adm should have been cor after admission. LPN assessment was part were sections that we stated she references Medicare and Medica Assessment Instrume completing MDS asse	e every 12 months. is not met as evidenced iew and clinical record iff failed to complete an imum data set) assessment ne frame for one of 58 ey sample, Resident #112. (112), the facility staff failed asion MDS assessment. b the facility on 1/12/23. A cal record revealed an ssment was not complete. n., an interview was (licensed practical nurse) #5 LPN #5 reviewed R112's #5 stated R112 was admitted mission MDS assessment mpleted by the 14th day I #5 stated it looked like the ially completed but there ere outstanding. LPN #5 is the CMS (Centers for aid Services) RAI (Resident ent) manual when	F 636	F636 Comprehensive Assessme timing 1-The Admission MDS assessme Resident # 112 was completed. 2-All current residents have the p to be affected. Residents admitte past 30 days will have their clinic audited by the MDSC, or designe verify their admission MDS was completed. 3-The Regional Director of Reimbursement, or designee will the MDSC staff on the requireme completing admission MDS asses 4-The MDS staff or designee will weekly audits x 8 weeks, then mo to verify new resident admissions Admission MDS assessment com 5-The results of the review will be discussed at the monthly QAPI m for needed continued audits or ad Administrator or Director of Nursi responsible for implementation of of correction. 6-Date of compliance 3/21/23	ent for potential d in the al record ee to educate nts for ssments. conduct onthly x2 s have an npleted. e neeting ction. The ng are	
		n., ASM (administrative staff ninistrator) and ASM #2 (the				

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	-	ND HUMAN SERVICES MEDICAID SERVICES					M APPROVE D. 0938-039	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING			E SURVEY PLETED	
		495391	B. WING				C / 08/2023	
NAME OF P	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE			
GLENBUF	RNIE REHAB & NURSING	GCENTER			001 LIBBIE AVE ICHMOND, VA 23226			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETIOI DATE	
F 636		e 75 rere made aware of the	F	636				
F 641 SS=D	above concern. Accuracy of Assessm		F	641			3/21/23	
	resident's status. This REQUIREMENT by: Based on staff interv and facility document the facility staff failed MDS (minimum data of 58 residents in the #48 and #51. The findings include: 1. The facility staff fail MDS (minimum data Resident #48. Resident #48. Resident #48. Resident #48. Resident #48. Resident #48. Resident #48. The most recent MDS assessment, a quarte ARD (assessment re coded the resident as the BIMS (brief interv indicating the resider impaired A review of	st accurately reflect the F is not met as evidenced riew, clinical record review t review, it was determined to complete an accurate set) assessment for two out survey sample, Residents illed to complete an accurate set) annual assessment for lmitted to the facility on es that included but were not hellitus, atrial fibrillation and S (minimum data set) erly assessment, with an ference date) of 11/6/22, s scoring a 15 out of 15 on riew for mental status) score,			F641 Accuracy of Assessments. 1-The MDS assessment for Resident # was corrected for tobacco usage. Resident # 51 was corrected to exclude Hospice. 2-All current residents that utilize tobac products have the potential to be affect All residents have the potential to be affected. The MDSC, or designee will audit residents utilizing tobacco to ensu- that this is reflected accurately on the MDS assessment. 3-The Regional Director of Reimbursement, or designee will educa all MDSC staff on accurately coding usage of Tobacco on the MDS assessment 4-The MDS staff or designee will audit residents with Tobacco usage to ensure this is coded correctly on the MDS assessment on a weekly basis x 8 wee then monthly x2. 5-The results of the audits will be discussed at the monthly QAPI meeting The committee will determine the need further audits and/or action. The Administrator or Director of Nursing are responsible for implementation of the	e cco ced. ure ate e ks, g. for g		

Event ID: V8T511

Facility ID: VA0392

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	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	PLE CONSTRUCTION		<u>0. 0938-039</u> E SURVEY		
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	· ,	3	Сом	PLETED		
		495391	B. WING			С		
NAME OF P	ROVIDER OR SUPPLIER	400001		STREET ADDRESS, CITY, STATE, ZIP COD		/08/2023		
GLENBUF	RNIE REHAB & NURSING	GCENTER		1901 LIBBIE AVE RICHMOND, VA 23226				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETIO DATE		
F 641	Continued From page	e 76	F 64	11				
	5/17/22 and revised Resident chooses to grounds. Understand declines smoking ces smoker. The resident On 2/6/23 at 2:50 PM	sation and independent prefers to smoke" I, Resident #48 was		plan of correction. 6-Date of Compliance 3/21/23	3			
	fence at the corner of parking lot and the ro center. When asked	oserved smoking on the far side of the white nce at the corner of the entrance to the facility arking lot and the road leading into the shopping enter. When asked how often he comes out to moke, Resident #48 stated three to four times er day.						
	AM, with LPN (license MDS Coordinator. W 2/8/22 annual MDS S #5 stated, "The MDS is an error. I will corr When asked what ref	PN #5 stated, the RAI						
	member) #1, the adm	I, ASM (administrative staff ninistrator and ASM #2, the ere made aware of the						
	2. For Resident #51	n was provided prior to exit. (R51), the facility staff le quarterly MDS (minimum t for hospice care.						
	. ,	o the facility with diagnoses e not limited to: debility (1).						

Facility ID: VA0392

If continuation sheet Page 77 of 213

		ID HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED D. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		E CONSTRUCTION	(X3) DATE COMF	E SURVEY PLETED
		495391	B. WING				C /08/2023
NAME OF P	ROVIDER OR SUPPLIER			s	STREET ADDRESS, CITY, STATE, ZIP CODE	_ .	
GLENBUF	RNIE REHAB & NURSING	CENTER	1901 LIBBIE AVE RICHMOND, VA 23226				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 641	with an ARD (assess 12/11/2022, (R51) sc BIMS (brief interview the resident was cogr daily decisions. Sect Procedures and Prog "Hospice care." The physician's order documented in part: "(Name of Hospice) r malnutrition. Status: 5/27/2022." "Order Date: 11/9/202 weights, No vitals, No No hospitalization." Review of the (R51's) with a revision date o part, "Focus. Hospice w/ (with) transition to to) stability on Comfo orders." On 02/08/23 at appro- interview was conduce practical nurse) #5, M the coding of hospice quarterly MDS assess 12/11/2022. LPN #5 error in the coding for to describe the proce MDS LPN #5 stated t (resident assessment On 02/08/2023 at appro-	IDS, a quarterly assessment ment reference date) of ored 15 out of 15 on the for mental status), indicating nitively intact for making ion "O Special Treatments, rams" coded (R51) for "s for (R51) dated elated to protein calorie Discontinue. End Date: 22. Comfort care. No o labs, No diagnostic tests, 0 comprehensive care plan f 01/05/2023 documented in e d/c'd (discontinued) 5/27 LTC (long term care) d/t (do rt Care measures per ximately 8:40 a.m., an ted with LPN (licensed IDS coordinator regarding care for (R51) on the sment with the ARD of stated that there was an ' hospice care. When asked dure for completing the hat they follow the RAI t instrument) manual.	F	641			

Facility ID: VA0392

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	-	D HUMAN SERVICES MEDICAID SERVICES			FOR	M APPROVED 0. 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		495391	B. WING			C /08/2023
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
GLENBUR	NIE REHAB & NURSING	CENTER		1901 LIBBIE AVE RICHMOND, VA 23226		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE
F 641	Continued From page	978	F 64	11		
	No further information	was provided prior to exit.				
	muscle bulk and redu heart and respiratory disuse. This informat website: Debilities de Medical dictionary (th	Debility is due to loss of ction in the efficiency of the system from disease or ion was obtained from the efinition of debilities by efreedictionary.com).				
F 655 SS=E	Baseline Care Plan CFR(s): 483.21(a)(1)-	(3)	F 65	55		3/21/23
	Planning §483.21(a) Baseline (§483.21(a)(1) The fac implement a baseline that includes the instr effective and person- that meet professiona The baseline care pla (i) Be developed within admission. (ii) Include the minimu necessary to properly including, but not limit (A) Initial goals based (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recomm	sility must develop and care plan for each resident uctions needed to provide centered care of the resident I standards of quality care. n must- n 48 hours of a resident's um healthcare information care for a resident ed to- l on admission orders.				
	care plan if the comp	plan in place of the baseline				

Facility ID: VA0392

If continuation sheet Page 79 of 213

	ISTRUCTION	OMB NO. 0938-0391 (X3) DATE SURVEY		
		COMPLETED		
495391 B. WING		C 02/08/2023		
NAME OF PROVIDER OR SUPPLIER STREET	STREET ADDRESS, CITY, STATE, ZIP CODE			
	LIBBIE AVE			
GLENBURNIE REHAB & NURSING CENTER RICHM	MOND, VA 23226			
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)			
review, and clinical record review, it was1-Rdetermined the facility staff failed to developwerand/or implement the baseline care plan for four2-Aof 58 residents in the survey sample, Residentsto b#117, #114, #112 and #365.30The findings include:to it1. For Resident #117 (R117), the facility staff3-Tfailed to develop a baseline care plan to addresslicethe resident's activities of daily living and the carecorfor a colostomy.assessment, a Medicare five day assessment, with an assessment reference date of 1/29/2022, the resident scored a 13 out of 15 on the BIMSfor(brief interview for mental status) score, indicatingAD	 ⁷⁶⁵⁵ Baseline care plan ⁷⁶⁵⁵ Baseline care plan ^{76sidents #117, #114, #112 and #365} ^{76sidents #115, #114, #112 and #365} 	al t ine nt, C all hly re ns nd		

Facility ID: VA0392

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CENTER	S FOR MEDICARE &	MEDICAID SERVICES				NO. 0938-039		
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /	LE CONSTRUCTION	· · ·	TE SURVEY MPLETED		
		495391	B. WING		C 02/08/2023			
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE				
GLENBUI	RNIE REHAB & NURSING	CENTER		1901 LIBBIE AVE RICHMOND, VA 23226				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE		
F 655	making daily decision Status, R117 was coo assistance of one sta ADLs (activities of da which they only requir assistance provided. Bowel, the resident w colostomy. The baseline care pla documented a focuse There were no other of care plan. An interview was con practical nurse) #1, of When asked who dev plan, LPN #1 stated t with the admission. If resident is admitted. V should be addressed LPN #1 stated, fall ris pain. When asked sho ADL status and colos would think so." When care plan is (on paper #1 stated it was in the resident is admitted, of assessment, and it br care plan. The care p with LPN #1. When a reference to the resid colostomy, LPN #1 state The facility policy, "Ca part, "POLICY: A licet with the interdisciplina	is. In Section G - Functional ded as requiring extensive ff member for most of their ily living) except eating in red supervision after set up In Section H - Bladder and ras coded as having a an dated, 1/28/2022, ed care area of nutrition. care areas addressed on the ducted with LPN (licensed in 2/8/2023 at 9:18 a.m. relops the baseline care he nurses on the floor start it t starts on the day the When asked what areas on the baseline care plan, ik, mobility, constipation, and ould the care plan address tomy care, LPN #1 stated, "I in asked where the baseline r or in the computer), LPN e computer, when the on the admission rings an area over onto the lan for R117 was reviewed sked if she saw any ent's ADL status or having a	F 65		Nursing			

Facility ID: VA0392

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		E CONSTRUCTION	(X3) DATE	
		495391	B. WING				C /08/2023
NAME OF P	ROVIDER OR SUPPLIER		•	S	STREET ADDRESS, CITY, STATE, ZIP CODE	-	
GLENBUF	NIE REHAB & NURSING	CENTER			1901 LIBBIE AVE RICHMOND, VA 23226		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE
F 655	maintain the highest p and psychosocial well PROCEDURE: 1. The Care Plan is initiated hours. 2. The Center representative(s) with care plan that include initial goals of the pati patient's medications instructions. Any serv administered by the C on behalf of the Center based on the details of plan." ASM (administrative s administrator, ASM #4. clinical services were concern on 2/7/2023 a No further information 2. For Resident #114 failed to implement th plan for ADL (activities R 114 was admitted to R114's baseline care documented, "ADL Se physical limitations. A grooming, dressing, o needed" A review of R114's AE records for June 2022 personal hygiene (cor	, and the necessary of services to attain or practical physical, mental, l-being of the patient. e computerized baseline and activated within 48 will provide the patient and a summary of the baseline s but is not limited to: The ient. A summary of the list. The patient's dietary ices and treatments to be center and personnel acting er. Any updated information of the comprehensive care staff member) #1, the 2, the interim director of the regional director of made aware of the above at 5:20 p.m. n was provided prior to exit. (R114), the facility staff e resident's baseline care s of daily living) assistance.	F	655			

Facility ID: VA0392

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM): 03/14/2023 APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·	E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		495391	B. WING		_		C 08/2023
NAME OF P	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
GLENBUF	RNIE REHAB & NURSING	CENTER		901 LIBBIE AVE RICHMOND, VA 23226			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BE ICED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 655	#1. CNA #1 stated th in the computer system stated blank spaces of they haven't been doo wasn't documented, it saying it wasn't done or evidence it's been see that you took care day or shift." On 2/7/23 at 12:00 p. conducted with LPN (LPN #3 stated the put	22. m., an interview was (certified nursing assistant) e CNAs document ADL care m and then on flowsheets if is not available. CNA #1 on the ADL records means cumented on. They say if it t wasn't done. "I'm not but there is nothing to justify done. They can't physically e of that client that particular	F 655				
	LPN #3 stated there a residents and the card On 2/7/23 at 5:02 p.m member) #1 (the adm director of nursing) we above concern. 3. For Resident #112 failed to implement th plan for PICC line (1) R112 was admitted to R112's baseline care documented, "The resivenous access. Adm ordered" A review of R112's cli	are people taking care of e plan should be followed. a., ASM (administrative staff inistrator) and ASM #2 (the ere made aware of the (R112), the facility staff e resident's baseline care medication administration. a the facility on 1/12/23. plan created on 1/12/23 sident has a PICC Line inister medications as hical record revealed a ed 1/12/23 for ceftriaxone					

Facility ID: VA0392

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	
		495391	B. WING				08/2023
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
GLENBUF	RNIE REHAB & NURSING	CENTER					
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 655	sodium (2) solution reintravenously every 2 Days. A review of R1 (medication administrevidence that ceftriax administered to the renurse's note dated 1/2 order." Further review including progress note MAR, failed to reveal given. On 2/7/23 at 12:00 p. conducted with LPN (LPN #3 stated the pur we can let people knot LPN #3 stated there are residents and the care On 2/7/23 at 5:02 p.m member) #1 (the adm director of nursing) we above concern. References: (1) "A peripherally ins (PICC) is a long, thin body through a vein in of this catheter goes in heart." The PICC hell medicines into your b obtained from the weal https://medlineplus.go 00461.htm (2) Ceftriaxone sodium This information was https://medlineplus.go	econstituted 2 grams 4 hours for infection for 25 12's January 2023 MAR ation record) failed to reveal one sodium was esident on 1/26/23. A 26/23 documented, "On w of R112's clinical record, tes and the January 2023 the scheduled dose was m., an interview was licensed practical nurse) #3. rpose of the care plan is, "so ow what the plan of care is." are people taking care of e plan should be followed. n., ASM (administrative staff inistrator) and ASM #2 (the ere made aware of the erted central catheter tube that goes into your n your upper arm. The end nto a large vein near your ps carry nutrients and ody" This information was	F	655			

Facility ID: VA0392

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	-	D HUMAN SERVICES					FORM): 03/14/2023 MAPPROVED
STATEMENT C	S FOR MEDICARE & I	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION		(X3) DATE	0. 0938-0391 SURVEY LETED
		495391	B. WING			_	(02/	C 08/2023
NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STA	ATE, ZIP CODE		
GLENBUR	NIE REHAB & NURSING	CENTER			01 LIBBIE AVE CHMOND, VA 23226			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BE CED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE
F 655	resident's PICC line (* R365 was admitted to review of R365's phys following: "PICC line - flush with (normal saline), then 8 (non-valved)." This or "NovoLOG Injection S Inject 4 units subcutat for DM (diabetes mell 2/3/23. A review of R365's bano information related resident's receiving in On 2/7/23 at 5:05 p.m member) #1, the adm director of nursing, and director of clinical serv these concerns. On 2/8/23 at 8:18 a.m nurse) was interviewed development of the bat the admitting nurse is and the MDS (minimu participates in develop line and insulin should resident's baseline ca are major parts of a re	seline care plan for the 1) and insulin. The facility on 1/31/23. A sician orders revealed the 10ml (milliliters) NS 5ml 10 units/ml heparin der was dated 2/2/23. Solution (Insulin Aspart) neously three times a day itus)." This order was dated seline care plan revealed to the PICC line or to the sulin. ., ASM (administrative staff inistrator, ASM #2, the d ASM #3, the regional vices, were informed of ., LPN (licensed practical d. When asked about the aseline care plan, she stated responsible for initiating it, m data set) nurse also bing it. She stated a PICC d definitely be a part of the re plan. She stated: "They	F 6	55				
	(1) "A device used to							

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	MENT OF HEALTH AN S FOR MEDICARE & I	D HUMAN SERVICES				FORM	D: 03/14/2023 MAPPROVED D. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	E CONSTRUCTION		(X3) DATE COMP	SURVEY PLETED
		495391	B. WING		_		C 108/2023
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	TATE, ZIP CODE		00/2020
GLENBUF	RNIE REHAB & NURSING	CENTER		1901 LIBBIE AVE RICHMOND, VA 23226			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 655 F 656 SS=E	blood transfusions. A into a vein in the uppe (threaded) into a large the heart called the su is inserted into a port blood or give fluids. A weeks or months and repeated needle stick inserted central cathe taken from the websit https://www.cancer.go ancer-terms/def/picc. Develop/Implement C CFR(s): 483.21(b)(1)(§483.21(b) Comprehe §483.21(b)(1) The fac implement a compreh care plan for each res resident rights set fort §483.10(c)(3), that ind objectives and timefra medical, nursing, and needs that are identifi assessment. The com describe the following (i) The services that a or maintain the reside physical, mental, and required under §483.2 (ii) Any services that a under §483.10, includ treatment under §483 (iii) Any specialized set	thin, flexible tube is inserted er arm and guided e vein above the right side of uperior vena cava. A needle outside the body to draw PICC may stay in place for helps avoid the need for s. Also called peripherally ter." This information is e ov/publications/dictionaries/c comprehensive Care Plan (3) ensive Care Plans cility must develop and ensive person-centered sident, consistent with the th at §483.10(c)(2) and cludes measurable ames to meet a resident's mental and psychosocial ed in the comprehensive aprehensive care plan must (- re to be furnished to attain ent's highest practicable psychosocial well-being as 24, §483.25 or §483.40; and would otherwise be required 25 or §483.40 but are not esident's exercise of rights ing the right to refuse .10(c)(6). ervices or specialized the nursing facility will	F 65	5			3/21/23

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 03/14/2023 MAPPROVED D. 0938-0391	
STATEMENT O	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495391	B. WING _				C 1 08/2023	
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE			
	NIE REHAB & NURSING	CENTER		19	901 LIBBIE AVE			
OLENDON		SOLATER		R	ICHMOND, VA 23226			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 656	Continued From page 86 recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.		F	656				
	 (iv)In consultation with resident's representation (A) The resident's good desired outcomes. (B) The resident's prefuture discharge. Fact whether the resident's 							
	local contact agencie entities, for this purpo (C) Discharge plans i plan, as appropriate,	ssed and any referrals to s and/or other appropriate ose. n the comprehensive care in accordance with the h in paragraph (c) of this						
	by the facility, as outl care plan, must-	rvices provided or arranged ined by the comprehensive petent and trauma-informed.						
		is not met as evidenced			F656 Develop/Implement Comprehe	nsive		
	responsible party inte clinical record review review it was determi	erviews, staff interview, , and facility document ned that the facility staff			Care plan 1- Residents # #6 and #113 were discharged. Resident #93 is receiving			
	-	/or implement the plan for three of 58 residents , Resident #6, #93, and			proper Incontinence care. 2-All current residents have the poter to be affected. The DON, or designe conduct an audit of current residents	e will		
	The findings include:				ensure the residents are receiving pro incontinence care and ensuring wour dressings are in place.	oper Id		
	-	R6), the facility staff failed to ehensive care plan to care.			3-The DON, or designee will educate licensed nurses and CNA□s on follow the plan of care in providing proper	ving		
	On the most recent M	IDS (minimum data set), an			Incontinence care and addressing an wounds that do not have dressings in			

Facility ID: VA0392

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	OF DEFICIENCIES	MEDICAID SERVICES	(X2) MULTI	PLE CONSTRUCTION		<u>O. 0938-03</u> E SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	` ´	G	· · ·	PLETED
						С
		495391	B. WING			2/08/2023
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CC	DDE	
GLENBUF	RNIE REHAB & NURSING	G CENTER		1901 LIBBIE AVE RICHMOND, VA 23226		
(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 C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETIO DATE
F 656	Continued From page	e 87	F 6	56		
1 000		nt with an ARD (assessment		place.		
		/11/2022, the resident		4-The DON or designee will	conduct	
		the BIMS (brief interview for		weekly audits x 8 weeks and		
	mental status) assess	sment, indicating the y impaired for making daily		x2 to verify that residents ar proper incontinence care an	-	
	-	documented R6 requiring		have dressings in place.		
	extensive assistance			5- Results of the audits will	be presented	
	toileting.			to the QAPI Committee for r	eview and	
	On 2/5/2023 at 1.38 1	o.m., an interview was		recommendation. The Administrator or Directo	or of Nursing	
	-	responsible party (RP). R6's		are responsible for impleme	-	
	RP voiced concerns i	regarding the resident being		plan of correction.		
		ed periods of time and often		6-Completion date 3/21/23		
		n they arrived to visit. R6's they found R6 soiled they				
		ht and the staff would not				
	-	d have to go out to find				
	someone to come in	to clean up R6.				
		care plan for R6 documented				
	- ·	is frequently incontinent of				
		and is not a candidate for a to: dementia. Created on:				
		n on: 11/30/2022." Under				
	"Interventions" it docu	umented in part, "Check				
	-	quently as needed. Created				
	on: 11/04/2022. Prov brief changes. Creat	vide toileting hygiene with ed on: 11/30/2022 "				
		activities of daily living)-Toilet				
	Use" documentation 2/1/2023-2/28/2023 f	for 1/1/2023- 1/31/2023 and ailed to evidence				
		ovided to R6 on the following				
	dates:	-				
	-	023, 1/2/2023, 1/3/2023,				
	1/7/2023, 1/8/2023, 1 1/30/2023, 2/4/2023					
		/1/2023, 1/2/2023, 1/6/2023,				
	1/8/2023, 1/9/2023, 1					

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	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIF	PLE CONSTRUCTION		O. 0938-039
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	G	CON	IPLETED
		495391	B. WING			С
NAME OF PI	ROVIDER OR SUPPLIER	455551		STREET ADDRESS, CITY, STATE, ZIP CO		2/08/2023
	RNIE REHAB & NURSING	CENTER		1901 LIBBIE AVE		
OLENDON		JOENTER		RICHMOND, VA 23226		
(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 C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETIO DATE
F 656	Continued From page	e 88	F 65	56		
		3, 1/22/2023, 1/26/2023,				
		3, 1/31/2023 and 2/5/2023.				
		2023, 1/7/2023, 1/8/2023,				
		3, 1/15/2023, 1/20/2023, 3, 1/29/2023, 1/31/2023,				
		2/3/2023, 2/4/2023 and				
	2/5/2023.					
	On 2/7/2023 at 11:06	a.m., an interview was				
		(certified nursing assistant)				
		ne CNAs document ADL care				
		em and then on flowsheets if				
		is not available. CNA #1 on the ADL records meant				
	-	not been documented on				
		hat if it was not documented,				
		A #1 stated that they could of done but there was nothing				
		that it was being done				
		not physically see that the				
		on that particular day or				
	shift.					
	On 2/8/2023 at 8:17 a	a.m., an interview was				
		(licensed practical nurse) #2.				
		e purpose of the care plan ow what the goals were for				
		at they were doing to meet				
	them for the resident	. LPN #2 stated that the				
	-	DS staff were responsible for				
	aeveloping, reviewing	g and revising the care plan.				
	The facility policy "Ca	are Planning" dated 11/01/19				
	documented in part, '					
		interdisciplinary team,				
		nents an individualized care in order to provide effective,				
	person-centered care	-				
	health-related care a					1

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		495391	B. WING				C 108/2023
NAME OF P	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE	<u>, </u>	
GLENBUF	RNIE REHAB & NURSING	CENTER			1901 LIBBIE AVE RICHMOND, VA 23226		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 656	maintain the highest p and psychosocial well Computerized care pl discipline on an ongoi patient occur, and rev quarterly assessment On 2/8/2023 at 11:23 staff member) #1, the interim director of nur regional director of cli aware of the concern. No further information 2. For Resident #93 to implement the comprovide incontinence treatment as ordered On the most recent M quarterly assessment reference date) of 1/1 assessed as being ind decisions. Section G extensive assistance toileting. Section M d stage 3 pressure ulce present on admission (A) The facility staff facomprehensive care p incontinence care to f On 2/5/2023 at 2:58 p conducted with R93 in that they were inconti brief. R93 stated that	 bractical physical, mental, l-being of the patient6. ans will be updated by each ing basis as changes in the riewed quarterly with the" a.m., ASM (administrative administrator, ASM #2, the sing and ASM #3, the nical services were made a.was provided prior to exit. (R93), the facility staff failed prehensive care plan to (A) care and (B) provide to a pressure ulcer. IDS (minimum data set), a with an ARD (assessment 8/2023, the resident was dependent in making daily documented R93 requiring from one staff member for ocumented R93 having four rs with three of them to the facility. ailed to implement the blan to provide timely R93. 	F	656			

Facility ID: VA0392

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PLETED
C / 08/2023
(X5) COMPLETION DATE

Facility ID: VA0392

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		495391	B. WING				C 08/2023
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
GLENBU	RNIE REHAB & NURSING	CENTER			1901 LIBBIE AVE RICHMOND, VA 23226		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 656	toileting, dressing, gro Created on: 10/22/20 documented, "The res with toileting. Created "Interventions" it docu and change briefs fre- on: 10/22/2022" On 2/6/2023 at 5:36 p conducted with CNA a incontinence care rou two hours. On 2/8/2023 at 8:17 a conducted with LPN (LPN #2 stated that the was to let the staff knot that resident and what them for the resident. (B) The facility staff fa plan to provide presso R93. On 2/6/2023 at 8:26 a conducted with R93 in that they had request 7:00 a.m. and was sti provide the care at 8:: last time they had bee care was around 4:00 On 2/06/2023 at 10:10 nursing assistant) #2 incontinence care to F observed to be heavil urine odor that was po observer's N95 mask	boming and bathing. 22" The care plan further sident requires assistance d on: 10/22/2022" Under umented in part, "Check quently as needed. Created 0.m., an interview was #7. CNA #7 stated that unds should be made every a.m., an interview was licensed practical nurse) #2. e purpose of the care plan ow what the goals were for at they were doing to meet alled to implement the care ure ulcer care as ordered for a.m., an interview was in their room. R93 stated ed incontinence care before Il waiting for staff to come to 26 a.m. R93 stated that the en provided incontinence o a.m. 6 a.m., CNA (certified was observed providing R93. R93's brief was y saturated with a strong	F	656			

Facility ID: VA0392

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	-	D HUMAN SERVICES MEDICAID SERVICES					FORM	D: 03/14/2023 MAPPROVED D. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		495391	B. WING			_		C 08/2023
NAME OF PF	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, ST	ATE, ZIP CODE	•=.	
GLENBUR	NIE REHAB & NURSING	CENTER			001 LIBBIE AVE ICHMOND, VA 23226			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 656	Continued From page with no dressing prese The comprehensive of 10/22/2022 document admitted to this SNF (with 3 Stage 3 pressu and other wounds. Sh alterations in her skin mobility, incontinence problems. Created or 01/10/2023." Under " documented in part, " as possible. Created 09/29/2022Treatme Created on: 10/22/202 and treatment as order 10/23/2022." The physician orders "Left ischium- cleanse dry, apply collagen pa alginate secure with b evening shift. Order I orders further docume cleanse with NS pat d pack with silver algina gauze as needed. Or Review of the eTAR (administration record) 12/1/2022-12/31/2022	92 ent to the area. are plan for R93 dated red in part, "[R93] was skilled nursing facility) with re ulcers, a surgical wound re is at risk for further integrity related to impaired , diabetes and circulation n: 09/29/2022. Revision on: Interventions" it Keep skin clean and dry on: nts to skin as ordered. 22. Wound care consults ered. Created on: for R93 documented in part, with NS (normal saline) pat riticles, pack with silver ordered gauze every Date: 01/19/2023." The ented, "Left ischium- ry, apply collagen particles, ite secure with bordered der Date: 01/19/2023."	F 6	56				
	completed to the left i 12/4/2022, 12/5/2022, 12/26/2022, 1/3/2023, 1/28/2023. The dates blank.	schium pressure ulcer on 12/7/2022, 12/8/2022, 1/14/2023, 1/16/2023 and listed were observed to be						

Facility ID: VA0392

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		ID HUMAN SERVICES MEDICAID SERVICES				FC	TED: 03/14/2023 ORM APPROVED NO. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION	(X3) DA	ATE SURVEY DMPLETED
		495391	B. WING				C 02/08/2023
NAME OF P	ROVIDER OR SUPPLIER		•	ST	REET ADDRESS, CITY, STATE, ZIP CODE	•	
GLENBUF	RNIE REHAB & NURSING	G CENTER			01 LIBBIE AVE CHMOND, VA 23226		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 656	 #2. CNA #2 stated th a.m. to 3:00 p.m. shif CNA #2 stated that th provided to R93 at 10 they had provided to stated that they felt th the needs of the resid they were given. On 2/08/2023 at 8:17 conducted with LPN (LPN #2 stated that w completed by signing stated that they could wound care was done eTAR. LPN #2 stated documented it was not the purpose of the ca know what the goals what they were doing resident. On 2/8/2023 at appro (administrative staff m administrator, ASM # nursing and ASM #3, clinical services were No further information 3. For Resident #113 develop a care plan to pressure injury. On the most recent M assessment, an adminiated assessment reference resident scored an 11 	(certified nursing assistant) hat they worked the 7:00 t and was assigned to R93. he incontinence care 0:16 a.m. was the first care them that morning. CNA #2 hat they were able to meet them that morning. CNA #2 hat they were able to meet then that morning. CNA #2 hat they were able to meet them that morning. Was and they were able to meet them that morning. Was dicensed practical nurse) #2. bound care was evidenced as off on the eTAR. LPN #2 not evidence that the e if there were blanks on the d that if it was not of done. LPN #2 stated that re plan was to let the staff were for that resident and to meet them for the ximately 11:30 a.m., ASM	F	656			

Facility ID: VA0392

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	
		495391	B. WING				08/2023
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	<u>. </u>	
GLENBUF	RNIE REHAB & NURSING	CENTER			1901 LIBBIE AVE RICHMOND, VA 23226		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE
F 656	resident was moderatidaily decisions. In Setthe resident was code pressure injury. (Presinjury is localized damunderlying soft tissue prominence or related device. The injury caropen ulcer and may be as a result of intense or pressure in combine tolerance of soft tissue may also be affected perfusion, co-morbidit tissue. Stage 4 Press skin and tissue loss Floss with exposed or of muscle, tendon, ligar ulcer. Slough and/or elepibole (rolled edges tunneling often occur. location. If slough or e of tissue loss this is a Injury.)(1) The comprehensive of to evidence documented, "Dakin's 0.125% (Sodium Hyp topically every day an wet to dry dressing or The physician order of documented, "Wound pressure ulcer stage for the stage of the physician order of the physician order of the physician order of documented, "Wound pressure ulcer stage of the physician order o	tely impaired for making ction M - Skin Conditions, ed as having a stage four sure Injury: A pressure hage to the skin and usually over a bony d to a medical or other in present as intact skin or an be painful. The injury occurs and/or prolonged pressure hation with shear. The e for pressure and shear by microclimate, nutrition, ties and condition of the soft ure Injury: Full-thickness full-thickness skin and tissue directly palpable fascia, nent, cartilage or bone in the eschar may be visible.), undermining and/or Depth varies by anatomical eschar obscures the extent in Unstageable Pressure care dated 9/20/2022 failed tation related to skin related re injury.	F	656			

Facility ID: VA0392

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMF	
		495391	B. WING _				08/2023
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
GLENBUR	RNIE REHAB & NURSING	CENTER			1901 LIBBIE AVE RICHMOND, VA 23226		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 656	cover with ABD (abdo shift for wound care." The physician order of documented, "Wound pressure ulcer stage f apply collagen, pack y cover with ABD pad d wound care." The Wound Care Spe 9/16/2022, document Present on admission The Wound Care Spe 9/21/2022, document Improving. Pressure The Wound Care Spe 10/5/2022, document	ated, 9/21/2022, I care: Clean right hip four with wound cleanser, with silver alginate and laily every day shift for ecialist Notes dated, ed in part, "Wound Status: a. Pressure Ulcer - Stage 4." ecialist Notes dated, ed in part, "Wound Status: Ulcer - Stage 4." ecialist Notes dated, ed in part, "Wound Status: ulcer - Stage 4." ecialist Notes dated, ed in part, "Wound Status: ulcer - Stage 4."	F	656			
	nurse) #2 on 2/7/2023 a.m. When asked the RN #2 stated it is to h resident, to follow the are achieving the goa care to meet their me asked if resident has that be included on th yes. An interview was com- practical nurse) #3 on When asked the purp #3 stated, it's to let th plan of care for that re	ir care, to make sure they ils. Kind of like a standard of asurable goals. When pressure injury/ulcer, should be care plan, RN #2 stated, ducted with LPN (licensed a 2/7/2023 at 11:50 a.m. ose of the care plan, LPN e people, medical staff, the esident. When asked if a ire injury/ulcer, should that					

Facility ID: VA0392

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		CONSTRUCTION	(X3) DATE COMF	
		495391	B. WING				08/2023
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	<u>, </u>	
GLENBUR	RNIE REHAB & NURSING	CENTER			901 LIBBIE AVE RICHMOND, VA 23226		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 656	absolutely. ASM (administrative s administrator, ASM #3 nursing, and ASM #3,	staff member) #1, the 2, the interim director of the regional director of	F	656			
	findings on 2/7/2023 a	was provided prior to exit.					
F 657 SS=D	ce/resmgr/npuap_pre Care Plan Timing and	m/npuap.site-ym.com/resour ssure_injury_stages.pdf I Revision	F	657			3/21/23
	be- (i) Developed within 7 the comprehensive as (ii) Prepared by an int includes but is not lim (A) The attending phy (B) A registered nurse resident. (C) A nurse aide with resident. (D) A member of food (E) To the extent pract the resident and the r An explanation must l medical record if the p and their resident rep not practicable for the resident's care plan.	orehensive care plan must days after completion of ssessment. erdisciplinary team, that ited to sician. with responsibility for the responsibility for the and nutrition services staff. ticable, the participation of esident's representative(s). be included in a resident's participation of the resident resentative is determined					

Facility ID: VA0392

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TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			TE SURVEY MPLETED
	495391	B. WING			C)2/08/2023
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE,		
GLENBURNIE REHAB & NURSIN	G CENTER		1901 LIBBIE AVE RICHMOND, VA 23226		
PREFIX (EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL & LSC IDENTIFYING INFORMATION)	ID PREFIZ TAG	PROVIDER'S PLA (EACH CORRECTIVI CROSS-REFERENCED	N OF CORRECTION E ACTION SHOULD BE D TO THE APPROPRIATE CIENCY)	(X5) COMPLETIO DATE
 or as requested by t (iii)Reviewed and re team after each assis comprehensive and assessments. This REQUIREMEND by: Based on observatire record review and fadetermined that the and/or revise the coordination of 58 residents. The findings include For Resident #101. The findings include For Resident #101 (revise the comprehended bed rails. On the most recent assessment, an adm ARD (admission refer the resident was assisting impaired for making) On 2/6/2023 at 9:00 their room in bed. Bobserved to be up an Additional observation at 4:15 p.m. and 2/7 bed with bilateral up The comprehensive 	 nined by the resident's needs he resident. vised by the interdisciplinary essment, including both the quarterly review T is not met as evidenced ons, staff interview, clinical acility document review, it was facility staff failed to review mprehensive care plan for in the survey sample, : R101), the facility staff failed ensive care plan for the use of MDS (minimum data set) nission assessment with an erence date) of 11/29/2022, sessed as being severely 	F	 F657 Care Plan Timin 1-The care-plan for Rebeen revised to include bed rails. 2-All current residents to be affected. The Undesignee will complete residents to ensure that reflects the use of bed The ADON, or designation of the audits including the use of bed The Unit Manager, of complete weekly audits monthly x 2 to ensure the for residents are reflect plan. Results of the audits the QAPI Committee for recommendation. The Administrator or D are responsible for imp plan of correction. Completion date 3/2 	essident #101 has e the provision for have the potential it Manager, or e an audit of current at the care plan rails. gnee will educate all e process for ed rails on the care or designee will s x 8 weeks, then that bed rails in use ted on the care will be presented to or review and birector of Nursing plementation of the	

Event ID: V8T511

Facility ID: VA0392

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM): 03/14/2023 MAPPROVED). 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		495391	B. WING		_		C 08/2023
NAME OF P	ROVIDER OR SUPPLIER		5	STREET ADDRESS, CITY, ST	ATE, ZIP CODE		
GLENBUF	RNIE REHAB & NURSING	CENTER		901 LIBBIE AVE RICHMOND, VA 23226			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE) CROSS-REFEREI	PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 657	pt (patient) performant transfers, self-care tar Date: 01/30/2023." On 2/8/2023 at 8:17 at conducted with LPN (LPN #2 stated that the was to let the nurses for that resident and withem. LPN #2 stated MDS staff were response revising the care plan rails should be address were being used. The facility policy "Cat documented in part, " coordination with the develops and implem plan for each patient if person-centered care at maintain the highest p and psychosocial well Computerized care pl discipline on an ongoin patient occur, and rev quarterly assessment The facility policy "De Safety" dated 11/01/1 licensed nurse will co input from the Interdis applicable and entered	A rails to facilitate improving the rails to facilitate improving the in bed mobility, sks, repositioning. Order a.m., an interview was licensed practical nurse) #2. e purpose of the care plan know what the goals were what they were meeting for that the nurses along with onsible for reviewing and . LPN #2 stated that bed ssed on the care plan if they re Planning" dated 11/01/19 A licensed nurse, in interdisciplinary team, ents an individualized care in order to provide effective, , and the necessary nd services to attain or oractical physical, mental, l-being of the patient6. ans will be updated by each ing basis as changes in the riewed quarterly with the "	F 657				

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			()(0)		OMB NO. 0938-03
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·		(X3) DATE SURVEY COMPLETED
		495391	B. WING		C 02/08/2023
NAME OF P	ROVIDER OR SUPPLIER	·	S	TREET ADDRESS, CITY, STATE, ZIP CODE	-
GLENBUI	RNIE REHAB & NURSING	G CENTER		901 LIBBIE AVE RICHMOND, VA 23226	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
F 657	regional director of cl aware of the concern	rsing and ASM #3, the inical services were made	F 657		
F 658 SS=D	Services Provided M	eet Professional Standards	F 658		3/21/23
	as outlined by the comust- (i) Meet professional This REQUIREMENT by: Based on staff intervand clinical record refacility staff failed to do follow professional st of 58 residents in the #113, #463, and #36 The findings include: 1. For Resident #113 failed to clarify two pl treatment of the sam On the most recent M assessment, an adm assessment reference resident scored an 1 interview for mental s resident was moderat daily decisions. In Sec	Γ is not met as evidenced view, facility document review view, it was determined the clarify physician orders and candards of practice for three survey sample, Residents 5. 6 (R113), the facility staff hysician orders for the		F 658 Services provided meet professional standards of care 1- Residents #365, #463, #113 were discharged. 2-All residents have the potential to be affected. Current residents with wound Dialysis and Insulin orders were review by the DON, or designee to verify accuracy of the orders. 3-The Staff Development Coordinator of designee will educate all licensed nurse on the process for clarifying MD orders 4-The DON or designee will conduct weekly audits x 8 weeks, then monthly to verify accuracy for residents with wound care, Insulin orders and Dialysis orders. 5 Results of the audits will be presente the QAPI Committee for review and recommendation. The Administrator or Director of Nursin are responsible for implementation of the plan of correction.	ls, red or es s. x2 d to g

Facility ID: VA0392

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		495391	B. WING				C 08/2023
NAME OF P	ROVIDER OR SUPPLIER		I	S	TREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
GLENBUR	RNIE REHAB & NURSING	CENTER			901 LIBBIE AVE RICHMOND, VA 23226		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI. DEFICIENCY)		(X5) COMPLETION DATE
F 658	The physician order of documented, "Dakin's 0.125% (Sodium Hyp topically every day ar wet to dry dressing or The September TAR record) documented to 9/16/2022 through 9/2 The physician order of documented, "Wound pressure ulcer stage apply collagen, pack cover with ABD (abdo shift for wound care." The September TAR order. The order was administered from 9/1 The physician order of documented, "Wound pressure ulcer stage apply collagen, pack cover with ABD (abdo shift for wound care." The September TAR order. The order was administered from 9/1 The physician order of documented, "Wound pressure ulcer stage apply collagen, pack cover with ABD pad d wound care." The September TAR order. The order was administered from 9/2 An interview was con nurse) #2, on 2/7/202 a.m. The above TAR When asked if there was ame wound, what sh	lated, 9/15/2022, s (1/4 strength) Solution ochloride) Apply to right hip id evening shift for apply for n wound." (treatment administration he above order. The order e administered from 28/2022. lated, 9/17/2022, care: clean right hip four with wound cleanser, with silver alginate and ominal) pad daily every day documented the above documented to be 8/2022 through 9/22/2022. lated, 9/21/2022, care: Clean right hip four with wound cleanser, with silver alginate and aily every day shift for	F	658	6-Completion date 3/21/23		

Facility ID: VA0392

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	MENT OF HEALTH AN S FOR MEDICARE & I					FORM): 03/14/2023 APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING		(X3) DATE SURVEY COMPLETED		
		495391	B. WING		_	(02/	C 08/2023
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	TATE, ZIP CODE		
GLENBUF	RNIE REHAB & NURSING	CENTER		1901 LIBBIE AVE RICHMOND, VA 23226			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 658	asked if she should ca practitioner to clarify t person inputting the n system could have wr forgot to discontinue t An interview was conc practical nurse) #3, th 2/7/2023 at 11:50 a.m reviewed with LPN #3 had two orders for the a nurse do, LPN #3 st doctor for clarification The facility document. Procedure Manual" do "Admission Physician for every patient at the readmission to activat PROCEDURE: 1. Upo or readmission or re-el licensed nurse will no and/or verifying physic receiving admission p physician, the nurse v include: a. Orders - m orders must include th patient, 1) Right name dosage. 3) Right routed diagnosis/reason for u evidence documentat physician orders. ASM (administrative s administrator, ASM #2 nursing, and ASM #3,	all the doctor or nurse he order, RN #2 stated the ew order into the computer itten the new order and he old order. ducted with LPN (licensed e unit manager, on . The above TAR was . When asked if a resident e same wound, what should rated, they need to call the "Nursing Policy and boumented in part, 's Orders must be provided e time of admission or the a medical plan of care. On every patient's admission entry to the Center, a tify the physician requesting cian's orders. 2. Upon hysician's orders from the vill record the order to edication and treatment the five rights: Right name of e of medication. 2) Right e. 4) Right time. 5) Include use." The Manual failed to ion related to clarifying	F 65	8			

Facility ID: VA0392

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391	
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED		
		495391	B. WING				C 08/2023	
NAME OF PR	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE			
GLENBUR	NIE REHAB & NURSING	CENTER						
					RICHMOND, VA 23226			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE	
F 658	(1) Pressure Injury: A damage to the skin ar usually over a bony p medical or other devic as intact skin or an op painful. The injury occ and/or prolonged press combination with sheat tissue for pressure ar affected by microclim co-morbidities and co Stage 4 Pressure Inju- tissue loss Full-thickn with exposed or direc- tendon, ligament, car Slough and/or eschar (rolled edges), under often occur. Depth va If slough or eschar ob loss this is an Unstag information was obtai website: https://cdn.ymaws.com ce/resmgr/npuap_pre 2. The facility staff fai complete physician's dialysis treatment. Resident #463 was an	n was provided prior to exit. pressure injury is localized and underlying soft tissue rominence or related to a ce. The injury can present ben ulcer and may be curs as a result of intense ssure or pressure in ar. The tolerance of soft ad shear may also be ate, nutrition, perfusion, ndition of the soft tissue. ury: Full-thickness skin and ess skin and tissue loss tly palpable fascia, muscle, tilage or bone in the ulcer. • may be visible. Epibole mining and/or tunneling ries by anatomical location. oscures the extent of tissue eable Pressure Injury. This ned from the following m/npuap.site-ym.com/resour ssure_injury_stages.pdf led to clarify/obtain a order for Resident #463's	F	658				
	limited to: diabetes m failure, acute respirate stage renal disease).	s that included but were not ellitus, congestive heart ory distress and ESRD (end						
		6 (minimum data set) are 5-day assessment, with reference date) of 1/30/23,						

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE COMP	E SURVEY PLETED
		495391	B. WING				C / 08/2023
NAME OF P	ROVIDER OR SUPPLIER		•		STREET ADDRESS, CITY, STATE, ZIP CODE	·	
GLENBUF	RNIE REHAB & NURSING	CENTER			1901 LIBBIE AVE RICHMOND, VA 23226		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE
F 658	coded the resident as the BIMS (brief interv indicating the residen impaired. A review of Procedures coded dia A review of the physic revealed, "Hemodialy Dialysis Days and Time: M, W, F_Pick of Dialysis Center:SF SPECIFY Transport Company: SPECIFY Transport Company: SPECIFY An interview wad con with LPN (licensed pr asked if this was a co stated, no, it is not. V would take, LPN #4 s clarify the order. An interview was con with LPN #7. When a LPN #7 stated, if that received, I would hav of what dialysis center resident. On 2/7/23 at 5:15 PM member) #1, the adm director of nursing, we findings. A review of the facility dated 3/24/20 reveale admission or readmis Center, a licensed nu	a scoring a 15 out of 15 on iew for mental status) score, t was not cognitively Section O-Special alysis-yes. cian orders, dated 1/28/23, sis Diagnosis: ESRD up time:SPECIFY PECIFY Phone #: SPECIFY Phone #: ducted on 2/7/23 at 3:30 PM actical nurse) #4. When mplete order, LPN #4 Vhen asked what action she tated, call the physician and ducted on 2/8/23 at 8:15 AM asked to review this order, was the dialysis order I e called to clarify the order r and the pickup time for the , ASM (administrative staff inistrator and ASM #2, the ere made aware of the r's "Physician Orders" policy ed, " Upon every patient's	F	658	8		

Facility ID: VA0392

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391	
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495391	B. WING				C 08/2023	
NAME OF PF	ROVIDER OR SUPPLIER		1	S	TREET ADDRESS, CITY, STATE, ZIP CODE			
GLENBUR	NIE REHAB & NURSING	CENTER			901 LIBBIE AVE RICHMOND, VA 23226			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 658	 indicated by patient's directions." No further information 3. For Resident #365 clarify a physician ord administer teaspoons On R365's admission the resident was asserintact, and oriented to situation. A review of R365's ph following order dated 2/3/23: "NovoLOG Inj Aspart) Inject 4 tsp (te three times a day for I A review of R365's Ja MARs (medication ad revealed this order wa four opportunities betted the nurses who signed administrations were during the survey. On 2/7/23 at 5:05 p.m member) #1, the administrations are director of clinical serithese concerns. On 2/8/23 at 8:18 a.m nurse) was interviewed R365's insulin order, statistical series and the survey. 	a was provided prior to exit. (R365) the facility failed to ler for Insulin which read to rather than units. assessment dated 1/31/23, essed to be cognitively o person, place, time, and hysician orders revealed the 1/31/23 and discontinued ection Solution (Insulin easpoons) subcutaneously DM (diabetes mellitus)." anuary and February 2023 lministration records) as signed off as given on ween 1/31/23 and 2/3/23. ed off on these not available for interview h., ASM (administrative staff inistrator, ASM #2, the hd ASM #3, the regional vices, were informed of	F	658				
		sne reviewed the order, and ot right." When asked to						

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING (X3) DATE SURVEY COMPLETED ABUILDING			D HUMAN SERVICES MEDICAID SERVICES			FOR	M APPROVED D. 0938-0391
1495391 B. WING 02/08/2022 NAME OF PROVIDER OR SUPPLIER STREET AND ENDERS. CITY, STATE_IPP CODE Call-BUBRIER REHAB & NURSING CENTER STREET AND ENDERSE OF TALL (BCOM DEFORMORY WIDT BEFICIENCES IN TALL REGULATION OR USE DEFICIENCES STREET AND ENDERSE OF TALL (BCOM DEFORMORY WIDT BEFICIENCES IN TALL REGULATION OR USE DEFICIENCES D PROVIDER PRACE OF ORTHONIC OF RECEDED IN TALL REGULATION OR USE DEFICIENCES D PROVIDER PRACE OF ORTHONIC OF RECEDED IN TALL REGULATION OR USE DEFICIENCES D PROVIDER PRACE OF ORTHONIC OF RECEDED IN TALL REGULATION OR USE DEFICIENCES D PROVIDER PRACE OF ORTHONIC OF RECEDED IN TALL REGULATION OR USE DEFICIENCES D PROVIDER PRACE OF ORTHONIC OF RECEDED IN TALL REGULATION OR USE DEFICIENCES D PROVIDER PRACE OF ORTHONIC OF RECEDED IN TALL REGULATION OR USE DEFICIENCES D PROVIDER PRACE OF ORTHONIC OF RECEDED IN TALL REGULATION OR USE DEFICIENCES D PROVIDER PRACE OF ORTHONIC OF RECEDENCE OF ORTHONIC OF RECEDENCE OF ORTHONIC OF RECEDENCES DEFICIENCES F 658 F 658 </td <td>STATEMENT C</td> <td>F DEFICIENCIES</td> <td>(X1) PROVIDER/SUPPLIER/CLIA</td> <td></td> <td></td> <td>(X3) DATE COME</td> <td>E SURVEY PLETED</td>	STATEMENT C	F DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA			(X3) DATE COME	E SURVEY PLETED
1901 LIBBLE AVE RICHMOND, VA 23226 OPAUER SUMMARY STATEMENT OF DEFICIENCIES PROTEENES PLAN OF CORRECTION REGULATORY OR LSC DENTIFYING INFORMATION PREFX PROTE PROTECNES PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOLD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) CONSEL (EACH CORRECTIVE ACTION DEFICIENCY) CONSEL (EACH CORRECTIVE ACTION SHOLD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) CONSEL (EACH CORRECTIVE ACTION AND AND ACTION ACTION AND ACTION ACTION ACTION ACTION ACTION ACTION ACTION ACTION ACTION ACTION ACTION ACTION ACTION ACTION ACTION			495391	B. WING			
RICHMOND, VA 23226 CMUID TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICEX MUST BE PRECEDED BY FULL RECOLLATORY OR LSCIDENTFYING INFORMATION) ID PROVIDE CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY OPEN CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY F 658 Continued From page 105 provide more details, she stated four teaspoons of insulin was a dangerous overdose. She stated doviously the resident did not receive that much insulin. She stated the nurses must have administered four units of insulin at each opportunity, instead of administring four teaspoons. She stated the order was put into the electronic medical record incorrectly. She stated the physician should have been contacted immediately to clarify the order. R Areview of the facility's nursing policy manual revealed, in part, "Admission Physician's Orders must be provided for every patient at the time of admission or readmission to activate a medical plan of care. PROCEDURE: J. Upon every patient's admission or readmission or re-entry to the Center, a licensed nurse will notify the physician's orders. J. Upon receiving admission physician's orders from the physician's orders. J. Upon receiving admission physician's orders from the physician's orders. J. Upon receiving admission physician's orders from the physician's orders. J. Right name of medication 2) Right dosage 3) Right route 4) Right time 5) Include diagnosis/reason for use." PROCEDURE:	NAME OF PF	ROVIDER OR SUPPLIER					
PREFIX TVG EACH DEFICIENCY MUST BE RECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TVG CEACH OCRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPRORNATE DEFICENCY) COMPLET DEFICENCY) F 658 Continued From page 105 provide more details, she stated four teaspoons of insulin was a dangerous overdose. She stated obviously the resident did not receive that much insulin. She stated the nurses must have administered four units of insulin at each opportunity, instead of administering four teaspoons. She stated the order was put into the electronic medical record incorrectly. She stated time diately to clarify the order. F 658 A review of the facility's nursing policy manual revealed, in part: "Admission Physician's Orders must be provided for every patient at the time of admission or readmission to activate a medical plan of care. PROCEDURE: I. Upon every patient's admission or readmission or re-entry to the Center, a licensed nurse will notify the physician storders from the physician, the nurse will record the order to include: a. Orders - medication and treatment orders must include the fire rights: Right name of medication 2) Right dosage 3) Right toxe 3) Right toxe 3) Right toxe 3) Right toxe 3) Right time 5) Include diagnosis/reason for use." F 658	GLENBUR	NIE REHAB & NURSING	CENTER				
 provide more details, she stated four teaspoons of insulin was a dangerous overdose. She stated obviously the resident did not receive that much insulin. She stated the nurses must have administered four units of insulin at each opportunity, instead of administering four teaspoons. She stated the order was put into the electronic medical record incorrectly. She stated the physician should have been contacted immediately to clarify the order. A review of the facility's nursing policy manual revealed, in part: "Admission Physician's Orders must be provided for every patient at the time of admission or readmission to activate a medical plan of care. PROCEDURE: Upon every patient's admission or readmission or re-entry to the Center, a licensed nurse will notify the physician physician's orders from the physician physician's orders. Upon receiving admission physician's orders from the physician admission or re-entry to the Center, a licensed nurse will notify the physician admission physician's orders. Upon receiving admission physician's orders from the physician admission physician's orders. Dur eceiving admission physician's orders from the physician admission or readmission or re-entry to the Center, a licensed nurse will notify the physician admission physician's orders. Right name of patient Right name of patient Right name of medication Right name of medication Right tome Include diagnosis/reason for use." 	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP) BE	(X5) COMPLETION DATE
	F 658	provide more details, of insulin was a dange obviously the resident insulin. She stated the administered four unit opportunity, instead of teaspoons. She state electronic medical rec the physician should I immediately to clarify A review of the facility revealed, in part: "Add must be provided for admission or readmiss plan of care. PROCEDURE: 1. Upon every patient or re-entry to the Cen notify the physician re physician's orders. 2. Upon receiving adr from the physician, th to include: a. Orders - medication include the five rights Right name of patient 1) Right name of med 2) Right dosage 3) Right route 4) Right time	she stated four teaspoons erous overdose. She stated t did not receive that much e nurses must have ts of insulin at each f administering four d the order was put into the cord incorrectly. She stated have been contacted the order. 's nursing policy manual mission Physician's Orders every patient at the time of sion to activate a medical 's admission or readmission ter, a licensed nurse will equesting and/or verifying mission physician's orders e nurse will record the order n and treatment orders must	F 65	8		
		No further information ADL Care Provided for CFR(s): 483.24(a)(2)	n was provided prior to exit. or Dependent Residents	F 67	7		3/21/23

Facility ID: VA0392

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TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION		e survey IPleted	
	495391	B. WING		C 02/08/2023		
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
			1901 LIBBIE AVE			
GLENBURNIE REHAB & NURSI	IG CENTER		RICHMOND, VA 23226			
PREFIX (EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION (CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE	
services to maintain personal and oral h This REQUIREMEN by: Based on observat responsible party in staff interview, and determined that the ADL (activities of da residents for five of sample, Resident # The findings include 1. For Resident #9 to provide timely ind On the most recent quarterly assessme reference date) of 1 assessed as being decisions. Section extensive assistand toileting. On 2/5/2023 at 2:58 conducted with R93 that they were incol brief. R93 stated th when they needed if they had to wait an because the staff w On 2/6/2023 at 8:26 was conducted with stated that they had	 y living receives the necessary a good nutrition, grooming, and ygiene; IT is not met as evidenced ion, resident and/or terview, clinical record review, facility document review it was facility staff failed to provide aily living) care to dependent 58 residents in the survey 93, #6, #114 #128, and #113. a: (R93), the facility staff failed continence care. MDS (minimum data set), a nt with an ARD (assessment /18/2023, the resident was independent in making daily G documented R93 requiring e from one staff member for B p.m., an interview was a in their room. R93 stated ntinent of urine and wore a at they called on their call bell ncontinence care and at times extended period of time 	F 67	 F677 ADL Care Provided for I Residents 1-Residents #6, #128, #113 an were discharged. Resident #93 receiving proper incontinence of 2-All current residents have the to be affected. Current residen audited by the DON, or design ensure that bathing, incontiner and proper dressing is provide 3-The ADON, or designee will certified nursing aides and lice nurses on providing incontinen proper dress and bathing requi 4- The Unit Manager, or design complete weekly audits x 8 we monthly x2 to ensure that incon care, bathing and that resident properly dressed. S- Results of the audits will be to the QAPI Committee for revi recommendation. The Administrator or Director of are responsible for implementation plan of correction. 6-Completion date 3/21/23 	d # 114 3 is care. e potential ts were ee to ace care d. educate all nsed ce care, irements. nee will eks, then ntinence s are presented iew and f Nursing		

Facility ID: VA0392

If continuation sheet Page 107 of 213

	-	D HUMAN SERVICES					FORM): 03/14/2023 MAPPROVED
STATEMENT C	S FOR MEDICARE & I of DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		CONSTRUCTION		(X3) DATE COMP	LETED
		495391	B. WING			_		C 08/2023
NAME OF PF	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
GLENBUR	NIE REHAB & NURSING	CENTER			901 LIBBIE AVE ICHMOND, VA 23226			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 677	their CNA (certified nu arrived at that time an soon to provide incont that as of 8:26 a.m., n provide incontinence of and their brief was sai last time they had bee care was on the night stated that at times th they were not used to someone to have to c of hearing excuses fro short-staffed and bein they had a wound on put a dressing on eve stated that the wound weekly and told them better. R93 stated that the schedule was for t that it had changed si The following observa 2/6/2023: At 8:31 a.m., a staff m entering R93's room v member exited the roo At 8:47 a.m., a staff m entering R93's room, r room at 9:02 a.m. At 9:19 a.m., a staff m entering R93's room, room with R93's meal On 2/06/2023 at 9:26	f and advised them that ursing assistant) had not d someone would be in tinence care. R93 stated o one had come in to care or follow up with them turated. R93 stated that the en provided incontinence shift around 4:00 a.m. R93 ey felt helpless because being dependent on lean them up and were tired om staff of being g too busy. R93 stated that their bottom which the staff ry couple of days. R93 nurse practitioner came in that the wound was getting at they were not sure what the wound care but knew nce it had improved. tions were made on member was observed with a meal tray. The staff om at 8:32 a.m. member was observed al plate into R93's room. ed the room at 8:47 a.m. member was observed the staff member exited the tray at 9:19 a.m. a.m., an interview was	F	677				
		R93 stated that the staff						

Facility ID: VA0392

If continuation sheet Page 108 of 213

		ID HUMAN SERVICES MEDICAID SERVICES					FORM	D: 03/14/2023
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			NSTRUCTION		(X3) DATE	D. 0938-0391 SURVEY PLETED
		495391	B. WING			_		C 08/2023
NAME OF PI	ROVIDER OR SUPPLIER			STRE	ET ADDRESS, CITY, ST	ATE, ZIP CODE		00/2020
				1901	LIBBIE AVE			
GLENBUR	NIE REHAB & NURSING	G CENTER		RICH	IMOND, VA 23226			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD B ICED TO THE APPROPRIA IEFICIENCY)		(X5) COMPLETION DATE
F 677	Continued From page	• 108	F 67	77				
		me into the room to bring						
		m up. R93 stated that their						
		they had not been provided						
	any incontinence care	e since around 4:00 a.m.						
	On 2/06/2023 at 9:41	a.m., two staff members						
		ng R93's room. The staff						
		they were with therapy and						
		vith the resident regarding						
		providing any incontinence pers exited the room at 9:43						
	a.m.	Jers exiled the room at 9.43						
	a.m.							
	On 2/06/2023 at 9:44	a.m., the call light was						
	observed to be on our	tside of R93's room.						
	On 2/06/2023 at 9:48	a.m., a staff member was						
		3's room to answer the call						
	-	ber was observed turning the						
	-	R93 that they were going to						
		at they needed a different needed to be cleaned up.						
	type of brief and they	fielded to be cleaned up.						
	On 2/06/2023 at 10:1	6 a.m., CNA #2 was						
		continence care to R93.						
		ved to be heavily saturated						
	-	lor that was present through						
		nask. R93's pressure ulcer						
	with no dressing pres	s observed to be uncovered ent to the area						
	with no dressing pres							
	The comprehensive of	are plan for R93 dated						
		ted in part, "LONG TERM						
		equires assistance with						
		ily living) related to health						
		on: 10/22/2022" Under						
		imented in part, "Assist as ility, incontinence care and						
	toileting, dressing, gro	-						

Facility ID: VA0392

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		495391	B. WING				C 08/2023
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
					1901 LIBBIE AVE		
GLENBUF	RNIE REHAB & NURSING	CENTER			RICHMOND, VA 23226		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 677	Created on: 10/22/20 documented, "The res with toileting. Created "Interventions" it docu and change briefs fre on: 10/22/2022" On 2/06/2023 at 10:1 conducted with CNA is worked the 7:00 a.m. assigned to R93. CN incontinence care pro was the first care they morning. CNA #2 sta were able to meet the the assignment they v On 2/6/2023 at 5:36 p conducted with CNA is incontinence care rou two hours. On 2/7/2023 at 11:50 conducted with LPN (LPN #3 stated that in should be made every The facility provided A Responsibilities for C documented in part, " (CNAs) will be given is assignments at the be Procedure:3. Prov information to the on- not completed, etc. 4. responsibilities/assign of care; make rounds	22" The care plan further sident requires assistance d on: 10/22/2022" Under imented in part, "Check quently as needed. Created 7 a.m., an interview was #2. CNA #2 stated that they to 3:00 p.m. shift and was A #2 stated that the vided to R93 at 10:16 a.m. / had provided to them that ted that they felt that they e needs of the residents with were given. 0.m., an interview was #7. CNA #7 stated that nds should be made every a.m., an interview was licensed practical nurse) #3. continence care rounds y two hours. ADL policy "Shift NA" dated 11/01/19 Certified Nursing Assistants shift responsibilities/patient eginning of each shift. ide pertinent patient coming shift, such as tasks Perform shift iments that promote quality , identify and address any eds, promptly respond to call	F	677			

Facility ID: VA0392

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		MEDICAID SERVICES	0			<u>O. 0938-039</u>
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		· · · ·	E SURVEY IPLETED
						С
		495391	B. WING		02	2/08/2023
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
GLENBU	RNIE REHAB & NURSING	G CENTER		1901 LIBBIE AVE RICHMOND, VA 23226		
(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 CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 677	Continued From pag	e 110	F 67	7		
	10	ings (reddened skin, etc.)"				
	(administrative staff r administrator, ASM # nursing and ASM #3,	2, the interim director of , the regional director of				
		e made aware of the concern. n was provided prior to exit.				
		R6), the facility staff failed to				
	admission assessme reference date) of 11 scored 1 out of 15 or mental status) asses resident was severel	y impaired for making daily 6 documented R6 requiring				
	conducted with R6's RP voiced concerns left soiled for extended found wet when they R6's RP stated that we they would ring the c	p.m., an interview was responsible party (RP). R6's regarding the resident being ed periods of time and being arrived to visit frequently. when they found R6 soiled all light and the staff did not they would have to go out to be in to clean up R6.				
	Use" documentation 2/1/2023-2/28/2023 f incontinence care pro	ovided to R6 on the following on 1/1/2023, 1/2/2023,				

Facility ID: VA0392

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		MEDICAID SERVICES		LE CONSTRUCTION		O. 0938-039	
	CORRECTION	IDENTIFICATION NUMBER:		3	· · · ·	IPLETED	
					С		
		495391	B. WING		0	2/08/2023	
NAME OF P	ROVIDER OR SUPPLIER	·		STREET ADDRESS, CITY, STATE, ZIP CODE			
GLENBUF	RNIE REHAB & NURSING	G CENTER		1901 LIBBIE AVE RICHMOND, VA 23226			
(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 CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE	(X5) COMPLETIO DATE	
F 677		e 111 3, 2/4/2023 and 2/5/2023.	F 67	7			
	On evening shift on 1 1/8/2023, 1/9/2023, 1 1/18/2023, 1/20/2023 1/27/2023, 1/29/2023 On night shift on 1/6/ 1/10/2023, 1/13/2023 1/22/2023, 1/28/2023	 (1/2023, 1/2/2023, 1/6/2023, 1/0/2023, 1/12/2023, 1/2/2023, 3, 1/22/2023, 1/26/2023, 3, 1/22/2023, 1/26/2023, 1/31/2023, 1/20/2023, 1/15/2023, 1/20/2023, 1/20/2023, 3, 1/29/2023, 1/31/2023, 2/4/2023 and 					
	in part, "The resident bladder and bowels a toileting program due 11/04/2022. Revisior "Interventions" it door and change briefs fre	care plan for R6 documented is frequently incontinent of and is not a candidate for a to: dementia. Created on: n on: 11/30/2022." Under umented in part, "Check equently as needed. Created <i>i</i> de toileting hygiene with ed on: 11/30/2022"					
	conducted with CNA	o.m., an interview was (certified nursing assistant) nat incontinence care rounds y two hours.					
	conducted with CNA CNAs document ADL system and then on f system is not availab spaces on the ADL re resident had not been	a.m., an interview was #1. CNA #1 stated the care in the computer lowsheets if the computer le. CNA #1 stated blank ecords meant that the n documented on and that it s not documented, it was not					
	done. CNA #1 stated it was not done but th evidence that it was b	I that they could not say that here was nothing to justify or being done because they see that the care was being					

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CENTER	S FOR MEDICARE & I	D HUMAN SERVICES MEDICAID SERVICES					FORM OMB NC	0: 03/14/2023 1 APPROVED 0: 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION			
		495391	B. WING			_		08/2023
NAME OF PF	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
GLENBUR	NIE REHAB & NURSING	CENTER			901 LIBBIE AVE RICHMOND, VA 23226			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	(EACH CORRE) CROSS-REFERE	EPLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 677	Continued From page	112	F	677				
	On 2/8/2023 at 11:23 staff member) #1, the interim director of nur- regional director of cli aware of the concern. No further information 3. For Resident #114 failed to provide perso shift on 6/15/22 and 6/24/22. A review of R114's AE records for June 2022 personal hygiene (cor shaving, washing/dryi day shift on 6/15/22 a 6/19/22 and 6/24/22. R114's baseline care documented, "ADL Se physical limitations. <i>A</i> grooming, dressing, o needed" On 2/7/23 at 11:06 a.r conducted with CNA (a.m., ASM (administrative administrator, ASM #2, the sing and ASM #3, the nical services were made was provided prior to exit. (R114), the facility staff onal hygiene during the day uring the evening shifts on DL (activities of daily living) Prevealed blank spaces for mbing hair, brushing teeth, ng face and hands) for the nd for the evening shift on plan dated 6/21/22 elf care deficit related to Assist with daily hygiene, rral care and eating as m., an interview was (certified nursing assistant)						
	#1. CNA #1 stated th in the computer syste the computer system stated blank spaces of "They haven't been do it wasn't documented, saying it wasn't done or evidence it's been of	e CNAs document ADL care m and then on flowsheets if is not available. CNA #1 on the ADL records means, ocumented on. They say if , it wasn't done. I'm not but there is nothing to justify done. They can't physically e of that client that particular						

Facility ID: VA0392

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						O. 0938-039
	OF DEFICIENCIES - CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			· · ·	E SURVEY IPLETED
			A. DOILDING		с	
		495391	B. WING		02	2/08/2023
NAME OF P	ROVIDER OR SUPPLIER	L		STREET ADDRESS, CITY, STATE, ZIP CODE		
GLENBUF	RNIE REHAB & NURSING	G CENTER		1901 LIBBIE AVE RICHMOND, VA 23226		
(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 CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE
F 677	Continued From page 113 On 2/7/23 at 5:02 p.m., ASM (administrative staff		F 67	7		
	member) #1 (the adn	ere made aware of the				
	CNA" documented, " responsibilities/assign of care; make rounds	ed, "Shift Responsibilities for 4. Perform shift nments that promote quality a, identify and address any eds, promptly respond to call				
	lights and notify the li pertinent patient findi 4. For Resident #128 failed to assist in dres					
	admission assessme	IDS (minimum data set), an nt with an ARD (assessment 22/23, R128 was coded as				
	being severely cognit daily decisions, havin the BIMS (brief interv	tively impaired for making ng scored three out of 15 on riew for mental status). The ns requiring the extensive personal hygiene,				
	was dressed in a hos location visible to visi p.m., 3:40 p.m., and	ting dates and times, R128 pital gown, and was in a tors and staff: 2/5/23 at 3:18 5:12 p.m.; 2/6/23 at 8:16 p.m.; 2/7/23 at 12:10 p.m.				
	nurse) #2 and LPN # services a resident sl ADL (activities of dail #2 stated morning ca	n., LPN (licensed practical 11 were asked what types of hould receive with morning y living) care each day. LPN re includes washing a ands, changing incontinence				

Facility ID: VA0392

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					<u>D. 0938-039</u>
F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		· · /	E SURVEY PLETED
		A. BUILDING			С
	495391	B. WING			/08/2023
OVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
NIE REHAB & NURSING	CENTER				
(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SH	IOULD BE	(X5) COMPLETIO DATE
briefs/assisting with teresident up in a chain dressed for the day. Vacceptable care for a day in a hospital gow LPNs #11 and #2 obsed, still dressed in a stated: "This is not ac [R128] changed." On 2/7/23 at 5:05 p.m member) #1, the adm director of nursing, ar director of clinical ser these concerns. On 2/8/23 at 10:18 a. assistant) #5 was intered ADL resident care corres. On 2/8/23 at 10:18 a. assistant) #5 was intered assistant, an arregular clothes. No further information 5. For R113, the facilit bathing for four days 10/10/2022. On the most recent M assessment, an admia assessment reference resident scored an 11 interview for mental s resident was moderat	bileting, repositioning a , and getting a resident When asked if it is resident to be dressed all n, she stated: "No, it is not." served R128 sitting up in the hospital gown. LPN #11 sceptable. Not at all. I will get n., ASM (administrative staff ninistrator, ASM #2, the nd ASM #3, the regional vices, were informed of m., CNA (certified nursing erviewed. He stated morning nsists of getting a resident e, brushing their teeth nd getting them dressed in n was provided prior to exit. ty staff failed to provide between 9/15/2022 through IDS (minimum data set) ission assessment, with an e date of 9/18/2022, the I out of 15 on the BIMS (brief itatus) score, indicating the tely impaired for making	F 67	7		
	A DEFICIENCIES CORRECTION OVIDER OR SUPPLIER NIE REHAB & NURSING SUMMARY ST. (EACH DEFICIENC REGULATORY OR I Continued From page briefs/assisting with the resident up in a chaired dressed for the day. Na acceptable care for a day in a hospital gow LPNs #11 and #2 obsections bed, still dressed in a stated: "This is not accelerated (R128] changed." On 2/7/23 at 5:05 p.m member) #1, the adm director of nursing, ard director of nursing, ard director of clinical serent these concerns. On 2/8/23 at 10:18 a. assistant) #5 was inter ADL resident care coup, washing their face combing their hair, ar regular clothes. No further information 5. For R113, the facilities bathing for four days 10/10/2022. On the most recent Massessment, an adminiant assessment, an adminiant assessment reference resident was moderard daily decisions. In Se	CORRECTION IDENTIFICATION NUMBER: IDENTIFICATION NUMBER: 495391 OVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 114 briefs/assisting with toileting, repositioning a resident up in a chair, and getting a resident dressed for the day. When asked if it is acceptable care for a resident to be dressed all day in a hospital gown, she stated: "No, it is not." LPNs #11 and #2 observed R128 sitting up in the bed, still dressed in a hospital gown. LPN #11 stated: "This is not acceptable. Not at all. I will get [R128] changed." On 2/7//23 at 5:05 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, and ASM #3, the regional director of clinical services, were informed of these concerns. On 2/8/23 at 10:18 a.m., CNA (certified nursing assistant) #5 was interviewed. He stated morning ADL resident care consists of getting a resident up, washing their face, brushing their teeth combing their hair, and getting them dressed in regular clothes. No further information was provided prior to exit. 5. For R113, the facility staff failed to provide bathing for four days between 9/15/2022 through	PEFICIENCIES CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPI A. BUILDING A95391 B. WING	EFFICIENCIES CORRECTION (X1) PROVIDERSUPPLER/ELA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A BUILDING 495391 STREET ADDRESS, CITY, STATE, ZIP CODE 1991 LIBBIE AVE RECHADRING CENTER STREET ADDRESS, CITY, STATE, ZIP CODE 1991 LIBBIE AVE RECHADRING CENTER SUMMARY STATEMENT OF DEFICIENCIES (EXA DEFICIENCY WILE TO PERCIENCIES PROLIDE RECULATORY OR LSC IDENTIFYING INFORMATION) IDE PREVX TAG PROVIDERS FLICE (ECA DEFICIENCY WILE TO PERCIENCIES (ECA DEFICIENCY WILE TO PERCIENCIES) (ECA DEFICIENCY WILE TO PERCIENCIES (ECA DEFICIENCY WILE TO PERCIENCIES) (ECA DEFICIENCY WILE TO PERCIENCIES) (ECA DEFICIENCY WILE A DEFICIENCIES) (ECA DEFICIENCY WILE A DEFICIENCY) IDE PREVX TAG PROVIDERS FLICE (ECA DEFICIENCY WILE (ECA) CORRECTIVE ACTIONS (CONSTRUCTION ON LOW ATTON) Continued From page 114 brief/sassisting with tolleting, repositioning a resident up in a chair, and getting a resident day in a hospital gown, be stated: "No, it is not." LPNs #11 and #2 observed R128 sitting up in the bed, still dressed in a hospital gown. LPN #11 stated: "This is not acceptable. Not at all. I will get [R128] changed." F 677 On 2/7/23 at 5:05 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, and ASM #3, the regional director of clinical services, were informed of these concerns. F 677 On 2/8/23 at 10:18 a.m., CNA (certified nursing assistant) #5 was interviewed. He stated morning ADL resident care consits of getting a resident up, washing their face, brushing their testh combing their hair, and getting them dressed in regular clothes. F 077 No further information was provided prior to exit. 5. For R	EFFORMES (X1) PROVUERSUPPLIERCLA IDENTIFICATION NUMBER: 495391 (X2) MUTPLE CONSTRUCTION A BUILDING (X3) DR3 COM OVIDER OR SUPPLIER 495391 8. WING 02 WE REHAB & NURSING CENTER 191 LIBBLE AVE 191 LIBBLE AVE RICHMOND, VA 23226 190 PROVIDER'S PLAN OF CONSECTION (EACH OPENCY MUST BE PRECEDED BY FULL RECILICIENT ON LISC DENTIFY TWO INFORMATION) PRETX PRETX PRETX PRETX RECILICIENT ON LISC DENTIFY TWO INFORMATION) PRETX P

Facility ID: VA0392

If continuation sheet Page 115 of 213

SINTERPRINT OF DEFICIENCIES MUM PLAN PLAN PLAN MERLINK (M) PROVIDERS MUM PLICE (M) PLAN MERLINK (M) PLAN MERLINK (D HUMAN SERVICES MEDICAID SERVICES				FORM	0: 03/14/2023 1 APPROVED 0. 0938-0391
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1981 LBBIE AVE RCHMOND, V2 32283 CMUID PREFX TAC SUMMARY STATEMENT OF DEFICIENCIES (LACH DEFICIENCY MUST BE PRECEDED BY FULL) (EACH CORRECTIVE CALSO DEFICIENCY MUST BE PRECEDED BY FULL) TAC DPROVIDERS R-MAY OF CORRECTION (EACH CORRECTIVE CALSO DEFICIENCY MUST BE PRECEDED BY FULL) (EACH CORRECTIVE CALSO DEFICIENCY MUST BE PRECEDED BY FULL) TAC DPROVIDERS R-MAY OF CORRECTION (EACH CORRECTIVE CALSO DEFICIENCY MUST BE PRECEDED BY FULL) DEFICIENCY OWER CORRECTION (EACH CORRECTIVE CALSO DEFICIENCY MUST BE PRECEDED BY FULL) DEFICIENCY OWER CORRECTION (EACH CORRECTIVE CALSO DEFICIENCY MUST BE PRECEDED BY FULL) DEFICIENCY OWER CORRECTION (EACH CORRECTIVE CALSO DEFICIENCY MUST BE PRECEDED BY FULL) DEFICIENCY OWER CORRECTION (EACH CORRECTIVE CALSO DEFICIENCY MUST BE PRECEDED BY ADDUMENTATION OF LSC DEFITIVES WAVE ON the day Shift On Mondays and Thursdays and as needed. It was documented the resident received bed baths rather than a shower. Under the heading, ADL (activities of daily living) bed bath, for September 2022, It was documented the resident received a bed bath ever, day except for 91/82022, and 10/12/0222 and 92/20/2022. There was nothing documented for 100/2022. The October 2022 CNA documentation revealed R113 was to receive a shower there existent received a bed bath, however there was nothing documented for 100/2022. If was the computer system is not available. CNA #1 stated the CNAs documentAtion Revealed R113 was to receive a shower there was nothing documented for 100/2022. State Char At #1 stated the CNAs documentAtion revealed R113 was to receive a shower there was nothing documented for 100/2022. State Char At #1 stated the CNAs documentAtion. The saying it wasn't done but there is nothing to countert of the state on than to saying it wasn't dore core of that client that particular day or shift.* <			495391	B. WING		_		
BLENDING FREHAB & NURSING CENTER RCHMOND, VA 23228 (M) [D] PMEPX TAG SUMMARY SITTEMENT OF DEFICIENCIES. (PACH DEFICIENCY WLIST EF REACEDER 9Y FULL. REGULTORY OR LSC IDENTIFING INFORMATION) ID PROVIDER 92 NOT CORRECTIVE OF CORRECTION CROSS-REFERENCE TO THE APPROPRIATE DEFICIENCY COMMENT FROM F 677 Continued From page 115 hygiene. F 677 F 677 F 677 F 677 Review of the CNA (certified nursing assistant) documentation for September 2022 documented R113 was to receive a shower on the day shift on Mondays and Thursdays and as needed. It was documented the resident received baths and chromented the resident received a babes of aduremented the resident received a bed bath every day except for 9/18/2022, 9/19/2022 and 9/20/2022. The was nothing documented for any type of bathing for those days. The October 2022 CNA documentation revealed R113 was to receive a shower on the resident received a bed bath, however there was nothing documented for 10/3/2022. and 10/10/2022, If was documented the resident received a bed bath, however there was nothing documented for 10/3/2022. The for 10/18/2022 and 10/10/2022, If was documented the resident received a bed bath, however there was nothing documented. The resident received a bed bath, however there was nothing documented. The resident received bank not available. CNA #1 stated the CNA documented. The resident received a bed bath, however there was nothing documented. It was to receive a shower nothing documented. It was to receive a shower nothing documented its resident received a ben documented. The resident received a ben documented for not systep if it was to documented. It was to doe resident received a ben documented. The ys any if it was to documented. It was to the comon	NAME OF PF	ROVIDER OR SUPPLIER		·	STREET ADDRESS, CITY, ST	ATE, ZIP CODE		
RCHMOND, VA 2322 OPAID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECTION REGULATORY OR ISCIDENTIFYING INFORMATION) D PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTION PRECIX.TORY OR ISCIDENTIFYING INFORMATION) D PRECIX TAG D PROVIDER'S PLAN OF CORRECTION (EACH CORRECTION CROSS-REFERENCE) TO THE PARPOPRIATE DEFICIENCY) CORRECTION (EACH CORRECTION PRECIX TAG CORRECTION (EACH CORRECTION (EACH CORRECTION DEFICIENCY) C CROSS DEFICIENCY) C C CROSS DEFICIENCY) C C C C C C C C C C C C C C C C C C C			OFNITER		1901 LIBBIE AVE			
Preferst TAG CEACH DEFICIENCY MUST BE PRECEDED BY FULL RECULTORY OR LSC DENTIFYING INFORMATION) PREFIX TAG CEACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCE TO THE APPROPRIATE CONSULT REFERENCE TO THE APPROPRIATE F 677 Continued From page 115 hygiene. F 677 F 677 Review of the CNA (certified nursing assistant) documentation for September 2022 documented R113 was to receive a shower on the day shift on Mondays and Thursdays and as needed. It was documented R113 received a shower on 9/26/2022. On 9/22/2022 and 9/29/2022, It was documented the resident received bed baths rather than a shower. Under the heading, ADL (activities of daily living) bed baths, for September 2022, It was documented the resident received a bed bath every day except for 9/18/2022. F 677 The October 2022 CNA documentation revealed R113 was to receive a shower bath of resident received a bed bath, however there was nothing documented for 10/3/2022. The October 2022 CNA documentation revealed R113 was to receive a shower/bed bath on Mondays and Thursdays. On 10/6/2022 and 10/10/2022, It was documented the resident received a bed bath, however there was nothing documented for 10/3/2022. On 27/23 at 11:06 a.m., an interview was conduced with CNA #1 stated the CNAs documented to resident if the computer system is not available. CNA #1 stated than's spaces on the ADL records means, "They haven't been documented. It wasn't done. The wasn't done, I'm not saying it wasn't done but there is nothing to justify or evidence it's been done. They say if it wasn't documented, it wasn't done. The y can't physically see that you took care of that client that particular day or shift. S21/23	GLENBUR	NIE REHAB & NURSING	CENTER		RICHMOND, VA 23226			
Fe84 Quality of Care F684 Quality of Care	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORREC CROSS-REFEREN	CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA		COMPLETION
documentation for September 2022 documented R113 was to receive a shower on the day shift on Mondays and Thursdays and as needed. It was documented R113 received a shower on 9/26/2022. On 9/22/2022 and 9/29/2022, it was documented the resident received bed baths rather than a shower. Under the heading, ADL (activities of daily living) bed bath, for September 2022, it was documented the resident received a bed bath every day except for 9/18/2022, 9/19/2022 and 9/20/2022. There was nothing documented for any type of bathing for those days. The October 2022 CNA documentation revealed R113 was to receive a shower/bed bath mondays and Thursdays. On 10/6/2022 and 10/10/2022, it was documented the resident received a bed bath, nowever there was nothing documented for 10/3/2022. On 2/7/23 at 11:06 a.m., an interview was conducted with CNA #1. CNA #1 stated the CNAs document 40. They say if it wasn't documented, it wasn't done. They can't phaysically spaces on the ADL records means, "They haven't been documented. They say if it wasn't documented, it wasn't done. I'm not saying it wasn't done but there is nothing to justify or evidence if's been done. They can't physically see that you took care of that client that particular day or shift."	F 677		9 115	F 6	77			
day or shift." F 684 Quality of Care F 684 3/21/23		Review of the CNA (c documentation for Se R113 was to receive a Mondays and Thursda documented R113 rec 9/26/2022. On 9/22/20 documented the resid rather than a shower. (activities of daily livin 2022, it was document bed bath every day ex 9/19/2022 and 9/20/20 documented for any ty days. The October 2022 CN R113 was to receive a Mondays and Thursda 10/10/2022, it was do received a bed bath, H documented for 10/3/20 On 2/7/23 at 11:06 a. conducted with CNA a CNAs document ADL system and then on fl system is not availabl spaces on the ADL re been documented on documented, it wasn't wasn't done but there evidence it's been doo	ptember 2022 documented a shower on the day shift on ays and as needed. It was ceived a shower on 022 and 9/29/2022, it was lent received bed baths Under the heading, ADL (g) bed bath, for September need the resident received a kcept for 9/18/2022, 022. There was nothing ype of bathing for those IA documentation revealed a shower/bed bath on ays. On 10/6/2022 and cumented the resident nowever there was nothing 2022. m., an interview was #1. CNA #1 stated the care in the computer owsheets if the computer e. CNA #1 stated blank cords means, "They haven't . They say if it wasn't is nothing to justify or ne. They can't physically					
		Quality of Care		F 6	84			3/21/23

Facility ID: VA0392

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED . 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		495391	B. WING _				C 08/2023
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
				19	901 LIBBIE AVE		
GLENBUF	NIE REHAB & NURSING	CENTER			RICHMOND, VA 23226		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD BE			(X5) COMPLETION DATE
F 684	Continued From page	9 116	F	684			
	applies to all treatment facility residents. Basis assessment of a resident that residents receive accordance with profe practice, the comprehe care plan, and the residents This REQUIREMENT by: Based on staff intervi- and clinical record revi- to provide care and se residents' highest leve residents' highest leve residents in the surve #22, #77 and #116. The findings include: 1. For Resident #114 failed to administer m medications in June 2 were available in the medication supply. A review of R114's cli following physician's of -6/9/22- omeprazole (capsule by mouth one gastroesophageal refi- 6/21/22-calcium with units- 1 tablet by mout COVID. -6/21/22-melatonin 3 bedtime for COVID.	ndamental principle that at and care provided to ed on the comprehensive bent, the facility must ensure treatment and care in essional standards of tensive person-centered sidents' choices. is not met as evidenced tew, facility document review view, the facility staff failed ervices to maintain el of well-being for four of 58 y sample, Residents #114, (R114), the facility staff ultiple physician ordered 2022. These medications facility over-the-counter nical record revealed the orders: 1) 20 mg (milligrams)- 1 e time a day for lux disease. vitamin D 600 mg/200			F684 Quality of care- Meds not administered as ordered 1-Residents #114, #22, and #116 were discharged. Resident #77 is receiving Gabapentin as ordered. 2-All current residents have the potenti to be affected. The DON, or designee of audit current residents for medication availability, by completing a MAR to medication cart verification audit, check ensure that wound treatment orders an place as ordered and Neuro assessme are completed as required. 3-The ADON, or designee will educate licensed nurses notify MD when Meds available, the process for refilling or obtaining medications, and awareness OTC medications available in the center obtaining orders for wound care; completion of Neurological assessmen requirements. 4-The Unit Managers will complete a weekly audit x 8 weeks and monthly x ensure the following: Medications are available for administration, MAR to medication cart audits to verify medications are available, wound care	al will e in nts all not of er;	

Facility ID: VA0392

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	S FOR MEDICARE & I					NO. 0938-039	
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>i</i>	PLE CONSTRUCTION G	· · ·	ATE SURVEY OMPLETED	
		495391	B. WING		C		
	ROVIDER OR SUPPLIER	495391	B. WING	STREET ADDRESS, CITY, STATE, ZIP COL		02/08/2023	
NAIVIE OF PI	ROVIDER OR SUPPLIER			1901 LIBBIE AVE			
GLENBUF	RNIE REHAB & NURSING	G CENTER		RICHMOND, VA 23226			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETIO DATE	
F 684	Continued From page	<u>9</u> 117	F 68	34			
	A review of R114's Ju administration record that omeprazole 20 m 6/10/22, and calcium units, melatonin 3 mg administered on 6/21/ spaces on the MAR). over-the-counter med these medications we On 2/7/23 at 12:00 p. conducted with LPN (LPN #3 stated when n order, they should put system for the pharma from the facility supply if the medication is du not arrived from the p On 2/8/23 at 8:31 a.m conducted with LPN # evidence medication is on the MAR. LPN #2 not been documented off on then you can sa been given. On 2/8/23 at 9:50 a.m member) #1 (the adm director of nursing) we above concern. Reference:	ine 2022 MAR (medication) failed to reveal evidence ing was administered on with vitamin D 600 mg/200 and vitamin C 500 mg were /22 (as evidenced by blank A review of the in-house lication supply list revealed ere available in the facility. m., an interview was licensed practical nurse) #3. nurses receive a physician's t the order into the computer acy and pull the medication y of immediate medications ue for administration and has harmacy.		orders are in place for wound Neurological assessments ar as required. 5 Results of the audits will be the QAPI Committee for revie recommendation. The Administrator or Director are responsible for implement plan of correction. 6-Completion date 3/21/23	e completed e presented to ew and of Nursing		
	the stomach. This inf the website:	formation was obtained from					

Facility ID: VA0392

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM): 03/14/2023 APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		495391	B. WING		_	(02/	C 08/2023
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	TATE, ZIP CODE	02/	00/2020
	NIE REHAB & NURSING	CENTED		1901 LIBBIE AVE			
GLENDUP	INIE REHAD & NURSING	GENTER		RICHMOND, VA 23226			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 684	Continued From page	- 118	F 68	4			
		R22), the facility staff failed cal assessment following a					
	quarterly assessment reference date) of 1/1 having no cognitive in	DS (minimum data set), a with an ARD (assessment 8/23, R22 was coded as npairment for making daily red 15 out of 15 on the for mental status).					
	following: "Effective Date: 2/3/2 Fall NoteResident h complaints of pain 10 headResident was a nurse and nurse aide neurological assessm	ent assessed. Therapeutic administered for pain." This					
	Change of Condition entering resident roor vomiting and in sever had a fall from previou pain in neck, head, ar limited ROM (range o extremitiesMD notifi to be sent to Er (emen evaluation and reques tomography) scan. Po been notified of current	ed and requested resident gency room) for further sted CT (computed DA (power of attorney) has nt events."					
	no evidence of a neur	's clinical record revealed ological assessment					

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM): 03/14/2023 APPROVED 0. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		495391	B. WING		_		C 08/2023
NAME OF P	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
			1	901 LIBBIE AVE			
GLENBUR	NIE REHAB & NURSING	CENTER	F	RICHMOND, VA 23226			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 684	what the resident's as following the fall on 2/ On 2/6/22 at 4:28 p.m She stated a CNA (ce had discovered R22 c rang the call bell. She arms and legs, and w person, place, time, a spoke with ASM (adm the director of nursing resident had sustaine that, at this time, the r had hit their head whe took vital signs and di assessment. When as assessed neurological remember. When ask her assessment findir nurse from a contract know how to use the record. She added: "I another resident that shift. There was a lot everything I knew to co On 2/6/22 at 5:42 p.m physician on 2/3/22, v stated LPN #10 never hit their head and was neck pain. He stated I resident's blood press gave an order for her blood pressure medic he had been told the fa and was having such	of what was assessed or sessment responses were 3/23. I., LPN #10 was interviewed. rtified nursing assistant) on the floor after the resident stated R22 could move his as alert and oriented to nd situation. She stated she inistrative staff member) #2, to let ASM #2 know the d a fall. LPN #10 stated resident told her that they en they fell. She stated she d a neurological sked what exactly she lly, she stated she could not ed where she documented ogs, she stated she was a agency, and she did not facility's electronic medical did have another family and wanted to be sent out that going on." She stated: "I did lo."	F 684				
	blood pressure medic he had been told the and was having such	ation. However, he stated if resident had hit their head severe head and neck pain, ited the nurse to send the					

	-	D HUMAN SERVICES MEDICAID SERVICES					FORM): 03/14/2023 APPROVED 0. 0938-0391
STATEMENT C	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ì, í		CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		495391	B. WING			_		C 08/2023
NAME OF PR	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
GLENBUR	NIE REHAB & NURSING	CENTER			901 LIBBIE AVE CICHMOND, VA 23226			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD B ICED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 684	Continued From page	120	F	684				
		., ASM #1, the 2, and ASM #3, the regional vices, were informed of						
	the night shift supervisions stated R22's fall happ the facility for her shift nurse never told her the head when they fell. So R22 had hit their head full neurological assess	a., RN (registered nurse) #3, sor, was interviewed. She ened before she arrived at t. She stated the resident's that the resident had hit their She stated if she had known d, she would have done a ssment, gotten vital signs, sent the resident to the ER.						
	She stated she arrived and was assigned to f #10 gave her report, L the resident had hit th stated she has freque the resident slept all n	I., LPN #8 was interviewed. d at 11:15 p.m. on 2/3/23, R22. She stated when LPN .PN #10 did not tell her that eir head during a fall. She ntly taken care of R22, and hight. She stated she had no ident needed a neurological her shift.						
	Program," revealed, in Immediate Responsib and document patient hours (3 consecutive neurological assessm	policy, "Falls Management o part: "Fall Occurrence ilitiesEvaluate, monitor, response for the first 24 shifts) post fall, include a ent if the fall was ne patient hit his/her head."						
	3. For Resident #77 (was provided prior to exit. R77), the facility staff failed entin (1) was administered						

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0.0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		495391	B. WING				C 08/2023
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
				1	901 LIBBIE AVE		
GLENBUR	RNIE REHAB & NURSING	CENTER		F	RICHMOND, VA 23226		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD F CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE
F 684	On the most recent M annual assessment w reference date) of 10/ scored 14 out of 15 or for mental status) ass resident was cognitive decisions. Section J scheduled pain medic pain during the asses On 2/5/2023 at 4:13 p conducted with R77 in that there were times their scheduled Gaba ran out and that the n they had run out and delivered the medicat took the Gabapentin f in their hands often, tl Gabapentin three time should have somethir medications. R77 sta to wait until the next of from pharmacy. The physician orders "Gabapentin capsule capsule by mouth two pain. Order Date: 08/ 08/11/2022" The or "Gabapentin capsule mouth at bedtime for Date: 08/11/2022. Sta Review of the eMAR administration record 1/1/2023-1/31/2023 a failed to evidence adm	IDS (minimum data set), an with an ARD (assessment (24/2022, the resident in the BIMS (brief interview bessment, indicating the ely intact for making daily documented R77 receiving cations and not having any sment period. b.m., an interview was in their room. R77 stated when they did not receive pentin because the facility urses would tell them that the pharmacy had not ion. R77 stated that they for neuropathy and had pain hat they needed their es a day, and the facility ing in place to not run out of ted that they normally had day to get the medication for R77 documented in part, 100 mg (milligram), give 1 o times a day for neuropathic (11/2022. Start Date: rders further documented, 100 mg, give 3 capsule by neuropathic pain. Order art Date: 08/11/2022"	F	684			

Facility ID: VA0392

If continuation sheet Page 122 of 213

	-					FORM): 03/14/2023 MAPPROVED
STATEMENT (S FOR MEDICARE & I	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		(X3) DATE	0. 0938-0391 SURVEY LETED
		495391	B. WING			02/	-
	ROVIDER OR SUPPLIER			TREET ADDRESS, CITY, ST		02/	08/2023
	ROVIDER OR SUFFLIER				RIE, ZIF CODE		
GLENBUR	RNIE REHAB & NURSING	CENTER		901 LIBBIE AVE RICHMOND, VA 23226			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BI ICED TO THE APPROPRIA IEFICIENCY)		(X5) COMPLETION DATE
F 684	Continued From page for administration of 0		F 684				
		was observed to be blank.					
		ailed to evidence a reason vas not administered on					
	The comprehensive c documented in part, "	care plan for R77 Pain related to disease					
	generalized discomfo	ity, Anemia, Depression, rt. Created on: 10/29/2021.					
	documented in part, "	21." Under "Interventions" it Administered [sic] pain cian orders. Created on:					
	10/29/2021"						
	On 2/7/2023 at 12:30 provided document lis	p.m., a review of the facility sting the available					
	dispensing system) d						
	"Gabapentin 100mg o 10Gabapentin 300n	capsule; PAR ng capsule; PAR 10"					
		a.m., an interview was (licensed practical nurse) #2.					
	LPN #2 stated that m	edications were evidenced					
	eMAR. LPN #2 state	d that if the medications n the eMAR they could not					
		ere given. LPN #2 stated mented it was not done.					
	LPN #2 stated that if	medications were not					
	available on the medi	cation cart the nurse had					
	access to the Omnice	ell to get some medications,					
	-	had access to the Omnicell,					
		s were granted temporary					
		ed that there was no reason					
	-	d not get their medication.					
	LPN #2 stated that the	ey had recently switched to					

Facility ID: VA0392

If continuation sheet Page 123 of 213

	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED 0. 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE	
		495391	B. WING				C 108/2023
NAME OF P	ROVIDER OR SUPPLIER	-			STREET ADDRESS, CITY, STATE, ZIP CODE		
					1901 LIBBIE AVE		
GLENBUR	NIE REHAB & NURSING	G CENTER			RICHMOND, VA 23226		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ЗE	(X5) COMPLETION DATE
F 684	for about 2 months not had some emergency mostly had to wait for medications in. On 2/8/2023 at 9:20 at conducted with LPN # there were no medicat would check the medicat carts, the check the C LPN #1 stated that the and notify the physicat the responsible party medication was not at On 2/8/2023 at 11:23 staff member) #3, the services stated that the current pharmacy on On 2/8/2023 at appro #1, the administrator, of nursing and ASM # clinical services were No further information Reference: (1) Gabapentin Gabapentin capsules are used along with o control certain types of have epilepsy. Gabap oral solution are also postherpetic neuralgia stabbing pain or ache	had the Omnicell in place bw, and prior to that they or medications in a box but pharmacy to bring the a.m., an interview was 41. LPN #1 stated that if ations for a resident they ication cart first and other Omnicell to see if available. ey would call the pharmacy an and the resident and/or and document that the vailable. a.m., ASM (administrative regional director of clinical hey had transitioned to the 12/15/2022. ximately 11:30 a.m., ASM ASM #2, the interim director 43, the regional director of made aware of the concern. h was provided prior to exit.	F	68	,		
		ck of shingles). Gabapentin lets (Horizant) are used to					

Facility ID: VA0392

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CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 093 STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING (X3) DATE SURV COMPLETED	
A. BUILDING	
495391 B. WING 02/08/20	12022
495391 B. WING 02/08/20 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	2023
1901 LIBBIE AVE	
GLENBURNIE REHAB & NURSING CENTER RICHMOND, VA 23226	
	(X5) COMPLETION DATE
F 684 Continued From page 124 F 684 treat restless legs syndrome (RLS; a condition that causes discomfort in the legs and a strong urge to move the legs, especially at night and when sitting or tying down). Cabapentin is in a class of medications called anticonvulsants. Gabapentin treats seizures by decreasing abnormal excitement in the brain. Gabapentin relieves the pain of PIN by changing the way the body senses pain. It is not known exactly how Gabapentin works to treat restless legs syndrome. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a694007.h tml 4. For Resident #116 (R116), the facility staff failed to assess and put treatments in place for a necrotic arterial wound. For the most recent MDS (minimum data set) assessment, an admission assessment, with an assessment reference date of 3/26/2022, the resident scored a 15 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was cognitively intact for making daily decisions. In Section M - Skin Conditions, R116 was not coded as having any type of wound. The hospital discharge instructions, dated, 3/22/2022, documented in part, "Discharge Diagnoses: Right bimalleolar fracture, PAD (peripheral arterial disease) with vascular wound - foot - Wound care followingContinue Betadine paint to dry gangronus areas blive daily Additional Recommendation: Wound care: na (not applicable)."	

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If continuation sheet Page 125 of 213

		ND HUMAN SERVICES MEDICAID SERVICES				F	NTED: 03/14/2023 ORM APPROVED 3 NO. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		ONSTRUCTION	(X3)	DATE SURVEY COMPLETED
		495391	B. WING				C 02/08/2023
NAME OF PI	ROVIDER OR SUPPLIER			STR	EET ADDRESS, CITY, STATE, ZIP CODE		
GLENBUR	NIE REHAB & NURSING	GCENTER			1 LIBBIE AVE HMOND, VA 23226		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 684	breakdown or skin co Identify location of sk appearance including applicable. Abdomen Right lower leg (front Other - left upper arm The Resident Evalua p.m. documented in p current skin breakdow the completed evalua for type and location. pedal pulses palpable foot or ankleBrader risk." The comprehensive of documented in part, ' breakdown related to "Interventions" docum treatment per physici infection such as pur localized heat, increa physician PRN (as ne The nurse's note date documented in part, ' The nurse practitione 11:33 a.m. document summaryHospital d fracture. PAD with va Course: Right bimalle multimodal pain contu therapy. PAD with va Betadine paint to dry (Review of systems).	s there any current skin onditions present? Yes. in conditions and describe g measurements, if - peritoneal dialysis site.) - Fx (fracture) cast intact. n multiple bruises." tion dated 3/22/2022 at 2:48 part, "Skin evaluation reveals wn/skin conditions; refer to ation and physician's orders Cardiovascular: Right e, no edema noted to right n Scale Score: 15.0 = low care plan dated, 3/23/2022, 'Focus: Actual skin gangrenous 2nd toe." The nented, "Administer an order. Report evidence of ulent drainage, swelling, used pain, etc. Notify eeded)."	F	684			

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	S FOR MEDICARE &					O. 0938-039	
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY IPLETED	
			A. BUILDING			С	
		495391	B. WING		02/08/2023		
NAME OF P	ROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP COD	•		
				901 LIBBIE AVE			
GLENBUR	RNIE REHAB & NURSING	GCENTER		RICHMOND, VA 23226			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE	
F 684	Continued From page	- 126	E 004				
F 004			F 684				
		n/Plan)PAD with vascular e Betadine paint to dry					
	documented in part,	ed, 3/24/2022 at 12:32 p.m. 'Cast intact to Rt lower leg. foot and resident able to					
	3/24/2022 at 8:07 p.r (chief complaint): Rig repeated falls and dif post) right ankle bina has a right foot with 2 treated by podiatrist f nonhealing and with toe with drainagef patient reporting she ankle at the fracture about her treatment a she has had her right least 4 - months, reco doctor" and reporting worsen and now befo turning black, reporting all right foot digit toes but denies any tinglin pain. Denies feeling a splint, denies any pai She states she would amputated to preven complicationsInspet 4 extremities negativ toe with gangrenous atrophic toenail and s	le physician note dated n. documented in part, "CC pht foot 2nd toe gangrene, ficulty walking. S/P (status alleolar fracturePatient also 2nd toe chronic wound, for the past few months, clinical signs of black 2nd Pt in room to start treatment, is not feeling pain in the right site, she has little information at the hospital. She reports t foot non healing wound at eiving wound care by "foot her wound continues to ore her fall her 2nd toe was ng decreased sensation on s, especially on the 2nd toe ng, numbness, or neuropathic any pressure due to posterior in on the right knee or hip. d like to have her 2nd to t further ections. Skin: Inspection of all e for rashes. Right foot 2nd changes, black in color and skinRLE (right lower ased sensation to superficial					

Facility ID: VA0392

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391	
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C		
		495391	B. WING				08/2023	
NAME OF PF	ROVIDER OR SUPPLIER	1		S	TREET ADDRESS, CITY, STATE, ZIP CODE			
GLENBUR	RNIE REHAB & NURSING	CENTER						
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ЗE	(X5) COMPLETION DATE	
F 684	Continued From page	9 127	F	684				
		record failed to evidence for the right foot 2nd toe.						
	at 8:41 a.m. documer present on admission	ecialist note dated 3/25/2022 nted in part, "Wound status: . Etiology: Arterial. % eschar - 100.00%. Dressing:						
	The physician order o documented, "Skin pr shift."	lated 3/25/2022, ep right second toe every						
	documented the above as administered on 3/	tment administration record) /e order. It was documented /25/2022 on the evening and umented as administered on shift.						
		d for R116 during their stay longer employed at the le for interview.						
	nurse) #2, on 2/7/202 a.m. When asked if the as necrosis, noted on where is that docume be on the admission a note. The nurse shou practitioner aware of orders can be put in p care nurse as they see When asked if a nurs necrotic area, what is do, RN #2 stated the	ducted with RN (registered 3 at approximately 10:30 here is a skin concern, such the admission of a resident, ented, RN #2 stated it would assessment and in a nurse's Id make the doctor or nurse the area so that treatment place. Also notify the wound ee all residents with wounds. e sees a resident with a expected of the nurse to same thing, document it in tify the doctor or nurse						
	at the facility were no facility and unavailabl An interview was con nurse) #2, on 2/7/202 a.m. When asked if th as necrosis, noted on where is that docume be on the admission a note. The nurse shou practitioner aware of orders can be put in p care nurse as they se When asked if a nurs necrotic area, what is do, RN #2 stated the the nurse's notes, not	longer employed at the le for interview. ducted with RN (registered 3 at approximately 10:30 here is a skin concern, such the admission of a resident, ented, RN #2 stated it would assessment and in a nurse's ld make the doctor or nurse the area so that treatment blace. Also notify the wound ee all residents with wounds. e sees a resident with a expected of the nurse to						

Facility ID: VA0392

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		D HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391
	F DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		495391	B. WING				08/2023
NAME OF PR	OVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
GLENBUR	NIE REHAB & NURSING	CENTER			901 LIBBIE AVE RICHMOND, VA 23226		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 686 SS=D	practical nurse) #3 on When asked if there is necrosis, noted on the where is that documed should be documente assessment and a pro- a nurse sees a reside is expected of the nur would do the best I ca we have available to p in my scope of practic were any standard wo stated she was not av ASM (administrative s administrator, ASM #2 nursing, and ASM #3, clinical services, were findings on 2/7/2023 a No further information Treatment/Svcs to Pre CFR(s): 483.25(b)(1)(§483.25(b) Skin Integ §483.25(b) Skin Integ §483.25(b)(1) Pressur Based on the comprel resident, the facility m (i) A resident receives professional standard pressure ulcers and d ulcers unless the indiv demonstrates that the (ii) A resident with pre	ace. ducted with LPN (licensed 2/7/2023 at 11:50 a.m. a a skin concern, such as a akin concern, such as a don'the admission skin ogress note. When asked if nt with a necrotic area, what se to do, LPN #3 stated, "I in to take care of it. What but on it. I would do what is ace." When asked if there bund care orders, LPN #3 vare of any. atff member) #1, the 2, the interim director of the regional director of the regional director of a made aware of the above at 5:20 p.m. at some provided prior to exit. event/Heal Pressure Ulcer i)(ii) rity re ulcers. hensive assessment of a lust ensure that- o care, consistent with s of practice, to prevent oes not develop pressure vidual's clinical condition by were unavoidable; and		684			3/21/23

Facility ID: VA0392

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CENTER	S FOR MEDICARE &	ND HUMAN SERVICES MEDICAID SERVICES			OMB NO.		
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /		(X3) DATE SURVEY COMPLETED		
		495391	B. WING		C 02/0	8/2023	
NAME OF P	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE			
GLENBU	RNIE REHAB & NURSING	G CENTER		901 LIBBIE AVE RICHMOND, VA 23226			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE	
F 686	with professional star promote healing, pre- new ulcers from dever This REQUIREMENT by: Based on observation document review, an was determined the fi- care and services to 58 residents in the su #113 and #93. The findings include: 1. For Resident #113 failed to administer tr injury per the physicial On the most recent M assessment, an adm assessment, an adm assessment reference resident scored an 17 interview for mental s resident was modera daily decisions. In Set the resident was cod pressure injury. (1) The physician order of documented, "Dakin" 0.125% (Sodium Hyp topically every day an wet to dry dressing of The September 2022 administration record order. The box to ind	ndards of practice, to vent infection and prevent eloping. Γ is not met as evidenced on, staff interview, facility d clinical record review, it facility staff failed to provide promote healing for two of urvey sample, Residents 6 (R113), the facility staff reatments for a pressure an orders. MDS (minimum data set) ission assessment, with an re date of 9/18/2022, the 1 out of 15 on the BIMS (brief status) score, indicating the tely impaired for making betton M - Skin Conditions, ed as having a stage four clated, 9/15/2022, s (1/4 strength) Solution bochloride) Apply to right hip nd evening shift for apply for n wound."	F 686		L d care as ential to ee will tion to neck hat the d nator will blowing nent ements linical ing vill be a wound provisions e will ss and letion of the s are in e		

Facility ID: VA0392

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		ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 03/14/2023 M APPROVED D. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		495391	B. WING				C /08/2023
NAME OF PF	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
GLENBUR	NIE REHAB & NURSING	CENTER			901 LIBBIE AVE		
				R	CCHMOND, VA 23226		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 686	Continued From page	e 130	F	686			
	The physician order of documented, "Wound pressure ulcer stage apply collagen, pack cover with ABD (abdo shift for wound care." The September 2022 administration record order. The box to indi administered was bla 9/19/2022. The physician order of documented, "Wound pressure ulcer stage apply collagen, pack cover with ABD pad of wound care." The September 2022 administration record order. The box to indi administered was bla 9/25/2022. The comprehensive of to evidence document concerns or a pressure An interview was con nurse) #2, on 2/7/202 a.m. When asked wh indicated, RN #2 state not done. The nurse of it off.	lated, 9/17/2022, d care: clean right hip four with wound cleanser, with silver alginate and ominal) pad daily every day TAR (treatment) documented the above cate the treatment was nk on 9/18/2022 and lated, 9/21/2022, d care: Clean right hip four with wound cleanser, with silver alginate and laily every day shift for TAR (treatment) documented the above cate the treatment was nk on 9/24/2022 and care dated 9/20/2022 failed tation related to skin related re injury. ducted with RN (registered c3 at approximately 10:30 at a blank on the TAR ed, if it's not documented it's could have forgotten to sign		000	proper incontinence care is provided. 5 Results of the audits will be present the QAPI Committee for review and recommendation. The Administrator or Director of Nursi are responsible for implementation of plan of correction. 6-Completion date 3/21/23	ng	
	An interview was con practical nurse) #3, th	ducted with LPN (licensed ne unit manager, on					

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-		ID HUMAN SERVICES MEDICAID SERVICES					FORM): 03/14/2023 APPROVED 0. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		495391	B. WING _			_	(02/	C 08/2023
NAME OF PROVIDER OR SU	PPLIER			ST	TREET ADDRESS, CITY, ST	ATE, ZIP CODE	02,	00/2020
				19	001 LIBBIE AVE			
GLENBURNIE REHAB &		CENTER		R	ICHMOND, VA 23226			
PREFIX (EACH	I DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	((EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
on the TAR sure. The facility Care/Dress "POLICY: A care/dressin physician as ordered. ASM (admin administrate nursing, and clinical serv findings on No further in (1) Pressure damage to usually over medical or of as intact sk painful. The and/or proto combination tissue for pr affected by co-morbiditi Stage 4 Pre- tissue loss I with expose tendon, liga Slough and (rolled edge often occur. If slough or	11:50 a.m indicates, policy, "Ge ing Change g change PROCEDI " nistrative s or, ASM #3, ices, were 2/7/2023 a nformation e Injury: A the skin au r a bony p other device in or an op e injury occ onged pres n with sheat ressure an microclimation e soure Injury conged pres n with sheat ressure an microclimation sessure Injury Full-thickn ed or direc ment, carl /or eschar ob	a. When asked what a blank LPN #3 stated she was not eneral Wound les" documented in part, nurse will provide wound (s) as ordered by JRE3. Provide treatments staff member) #1, the 2, the interim director of the regional director of e made aware of the above	F	86				

Facility ID: VA0392

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DEPARTMENT OF HEALTH AND CENTERS FOR MEDICARE & ME					FORM	APPROVED 0. 0938-0391
	1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
	495391	B. WING			C 02/08/2023	
NAME OF PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	:	
GLENBURNIE REHAB & NURSING CI	ENTER			901 LIBBIE AVE ICHMOND, VA 23226		
PREFIX (EACH DEFICIENCY M	EMENT OF DEFICIENCIES IUST BE PRECEDED BY FULL DENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
 ce/resmgr/npuap_pressi 2. For Resident #93 (Rg to provide care and serve of a pressure ulcer (1). On the most recent MDS quarterly assessment wireference date) of 1/18/2 assessed as being indep decisions. Section G do extensive assistance froto toileting. Section M doc stage 3 pressure ulcers present on admission to On 2/6/2023 at 8:26 a.m conducted with R93 in th that they had requested 7:00 a.m. and was still w provide the care at 8:26 last time they had been care was around 4:00 a. On 2/06/2023 at 10:16 a nursing assistant) #2 wa incontinence care to R93 observed to be heavily surine odor that was pressing present. The physician orders for 	ed from the following npuap.site-ym.com/resour ure_injury_stages.pdf 93), the facility staff failed vices to promote healing S (minimum data set), a ith an ARD (assessment 2023, the resident was pendent in making daily ocumented R93 requiring on one staff member for cumented R93 having four with three of them o the facility. h., an interview was heir room. R93 stated incontinence care before waiting for staff to come to a.m. R93 stated that the provided incontinence .m. a.m., CNA (certified as observed providing 3. R93's brief was saturated with a strong sent through this R93's pressure ulcer to served to be uncovered it to the area. r R93 documented in part, vith NS (normal saline) pat icles, pack with silver	F	686			

Facility ID: VA0392

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	-	D HUMAN SERVICES MEDICAID SERVICES					FORM): 03/14/2023 APPROVED 0. 0938-0391
STATEMENT C	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		495391	B. WING			_		C 08/2023
NAME OF PF	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STA	TE, ZIP CODE		
GLENBUR	NIE REHAB & NURSING	CENTER			001 LIBBIE AVE ICHMOND, VA 23226			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	((EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BE CED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE
F 686	orders further docume cleanse with NS pat d pack with silver algina gauze as needed. Or Review of the eTAR (administration record) 12/1/2022-12/31/2022 2/1/2023-2/28/2023 fa completed to the left i 12/4/2022, 12/5/2022 12/26/2022, 1/3/2023 1/28/2023. The dates blank. The comprehensive of 10/22/2022 document admitted to this SNF (with 3 Stage 3 pressu and other wounds. Sh alterations in her skin mobility, incontinence problems. Created or 01/10/2023." Under " documented in part, " as possible. Created 09/29/2022Treatme Created on: 10/22/202 and treatment as order 10/23/2022." The Wound evaluation documented in part, " cm (centimeter) Width 2.50Wound status In frequency Daily"	Date: 01/19/2023." The ented, "Left ischium- lry, apply collagen particles, the secure with bordered der Date: 01/19/2023." electronic treatment for R93 dated 2, 1/1/2023-1/31/2023 and ailed to evidence treatment schium pressure ulcer on , 12/7/2022, 12/8/2022, , 1/14/2023, 1/16/2023 and a listed were observed to be are plan for R93 dated ted in part, "[R93] was skilled nursing facility) with re ulcers, a surgical wound he is at risk for further integrity related to impaired , diabetes and circulation n: 09/29/2022. Revision on: Interventions" it Keep skin clean and dry on: nts to skin as ordered. 22. Wound care consults ered. Created on: in dated 2/1/2023 for R93 Left ischium length 0.86 n 0.76 cmDepth (cm) mprovingDressing change	F 6	86				
	On 2/06/2023 at 10:17	7 a.m., an interview was						

Facility ID: VA0392

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	MENT OF HEALTH AN S FOR MEDICARE & I	D HUMAN SERVICES				FORM	: 03/14/2023 APPROVED . 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	PLE CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		495391	B. WING		_	C 02/08/2023	
NAME OF P	ROVIDER OR SUPPLIER		•	STREET ADDRESS, CITY, S	TATE, ZIP CODE		
GLENBUF	RNIE REHAB & NURSING	CENTER		1901 LIBBIE AVE RICHMOND, VA 23226			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 686	conducted with CNA (#2. CNA #2 stated th a.m. to 3:00 p.m. shift CNA #2 stated that th provided to R93 at 10 they had provided to f stated that they felt th the needs of the resid they were given. On 2/08/2023 at 8:17 conducted with LPN (LPN #2 stated that we completed by signing stated that they had a week who completed them off and when the were responsible and #2 stated that the wou on the wounds and th complete any addition LPN #2 stated that the wou on the wounds and th complete any addition LPN #2 stated that the eT/ nurse and things look when they were not s that they could not ev was done if there wer #2 stated that if it was done. On 2/8/2023 at approx #1, the administrator, of nursing and ASM # clinical services were	certified nursing assistant) at they worked the 7:00 and was assigned to R93.	F 68	36			

Facility ID: VA0392

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	-	D HUMAN SERVICES MEDICAID SERVICES			FOR	M APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		495391	B. WING _			2/08/2023
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	•	
GLENBUR	RNIE REHAB & NURSING	CENTER		1901 LIBBIE AVE RICHMOND, VA 23226		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE ((EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 689 SS=D	A pressure sore is an down when something against the skin. Pres the severity of sympto stage. Stage IV is the painful area on the sk when pressed. This is is forming. The skin m soft. Stage II: The sk sore. The area around irritated. Stage III: The open, sunken hole ca below the skin is dam see body fat in the cra pressure ulcer has be damage to the muscle to tendons and joints. obtained from the wel https://medlineplus.go 00740.htm. Free of Accident Haza CFR(s): 483.25(d)(1)(1) §483.25(d) Accidents The facility must ensu §483.25(d)(2)Each re supervision and assis accidents. This REQUIREMENT by: Based on staff intervi and facility document the facility staff failed	area of the skin that breaks g keeps rubbing or pressing ssure sores are grouped by oms. Stage I is the mildest worst. Stage I: A reddened, in that does not turn white a sign that a pressure ulcer may be warm or cool, firm or in blisters or forms an open d the sore may be red and ue skin now develops an lled a crater. The tissue aged. You may be able to ater. Stage IV: The come so deep that there is e and bone, and sometimes This information was osite: ov/ency/patientinstructions/0 ards/Supervision/Devices (2)	F 6			3/21/23

Event ID: V8T511

Facility ID: VA0392

If continuation sheet Page 136 of 213

		ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 03/14/ FORM APPRO OMB NO. 0938-0
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DATE SURVEY COMPLETED C
		495391	B. WING		02/08/2023
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	•
GLENBUR	NIE REHAB & NURSING	G CENTER		1901 LIBBIE AVE RICHMOND, VA 23226	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE COMPLET
F 689	Continued From page	e 136	F 68	9	
	The findings include: 1. The facility staff fai smoking paraphernal use. Resident #48 was ad 4/13/20 with diagnosi limited to: diabetes m depression. The most recent MDS assessment, a quarte ARD (assessment rel coded the resident as the BIMS (brief interv indicating the resident impaired. A review of the comp 5/17/22 and revised 1 "FOCUS: Resident ch off facility grounds. U facility, declines smole independent smoker. smoke. INTERVENT interventions and cerr procedures, smoke fr grounds. Flag placed	led to ensure Resident #48's ia was secured when not in mitted to the facility on is that included but were not ellitus, atrial fibrillation and S (minimum data set) erly assessment, with an ference date) of 11/6/22, is scoring a 15 out of 15 on iew for mental status) score, it was not cognitively rehensive care plan dated 1/2/23, which revealed, nooses to smoke -will smoke inderstands smokefree king cessation and The resident prefers to		 2-All current residents have the to be affected. All residents will be re-educated on the safe measures for the use of smoking materials by the Administrator, designee. 3-The Administrator, or designe educate all staff on the facility policy and handling of smoking 4-The DON or designee will convectly audits x 8 weeks and the x2 to ensure that the residents following the safety measures materials. 5- Results of the audits will be to the QAPI Committee for revised recommendation. The Administrator or Director of are responsible for implementation. 6-Completion date 3/21/23 	no smoke ety ing , or nee will smoking g material. omplete hen monthly s are for smoking presented riew and of Nursing
	smoking cessation (i. medications, etc.). S needed. Educate on A review of the facility Evaluation" dated 8/2	moking assessment as facility smoking policy."			

Facility ID: VA0392

If continuation sheet Page 137 of 213

						FORM): 03/14/2023 APPROVED 0. 0938-0391
STATEMENT O	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·	E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		495391	B. WING		_	C 02/08/2023	
NAME OF PI	ROVIDER OR SUPPLIER		-	STREET ADDRESS, CITY, ST	ATE, ZIP CODE		
GLENBUR	NIE REHAB & NURSING	CENTER		1901 LIBBIE AVE RICHMOND, VA 23226			
(X4) ID PREFIX TAG	LAN OF CORRECTION IDENTIFICATION NUMBE 495391 E OF PROVIDER OR SUPPLIER NBURNIE REHAB & NURSING CENTER (EACH DEFICIENCY MUST BE PRECEDED BY FU AG REGULATORY OR LSC IDENTIFYING INFORMATION	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BE ICED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 689	supervision to smoke. On 2/6/23 at 2:50 PM observed smoking on fence at the corner of parking lot and the ro- center. When asked smoke, Resident #48 per day. When asked smoke, Resident #48 there is a book at the and smoke and then g sign in. When asked and lighter, Resident the staff had them, bu with them and gave th	, Resident #48 was the far side of the white the entrance to the facility ad leading into the shopping how often he comes out to stated three to four times the process for him to stated, I sign out and in, reception desk. I come out go back to my room after I if he keeps his cigarettes #48 stated, yes, at one point at they could not keep up hem back to us.	F 689				
	asked if he would sho cigarettes and lighter, there is no one but me and I am going to kee On 2/7/23 at approxim review of a facility eve staff education on the 12/31/22 and 1/2/23 w objectives for 12/31/2 smoking paraphernali residents, packaged a room. Staff is to give residents per request, supplies back from re up". An interview was con- with LPN (licensed pr	w me where he stores his Resident #48 stated, no, who knows where they are p it that way. hately 12:30 PM, during the ent synopsis, evidence of smoking policy dated vas provided. The learning 2 were revealed to be, "All a has to be taken from all and placed in medication smoking materials to staff must take smoking					

Facility ID: VA0392

If continuation sheet Page 138 of 213

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM): 03/14/2023 MAPPROVED). 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		495391	B. WING		_		C 08/2023
NAME OF P	ROVIDER OR SUPPLIER		5	STREET ADDRESS, CITY, ST	ATE, ZIP CODE		
GLENBU	RNIE REHAB & NURSING	CENTER		901 LIBBIE AVE RICHMOND, VA 23226			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BE ICED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 689	a smoking assessment independent smoker of If they are independent that is attached to the more visible to the tran- keeps the smoking im- the facility, LPN #6 st smoking implements. An interview was com- with LPN #5, the MDS coordinator. When as- smoking implements is stated, we are utilizing believe the front desk the residents come ba- On 2/8/23 at 9:35 AM entering the building a signed himself in and implements to the reco An interview was com- AM, with OSM (other desk receptionist. Wil give their cigarettes a receptionist when the stated, no, the resident lighters with them. On 2/7/23 at 5:15 PM member) #1, the adm director of nursing, we findings.	ker, LPN #6 stated, there is in done to if they are an or if they need supervision. Int, there is an orange flag ir wheelchair, so they will be ffic. When asked who oplements when they are in ated, they give us their ducted on 2/8/23 at 8:30 AM 6 (minimum data set) sked who keeps the for the residents, LPN #5 g the smoking policy. I takes their materials when ack in from smoking. , a resident was observed after smoking. The resident did not give any smoking eeptionist. ducted on 2/8/23 at 9:50 staff member) #9, the front hen asked if the residents nd lighters to the y enter the facility, OSM #9 hts keep their cigarettes and , ASM (administrative staff inistrator and ASM #2, the ere made aware of the mately 11:00 AM, ASM #1, "Patient Smoking	F 689				

Facility ID: VA0392

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		495391	B. WING _				C 08/2023
NAME OF PF	ROVIDER OR SUPPLIER			ST	IREET ADDRESS, CITY, STATE, ZIP CODE		
GLENBUR	NIE REHAB & NURSING	CENTER			001 LIBBIE AVE ICHMOND, VA 23226		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	ĸ	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 689	Continued From page	9 139	F	689			
	A review of the facilitie Free Environment" por "Facility promote a sm environment. Use of electronic smoking pa- within the facility." No further information 2. For Resident #96 (to evidence that they secured when not in the On the most recent M quarterly assessment reference date) of 12/ out of 15 on the BIMS status), indicating the for making daily deciss The facility's "Smokin dated 12/20/2022 door the resident smoke?" INTERVIEW" it docur understands that smot (cigarettes, cigar, pipe systems (electronic ci matches, etc.) must b under control of the c Yes." On 02/05/2023 at app was observed outside On 02/06/2023 at app	es "Smoke/Tobacco/Vapor blicy dated 1/23/20 revealed, noke/tobacco/vapor free tobacco products and other araphernalia is not permitted a was provided prior to exit. R96), the facility staff failed smoking paraphernalia was use. IDS (minimum data set), a with an ARD (assessment /20/2022, (R96) scored 13 6 (brief interview for mental resident is cognitively intact sions. g-Safety Screen" for (R96) cumented in part, "1. Dose Yes." Under "F. nented in part, "10. Patient					
	On 02/07/2023 at app	proximately 9:17 a.m., during					

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		D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` <i>`</i>		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		495391	B. WING				C 08/2023
NAME OF P	ROVIDER OR SUPPLIER		•	S	STREET ADDRESS, CITY, STATE, ZIP CODE		
GLENBUF	RNIE REHAB & NURSING	CENTER			1901 LIBBIE AVE RICHMOND, VA 23226		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 689	wheelchair revealed t laying on the seat. W their cigarettes (R96) two or three cigarettes rest to the person at t come back into the fa asked about a lighter the lighter with them a On 2/8/2023 at appro- interview was conduc practical nurse) #6. V are implemented whe a smoker, LPN #6 sta assessment done to o independent smoker of If they are independent that is attached to the more visible to the tra- keeps the smoking im the facility, LPN #6 sta smoking implements. On 2/8/2023 at appro- interview was conduc (minimum data set) co who keeps the smoking residents, LPN #5 sta smoking policy. I belit their materials when t from smoking. On 2/8/2023 at appro- interview was conduc (member) #9, the from asked if the residents lighters to the reception	6), an observation of their wo packs of cigarettes then asked where they keep stated that they take out is from a pack and give the he front desk when they cility from smoking. When (R96) stated that they keep all the time. ximately 8:00 a.m., an ted with LPN (licensed When asked what actions in a resident is identified as ited, there is a smoking determine if they are an or if they need supervision. int, there is an orange flag ir wheelchair, so they will be ffic. When asked who oplements when they are in ated, they give us their ximately 8:30 a.m., an ted with LPN #5, the MDS pordinator. When asked	F	689			

Facility ID: VA0392

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	S FOR MEDICARE &	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE	CONSTRUCTION	OMB NC (X3) DATE). 0938-039 SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING			COMPLETED	
		495391	B. WING				08/2023
NAME OF PI	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
GLENBUR	RNIE REHAB & NURSING	G CENTER			901 LIBBIE AVE RICHMOND, VA 23226		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 689	Continued From page keep their cigarettes	e 141 and lighters with them.	F	689			
	(administrative staff n was made aware of t	-					
F 691 SS=D	Colostomy, Urostomy	n was provided prior to exit. /, or lleostomy Care	F	691			3/21/23
	care. The facility must ensure require colostomy, ur services, receive suc professional standard comprehensive perso the resident's goals a	h care consistent with ds of practice, the on-centered care plan, and					
	Based on staff interv and clinical record re facility staff failed to p	view, facility document review view, it was determined the provide care and services for of 58 residents in the survey 17.			F691 Colostomy, Urostomy, or Ileostor Care - 1-Resident # 117 was discharged. 2-All current residents receiving Colostomy care have the potential to be affected. The Unit Manager, or designe will audit residents with colostomies to	e	
	The facility staff failed bag was cared for an (R117).	d to evidence the colostomy d emptied for Resident #117			ensure that the Colostomy care is being documented in the ADL portion of the clinical record and that the care for the colostomy is reflected on the care plan. 3-The ADON, or designee will educate	-	
	assessment, a Medic with an assessment r the resident scored a (brief interview for me	ADS (minimum data set) eare five day assessment, reference date of 1/29/2022, 13 out of 15 on the BIMS ental status) score, indicating cognitively impaired for			certified nursing aides and licensed nurses on the process for documentation of colostomy care provided and inclusion of the colostomy care on the care plan. 4-The Unit Manager, or designee will complete weekly audits x 8 weeks and	on	

Facility ID: VA0392

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		MEDICAID SERVICES		PLE CONSTRUCTION	OMB NO. 0938 (X3) DATE SURVEY	
	CORRECTION	IDENTIFICATION NUMBER:	. ,	G	COMPLETED	Ŷ
					С	
		495391	B. WING		02/08/202	23
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIF	CODE	
GLENBUF	RNIE REHAB & NURSING	GCENTER		1901 LIBBIE AVE RICHMOND, VA 23226		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE COMP O THE APPROPRIATE DA	X5) PLETION ATE
F 691	Continued From page	e 142	F 69	91		
	making daily decision	ns. In Section G - Functional		then monthly x2 to ensure	e that colostomy	
		ded as requiring extensive		care is documented in the		
	assistance of one staff member for most of their ADLs (activities of daily living) except eating in			the clinical record and inc	cluded in the care	
		ired supervision after set up		plan. 5 Results of the audits wi	Il be presented to	
		In Section H - Bladder and		the QAPI Committee for I	-	
Bowel, the resident was coded as having a colostomy. There was no care plan for the care of a colostomy.			recommendation.			
			The Administrator or Dire are responsible for imple			
			plan of correction. 6-Completion date 3/21/2	3		
	"Colostomy: change l Ostomy supplies as in spray, adhesive remo	dated, 1/26/2022 read, bag and care as indicated. ndicated, odor eliminator ove wipes, ostomy paste, ostomy tape, as needed for magement."				
		f daily living) documentation				
	documentation to ind	s reviewed. There was no icate that colostomy				
	care/emptying of the					
	provided. Under "Bo following was docume					
	documented for all ca	. to 3:00 p.m. (7-3) - 97 ategories, according to the				
	indicates "not applica					
	applicable	.m11 p.m.) - 97 - not				
	1/28/2022 - 11-7 (11 applicable 1/28/2022 - 7-3 - blar	p.m7 a.m.)- 97 - not nk, no documentation				
	An interview was con	nducted with LPN (licensed n 2/8/2023 at 9:18 a.m.				

Facility ID: VA0392

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	S FOR MEDICARE &	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION		E SURVEY
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		CON	IPLETED
		495391	B. WING		0:	C 2/08/2023
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
GLENBUF	RNIE REHAB & NURSING	G CENTER		1901 LIBBIE AVE RICHMOND, VA 23226		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 691	ostomy bag, LPN #1 CNAs (certified nursin The nurse normally d replacing the bags. T the CNA documentat applicable" should be documentation under stated, no. An interview was con 2/8/2023 at 10:17 a.n a colostomy bag, CN When asked how ofte checked, CNA #5 sta with colostomies even hours. When asked w the emptying of the c in (name of computer documentation was m asked if it should be of applicable, CNA #5 s colostomy. After revie with the above inform they could tell if the c CNA #5 stated no an correct documentatio colostomy. The facility policy, "C in part, "POLICY: Col will be applied/chang ordered by physician	esponsible for emptying an stated the nurse and the ng assistants) can empty it. leals with the seal and he output is documented in ion. When asked if, "not e documented on the ADL bowel movement, LPN #1 adducted with CNA # 5 on n. When asked who empties A #5 stated the CNA did. en a colostomy bag is ted they check residents ry one to two and a half where the documentation of olostomy is, CNA #5 stated r program). The above ADL eviewed with CNA #5. When	F 69*			

Facility ID: VA0392

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			0.00		OMB NO. 0938-03		
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED		
		495391	B. WING		C 02/08/2023		
NAME OF PI	ROVIDER OR SUPPLIER	I		STREET ADDRESS, CITY, STATE, ZIP CODE			
GLENBUF	RNIE REHAB & NURSING	CENTER		1901 LIBBIE AVE RICHMOND, VA 23226			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLÉTIO		
F 691	clinical services, were findings on 2/8/2023	, the regional director of e made aware of the above	F 69	1			
F 694 SS=E	Parenteral/IV Fluids CFR(s): 483.25(h)		F 69	4	3/21/23		
	with professional star accordance with phys comprehensive perso the resident's goals a This REQUIREMENT by: Based on observatio interview, facility doct record review, the fac care and services for venous access device the survey sample, R The findings include: 1. For Resident #112 failed to evidence mat (peripherally inserted the date of admission On R112's admission the resident was asse	 on-centered care plan, and nd preferences. is not met as evidenced n, resident interview, staff ument review, and clinical cility staff failed to provide maintenance of a central e for two of 58 residents in esidents #112 and #365. (R112), the facility staff intenance care for a PICC central catheter) (1), from a, 1/12/23, until 2/2/23. assessment dated 1/12/23, essed to be cognitively 		F694 Parenteral/IV fluids 1-Resdients #112 and #365 were discharged. 2-All current residents receiving IV flu have the potential to be affected. The DON, or designee will complete audits residents with IV access to ensure tha the care of the PICC or IV access is reflected in the Orders and on the care plan and followed appropriately. 3-The Staff Development Coordinator designee will educate all licensed nur on obtaining orders for the care of IV access/PICC line and following the pla care provisions for the IV access/PICC line.	s of at e or ses an of		
	situation. On 2/5/23 at 2:54 p.n have a double lumen	o person, place, time, and n., R112 was observed to (two lines) PICC line rm. When asked about the		 4-The Unit Manager, or designee will complete weekly audits x 8 weeks, the monthly x2 to ensure that IV access/F line care orders are in place, reflected the care plan and the care is implement appropriately. 	PICC I on		

Facility ID: VA0392

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		MEDICAID SERVICES	(X2) MULTIP	PLE CONSTRUCTION	OMB NO. 0938- (X3) DATE SURVEY	
	CORRECTION	IDENTIFICATION NUMBER:	· /	B	COMPLETED	
					С	
		495391	B. WING		02/08/2023	3
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZI	P CODE	
GLENBU	RNIE REHAB & NURSING	GCENTER		1901 LIBBIE AVE RICHMOND, VA 23226		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED TI DEFICIE	CTION SHOULD BE COMPLE O THE APPROPRIATE DAT	ETION
F 694	Continued From page	e 145	F 69	94		
care t staff o line, a line re A revi part: "2/1/2 Admin Soluti intrav 24 ho clogg "2/2/2 Admin patier came NACL succe Flush contir A revi follow with 1	care the staff gave the staff did not always he line, and had only sta- line recently. A review of R112's pre- part: "2/1/2023 22:14 (10: Administration Note" Solution (antibiotic ad- intravenously)Use 2 24 hours for infection clogged." "2/2/2023 02:20 (2:20 Administration Note"	are the staff gave the PICC line, R112 stated the taff did not always have the supplies to flush the ne, and had only started putting heparin in the ne recently. A review of R112's progress note revealed, in eart: 2/1/2023 22:14 (10:14 p.m.) Orders - administration Note Text: Ceftriaxone Sodium Solution (antibiotic administered ntravenously)Use 2 gram intravenously every 4 hours for infection for 25 Days. Picc line		 5 Results of the audits w the QAPI Committee for recommendation. The Administrator or Dire are responsible for imple plan of correction. 6-Completion date 3/21/ 	review and ector of Nursing mentation of the	
	came to bedside to a NACL (normal saline successful. Updated Flush and 0.9% NAC continue to monitor p	vas occluded. RN Supervisor ssess PICC Line using 0.9%) flush. RN supervisor was orders include Heparin CL flush Q (each) Shift. Will vatient status."				
	with 10ml (milliliters) 10 units/ml heparin (i					
	(medication administ evidence of PICC line	12's medical record, / and February 2023 MARs ration records) revealed no e flushing prior to 2/2/23, in's order had been followed				
	staff member) #4, the R112's attending phy	m., ASM (administrative e nurse practitioner (NP) for sician, was interviewed. ders needed to be written				

Facility ID: VA0392

If continuation sheet Page 146 of 213

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		495391	B. WING				C 08/2023
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	·	
GLENBUF	RNIE REHAB & NURSING	CENTER			1901 LIBBIE AVE RICHMOND, VA 23226		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 694	and implemented for line, she stated: "You have a protocol. You She stated the freque how often the line wa medications to the res assume it would need normal saline. I don't here." On 2/7/23 at 5:05 p.m administrator, ASM # and ASM #3, the regis services, were inform On 2/8/23 at 8:18 a.m nurse) #2 was intervie PICC line care, she s whatever the order is needed regular flushi dressing changes. A review of the facility Intravenous (IV) Acce Protocol," revealed, in ProtocolsIntermitter (normal saline)Med units/ml Heparin." No further information (1) "A device used to treatments, including blood transfusions. A into a vein in the uppe (threaded) into a large the heart called the su is inserted into a port	a resident who has a PICC have to flush it. I think they flush it with normal saline." ency of flushing depended on s used to administer sident. She stated: "I would to be flushed daily with know that we use heparin h., ASM #1, the 2, the director of nursing, onal director of clinical ed of these concerns. h., LPN (licensed practical ewed. When asked about tated: "You have to go by " She stated PICC lines ing, and needed to have to document, "Infusion ess Line Maintenance in part: "Flush it nonvalved10ml NS ication10ml NS3ml 10 in was provided prior to exit. draw blood and give intravenous fluids, drugs, or thin, flexible tube is inserted	F	694			

Facility ID: VA0392

If continuation sheet Page 147 of 213

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM): 03/14/2023 APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /	CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		495391	B. WING			(02/	C 08/2023
NAME OF P	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STA	TE, ZIP CODE		
GLENBU	RNIE REHAB & NURSING	CENTER		901 LIBBIE AVE RICHMOND, VA 23226			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFERENC	PLAN OF CORRECTION TIVE ACTION SHOULD BE CED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE
F 694	repeated needle stick inserted central cather taken from the websit https://www.cancer.go ancer-terms/def/picc. 2. For Resident #365 failed to evidence ma (peripherally inserted the date of admission resident's discharge of On 2/6/23 at 8:29 a.m remember the staff flu there was some kind A review of R365's cli evidence that PICC lin scheduled or complet admission to the facili On 2/7/23 at 11:13 a.l staff member) #4, the R112's attending phys When asked what or and implemented for line, she stated: "You have a protocol. You She stated the freque how often the line was medications to the res assume it would need normal saline. I don't here."	helps avoid the need for s. Also called peripherally tter." This information is e pv/publications/dictionaries/c (R365), the facility staff intenance care for a PICC central catheter) (1) from , 1/31/23 through the on 2/7/23. A., R365 stated they did not ushing the PICC line "unless of problem." nical record revealed no ne flushes had been ted for R365 since ity. m., ASM (administrative rurse practitioner (NP) for sician, was interviewed. ders needed to be written a resident who has a PICC have to flush it. I think they flush it with normal saline." mcy of flushing depended on s used to administer sident. She stated: "I would d to be flushed daily with know that we use heparin	F 694				

Facility ID: VA0392

If continuation sheet Page 148 of 213

CENTER					OMB NO. 0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			A. BUILDING	·	с
		495391	B. WING		02/08/2023
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	02/06/2023
				1901 LIBBIE AVE	
GLENBUR	NIE REHAB & NURSIN	G CENTER		RICHMOND, VA 23226	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	DATE
F 694	Continued From pag	e 148	F 69	4	
1 034		ional director of clinical	F 09	4	
		ned of these concerns.			
	On 2/8/23 at 8:18 a.r	n., LPN (licensed practical			
		iewed. When asked about			
		stated: "You have to go by			
		s." She stated PICC lines			
	needed regular flush dressing changes.	ing, and needed to have			
	No further informatio	n was provided prior to exit.			
F 695		stomy Care and Suctioning	F 69	5	3/21/23
SS=D	CFR(s): 483.25(i)	, , , , , , , , , , , , , , , , , , , ,			
	§ 483.25(i) Respirato	ory care, including			
		nd tracheal suctioning.			
	-	ure that a resident who			
		re, including tracheostomy			
		ctioning, is provided such professional standards of			
		hensive person-centered			
		nts' goals and preferences,			
	and 483.65 of this su	o 1 <i>i</i>			
		T is not met as evidenced			
	by:				
		nterview, staff interview,		F695 Respiratory/Tracheostomy Care	
		/ and facility document		and Suctioning 1 Posident #05 has the personal trace	h
	review, the facility sta	an failed to provide nt per plan of care; and failed		1-Resident #95 has the necessary trac and respiratory equipment available ar	
		quipment in a sanitary		the respiratory equipment is stored in a	
		residents in the survey		sanitary manner.	
	sample, Resident #9	5.		2-All current residents receiving and/or	
	The findings include:	:		performing self-Tracheostomy Care an that have respiratory equipment have t	
	The facility staff fails	d to ensure an ambu bag,		potential to be affected. The DON, or designee will complete an audit of	
		care kits and an inner		residents requiring trach care to ensure	e
		bedside of Resident #95 per		the necessary supplies are available a	

Event ID: V8T511

Facility ID: VA0392

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	OF DEFICIENCIES	MEDICAID SERVICES		LE CONSTRUCTION		NO. 0938-039 ATE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	· /		· · ·	OMPLETED
						С
		495391	B. WING			02/08/2023
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	E	
GLENBUR	NIE REHAB & NURSING	G CENTER		1901 LIBBIE AVE RICHMOND, VA 23226		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 695	Continued From page	e 149	F 69	15		
		an; and failed to store the		that respiratory equipment in u		
		mask, used for nebulizer		residents is stored appropriate		
	treatments, in a sanit	ary manner.		3-The ADON, or designee will licensed nurses on the proces		
	Resident #95 was ad	mitted to the facility on		ensuring Trach care supplies a		
	0	es that included but were not		bedside and storage of respira	atory	
	limited to: trach, mali dysphagia and anem	ignant neoplasm of pharynx,		equipment. 4-The Unit Managers, or desig	unoo will	
	dyspriagia and anem	ια.		conduct weekly audits x 8 wee		
	The most recent MDS	, ,		monthly x2 of residents received	-	
		erly assessment, with an ference date) of 12/28/22,		care to verify supplies are at the and that respiratory equipment		
	•	s scoring a 15 out of 15 on		a sanitary manner.		
	the BIMS (brief interv	iew for mental status) score,		5 Results of the audits will be		
	indicating the residen impaired.	t was not cognitively		the QAPI Committee for review recommendation.	v and	
	impaneu.			The Administrator or Director of	of Nursing	
		rehensive care plan dated		are responsible for implementa		
	10/22/22 documented risk for complications	d in part, "the resident is at		plan of correction. 6-Completion date 3/21/23		
		lary to history of cancer.				
	INTERVENTIONS: A	Administer nebulizers as				
		/valve/mask) bag and trach ange inner cannula daily as				
		r signs and symptoms of				
	respiratory complicati	ions including infection and				
		ge or mucous plug and notify				
		fer to pulmonologist as ay provide his own trach				
	care as he feels able					
	Tracheostomy care p change per order."	er order. Tracheostomy tie				
		cian orders dated 10/7/22, and trach collar to be kept at				
	-	ch ties every week and as				
	needed if soiled or we	et. every day shift every				
		nner cannula to be kept at inner diameter) 9.4mm O.D.				

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	-	D HUMAN SERVICES MEDICAID SERVICES					FORM): 03/14/2023 / APPROVED). 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ì í		CONSTRUCTION			SURVEY LETED
		495391	B. WING			_		08/2023
NAME OF P	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
GLENBUF	RNIE REHAB & NURSING	CENTER			901 LIBBIE AVE RICHMOND, VA 23226			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BI ICED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 695	provide his own trach An interview was com- with Resident #95. Whis trach, Resident #95 trach." When asked in needs, Resident #95 supplies. I would like more, but I am trying Can we talk in the mod An interview was com- AM with Resident #95 trach care supplies, F not an inner cannula, clean my trach every use the water from the do not have a brush to would like one of thos care kits, inner cannu #95's room. On 2/6/23 at 10:00 Af supplies in the clean af #95's unit revealed 15 cannulas. An ambu bac On 2/6/23 at 11:10 Af conducted in the clea unit in the facility. LP assisted. When aske LPN #3 stated, we do this side because the unit. If they were com- the kits from upstairs. inner cannulas, LPN # order them from our states.	m length. Resident may care as he feels able." ducted on 2/5/23 at 5:04 PM /hen asked who cares for 95 stated, "I take care of my f he has the supplies he stated "No, I do not have to talk with you about this to get my laundry together. wring?" ducted on 2/06/23 at 8:06 5. When asked about his resident #95 stated, there is I would like to have one. I morning when I get up. I e tap in the bathroom sink. I o clean the cannula with. I se also. There were no trach la or ambu bag in Resident 5. trach care kits but no inner ag was on the code cart.	F	695				

Facility ID: VA0392

If continuation sheet Page 151 of 213

					FORM	APPROVED 0. 0938-0391
	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMF	
	495391	B. WING				08/2023
PLIER		•	S	TREET ADDRESS, CITY, STATE, ZIP CODE	•	
NURSING	CENTER					
DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFI TAG	x			(X5) COMPLETION DATE
dditional 5:15 PM the adm ursing, we he facility 11/1/19 i over patie n storage he facility 11/1/19 i orvided with the p RE: If inn ble: ner can ner can ner can sterile ne e cleaner a and rer inside ar sterile ne the cleaner a and rer inside ar sterile ne sterile	bags are stored upstairs. A ASM (administrative staff inistrator and ASM #2, the ere made aware of the r's "Respiratory Equipment" revealed, "Place trach ent's stoma/trach. Store a bag when not in use." r's "Tracheostomy Care" revealed, "Tracheostomy by licensed nurses in ohysician's order. er cannula is hula from trach tube. normal saline. /brush to clean inside the move all secretions. ad outside of the inner ormal saline. Shake hy excess sterile saline. hula, secure into place." in was provided prior to exit. agement. are that pain management is who require such services, ssional standards of practice, erson-centered care plan,					3/21/23
	CARE & CARE & CARE & CARE & CARE & COMPACE	PPLIER NURSING CENTER MURSING CENTER MMARY STATEMENT OF DEFICIENCIES DEFICIENCY MUST BE PRECEDED BY FULL ATORY OR LSC IDENTIFYING INFORMATION) rom page 151 additional bags are stored upstairs. 5:15 PM, ASM (administrative staff , the administrator and ASM #2, the ursing, were made aware of the he facility's "Respiratory Equipment" 11/1/19 revealed, "Place trach over patient's stoma/trach. Store in storage bag when not in use." he facility's "Tracheostomy Care" 11/1/19 revealed, "Tracheostomy provided by licensed nurses in with the physician's order. RE: If inner cannula is ble: nner cannula from trach tube. in sterile normal saline. e cleaner/brush to clean inside the a and remove all secretions. inside and outside of the inner a sterile normal saline. Shake emove any excess sterile saline. nner cannula, secure into place." formation was provided prior to exit. ement	CARE & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULT A. BUILDI 495391 B. WING_ PPLIER NURSING CENTER IMMARY STATEMENT OF DEFICIENCIES DEFICIENCY MUST BE PRECEDED BY FULL ATORY OR LSC IDENTIFYING INFORMATION) ID PREFI TAG rom page 151 F d additional bags are stored upstairs. 5:15 PM, ASM (administrative staff , the administrator and ASM #2, the ursing, were made aware of the he facility's "Respiratory Equipment" 11/1/19 revealed, "Place trach over patient's stoma/trach. Store in storage bag when not in use." he facility's "Tracheostomy Care" 11/1/19 revealed, "Tracheostomy provided by licensed nurses in with the physician's order. XE: If inner cannula is ble: nner cannula from trach tube. n sterile normal saline. e cleaner/brush to clean inside the a and remove all secretions. inside and outside of the inner e sterile normal saline. Sterile normal saline. Shake emove any excess sterile saline. nner cannula, secure into place." formation was provided prior to exit. ement F d .25(k) Pain Management. nust ensure that pain management is residents who require such services, ith professional standards of practice, lensive person-centered care plan, dents' goals and preferences.	CARE & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE IDENTIFICATION NUMBER: (X2) MULTIPLE ABJ331 B. WING	CARE & MEDICAID SERVICES (x1) PROVIDER/SUPPLER/CLIA UBITIFICATION NUMBER: 495391 B WING PHLER NURSING CENTER STREET ADDRESS, CITY, STATE, ZIP CODE 1991 LBBIE AVE RICHMOND, VA 23226 PROVIDER'S PLAN OF CORRECTION INMARY STATEMENT OF DEFICIENCIES DEFICIENCY WILL ATORY OR LSC IDENTIFYING INFORMATION) Tom page 151 Additional bags are stored upstairs. 5:515 PM, ASM (administrative staff the administrative staff the administrative and ASM #2, the ursing, were made aware of the F 695 he facility's "Respiratory Equipment" 11//19 revealed, "Place trach over patient's stoma/trach. Store in storage bag when not in use." he facility's "Tracheostomy Care" 11//19 revealed, "Place trach storie normal saline. F 697 bie: nner cannula from trach tube: n sterile normal saline. F 697 resident work as provided prior to exit. ement .25(k) F 697	ALTH AND HUMAN SERVICES FOR CARE & MEDICAID SERVICES OMB NC CARE & MEDICAID SERVICES OMB NC CARE & MEDICAID SERVICES OMB NC (2) MULTIPLE CONSTRUCTION (2) MULTIPLE CONSTRUCTION A BUILDING 495391 0. WING (2) MULTIPLE CONSTRUCTION A BUILDING 495391 0. WING (2) MULTIPLE CONSTRUCTION A BUILDING 495391 0. WING (2) MULTIPLE CONSTRUCTION A BUILDING 10 WING CENTER NURSING CENTER NURSING CENTER NURSING CENTER NURSING CENTER NURSING CENTER NURSING CENTER 10 PREVIX 10 DI DEFICIENCY STATE, 2/P CODE 190 LIBBIE AVE 191 LIBBIE AVE 191 LIBBIE AVE 191 LIBBIE AVE 191 LIBBIE AVE 192 CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY (3) 10 DI 10 PREVIX 10 CORRECTIVE ACTION SHOULD BE 10 CI 10 CORRECTIVE ACTION SHOULD BE 10 CI 10 CORRECTIVE ACTION SHOULD BE 10 CI 10 CI 1

Facility ID: VA0392

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				PRINTED: 03/14/2023 FORM APPROVED OMB NO. 0938-0391
OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED
	495391	B. WING		C 02/08/2023
ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
RNIE REHAB & NURSING	G CENTER			
(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETION
by: Based on staff interv review, and clinical re failed to implement a for one of 58 resident Resident #22. The findings include: For Resident #22 (R2 administer pain media physician orders and failed to intervene aft 2/3/23. On the most recent M quarterly assessment reference date) of 1/1 having no cognitive in decisions, having sco BIMS (brief interview A review of R22's pro following: "Effective Date: 2/3/2 Fall NoteResident H complaints of pain 10 headResident was nurse and nurse aide neurological assessm care and medication in note was written by L nurse) #10. "Effective Date: 2/4/2 Change of Condition entering resident room	iew, facility document cord review, the facility staff pain management program is in the survey sample, 22), the facility staff failed to cation according to the applicable pain scale, and er a pain reassessment on 4DS (minimum data set), a t with an ARD (assessment 18/23, R22 was coded as mpairment for making daily ored 15 out of 15 on the for mental status). Agress notes revealed the 023 21:58 (9:58 p.m.) Type: had no injuries from fall, but 1/10 in the neck and the assisted off the floor by . VS (vital signs), nent assessed. Therapeutic administered for pain." This PN (licensed practical 023 08:02 (8:02 a.m.) Type: Note Text Writer notes upon m, writer notes resident	F 697		gnee will that pain cate all d notifying quately ee will and nts with pir pain esented v and
	S FOR MEDICARE & OF DEFICIENCIES CORRECTION ROVIDER OR SUPPLIER RNIE REHAB & NURSING SUMMARY ST (EACH DEFICIENC REGULATORY OR I Continued From page by: Based on staff interv review, and clinical re failed to implement a for one of 58 resident Resident #22. The findings include: For Resident #22 (R2 administer pain medii physician orders and failed to intervene aft 2/3/23. On the most recent M quarterly assessment reference date) of 1/1 having no cognitive in decisions, having scc BIMS (brief interview A review of R22's pro following: "Effective Date: 2/3/2 Fall NoteResident # complaints of pain 10 headResident was nurse and nurse aide neurological assessm care and medication note was written by L nurse) #10. "Effective Date: 2/4/2 Change of Condition entering resident room vomiting and in severe	FORRECTION IDENTIFICATION NUMBER: SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 152 by: Based on staff interview, facility document review, and clinical record review, the facility staff failed to implement a pain management program for one of 58 residents in the survey sample, Resident #22. The findings include: For Resident #22 (R22), the facility staff failed to administer pain medication according to the physician orders and applicable pain scale, and failed to intervene after a pain reassessment on 2/3/23. On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 1/18/23, R22 was coded as having no cognitive impairment for making daily decisions, having scored 15 out of 15 on the BIMS (brief interview for mental status). A review of R22's progress notes revealed the following: "Effective Date: 2/3/2023 21:58 (9:58 p.m.) Type: Fall NoteResident had no injuries from fall, but complaints of pain 10/10 in the neck and the headResident was assisted off the floor by nurse and nurse aide. VS (vital signs), neurological assessment assesses. Therapeutic care and medication administered for pain." This	ES FOR MEDICARE & MEDICAID SERVICES OF DEFICIENCIES CORRECTION (X1) PROVIDER/SUPPLIER/CLA IDENTIFICATION NUMBER: A95391 ROVIDER OR SUPPLIER ROVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 152 by: Based on staff interview, facility document review, and clinical record review, the facility staff failed to implement a pain management program for one of 58 residents in the survey sample, Resident #22. The findings include: For Resident #22 (R22), the facility staff failed to administer pain medication according to the physician orders and applicable pain scale, and failed to intervene after a pain reassessment on 2/3/23. On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 1/18/23, R22 was coded as having no cognitive impairment for making daily decisions, having scored 15 out of 15 on the BIMS (brief interview for mental status). A review of R22's progress notes revealed the following: "Effective Date: 2/3/2023 21:58 (9:58 p.m.) Type: Fail NoteResident had no injuries from fail, but complaints of pain 10/10 in the neck and the headResident was assisted off the floor by nurse and nurse aide. VS (vital signs), neurological assessment assessed. Therapeutic care and medication administered for pain." This note was written by LPN (licensed practical nurse) #10. "Effective Date: 2/4/2023 08:02 (8:02 a.m.) Type: Change o	SPOR MEDICARE & MEDICAID SERVICES OF DEFICIENCIES (X1) FROVIDERSUPPLIERCUA (22) MULTIPLE CONSTRUCTION A 95391 B (22) MULTIPLE CONSTRUCTION ROVIDER OR SUPPLIER 98 WING

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	MENT OF HEALTH AN S FOR MEDICARE & I						FORM): 03/14/2023 APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		495391	B. WING			_		C 08/2023
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE	•=-	
GLENBUF	NIE REHAB & NURSING	CENTER			901 LIBBIE AVE RICHMOND, VA 23226			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BE ICED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 697	limited ROM (range of extremitiesMD notifit to be sent to Er (emer evaluation and request tomography) scan. PC been notified of current A review of R22's phy following order, dated (Tylenol) 500 mg (mill mouth every 4 hours a This review also reveat dated 1/29/23: "Trama tablet by mouth every moderate and severe A review of R22's Feb (medication administra- received 1000 mg of 2/3/23. Further review of R22 the resident's pain wa by LPN #10, and the r out of 10. There is no record that LPN #10 co options to R22 or con- update him regarding the next pain assessin R22's pain was rated On 2/6/22 at 4:28 p.m She stated she spoke who told her to "give to did have another fami wanted to be sent out	ad left arm, writer notes f motion) in upper ed and requested resident gency room) for further sted CT (computed DA (power of attorney) has nt events." sician orders revealed the 8/31/22: "Acetaminophen igrams) Give 2 tablets by as needed for Mild Pain." aled the following order adol Tablet 50 mg Give 1 6 hours as needed for pain." ruary 2023 MAR ation record) revealed R22 Fylenol at 7:14 p.m. on 's clinical record revealed s reassessed at 11:23 p.m. resident reported pain was 6 evidence in the clinical offered additional pain relief tacted the physician to the resident's pain level. At nent for R22 at 4:37 a.m.,	F	697				

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED . 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION		(X3) DATE	SURVEY LETED
		495391	B. WING				08/2023
NAME OF PI	ROVIDER OR SUPPLIER		•	STREET ADDRESS, CITY, STATE, ZIP CODE	 E		
GLENBUR	NIE REHAB & NURSING	CENTER		1901 LIBBIE AVE RICHMOND, VA 23226			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE		(X5) COMPLETION DATE
F 697	Continued From page	• 154	F 6	997			
		n., ASM #1, the 2, and ASM #3, the regional vices, were informed of					
	When asked if she we pain to be mild, mode "It is severe." When a both Tramadol and Ty these medications sh resident reporting 10 would definitely give to what she would do if	n., LPN #2 was interviewed. buld consider 10 out of 10 to erate, or severe, she stated: isked if she had orders for vlenol as need, which of e would choose to give a out of 10 pain, she stated: "I the Tramadol." When asked the same patient reported the next assessment, she he doctor and ask for					
	revealed, in part: "If p physician. Any unusu interventions are to b	ding notification of physician					
F 698 SS=D	Dialysis	n was provided prior to exit.	F 6	598			3/21/23
	require dialysis receiv with professional star comprehensive perso the residents' goals a	are that residents who we such services, consistent adards of practice, the on-centered care plan, and nd preferences.					

Facility ID: VA0392

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	OF DEFICIENCIES	MEDICAID SERVICES		PLE CONSTRUCTION		NO. 0938-039 TE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:		G	. ,	MPLETED
						С
		495391	B. WING		0	2/08/2023
NAME OF P	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIF	PCODE	
	RNIE REHAB & NURSING	CENTER		1901 LIBBIE AVE		
OLENDOI				RICHMOND, VA 23226		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETIO DATE
F 698	Continued From page	e 155	F 69	28		
	- 15	iew, resident interview,	100	F698□ Dialysis		
		and facility document		1-Residents #463 and #1	127 were	
		lined the facility staff failed to		discharged.		
	ensure ongoing comr	nunication with the dialysis		2-All current residents re-	U	
		esidents in the survey		treatments have the pote		
	sample, Resident #46	63 and #127.		affected. The DON, or de		
				review current residents		
	The findings include:			treatment to ensure that	-	
	1 For Resident #463	, the facility failed to ensure		communication form is be 3-The ADON or designee		
		ommunication with the		licensed nurses on the pl		
	dialysis facility for 2 o			Dialysis communication f		
		23, on the dates of 1/30/23		4-The Unit Managers or o		
	and 2/6/23.			conduct weekly audits x		
				x2 to verify residents rec		
		dmitted to the facility on		treatments have a compl		
	•	es that included but were not distage renal disease).		communication log is ser back with each Dialysis t	-	
		u stage renai uisease).		5- Results of the audits w		
	The most recent MDS	S (minimum data set)		to the QAPI Committee for		
		are 5-day assessment, with		recommendation.		
	an ARD (assessment	reference date) of 1/30/23,		The Administrator or Dire	ector of Nursing	
		s scoring a 15 out of 15 on		are responsible for imple	mentation of the	
		riew for mental status) score,		plan of correction.		
	indicating the residen			6-Completion date 3/21/	23	
	impaired. A review of Procedures coded dia					
	A review of the comp	rehensive care plan dated				
		OCUS: the resident is at				
		nplications secondary to				
	requiring hemodialysi					
		Dialysis Vascular Access. dialysis days if ordered by				
		Diagnostics as ordered.				
		d symptoms of bleeding or				
		ticoagulation use during				
	dialysis. Observe for	signs and symptoms of				
	acomplications related	to ESRD including but not				

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		495391	B. WING				C 108/2023
NAME OF P	ROVIDER OR SUPPLIER		•		STREET ADDRESS, CITY, STATE, ZIP CODE	-	
GLENBUF	RNIE REHAB & NURSING	CENTER			1901 LIBBIE AVE RICHMOND, VA 23226		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 698	limited to fluid overload the access site, hypor cardiac distress and r lunch or snacks to be dialysis as needed. T A review of the physic revised 2/7/23 reveale Diagnosis: ESRD Dia Pick up time: Dialysis An interview was con- with Resident #463. The communication book Resident #463 stated goes with me." A review of Resident 2/5/23, evidenced a state for Resident #463 wa approximately 2:30 P On 2/7/23 at 4:49 PM the facility, their dialys treatments for 1/30/23 An interview was con- with LPN (licensed pr asked the purpose of sheets, LPN #7, they the resident's current pertinent information then they are to comp us to have when the r asked to validate the LPN #7 stated, there	ad, hemorrhage, infection to tension, respiratory and/ or notify MD as indicated. Pack sent with the resident to "herapeutic diet as ordered." cian order dated 1/28/23 and ed, "Hemodialysis lysis Days and Time: MWF Center: (Name). ducted on 2/5/23 at 5:15 PM When asked if she takes a with her to dialysis, , "Yes, there is a book that #463's dialysis book on heet missing on 1/30/23. //sis communication sheets s made on 2/7/23 at	F	69	8		

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE COMF	SURVEY PLETED
		495391	B. WING				C 08/2023
NAME OF P	ROVIDER OR SUPPLIER		•		STREET ADDRESS, CITY, STATE, ZIP CODE		
GLENBU	RNIE REHAB & NURSING	CENTER			1901 LIBBIE AVE RICHMOND, VA 23226		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 698	for 1/30/23, 2/1/23, 2/ LPN #7 was asked if sheets were present, Two are missing. On 2/7/23 at 5:15 PM member) #1, the adm director of nursing, we findings. A review of the facility facility which revealed both parties shall ens documented evidence and communication b and ESRD dialysis ur include, but not be lin conferences, and car A review of the facility dated 11/1/19, reveal Communication Form sending patient for dia No further information 2. For Resident #127 there was ongoing co dialysis facility for 3 o January-February 202 2/2/23 and 2/7/23. Resident #127 was a 1/18/23 with diagnose limited to: ESRD (end The most recent MDS assessment, a Medic	 (3/23 and 2/6/23. When all the communication she stated, no they are not. (ASM (administrative staff ninistrator and ASM #2, the ere made aware of the ('s dialysis contract with the d, "Collaboration of Care: ure that there is e of collaboration of care etween the nursing facility nit. Documentation shall nited to, participation in care e plan." ('s "Hemodialysis" policy ed, "The Dialysis nill be initiated prior to alysis." n was provided prior to exit. (', the facility failed to ensure emmunication with the ut of 9 visits in 23, on the dates of 1/24/23, dmitted to the facility on es that included but were not a stage renal disease). 	F	698	8		

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		ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 03/14/2023 M APPROVED D. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	`, ´		CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		495391	B. WING				C / 08/2023
NAME OF P	ROVIDER OR SUPPLIER		•	ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
GLENBUF	RNIE REHAB & NURSING	G CENTER			901 LIBBIE AVE ICHMOND, VA 23226		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 698	coded the resident as the BIMS (brief interv indicating the residen impaired. A review of Procedures coded dia A review of the comp 1/18/23, revealed, "Fe increased risk for com requiring hemodialysi INTERVENTIONS: A shift. DIALYSIS DAY DIALYSIS CENTER: NAME). Dialysis Vas graft or central venou not use (SPECIFY SI Medications on dialys physician. Labs and Observe for signs and bruising related to an dialysis. Observe for complications related limited to fluid overloa the access site, hypo cardiac distress and r lunch or snacks to be dialysis as needed. T treatment as ordered A review of the physic revealed, "Hemodialy Dialysis Days and Tim Pick up time:10 am D An interview was con with Resident #127. communication book	a scoring a 15 out of 15 on iew for mental status) score, it was not cognitively Section O-Special alysis-yes. rehensive care plan dated OCUS: the resident is at nplications secondary to is due to ESRD. Assess Bruit and Thrill every S: (SPECIFY DAYS). (SPECIFY CENTER cular Access (Specify fistula, is catheter and location). Do DE) arm for vitals. Hold sis days if ordered by Diagnostics as ordered. d symptoms of bleeding or ticoagulation use during signs and symptoms of to ESRD including but not ad, hemorrhage, infection to tension, respiratory and/ or notify MD as indicated. Pack e sent with the resident to Therapeutic diet as ordered to fistula site."	F	698			

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	-	D HUMAN SERVICES MEDICAID SERVICES					FORM	D: 03/14/2023 MAPPROVED D. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION		(X3) DATE COMF	SURVEY LETED
		495391	B. WING _			_		C 08/2023
NAME OF PI	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, ST	ATE, ZIP CODE	02/	00/2020
				19	01 LIBBIE AVE			
GLENBUF	RNIE REHAB & NURSING	CENTER			ICHMOND, VA 23226			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	K	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD B ICED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE
F 698	Continued From page	9 159	F6	698				
		#127's dialysis book on eets missing on 1/24/23 and						
	A request for the dialy for Resident #127 wa approximately 2:30 P							
	-	was faxed at 3:21 PM on sheets for 1/24/23 and						
	member) #1, the adm director of nursing, we findings. When aske ASM #2, the director, dialysis center. When forms would have bee	ASM #2 stated, sometimes						
	with LPN (licensed pr asked the purpose of sheets, LPN #7, they the resident's current pertinent information then they are to comp us to have when the r asked to validate the LPN #7 stated, there 1/21/23, 1/26/23, 1/26 The dialysis treatmen 1/21/23, 2/4/23 and 2/7 asked if all the comm	ducted on 2/8/23 at 8:15 AM actical nurse) #7. When the dialysis communication are forms to communicate vital signs and any other to the dialysis facility and blete the bottom portion for resident returns. When dialysis sheets in the book, are sheets done on 1/19/23, 8/23, 1/31/23 and 2/4/23. ts were ordered for 1/19/23, 6/23, 1/28/23, 1/31/23, 7/23. When LPN #7 was unication sheets were to they are not. Three are						

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CENTERS FOR MEDICARE STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF			O. 0938-0391
		A. BUILDING	PLE CONSTRUCTION G	· · /	E SURVEY PLETED C
	495391	B. WING		02	2/08/2023
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
GLENBURNIE REHAB & NURSI	NG CENTER		1901 LIBBIE AVE RICHMOND, VA 23226		
PREFIX (EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
 2/7/23. The faxed 2/2/23 were not in the facility which reveated both parties shall end documented evider and communication and ESRD dialysis include, but not be conferences, and confe	As of 1/24/23, 2/2/23 and sheets for dates 1/24/23 and he communication book. lity's dialysis contract with the led, "Collaboration of Care: insure that there is noce of collaboration of care in between the nursing facility unit. Documentation shall limited to, participation in care are plan." lity's "Hemodialysis" policy aled, "The Dialysis rm will be initiated prior to dialysis." on was provided prior to exit. 1)-(4) ils. tempt to use appropriate installing a side or bed rail. If used, the facility must ensure use, and maintenance of bed not limited to the following es the resident for risk of ed rails prior to installation. ew the risks and benefits of	F 69			3/21/23

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			()(0)			NO. 0938-03
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	PLE CONSTRUCTION G	· · ·	ATE SURVEY OMPLETED
			A. BUILDIN	G		С
		495391	B. WING			02/08/2023
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C		02/00/2023
				1901 LIBBIE AVE		
GLENBUF	RNIE REHAB & NURSIN	G CENTER		RICHMOND, VA 23226		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETIO DATE
F 700		101				
F 700			F 70	00		
		e that the bed's dimensions ne resident's size and weight.				
	§483.25(n)(4) Follow	the manufacturera'				
		nd specifications for installing				
	and maintaining bed					
		T is not met as evidenced				
	by:					
		on, staff interview, facility		F700 Bed Rails-		
	document review, an	d clinical record review, the		1-The bed rail assessment	and consent	
		implement side rail safety		for resident #363 was com	pleted.	
	procedures for one o	f 58 residents in the survey		2-All current residents with		
	sample, Resident #3	63.		the potential to be affected		
	The findings include:			designee will audit resident in place to ensure that the		
				assessment was completed		
		R363), the facility staff to		3-The ADON, or designee		
		the use of side rails,		licensed nurses on the proc		
		regarding the risks and		assessing the need for bed		
		e rails, and obtain consent		providing the documented		
	from the resident for	the use of side rails.		and obtaining consent for the	ne use of side	
	On 2/5/23 at 3.14 n r	n. and 2/6/23 at 8:12 a.m.,		rails as needed. 4-The Unit Managers or de	signoo will	
		in bed with eyes closed.		conduct weekly audits x 8 v		
		re up on both sides of the		x2 of residents with bed rai		
	resident's bed.	te up on bour sides of the		proper assessment and that	•	
	A review of P362's a	dmission assessment dated		obtained and documented. 5- Results of the audits will	he presented	
		art: "Does the resident need		to the QAPI Committee for		
		ng and/or rising from supine		recommendation.		
	-	sition as mobility enabler?		The Administrator or Direct	or of Nursina	
		of indicated as a mobility		are responsible for implement	•	
	enabler at this time.	-		plan of correction.		
	resident/resident rep	resentative preference? No."		6-Completion date 3/21/23	3	
	Further review of R3	63's clinical record failed to				
		information regarding the				
	-		1			
	resident's use of side	e rails, including informed				

Facility ID: VA0392

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	-	ID HUMAN SERVICES				FORM	/ APPROVED
	DF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLI	E CONSTRUCTION	(X3) DATE	0. 0938-0391 SURVEY
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING _		COMPLETE	
		495391	B. WING				C 08/2023
NAME OF PF	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE	· · · · ·	
GLENBUR	NIE REHAB & NURSING	CENTER			1901 LIBBIE AVE RICHMOND, VA 23226		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 700	Continued From page		F	700			
	nurse) #2 was intervie resident to use side ra- responsibility to make positioning and mobil nurse does an assess admission process. If determines that the re- or if the resident or fa- rails, the admitting nu- recommendation to the complete a recommen- stated if physical ther- side rails, the nurse re- that day contacts mai install side rails. She is educated on the risks rails, and must sign a the side rails being pla- resident to use.	e sure they are needed for ity. She stated the admitting sment as a part of the the admitting nurse esident needs the side rails, mily members ask for side rse sends a ne physical therapists, who indation separately. She apy signs off on the use of esponsible for the resident intenance and asks them to stated a resident must be and benefits of the side in informed consent prior to aced on the bed for the					
	member) #1, the adm director of nursing, ar	n., ASM (administrative staff inistrator, ASM #2, the nd ASM #3, the regional vices, were informed of					
	Device Assessment w documentation of the	y policy, "Device ety," revealed, in part: "The vill be completed to provide needs, and risk factors a restraint or device by the					
F 710 SS=D	No further information Resident's Care Supe CFR(s): 483.30(a)(1)(F	710			3/21/23

Facility ID: VA0392

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391	
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ì í		E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED	
		495391	B. WING			C 02/08/2023		
NAME OF P	ROVIDER OR SUPPLIER	I		5	STREET ADDRESS, CITY, STATE, ZIP CODE			
GLENBUF	RNIE REHAB & NURSING	CENTER			1901 LIBBIE AVE RICHMOND, VA 23226			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE	
F 710	Continued From page	e 163	F	710				
	recommendation that a facility. Each reside care of a physician. <i>J</i> assistant, nurse pract specialist must provid immediate care and r §483.30(a) Physician The facility must ensu §483.30(a)(1) The me is supervised by a ph §483.30(a)(2) Anothe medical care of reside physician is unavailat This REQUIREMENT by: Based on observatio interview, facility docu record review, the fac initiate orders for a m for one of six resident administration observ The findings include: For Resident #416, th	sonally approve in writing a an individual be admitted to ent must remain under the A physician, physician itioner, or clinical nurse le orders for the resident's needs. Supervision. ure that- edical care of each resident ysician; or physician supervises the ents when their attending ble. T is not met as evidenced n, resident interview, staff umentation, and clinical cility physician failed to edication in a timely manner ts in the medication ration, Resident #416.			F710 Resident Care Supervised by a Physician 1-Resident #416 was discharged. 2-All current residents have the potenti to be affected. The DON, or designee v review newly admitted residents to ensi that medications are ordered timely and available for administration. 3-The DON or designee will educate all licensed nurses on the process for ordering medications timely and the process for obtaining medications for	will sure d		
	On R416's admission the resident was asse intact, and oriented to situation. A review of	assessment dated 1/31/23, essed to be cognitively person, place, time, and R416's diagnoses revealed of the pancreas surgically			administration. 4-The Unit Managers or designee will conduct weekly audits x 8 weeks, then monthly x2 to verify medications are available for administration and ordered timely.			

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TATEMENT O	F DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	PLE C	ONSTRUCTION	(X3) [DATE SURVEY	
	CORRECTION	IDENTIFICATION NUMBER:					OMPLETED	
						С		
		495391	B. WING				02/08/2023	
NAME OF PR	OVIDER OR SUPPLIER			STR	EET ADDRESS, CITY, STATE, ZIP CODE			
GLENBUR	NIE REHAB & NURSING	G CENTER			1 LIBBIE AVE HMOND, VA 23226			
(X4) ID PREFIX TAG	SUMMARY ST. (EACH DEFICIENC REGULATORY OR I	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETIO DATE		
F 710	Continued From page	e 164	F 71	10				
	removed prior to adm				5- Results of the audits will be pres	ented		
					to the QAPI Committee for review a	and		
	On 2/4/23 at 9:02 a.m administration observ	n. during the medication			recommendation. The Administrator of Nu	roina		
		vas observed preparing			The Administrator or Director of Nu are responsible for implementation			
	. ,	ister to R416. LPN #11			plan of correction.			
		ze is not in the cart." She			6-Completion date 3/21/23			
		told there was a problem surance coverage, and the						
		send the medication to the						
		ation of payment. At 9:16						
		ative staff member) #6, who						
	-	physician, approached LPN M #6 that R416 had not						
		ancreaze because of						
		ssues. ASM #6 stated: "That						
	is his lifesaving medic food without it."	cation. He cannot digest his						
		n., R416 was sitting up in ay (2/7/23) he had received						
		reaze since arriving at the						
		t lunchtime, the nurse came						
	in and showed me the							
		ed it." When asked what						
		Pancreaze, he stated he has and foul-smelling stools. He						
	stated: "My body can	0						
	A review of R416's ph	nysician's orders revealed						
	the following order da	ated 2/3/23: "Pancreaze Oral						
		ease Particles4200 -						
	meals for pancreatic i	capsule by mouth with insufficiency."						
	A review of pharmacy	/ receipts for R416 revealed						

Facility ID: VA0392

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	MENT OF HEALTH AN S FOR MEDICARE & I	D HUMAN SERVICES MEDICAID SERVICES				FORM): 03/14/2023 // APPROVED). 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ì í		E CONSTRUCTION	(X3) DATE	
		495391	B. WING				C 08/2023
NAME OF P	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE		
	RNIE REHAB & NURSING	CENTER		1	1901 LIBBIE AVE		
01211201				I	RICHMOND, VA 23226		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 710	On 2/8/23 at 8:07 a.m When asked if he was received Pancreaze u stated: "The nurse ca understand the order. has a history of [name remove part of the pa process he follows for residents, he stated: " who review the medic question, they will cal received a phone call Pancreaze, he stated they called me or not. On 2/8/23 at 11:24 a.I administrator, ASM #2 and ASM #3, the regio services, were inform A review of the facility Physical," revealed, ir Admission Medical Ca Physical) must be pro admission, or within 4 The admission medic prescribed and signed physicianThe comp to include at a minimu 1) Primary diagnosis; 2) Identification of pat 3) Medical history and 4) Orders for medicat No further information (1) Pancrelipase delat (Creon, Pancreaze, P	 ASM #6 was interviewed. a aware R416 had not intil lunchtime on 2/7/23, he lled me. They could not "He added: "This resident e of a surgical procedure to ncreas]." When asked the rordering medications for The nurses are the ones ations. If they have a I me." When asked if he regarding R416's : "I don't remember whether " m., ASM #1, the 2, the director of nursing, onal director of clinical ed of these concerns. policy, "History and n part: "A Physician's are Plan (History and vided at the time of 8 hours after admission. al plan of care is to be d by the attending lete medical plan of care is im: ient problems; d physical exam; ions." 	F	710			

Facility ID: VA0392

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	-	D HUMAN SERVICES MEDICAID SERVICES			FOR	0. 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G		E SURVEY IPLETED C
		495391	B. WING		02	2/08/2023
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	•	
GLENBUF	RNIE REHAB & NURSING	CENTER		1901 LIBBIE AVE RICHMOND, VA 23226		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 710 F 712 SS=D	adults who do not have enzymes (substances so it can be digested) condition that affects produces several imp enzymes needed to d delayed-release caps to improve digestion i surgery to remove all stomach." This inform website https://medlineplus.go tml. Physician Visits-Frequ CFR(s): 483.30(c)(1)- §483.30(c) Frequency §483.30(c)(1) The res physician at least onc 90 days after admissi 60 thereafter. §483.30(c)(2) A physi timely if it occurs not I date the visit was req §483.30(c)(3) Except (c)(4) and (f) of this se visits must be made to set in SNF alternate between per and visits by a physic practitioner or clinical accordance with para	ve enough pancreatic a needed to break down food because they have a the pancreas (a gland that ortant substances including igest food)Pancrelipase ules (Creon) are also used n people who have had or part of the pancreas or lation was taken from the ov/druginfo/meds/a604035.h uency/Timeliness/Alt NPP (4) y of physician visits sidents must be seen by a se every 30 days for the first on, and at least once every cian visit is considered later than 10 days after the uired. as provided in paragraphs ection, all required physician by the physician personally. option of the physician, s, after the initial visit, may rsonal visits by the physician ian assistant, nurse	F 7'			3/21/23

Facility ID: VA0392

If continuation sheet Page 167 of 213

TATEMENT C	F DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIF	PLE	CONSTRUCTION	(X3) DATE	SURVEY	
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	G		COMF	PLETED	
			D. MINIO			С		
		495391	B. WING			02	/08/2023	
NAME OF PF	OVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE			
GLENBUR	NIE REHAB & NURSING	GCENTER	1901 LIBBIE AVE RICHMOND, VA 23226					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 712	Continued From page	e 167	F 71	12				
		view, clinical record review			F712 Physician			
		t review, it was determined			Visits-Frequency/Timeliness/Alternate			
	that the facility staff fa	ailed to ensure timely			NPPs			
		ne of 58 residents in the			1- Resident #67 was seen by the Provi	der		
	survey sample; Resid	dent #67.			as required.			
	The findings includes				2-All current residents have the potentia to be affected. The Medical Records	al		
	The findings include:				director, or designee will complete an			
	For Resident #67, the	ere were no physician visits			audit to ensure residents have been se	en		
	for 125 days.				by the Provider, as required.	011		
	,				3-The Administrator, or designee will			
		al record for physicians visits			educate the medical staff on the			
		revealed physician visits			requirements for resident visits.			
		8/25/22 and 10/6/22. Up to			4-The Medical Records staff will condu	ct		
	-	2/7/23, there had been no			weekly monthly audits x2 to verify all	~		
	record, for a total of 1	its identified in the clinical			residents receive a therapeutic visit from their physician as required.	n		
	physician's visit.				5 Results of the audits will be presented the QAPI Committee for review and	d to		
	On 2/7/23 at 5:00 PM	1 at the end-of-day meeting,			recommendation.			
		ive Staff Member) the			The Administrator or Director of Nursing	9		
	Administrator ASM #2	2 the interim Director of			are responsible for implementation of the	ne		
		the Regional Director of			plan of correction.			
		re made aware of the			6-Completion date 3/21/23			
	-	equested to see if there were d anywhere else that had not						
	-	ectronic health record.						
		1 an interview was conducted						
		rse Practitioner. She stated is on the list to be seen again						
		d that she is provided a list						
		seen. She stated she was						
	not sure where the list	st comes from; just that she						
		ends it to the physician.						
		hysician / nurse practitioner						
		ility's electronic health record						
	system and does not there would not be ar	use a separate system, so						

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	MENT OF HEALTH AN S FOR MEDICARE & I						FORM): 03/14/2023 MAPPROVED). 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE COMP	SURVEY LETED	
		495391	B. WING					C 08/2023
NAME OF P	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STA	ATE, ZIP CODE		
GLENBUR	RNIE REHAB & NURSING	CENTER			901 LIBBIE AVE ICHMOND, VA 23226			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	<	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BI CED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE
F 712	else. When asked ho seen, she said every is is believed the resider to the list for the previ she believed was to b visit. The resident she approximately Decem requirement was for e On 2/8/23 at 10:30 AM conducted with RN #1 Assistant Director of N tracks physicians visit she stated that the ph and track who they ne She stated that the ph according to if there is recertification, or a ch stated that the facility physicians are seeing condition or a new ad often are residents to the discretion of the p residents are to be se no one tracking that, s track it themselves. A review was conduct "Physician Document 11/1/19, "1. Physician progress note must be for the first 90 days of 60 days thereafter. 2 visit, a qualified nurse assistant may make e accordance with state	w often a resident is to be 90 days. She stated that it nt was missed being added ous required visit, which e January 2023 for a 90 day ould have been seen aber 6, 2022, as the every 60 days. M an interview was ((Registered Nurse), the Aursing. When asked who is to ensure they are timely, ysicians print their own lists and to see, themselves. hysicians see residents is a new admission, a ange of condition. She does not know who the unless there is a change of mission. When asked how be seen, she stated it is at rovider. When asked how be seen, she stated it is at rovider. When asked if the en every 60 days, is there she stated the providers end of the facility policy ation" policy #2304 dated visits with a corresponding e complete at least monthly if the patient stay and every . After the initial physician practitioner or physician every other required visit in	F7	712				

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	OF DEFICIENCIES	MEDICAID SERVICES		PLE CONSTRUCTION		NO. 0938-039 ATE SURVEY	
	CORRECTION	IDENTIFICATION NUMBER:		G		MPLETED	
			A. DOILDIN	5		с	
		495391	B. WING			02/08/2023	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO			
				1901 LIBBIE AVE			
GLENBUR	RNIE REHAB & NURSING	GENTER					
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETIO DATE	
E 740		100					
F 712	15		F 7	12			
		as provided by the end of the					
F 727	survey. 727 RN 8 Hrs/7 days/Wk, Full Time DON		F 7			3/21/23	
г / 2/ SS=D	-					5/21/25	
	§483.35(b) Registere						
	§483.35(b)(1) Except						
		f this section, the facility					
		s of a registered nurse for at ours a day, 7 days a week.					
		iours a day, 7 days a week.					
	§483.35(b)(2) Except	t when waived under					
		f this section, the facility					
		istered nurse to serve as the					
	director of nursing or	n a full time basis.					
	\$483.35(b)(3) The di	rector of nursing may serve					
		ly when the facility has an					
	average daily occupa	ancy of 60 or fewer residents.					
	This REQUIREMENT	Γ is not met as evidenced					
	by:						
		view and facility document		F727 RN 8 hrs./7days wee	k Full time		
		nined that the facility staff N (registered nurse) was on		DON 1-The facility is ensuring that	at PN bour		
	duty on one of 31 day	(U		coverage is being provided			
		,		2-The DON, or designee wi			
	The findings include:			current schedule to ensure			
				coverage is being provided			
		d to ensure an RN was on		3-The DON or designee wil			
	duty at least eight co	nsecutive hours on		staffing coordinator and Nu	-		
	01/05/2023.			Leadership team on the pro having an RN in the building			
	On 02/07/2023 at ap	proximately 3:25 p.m., a		week 8 hours a day.	g , days a		
		s "As worked schedule"		4-The DON/Administrator o	r designee will		
		ough 01/31/2023 was		conduct weekly audits x 8 w			
		(certified nursing assistant)		monthly x2 to verify that add			
		or. The review revealed that		coverage is provided			
	on 01/05/2023. the fa	acility failed to maintain		5- Results of the audits will	be presented		

Event ID: V8T511

Facility ID: VA0392

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MEILTIPI	E CONSTRUCTION	(X3) DATE SURVEY	
	CORRECTION	IDENTIFICATION NUMBER:	. ,		COMPLETED	
					С	
		495391	B. WING		02/08/2023	
NAME OF P	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE			
GLENBUF	RNIE REHAB & NURSING	CENTER				
	1			RICHMOND, VA 23226		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE	
F 727	Continued From page	e 170	F 727	,		
	-	erage for a 24-hour period.	1 121	to the QAPI Committee for review and		
		e lack of eight hours of RN		recommendation.		
	coverage on 01/05/20 oversight in schedulir	023, CNA #4 stated it was an ng.		The Administrator or Director of Nursing are responsible for implementation of the second sec	•	
	On 02/08/2022 at any	revimetely 10:20 c m ASM		plan of correction.		
		proximately 10:30 a.m., ASM nember) #1, administrator,		6-Completion date 3/21/23		
	was made aware of the					
	No further information	n was provided prior to exit.				
	Nurse Aide Peform R CFR(s): 483.35(d)(7)	eview-12 hr/yr In-Service	F 730		3/21/23	
	The facility must com of every nurse aide a months, and must pro education based on t reviews. In-service tr requirements of §483	ovide regular in-service he outcome of these aining must comply with the				
		iew and employee record		F730 Nurse Aide Perform review		
	review it was determi	ned that the facility staff		1-Staff members #1, #6. #8. #9 and #1	0	
	failed to ensure CNA			have a Performance evaluation		
	for five of five CNA re	annual performance reviews cords reviewed.		completed. 2All CNA team members have the potential to be affected. An audit will be		
	The findings include:			completed, by HR to ensure annual performance evaluations have been		
		ord review was conducted of		completed.		
	-	ce reviews of five CNAs.		3-The Administrator or designee will		
	This review failed to e performance reviews	for the following CNAs:		provide in-service education to Administrative Nurses on the requirement for timely Performance valuations	ent	
	1. CNA #1 - hire date	e 01/01/2020, no evidence of		for timely Performacny evaluations. 4-The Human Resources staff member	or	
		between 01/01/2021 and		designee will conduct weekly audits x &		
	01/01/2022.			weeks, then monthly x2 to ensure team		

Event ID: V8T511

Facility ID: VA0392

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	OF DEFICIENCIES	MEDICAID SERVICES		LE CONSTRUCTION		10. 0938-039 TE SURVEY	
	CORRECTION	IDENTIFICATION NUMBER:			. ,	COMPLETED	
						С	
		495391	B. WING		o	02/08/2023	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, 2	ZIP CODE		
GLENBUR	NIE REHAB & NURSING	G CENTER		1901 LIBBIE AVE RICHMOND, VA 23226			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE CROSS-REFERENCED	N OF CORRECTION ACTION SHOULD BE TO THE APPROPRIATE CIENCY)	(X5) COMPLETION DATE	
F 730	Continued From page	e 171	F 73	0			
	2. CNA #6 - hire date	e 01/01/2020, no evidence of		members receive perfo	rmance		
		petween 01/01/2021 and		evaluations timely.			
	01/01/2022.	01/01/2020, no evidence of		5 Results of the audits the QAPI Committee fo			
		between 01/01/2021 and		recommendation.			
	01/01/2022.			The Administrator or Di			
		01/01/2020, no evidence of		are responsible for imp	lementation of the		
	01/01/2022.	petween 01/01/2021 and		plan of correction. 6-Completion date 3/2	1/23		
		e 01/20/2020, no evidence			1/20		
	of performance review 01/20/2022.	w between 01/20/2021 and					
	interview was conduct member) #10, human asked for the competency listed above OSM #1 have the competency to locate them. When procedure for the con- stated that the review managers with the CH anniversary date for or reviews then are sen- be filed. The facility's policy "F documented in part, '	completing the competency t to human resource office to Performance Appraisal" 'Generally, all employees will					
	receive a performance (90) days of employm This includes Full-tim PRN." On 02/08/2023 at app	e appraisal around ninety nent and annually thereafter. le, Part-time, Casual, and proximately 10:30 a.m., ASM nember) #1, administrator,					

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391	
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMF		
		495391	B. WING			02/08/2023		
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	•		
GLENBUF	RNIE REHAB & NURSING	CENTER			901 LIBBIE AVE RICHMOND, VA 23226			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG				(X5) COMPLETION DATE	
F 732 SS=C	CFR(s): 483.35(g)(1)- §483.35(g) Nurse Sta §483.35(g) (1) Data re- must post the followin basis: (i) Facility name. (ii) The current date. (iii) The total number by the following categr unlicensed nursing str resident care per shift (A) Registered nurses (B) Licensed practical vocational nurses (as (C) Certified nurse aid (iv) Resident census. §483.35(g)(2) Posting (i) The facility must poster (A) Clear and readabl (B) In a prominent plaresidents and visitors §483.35(g)(3) Public as staffing data. The fact written request, maker available to the public exceed the communit §483.35(g)(4) Facility requirements. The far posted daily nurse sta 18 months, or as requires and the staffing date.	(4) fing Information. equirements. The facility information on a daily and the actual hours worked pories of licensed and aff directly responsible for t: S. I nurses or licensed defined under State law). des. g requirements. post the nurse staffing data in (g)(1) of this section on a inning of each shift. ted as follows: le format. tece readily accessible to access to posted nurse cility must, upon oral or a nurse staffing data c for review at a cost not to y standard.	F	732			3/21/23	

Facility ID: VA0392

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STATEMENT (OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION	(X3) DATE SURVEY
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:		i	COMPLETED
					С
		495391	B. WING		02/08/2023
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
GLENBUF	NIE REHAB & NURSING	CENTER		1901 LIBBIE AVE RICHMOND, VA 23226	
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORR	ECTION (X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE COMPLETI
F 732	Continued From page	e 173	F 73	2	
	by:				
		n, staff interview and facility		F732 Posted Nurse Staffing	
		as determined that the		staffing not posted on entrance	
	facility staff failed to d			1-Nursing Staffing hours are now	w being
	staffing information or	n one of four days.		posted daily as required. 2-The Administrative Nurses or	designee
	The findings include:			will educate the staff coordinator Department Heads on the impor	r and
	The facility staff failed	I to display the nurse staffing		posting the staffing schedule da	
		iled to display the nurse		include weekends.	
	staffing on 02/06/202	3 prior to the beginning of		3-The MOD will ensure that the	staff
	the shift.			posting is current on each week 4-The ADON or designee will co	onduct
		0 p.m., observation of the		daily audits on weekdays X 4 we	
		inden Unit nurse's station		weekly X 4 weeks and daily X 1	
	and immediate surrou Bradford Unit and imr	nding area, and the mediate surrounding area,		verification of the staffing sched posting.	ule
		facility's staff posting.		5- Results of the audits will be p to the QAPI Committee for revie	
	On 02/05/2023 at 5:3	0 p.m., observation of the		recommendation he Administrat	
		inden Unit nurse's station		Director of Nursing are responsi	ble for
	and immediate surrou			implementation of the plan of co	prrection.
		nediate surrounding area,		6-Date of Compliance: 3/21/23	
	failed to evidence the	facility's staff posting.			
	On 02/06/2023 at 8:3	0 a.m., observation of the			
		inden Unit nurse's station			
	and immediate surrou	unding area, and the			
		nediate surrounding area,			
	tailed to evidence the	facility's staff posting.			
	On 02/07/2023 at app	proximately 3:30 p.m., an			
		ted with CNA #4, staffing			
		sked about the procedure			
		urse staffing information			
		lace the staffing sheet in a receptionist desk in the			
		lity each morning by 8:00			
		Friday. When asked who			

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TATEMENT OF	DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	· · ·	CONSTRUCTION	(X3) DA	NO. 0938-039 ATE SURVEY	
ND PLAN OF C	ORRECTION	IDENTIFICATION NUMBER:	A. BUILDING			COMPLETED	
		495391	B. WING		02/08/2023		
NAME OF PRO	OVIDER OR SUPPLIER			REET ADDRESS, CITY, STATE, ZIP C	ODE		
GLENBURNIE REHAB & NURSING CENTER				01 LIBBIE AVE ICHMOND, VA 23226			
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE			
F 755 SS=E	Saturdays and Sunda but by the receptionis did not have a perma informed of the obser #4 stated that the rec know they were supp posting on Sunday ar staff posting displayed Monday. When aske should be displayed (be displayed at the be The facility's policy "E Summary" documente Nurse Staffing Summ morning. 2. The Cen the first shift census a should be completed each shift. The staffin nursing individuals wh for patient care during nurses, licensed prac nurse aids. Identify th working per category number of hours work On 02/08/2023 at app (administrative staff n was made aware of th No further information	isplaying the staff posting on hys CNA #4 stated it is put t and added that the facility nent receptionist. When vations stated above CNA eptionist probably did not osed to display the staff nd that they didn't get the d until 11:00 a.m. on d what time the staff posting CNA #4 stated that it should eginning of the shift. Daily Nurse Staffing Report ed in part, "The MFA Daily ary must be initiated each ter name, current date and and staffing information posted at the beginning of g data must reflect those no are directly responsible g the shift i.e., registered tical nurses and certified e total number of staff per shift and the actual ked per category per shift." Droximately 10:30 a.m., ASM nember) #1, administrator, ne above findings.	F 732			3/21/23	

Facility ID: VA0392

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		ND HUMAN SERVICES MEDICAID SERVICES		PRINTED: 03/14/202 FORM APPROVEI OMB NO. 0938-039				
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		495391	B. WING		C 02/08/2023			
NAME OF P	ROVIDER OR SUPPLIER		•	STREET ADDRESS, CITY, STATE, ZIF	• • • • • • • • • • • • • • • • • • •			
GLENBUF	RNIE REHAB & NURSING	G CENTER		1901 LIBBIE AVE RICHMOND, VA 23226				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE COMPLETION O THE APPROPRIATE DATE			
F 755	them under an agree §483.70(g). The facil personnel to administ permits, but only und a licensed nurse. §483.45(a) Procedure pharmaceutical servic that assure the accur dispensing, and admi biologicals) to meet th §483.45(b) Service C must employ or obtai pharmacist who- §483.45(b)(1) Provide aspects of the provisi the facility. §483.45(b)(2) Establi receipt and dispositio sufficient detail to ena reconciliation; and §483.45(b)(3) Determ order and that an acc is maintained and per This REQUIREMENT by: Based on observatio responsible party inter record review, and fa was determined that ensure that medicatic administration for six sample, Residents #6 #365 and for one of si	ment described in lity may permit unlicensed ter drugs if State law er the general supervision of es. A facility must provide ces (including procedures ate acquiring, receiving, inistering of all drugs and he needs of each resident. Consultation. The facility n the services of a licensed es consultation on all ion of pharmacy services in shes a system of records of on of all controlled drugs in able an accurate nines that drug records are in count of all controlled drugs riodically reconciled. T is not met as evidenced on, resident interview, erview, staff interview, clinical cility document review, it the facility staff failed to ons were available for of 58 residents in the survey 5, #77, #114, #112, #118,	F7	755 F755 Pharmacy Services/Procedures/Pha □ 1-Residents #6, #114, #1 and #365 were discharge has medications available administration. 2-All current residents ha to be affected. The medic	112, #118, #416 ed. Resident #77 e for ave the potential			

Facility ID: VA0392

		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 03/14/20 FORM APPROVE OMB NO. 0938-03	
	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DATE SURVEY COMPLETED	
		495391	B. WING		C 02/08/2023	
NAME OF PR	OVIDER OR SUPPLIER	•	•	STREET ADDRESS, CITY, STATE, ZIP CODE		
	NIE REHAB & NURSING	CENTER		1901 LIBBIE AVE		
			RICHMOND, VA 23226			
(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 CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE COMPLETION	
F 755	Continued From page	a 176	F 75	5		
1 700	#416.	9170			or	
	The findings include:			be audited by the Unit Manager designee to verify that all ordere medications are available for		
	-	R6), the facility staff failed to		administration. 3-The ADON or designee will ed	lucate all	
		azobactam, an antibiotic,		licensed nurses on the process f	for	
	was acquired from the	· ·		obtaining meds and completing		
	administration in a tin	-		medications, notifying the MD if medication is not available and	a	
		1DS (minimum data set), an		documentation of medication		
		nt with an ARD (assessment		administration in the clinical reco		
		/11/2022, the resident on the BIMS (brief interview		4-The Unit Managers or designe conduct weekly audits x 8 weeks		
		sessment, indicating the		monthly x 2 to ensure residents		
		y impaired for making daily		receiving their medications as or		
	decisions.			Results of the audits will be pres the QAPI Committee for review a	sented to	
		o.m., an interview was responsible party (RP). The		recommendation. The Administration Director of Nursing are responsil		
	RP voiced concerns r			implementation of the plan of co	rrection.	
		ation with facility staff		5-Date of Compliance: 3/21/23		
		R6's RP stated that the				
		multiple doses of their dered in January of 2023.				
		for R6 documented in part, ctam (antibiotic) in Dex				
	-	-0.25 GM (gram)/50ML				
		gram intravenously every 8				
	. ,	7 days start PIV (peripheral				
	-	Order Date: 01/20/2023. 23. End Date: 01/25/2023."				
	The progress notes fo - "1/20/2023 22:23 (1	or R6 documented in part, 0:23 p.m.)				
		am in Dex Solution 2-0.25				
	•	gram intravenously every 8				
		7 Days start PIV. Awaiting				

					OMB NO. 0938-03 (X3) DATE SURVEY		
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION	· · · ·	E SURVEY IPLETED	
			A. DOILDING			с	
		495391	B. WING		0	2/08/2023	
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD			
GLENBUR	NIE REHAB & NURSING	G CENTER		1901 LIBBIE AVE			
				RICHMOND, VA 23226			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE APPROPRIATE	(X5) COMPLETIO DATE	
F 755	Continued From page	e 177	F 75	55			
	- "1/21/2023 06:34 (6		175				
		am in Dex Solution 2-0.25					
		gram intravenously every 8					
	hours for infection for	7 Days start PIV. On					
	order."						
	Review of the eMAR	(electronic medication					
	administration record	•					
	1/1/2023-1/31/2023 0	•					
	-	tam in Dex Solution 2-0.25					
		gram intravenously every 8					
	Date: 01/20/2023 140	7 Days start PIV. Order					
		1/25/2023 1500 (3:00 p.m.)."					
		ted the first dose of the					
	antibiotic administere	ed on 1/21/2023 at 2:00 p.m.					
	On 2/7/2023 at 12:30) p.m., the facility provided a					
		available medications in the					
		omated dispensing system)					
		nce stock of the ordered					
	Piperacillin-Tazobact	am.					
	On 2/8/2023 at 8:17 :	a.m., an interview was					
		(licensed practical nurse) #2.					
	LPN #2 stated that w	hen they get an order for					
	•	ered it into the computer and					
		pharmacy to be processed.					
		depended on the time that it nen it would be filled because					
		window. LPN #2 stated that					
		medication was ordered					
		rould come on the 9:00 p.m.					
		PN #2 stated that the					
		ways come when they were					
		nursing staff have to call the					
	•	N #2 reviewed R6's eMAR					
		2023 which documented the					

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		D HUMAN SERVICES MEDICAID SERVICES				FORM): 03/14/2023 APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		495391	B. WING	_		C 08/2023	
NAME OF PI	ROVIDER OR SUPPLIER		s	STREET ADDRESS, CITY, ST	ATE, ZIP CODE	-	
GLENBUR	NIE REHAB & NURSING	CENTER		901 LIBBIE AVE RICHMOND, VA 23226			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BE ICED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 755	being available from p they understood that is their antibiotic due to issues and saw the co On 2/8/2023 at 9:20 a conducted with LPN # there were no medical would check the medic carts, the check the C LPN #1 stated that the and notify the physical the responsible party medication was not at On 2/8/2023 at approx (administrative staff m administrator, ASM #3, clinical services were No further information 2. For Resident #77 (to ensure that Gabapp administration as order On the most recent M annual assessment w reference date) of 10/ scored 14 out of 15 of for mental status) ass resident was cognitive decisions. Section J	ed due to the medication not oharmacy and stated that R6 missed multiple doses of pharmacy and IV access oncern. I.m., an interview was th. LPN #1 stated that if tions for a resident they cation cart first and other omnicell to see if available. ey would call the pharmacy an and the resident and/or and document that the vailable. ximately 11:30 a.m., ASM nember) #1, the 2, the interim director of the regional director of the regional director of made aware of the concern. was provided prior to exit. R77), the facility staff failed entin (1) was available for ered. DS (minimum data set), an ith an ARD (assessment 24/2022, the resident in the BIMS (brief interview essment, indicating the ely intact for making daily documented R77 receiving rations and not having any	F 755				
	On 2/5/2023 at 4:13 p	.m., an interview was					

Facility ID: VA0392

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM APPROVED OMB NO. 0938-0391		
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE		
		495391	B. WING				C /08/2023	
NAME OF P	ROVIDER OR SUPPLIER		•	S	STREET ADDRESS, CITY, STATE, ZIP CODE	-		
GLENBUF	RNIE REHAB & NURSING	CENTER			1901 LIBBIE AVE RICHMOND, VA 23226			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	FIX (EACH CORRECTIVE ACTION SHOULD BE			(X5) COMPLETION DATE	
F 755	conducted with R77 in that there were times their scheduled Gaba ran out. R77 stated th them that they had ru not delivered the med they took the Gabape pain in their hands off needed their Gabape the facility should hav run out of medications normally had to wait u medication from phart The physician orders "Gabapentin capsule capsule by mouth two pain. Order Date: 08/ 08/11/2022" The or "Gabapentin capsule mouth at bedtime for Date: 08/11/2022. St Review of the eMAR administration record 11/1/2022-11/30/2022 failed to evidence adr Gabapentin on 11/3/2 at 9:00 a.m., 11/23/20 at 9:00 p.m., and 12/7 5:00 p.m. The progress notes fo - "11/5/2022 09:47 (9: Gabapentin Capsule mouth two times a da order." - "11/28/2022 22:54 (1)	n their room. R77 stated when they did not receive pentin because the facility hat the nurses would tell n out and the pharmacy had lication. R77 stated that intin for neuropathy and had ten. R77 stated that they ntin three times a day and re something in place to not s. R77 stated that they until the next day to get the macy. for R77 documented in part, 100 mg (milligram), give 1 o times a day for neuropathic (11/2022. Start Date: ders further documented, 100 mg, give 3 capsule by neuropathic pain. Order art Date: 08/11/2022" (electronic medication) for R77 for 2 and 12/1/2022-12/31/2022 ministration of the 1022 at 9:00 p.m., 11/5/2022 (1/2022 at 9:00 a.m. and or R77 documented in part,	F	755				

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	F DEFICIENCIES	MEDICAID SERVICES		PLE CONSTRUCTION		10. 0938-039 TE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	· · ·		· · · ·	MPLETED
						С
		495391	B. WING		0	2/08/2023
NAME OF PF	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, Z	IP CODE	
GLENBUR	NIE REHAB & NURSING	CENTER		1901 LIBBIE AVE RICHMOND, VA 23226		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE) CROSS-REFERENCED DEFICI	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETION DATE
F 755	Continued From page	e 180	F 75	55		
		neuropathic pain. Only two	-			
	capsule in supply 2 g	iven."				
	- "12/11/2022 08:03 (
		100 MG Give 1 capsule by				
	Awaiting delivery fron	ly for neuropathic pain.				
	- "12/11/2022 21:04 (
		100 MG Give 1 capsule by				
		y for neuropathic pain. On				
	way from pharmacy."					
		a.m., an interview was				
		(licensed practical nurse) #2.				
		hen they get an order for				
	-	ered it into the computer and pharmacy to be processed.				
		depended on the time that it				
		ien it would be filled because				
		window. LPN #2 stated that				
		medication was ordered				
		ould come on the 9:00 p.m.				
		.PN #2 stated that the vays come when they were				
		nursing staff have to call the				
		I #2 stated that they had				
		a new pharmacy and had the				
	-	medication dispensing				
		bout 2 months now. LPN				
	#2 stated that prior to	o that they had some ons in a box but mostly had				
		to bring the medications in.				
	On 2/8/2023 at 9:20 a	a.m., an interview was				
		#1. LPN #1 stated that if				
		ations for a resident they				
		ication cart first and other				
		Omnicell to see if available. ey would call the pharmacy				
	I PIN # I SIATED THAT TH	ey would call the pharmacy		1		1

Facility ID: VA0392

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE	
		495391	B. WING				C 108/2023
NAME OF P	ROVIDER OR SUPPLIER	-		:	STREET ADDRESS, CITY, STATE, ZIP CODE		
					1901 LIBBIE AVE		
GLENBUR	NIE REHAB & NURSING	G CENTER			RICHMOND, VA 23226		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ЗE	(X5) COMPLETION DATE
F 755	medication was not at On 2/8/2023 at 11:23 staff member) #3, the services stated they h pharmacy until 12/15/ the current pharmacy list of medications of i available prior to 12/1 all they were able to p provided failed to evice On 2/8/2023 at appro #1, the administrator, of nursing and ASM # clinical services were No further information Reference: (1) Gabapentin Gabapentin capsules are used along with o control certain types of have epilepsy. Gabap oral solution are also postherpetic neuralgia stabbing pain or ache or years after an attace extended-release tab treat restless legs syn that causes discomfor urge to move the legs when sitting or lying of class of medications of Gabapentin treats sei	and document that the vailable. a.m., ASM (administrative regional director of clinical had contracted with another /2022 and then switched to . ASM #3 provided a partial in-house medication 5/2022 and stated that was provide. Review of the list dence Gabapentin 100mg. ximately 11:30 a.m., ASM ASM #2, the interim director 43, the regional director of made aware of the concern. a was provided prior to exit. , tablets, and oral solution ther medications to help of seizures in people who bentin capsules, tablets, and used to relieve the pain of a (PHN; the burning, es that may last for months ck of shingles). Gabapentin lets (Horizant) are used to not reference to a strong a, especially at night and lown). Gabapentin is in a called anticonvulsants. zures by decreasing	F	755	5		
	when sitting or lying of class of medications of Gabapentin treats sei abnormal excitement	lown). Gabapentin is in a called anticonvulsants.					

Facility ID: VA0392

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		495391	B. WING				C 108/2023
NAME OF P	ROVIDER OR SUPPLIER		•		STREET ADDRESS, CITY, STATE, ZIP CODE		
GLENBUF	RNIE REHAB & NURSING	CENTER			1901 LIBBIE AVE RICHMOND, VA 23226		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 755	body senses pain. It is Gabapentin works to syndrome. This inform the website: https://medlineplus.go tml 3. For Resident #114 failed to administer the medication mupirocin the physician ordered A review of R114's cli following physician's of -6/10/22-mupirocin oi sacrum/buttocks rash days (scheduled at 9: -6/21/22 (12:32 a.m.)- (milligrams)- 1 capsul for 14 days for COVIE A review of R114's Ju administration record (treatment administratevidence that mupirod 6/15/22 at 9:00 p.m. at administered on 6/21/ evidenced by blank sp TAR). On 2/7/23 at 12:00 p. conducted with LPN (LPN #3 stated when more order, they should put system for the pharmacy pharmacy to see the opharmacy	s not known exactly how treat restless legs mation was obtained from ov/druginfo/meds/a694007.h (R114), the facility staff e physician ordered ointment (1) on 6/15/22 and medication zinc on 6/21/22. nical record revealed the orders: ntment 2%- apply to two times a day for ten 00 a.m. and 9:00 p.m.) -zinc sulfate 220 mg e by mouth one time a day 0 (scheduled at 9:00 a.m.) ne 2022 MAR (medication) and June 2022 TAR tion record) failed to reveal cin was administered on and zinc sulfate was /22 at 9:00 a.m. (as paces on the MAR and m., an interview was licensed practical nurse) #3. nurses receive a physician's t the order into the computer acy, wait a little bit for the order then contact the e medication STAT edication cannot be pulled	F	75	5		

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		LE CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		495391	B. WING				C /08/2023
NAME OF PI	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
GLENBUR	RNIE REHAB & NURSING	CENTER			1901 LIBBIE AVE RICHMOND, VA 23226		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE
F 755	needed). On 2/8/23 at 8:31 a.m conducted with LPN # evidence medication on the MAR. LPN #2 not been documented off on then you can sa been given. On 2/8/23 at 9:50 a.m member) #1 (the adm director of nursing) w above concern. The different pharmacy in an Omnicell. ASM #1 provide a list for the S supply of medications period. Reference: (1) Mupirocin ointmer treat skin infections. obtained from the we https://medlineplus.go tml 4. For Resident #112 failed to obtain and ac ordered antibiotic, cef 1/26/23. A review of R112's cli physician's order date sodium solution recor	cility that can be used if A, an interview was #2. LPN #2 stated nurses administration by signing off stated if a medication has a s being given or signed ay the medication hasn't A, ASM (administrative staff inistrator) and ASM #2 (the ere made aware of the facility contracted with a June 2022 and did not use I and ASM #2 could not STAT box (another general b) used during that time At is an antibiotic used to This information was bsite: bv/druginfo/meds/a688004.h (R112), the facility staff dminister the physician ftriaxone sodium (1), on nical record revealed a ed 1/12/23 for ceftriaxone	F	75	5		
	Days. A review of R1	12's January 2023 MAR ation record) failed to reveal					

Facility ID: VA0392

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		495391	B. WING				C 08/2023
NAME OF P	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE	·	
GLENBUF	RNIE REHAB & NURSING	CENTER			1901 LIBBIE AVE RICHMOND, VA 23226		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 755	evidence that ceftriax administered to the re- nurse's note dated 1/2 order." Further review (including progress no MAR) failed to reveal given. (Ceftriaxone so available in the Omnie medications in the fac needed]). On 2/7/23 at 12:00 p. conducted with LPN (LPN #3 stated nurses pharmacy to send a no (immediately) if the me from the Omnicell. LF document they are wa the pharmacy, then the if the medication is re On 2/7/23 at 5:02 p.m member) #1 (the adm director of nursing) we above concern. Reference: (1) Ceftriaxone sodium This information was https://medlineplus.go tml 5. For Resident #118 failed to administer th medication gabapenti A review of R118's cli physician's order date	one sodium was esident on 1/26/23. A 26/23 documented, "On w of R112's clinical record betes and the January 2023 the scheduled dose was odium 2 grams dose was not cell [a general supply of cility that can be used if m., an interview was licensed practical nurse) #3. is should contact the nedication STAT edication cannot be pulled PN #3 stated if nurses aiting for a medication from ne nurses should document ceived and administered. n., ASM (administrative staff inistrator) and ASM #2 (the ere made aware of the m is used to treat infection. obtained from the website: ov/druginfo/meds/a685032.h (R118), the facility staff e physician ordered	F	755			

Facility ID: VA0392

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		495391	B. WING				C 108/2023
NAME OF PI	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	<u>•</u>	
GLENBUR	NIE REHAB & NURSING	CENTER			1901 LIBBIE AVE RICHMOND, VA 23226		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 755	mouth three times a costeoarthritis. The mileion of the second structure of th	lay for right hip edication was scheduled at and 10:00 p.m. A review of 21 MAR (medication) failed to reveal the histered on 11/5/21 at 10:00 lated 11/5/21 documented, oharmacy." Further review ord (including progress notes 21 MAR) failed to reveal the given. m., an interview was licensed practical nurse) #3. hurses receive a physician's t the order into the computer acy, wait a little bit for the order then contact the emedication STAT edication cannot be pulled general supply of cility that can be used if h., ASM (administrative staff inistrator) and ASM #2 (the ere made aware of the facility contracted with a 2021 and did not use an ad ASM #2 could not provide a (another general supply of ring that time period.	F	755			

Facility ID: VA0392

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	-	D HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE	E SURVEY PLETED
		495391	B. WING			02	C 2/08/2023
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	_ ·	
GLENBUF	RNIE REHAB & NURSING	CENTER			1901 LIBBIE AVE RICHMOND, VA 23226		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 755	(medication for restlet anti-rejection medicat and Cefepime (an intr available for administ On R365's admission the resident was asse- intact, and oriented to situation. On 2/6/23 at 8:29 a.m disappointment in what to admission, and what delivered regarding m stated: "I have just re- and I have a terrible in belly." The resident et infection would increa- body would reject the before admission, the "promised me" that the anti-rejection drugs nor resident arrived at the turned out to not be tr took "a day or two" fo medications to arrive. antibiotics were slow A review of R365's pr part: "1/31/2023 22:01 (10: Administration Note T Oral Tablet 100 MG (n mouth two times a da	cycline (an antibiotic), il (an anti-rejection transplant), Pramipexole ss legs), Tacrolimus (an ion for organ transplant), ravenous antibiotic) were ration. assessment dated 1/31/23, assed to be cognitively person, place, time, and a., R365 expressed at the facility promised prior at the facility actually nedication. The resident ceived a brand new kidney, infection in a wound in my expressed fear that the ise the chance that their kidney. The resident stated a dmission coordinator e facility would have all the eeded by the time the facility. R365 stated: "This ue at all." R365 stated it r the anti-rejection R365 stated: "I think the to come, too." ogress notes revealed, in 01 p.m.) Orders - fext: Doxycycline Hyclate milligrams) Give 1 tablet by y for infection for 10 Days unces of water, do not lie	F	75	5		

Facility ID: VA0392

If continuation sheet Page 187 of 213

		ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		495391	B. WING				C 1 08/2023
NAME OF P	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE	1 02.	
GLENBU	RNIE REHAB & NURSING	CENTER			1901 LIBBIE AVE RICHMOND, VA 23226		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE
F 755	medication." "1/31/2023 22:02 (10: Administration Note T Oral Capsule 250 MG times a day for Kidne medication." "1/31/2023 22:03 (10: Administration Note T Dihydrochloride Oral by mouth every 8 hou Awaiting on medication "1/31/2023 22:03 (10: Administration Note T Capsule Give 1 capsu day for Infection. Awa "2/2/2023 06:48 (6:48 Administration Note T 2 GM/100ML (grams gram intravenously ev pseudomonas infection (11:59 p.m.) Called pl of pharmacy employed pharmacy for delivery On 2/7/23 at 5:05 p.m administrator, ASM #: and ASM #3, the regis services, were inform On 2/8/23 at 8:18 a.m nurse) #2, a unit man stated it can be difficu a newly admitted resi	202 p.m.) Orders - fext: Mycophenolate Mofetil G Give 3 tablet by mouth two y Disorders. Awaiting on 203 p.m.) Orders - fext: Pramipexole Tablet 0.5 MG Give 1 tablet urs for Restless legs. on." 203 p.m.) Orders - fext: Tacrolimus Oral ule by mouth two times a aiting on medication." 3 a.m.) Orders - fext: Cefepime HCI Solution per 100 milliliter) Use 2 very 8 hours for on until 02/05/2023 23:59 harmacy spoke with [name be) will called (sic) local ." 1. ASM #1, the 2, the director of nursing, onal director of clinical ed of these concerns. 1. LPN (licensed practical ager, was interviewed. She ult to get all the medications	F	755			

Facility ID: VA0392

If continuation sheet Page 188 of 213

		MEDICAID SERVICES		LE CONSTRUCTION		IO. 0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		· · /	IE SURVEY MPLETED
			A. DOILDING			С
		495391	B. WING		0	2/08/2023
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD		
	RNIE REHAB & NURSIN	COENTER		1901 LIBBIE AVE		
GLENBUR	THE REHAD & NORSING	5 GENTER		RICHMOND, VA 23226		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE
F 755	Continued From page	e 188	F 75	5		
		armacy run, or you have to	175	5		
		n a local pharmacy." She				
		uld be given medications				
	prescribed for them v	when they are due.				
	6 Ear #446 (D440)	the facility staff failed to				
	ensure Pancreaze (1	the facility staff failed to) was available for				
		2/3/23 through 2/6/23.				
		5				
		n assessment dated 1/31/23,				
		essed to be cognitively o person, place, time, and				
		R416's diagnoses revealed				
		of the pancreas surgically				
	removed prior to adm					
	On 2/4/23 at 9:02 a.r	n. during the medication				
	administration observ	vation, LPN (licensed				
		was observed preparing				
		hister to R416. LPN #11				
		ze is not in the cart." She told there was a problem				
		surance coverage, and the				
		send the medication to the				
		ation of payment. At 9:16				
		rative staff member) #6, who				
		g physician), approached bld ASM #6 that R416 had not				
		Pancreaze because of				
		6M #6 stated: "That is his				
		. He cannot digest his food				
		stated she would see what				
	building for the reside	o get the medication in the ent.				
		n., R416 was sitting up in lay (2/7/23) he had received				
		creaze since arriving at the				
		t lunchtime, the nurse came				

Facility ID: VA0392

If continuation sheet Page 189 of 213

	-	D HUMAN SERVICES MEDICAID SERVICES				FORM): 03/14/2023 MAPPROVED). 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 Y /	E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		495391	B. WING		_		C 08/2023
NAME OF PI	ROVIDER OR SUPPLIER		5	STREET ADDRESS, CITY, STA	ATE, ZIP CODE		
GLENBUR	NIE REHAB & NURSING	CENTER		1901 LIBBIE AVE RICHMOND, VA 23226			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BE ICED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 755	happens without the F orange, oily, strong, a stated: "My body can' A review of R416's ph the following order da Capsule Delayed Rela 14200 UNITGive 1 of meals for pancreatic i A review of R416's Fe (medication administr medication was signe three doses), 2/5/34 a (5:00 p.m.). The medi not given on 2/5/23 at and 2/6/23 at 8:00 a.r A review of pharmacy the medication was no from the pharmacy ur On 2/7/23 at 5:05 p.m administrator, ASM #2 and ASM #3, the regio services, were inform On 2/8/23 at 10:52 a.1 just spoken to the pha pharmacy was taking the Pancreaze to R41 stated: "The delay in g an error on their part."	e bottle. She said the ed it." When asked what Pancreaze, he stated he has nd foul-smelling stools. He t digest the food." ysician's orders revealed ted 2/3/23: "Pancreaze Oral ease Particles4200 - capsule by mouth with nsufficiency." bruary 2023 MAR ation record) revealed the d off as given on 2/4/23 (all t 5:00 p.m., and 2/6/23 cation was documented as 8:00 a.m., and 12:00 p.m., n. and 12:00 noon. receipts for R416 revealed of delivered to the facility til 2/7/23. A., ASM #1, the 2, the director of nursing, onal director of clinical ed of these concerns. m., ASM #3 stated she had armacy. She stated the responsibility for not getting 6 in a timely manner. She getting the medication was	F 755				
	No further information (1) Pancrelipase delay						

Facility ID: VA0392

If continuation sheet Page 190 of 213

	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		E CONSTRUCTION	(X3) DATE COMP	
		495391	B. WING				08/2023
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
GLENBU	RNIE REHAB & NURSING	CENTER			1901 LIBBIE AVE RICHMOND, VA 23226		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 755 F 756 SS=D	(Creon, Pancreaze, P used to improve diges adults who do not have enzymes (substances so it can be digested) condition that affects produces several imp enzymes needed to d delayed-release caps to improve digestion i surgery to remove all stomach." This inform website https://medlineplus.go tml. Drug Regimen Review CFR(s): 483.45(c)(1)(§483.45(c) Drug Regi §483.45(c)(1) The dru must be reviewed at I licensed pharmacist. §483.45(c)(2) This rev of the resident's medi §483.45(c)(4) The pha irregularities to the atti facility's medical direct and these reports mu (i) Irregularities red (d) of this section for a (ii) Any irregularities re attending physician a	Pertzye, Ultresa, Zenpep) are stion of food in children and ve enough pancreatic is needed to break down food because they have a the pancreas (a gland that ortant substances including igest food)Pancrelipase ules (Creon) are also used in people who have had or part of the pancreas or nation was taken from the ov/druginfo/meds/a604035.h w, Report Irregular, Act On 2)(4)(5) men Review. Ig regimen of each resident east once a month by a view must include a review cal chart. armacist must report any tending physician and the stor and director of nursing, st be acted upon. de, but are not limited to, any riteria set forth in paragraph an unnecessary drug. noted by the pharmacist st be documented on a		755			3/21/23

Facility ID: VA0392

If continuation sheet Page 191 of 213

		ID HUMAN SERVICES MEDICAID SERVICES				FORM APPROVE B NO. 0938-039
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
		495391	B. WING		_	C 02/08/2023
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	TATE, ZIP CODE	
	NIE REHAB & NURSING	CENTER		1901 LIBBIE AVE		
OLENDOI		SOLNILK		RICHMOND, VA 23226		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE) CROSS-REFEREI	S PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 756	minimum, the resider and the irregularity th (iii) The attending phy resident's medical red irregularity has been action has been take be no change in the r physician should doc the resident's medical §483.45(c)(5) The fac maintain policies and drug regimen review	nt's name, the relevant drug, the pharmacist identified. ysician must document in the cord that the identified reviewed and what, if any, n to address it. If there is to medication, the attending ument his or her rationale in	F 7	56		
	when he or she ident requires urgent action This REQUIREMENT by: Based on staff interv review, and clinical re determined the facilit monthly drug regimen the pharmacist for on survey sample, Resid #42. The findings include:	y staff failed to evidence n reviews were conducted by le of 58 residents in the		Irregular, Act On 1-The MMR was co by the Physician fo 2-All current reside to be affected. The obtain the MMR co residents and ensu addressed appropr	ents have the potential DON, or designee will ompleted for current ure that the MMR⊡s are riately. ducate all DON and	
	1/20/17. Resident #4 were not limited to He pressure, heart failure (post-traumatic stress (obsessive compulsiv A review of the comp	I2's diagnoses included but epatitis A, high blood e, depression, PTSD s disorder) and OCD ve disorder). rehensive care plan dated OCUS: At risk for adverse		process for obtaining review and ensuring addressed appropre 4-The DON, or des weekly audits x 8 v to ensure that the f area addressed ap 5- Results of the au	ng pharmacy regimen ng that they MMR s are riately and timely. signee will conduct veeks, then monthly x2 MMR s completed	

Facility ID: VA0392

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED D. 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		495391	B. WING				C / 08/2023
NAME OF P	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
GLENBU	RNIE REHAB & NURSING	CENTER			901 LIBBIE AVE SICHMOND, VA 23226		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) COMPLETION DATE
F 756	medication/depressio antipsychotic medicat Evaluate effectiveness medications for possi psychotropic drugs. If ADL ability or mood/b change. Provide pati benefits of medication consult and follow-up environmental noise/o sleep. Report to phys reaction such as decl in positioning/ambula complaints of dizzines On 2/7/23 at 12:39 PI medication review, it monthly medication re missing from the doct 8/22 and 9/22. On 2/08/23 the admir and 8/22 medication in On 2/8/23 at 1:00 PM verified there were no Resident #42. On 2/7/23 at 5:15 PM member) #1, the adm director of nursing, we findings. A review of the facility Management/Medication in pharmacist will provide to the Medical Director	n/PTSD, anti-anxiety. Use of tion. INTERVENTIONS: as and side effects of ble decrease/elimination of Notify physician of decline in behavior related to a dosage ent education to risks and hs as needed. Psychiatrist as needed. Reduce distractions to facilitate sician signs of adverse ine in mental status decline tion ability, lethargy, ss and tremors." M, during Resident #42's was revealed that the egimen reviews (MRR) were umentation for 2/22, 3/22, histrator provided the 3/22 regimen reviews. A ASM #1, the administrator b additional MRRs for	F	756	recommendation. The Administrator or Director of Nursi are responsible for implementation of plan of correction. 6- Date of completion 3/21/23.	-	

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TATEMENT (DF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í	IPLE CONSTRUCTION	OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED
		495391	B. WING _		C 02/08/2023
	ROVIDER OR SUPPLIER	G CENTER		STREET ADDRESS, CITY, STATE, Z 1901 LIBBIE AVE RICHMOND, VA 23226	· · · · · · · · · · · · · · · · · · ·
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN (EACH CORRECTIVE CROSS-REFERENCED	
F 756 F 759 SS=D	Services Provider Re 8/20 revealed, "Reviewing the media (MRR) of each reside frequently under certa documenting the revi medical record or in a using electronic docu No further information Free of Medication El CFR(s): 483.45(f)(1) §483.45(f) Medication The facility must ensu	e email or hard copy." I's "Consultant Pharmacist quirements" policy, dated cation regiment review ent at least monthly, or more ain conditions and ew and findings in the a readily retrievable format if mentation." In was provided prior to exit. rror Rts 5 Prcnt or More In Errors. ure that its-		759	3/21/23
	percent or greater; This REQUIREMENT by: Based on observatio interview, facility doct record review, it was staff failed to adminis free of medication err two of six residents in administration observ #416. There were two opportunities, resultin of 6.06%. The findings include: 1. The facility staff fai	ation, Residents #56 and		F759 Free of Medicatio 5% or More 1-Resident #416 was di Resident #56 is receivir ordered. LPN #11 was n proper administration of 2-All current residents n medications have the p affected by deficient pra handwashing or medica administration. 3-The ADON,or designed licensed nurses on the washing and education administration with inha	ischarged. ng medications as re-educated on f medication. receiving otential to be actice in ation ee will educate all process of Hand on Medication

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	-	D HUMAN SERVICES MEDICAID SERVICES			FOR	D: 03/14/2023 MAPPROVED D. 0938-0391	
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /	E CONSTRUCTION	(X3) DATE COMF	E SURVEY PLETED	
		495391	B. WING			C /08/2023	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
	NIE REHAB & NURSING	OFNITER		1901 LIBBIE AVE			
GLENDUR	INIE REMAD & NURSING	CENTER	1	RICHMOND, VA 23226			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
F 759	Continued From page of Breo Ellipta dry pow On 2/06/23 at 8:48 a.1 nurse) #1 prepared m administered to R56. Ellipta powder inhaler correct amount of me the inhaler, and had ti of the medication. LPI from the resident, and cart without instructing mouth with water and not rinse their mouth of A review of R56's phy order dated 9/23/22: " MCG/INH (microgram Powder, breath activa one time a day for COPD (chronic obstru On 2/8/23 at 8:18 a.m nurse) #2 was intervie action a nurse should medication from a dry resident, she stated: " their mouth out." Whe necessary, she stated	e 194 wder inhaler (1). m., LPN (licensed practical redications to be LPN #11 took the Breo to R56, prepared the dication to be delivered by he resident inhale one puff N #11 took the inhaler back d returned to the medication g the resident to rinse their spit the water out. R56 did on their own. sician's orders revealed an Breo Ellipta 100-25 winhalation) Aerosol ted Give 1 puff by mouth active pulmonary disease)."	F 759	DEFICIENCY)	l ng hat vd ly. ted to		
	staff member) #1, the director of nursing, an director of clinical serv these concerns. A review of the facility book, Mosby's 2023 N	m., ASM (administrative administrator, ASM #2, the ad ASM #3, the regional vices, were informed of 's medication reference Jursing Drug Reference, information under the					

Facility ID: VA0392

If continuation sheet Page 195 of 213

	-	ID HUMAN SERVICES				FORM	03/14/2023 APPROVED
STATEMENT (DF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			(X3) DATE	D. 0938-0391 SURVEY PLETED
		495391	B. WING		-		C 08/2023
NAME OF P	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STA	ATE, ZIP CODE	, <u>, , , , , , , , , , , , , , , , , , </u>	
GLENBUF	RNIE REHAB & NURSING	CENTER		901 LIBBIE AVE RICHMOND, VA 23226			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BE CED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE
F 759	with water after inhala solution." No further information is used to control whe coughing, and chest t and chronic obstructiv group of diseases tha airways, that includes emphysema). Fluticas medications called sta swelling in the airway medications called lor (LABAs). It works by passages in the lungs breathe." This informa	ation and expectorate rinse ation and expectorate rinse a was provided prior to exit. of fluticasone and vilanterol eezing, shortness of breath, ightness caused by asthma /e pulmonary (COPD; a it affect the lungs and c chronic bronchitis and sone is in a class of eroids. It works by reducing s. Vilanterol is in a class of ng-acting beta-agonists relaxing and opening air	F 759				
	administer Pancreaze physician. On R416's admission the resident was asse intact, and oriented to situation. A review of the resident had part removed prior to adm On 2/4/23 at 9:02 a.m administration observ practical nurse) #11 w	n. during the medication					

Facility ID: VA0392

If continuation sheet Page 196 of 213

		ID HUMAN SERVICES MEDICAID SERVICES				FC	TED: 03/14/2023 ORM APPROVED NO. 0938-0391
STATEMENT O	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •		CONSTRUCTION	(X3) D/	ATE SURVEY DMPLETED
		495391	B. WING				C 02/08/2023
NAME OF PI	ROVIDER OR SUPPLIER			STF	REET ADDRESS, CITY, STATE, ZIP CODE		
	NIE REHAB & NURSING	CENTER		190	1 LIBBIE AVE		
				RIC	CHMOND, VA 23226		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 759	stated: "His Pancreaz stated she had been with the resident's ins pharmacy would not a facility without verifica a.m., ASM (administr was R416's attending LPN #11. LPN #11 to received any of the P insurance issues. AS lifesaving medication without it." LPN #11 s needed to be done to building for the reside On 2/7/23 at 3:15 p.m bed. He stated that d his first dose of Panc	Continued From page 196 stated: "His Pancreaze is not in the cart." She stated she had been told there was a problem with the resident's insurance coverage, and the oharmacy would not send the medication to the acility without verification of payment. At 9:16 a.m., ASM (administrative staff member) #6, who was R416's attending physician), approached .PN #11. LPN #11 told ASM #6 that R416 had not eceived any of the Pancreaze because of nsurance issues. ASM #6 stated: "That is his fesaving medication. He cannot digest his food without it." LPN #11 stated she would see what needed to be done to get the medication in the building for the resident.		759			
	happens without the orange, oily, strong, a stated: "My body can	red it." When asked what Pancreaze, he stated he has and foul-smelling stools. He 't digest the food." hysician's orders revealed					
	the following order da Capsule Delayed Rel	ated 2/3/23: "Pancreaze Oral ease Particles4200 - capsule by mouth with					
	and ASM #3, the regi	n., ASM #1, the 2, the director of nursing, onal director of clinical red of these concerns.					
	A review of the facility Management," reveal members are to refer	led, in part: "Nursing staff					

Facility ID: VA0392

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		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 03/14/ FORM APPRO OMB NO. 0938-
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495391	B. WING		C 02/08/2023
NAME OF P	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE	
GLENBUF	NIE REHAB & NURSING	GCENTER		001 LIBBIE AVE ICHMOND, VA 23226	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
F 759 F 760 SS=D	Procedures Manual r delivery, monitoring a for promoting efficient medication administr practice." No further information (2) Pancrelipase dela (Creon, Pancreaze, F used to improve dige adults who do not ha enzymes (substance so it can be digested condition that affects produces several imp enzymes needed to o delayed-release caps to improve digestion surgery to remove all stomach." This inform website https://medlineplus.g tml. Residents are Free o CFR(s): 483.45(f)(2) The facility must ensis §483.45(f)(2) Reside medication errors. This REQUIREMENT by: Based on observatio interview, facility doc	Pharmacy Services and egarding medication orders, and other related processes cy and consistency in ation and standards of best in was provided prior to exit. Ayed-release capsules Pertzye, Ultresa, Zenpep) are stion of food in children and ve enough pancreatic is needed to break down food) because they have a the pancreas (a gland that bortant substances including digest food)Pancrelipase sules (Creon) are also used in people who have had or part of the pancreas or nation was taken from the ov/druginfo/meds/a604035.h of Significant Med Errors ure that its- ints are free of any significant T is not met as evidenced on, resident interview, staff umentation, and clinical cility staff failed to prevent a	F 759	F760 Residents are free of significant med errors. □ 1-Residents # 416 was discharged. 2-All current residents have the potenti	3/21/23

Event ID: V8T511

Facility ID: VA0392

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STATEMENT (DF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DA	IO. 0938-039 TE SURVEY MPLETED
		495391	B. WING		0	C 2/08/2023
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C		
GLENBUR	NIE REHAB & NURSING	3 CENTER		1901 LIBBIE AVE		
				RICHMOND, VA 23226		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 760	Continued From page	e 198	F 76	0		
T F a C t t i i	observation, Resider			be audited by the Unit Man designee to verify that all o	•	
	The findings include:			medications are available f administration.	or	
		he facility staff failed to e (1) during the medication		3-The ADON, or designee licensed nurses on the pro-		
	administration observ	()		obtaining unavailable medi administer per physician or	cation to	
	On R416's admissior	n assessment dated 1/31/23,		documentation requiremen		
		essed to be cognitively		medication administration.		
		o person, place, time, and [•] R416's diagnoses revealed		and responsible party (RP) weekly medication not give		
		of the pancreas surgically		new orders per physician w	•	
	removed prior to adm	nission to the facility.		documentation.		
	On 2///23 at 9:02 a n	n. during the medication		4-The Unit Managers or de conduct weekly audits x 8	-	
		vation, LPN (licensed		monthly x2 to verify resider		
	practical nurse) #11 v	was observed preparing		medications as ordered by	MD , the MD is	
		nister to R416. LPN #11 ze is not in the cart." She		notified of medications not that medications are docur		
		told there was a problem		administered.	nemeu as	
	with the resident's ins	surance coverage, and the		5 Results of the audits will	be presented to	
		send the medication to the		the QAPI Committee for re	view and	
	-	ation of payment. At 9:16 rative staff member)#6, who		recommendation. The Administrator or Direct	or of Nursina	
		g physician), approached		are responsible for implem	•	
		old ASM #6 that R416 had not		plan of correction.	100	
		Pancreaze because of SM #6 stated: "That is his		6- Date of completion 3/21	/23.	
		. He cannot digest his food				
		stated she would see what				
	needed to be done to building for the reside	o get the medication in the ent.				
	-	n., R416 was sitting up in				
		lay (2/7/23) he had received creaze since arriving at the				
		t lunchtime, the nurse came				
	-	e bottle. She said the				

Facility ID: VA0392

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM): 03/14/2023 MAPPROVED). 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		495391	B. WING		_		C 08/2023
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	TATE, ZIP CODE		
GLENBU	RNIE REHAB & NURSING	CENTER		1901 LIBBIE AVE RICHMOND, VA 23226			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE) CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 760	pharmacy just deliver happens without the F orange, oily, strong, a stated: "My body can' A review of R416's pr the following order da Capsule Delayed Rel 14200 UNITGive 1 meals for pancreatic i A review of R416's Fe (medication administr medication was signe three doses), 2/5/34 a (5:00 p.m.). The medi not given on 2/5/23 at and 2/6/23 at 8:00 a.r A review of pharmacy the medication was ne from the pharmacy ur On 2/7/23 at 5:05 p.m administrator, ASM #2 and ASM #3, the regis services, were inform A review of the facility Management," reveal members are to refere contracted provider's Procedures Manual re delivery, monitoring a for promoting efficience medication administrator	ed it." When asked what Pancreaze, he stated he has and foul-smelling stools. He t digest the food." hysician's orders revealed ted 2/3/23: "Pancreaze Oral ease Particles4200 - capsule by mouth with nsufficiency." ebruary 2023 MAR ation record) revealed the d off as given on 2/4/23 (all at 5:00 p.m., and 2/6/23 teation was documented as t 8:00 a.m., and 12:00 p.m., n. and 12:00 noon. receipts for R416 revealed of delivered to the facility ntil 2/7/23. h., ASM #1, the 2, the director of nursing, onal director of clinical ed of these concerns. r policy, "Medication ed, in part: "Nursing staff ence the established Pharmacy Services and egarding medication orders, nd other related processes	F 76	0			

Facility ID: VA0392

If continuation sheet Page 200 of 213

	-	D HUMAN SERVICES MEDICAID SERVICES				FORM APPROVED OMB NO. 0938-0391	
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED C	
		495391	B. WING			02/08/2	023
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, Z	IP CODE		
GLENBUR	RNIE REHAB & NURSING	CENTER		1901 LIBBIE AVE RICHMOND, VA 23226			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD BE			(X5) MPLETION DATE
F 760	(1) Pancrelipase dela	yed-release capsules	F 7	760			
F 840	used to improve diges adults who do not have enzymes (substances so it can be digested) condition that affects produces several imp enzymes needed to d delayed-release caps to improve digestion i surgery to remove all stomach." This inform website https://medlineplus.go	a needed to break down food because they have a the pancreas (a gland that ortant substances including ligest food)Pancrelipase ules (Creon) are also used n people who have had or part of the pancreas or lation was taken from the ov/druginfo/meds/a604035.h	F8	340		3/21	1/23
SS=D	CFR(s): 483.70(g)(1)(§483.70(g) Use of out §483.70(g)(1) If the fa qualified professional service to be provided must have that service person or agency outs arrangement describe Act or an agreement of (2) of this section. §483.70(g)(2) Arrange section 1861(w) of the pertaining to services resources must speci assumes responsibilit (i) Obtaining services standards and princip	(2) tside resources. acility does not employ a person to furnish a specific d by the facility, the facility e furnished to residents by a side the facility under an ed in section 1861(w) of the described in paragraph (g) ements as described in e Act or agreements furnished by outside fy in writing that the facility ry for- that meet professional					

Facility ID: VA0392

If continuation sheet Page 201 of 213

	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		CONSTRUCTION	(X3) DATE COMP	
		495391	B. WING				08/2023
NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE	•	
GLENBU	RNIE REHAB & NURSING	CENTER			01 LIBBIE AVE CHMOND, VA 23226		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI, DEFICIENCY)		(X5) COMPLETION DATE
F 840	and (ii) The timeliness of t This REQUIREMENT by: Based on staff intervi review, it was determ have a written agreen contracted dialysis cer The findings include: The facility failed to e with one dialysis cent received dialysis serv During the entrance of 2/5/23, a request was contracts or agreeme On 2/6/23, a review o evidenced no contract company. On 2/6/23 at approxim (administrative staff m administrator stated, ' am going through to g On 2/7/23 at 5:15 PM member) #1, the adm director of nursing, we findings. ASM #1 sta contracts I have.''	he services. is not met as evidenced iew and facility document ined the facility staff failed to nent for one of six inters. vidence a written agreement er where Resident #127 ices. conference to the facility on made for the dialysis nts to be provided. If the dialysis contracts t for the one dialysis nately 3:45 PM, ASM hember) #1, the 'There are more contracts I get you that contract.'' , ASM (administrative staff inistrator and ASM #2, the ere made aware of the	F8	340	 F840 Use of Outside resources □ 1-The Dialysis contract was obtained. 2-The Administrator will complete an a to ensure that written agreements are place with all contracted services. 3-The Vice President of Operations wile educate Administrator or designee on to obtain the contracts needed for all outside services 4-The Administrator or designee will conduct monthly audits x x2 to verify contracts are active. 5- Results of the audits will be present to the QAPI Committee for review and recommendation. The Administrator or Director of Nursin are responsible for implementation of the plan of correction. 6- Date of completion 3/21/23. 	in I how ed	

Facility ID: VA0392

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		MEDICAID SERVICES	<i>a</i>			NO. 0938-039
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	· · ·	ATE SURVEY OMPLETED
		495391	B. WING			C 02/08/2023
NAME OF PI	ROVIDER OR SUPPLIER	I		STREET ADDRESS, CITY, STATE, ZIP CODE	I	
GLENBUR	RNIE REHAB & NURSING	G CENTER		1901 LIBBIE AVE RICHMOND, VA 23226		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE
F 842	Continued From page	e 202	F 84	2		
F 842			F 84			3/21/23
SS=D	CFR(s): 483.20(f)(5),	483.70(i)(1)-(5)				
	 (i) A facility may not resident-identifiable to (ii) The facility may represent the facility may represent the facility may represent the factor of the factor	elease information that is o an agent only in ntract under which the agent disclose the information he facility itself is permitted				
	professional standard	al records on each resident				
	(ii) Complete, (ii) Accurately docum	ented;				
	(iii) Readily accessibl (iv) Systematically or	e; and				
	all information contain regardless of the form records, except when (i) To the individual, or representative where					
	with 45 CFR 164.506 (iv) For public health	ted by and in compliance ; activities, reporting of abuse,				
	activities, judicial and law enforcement purp	violence, health oversight administrative proceedings, poses, organ donation urposes, or to coroners,				

Facility ID: VA0392

If continuation sheet Page 203 of 213

		ID HUMAN SERVICES				FORM	APPROVED	
	S FOR MEDICARE &	MEDICAID SERVICES	(X2) MU		ECONSTRUCTION	(X3) DATE	0. 0938-0391	
	CORRECTION	IDENTIFICATION NUMBER:					LETED	
			-	-		(C	
		495391	B. WING			02/	08/2023	
NAME OF P	ROVIDER OR SUPPLIER		•	s	STREET ADDRESS, CITY, STATE, ZIP CODE			
	NIE REHAB & NURSING	CENTED		1	901 LIBBIE AVE			
GLENDON		SCENTER		F	RICHMOND, VA 23226			
(X4) ID		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID	124	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	_	(X5) COMPLETION	
PREFIX TAG		LSC IDENTIFYING INFORMATION)	PREF TAG		CROSS-REFERENCED TO THE APPROPRIA		DATE	
					DEFICIENCY)			
F 842			F	842				
		uneral directors, and to avert						
		alth or safety as permitted						
	by and in compliance	with 45 CFR 164.512.						
	§483.70(i)(3) The fac	ility must safeguard medical						
	record information ag	ainst loss, destruction, or						
	unauthorized use.							
	8483 70(i)(4) Modical	records must be retained						
	for-	records must be retained						
		required by State law; or						
		e date of discharge when						
	there is no requireme							
		ars after a resident reaches						
	legal age under State	aw.						
	§483.70(i)(5) The me	dical record must contain-						
	(i) Sufficient informati	on to identify the resident;						
		sident's assessments;						
	(III) The comprehensing provided;	ve plan of care and services						
		/ preadmission screening						
	and resident review e							
	determinations condu							
		's, and other licensed						
	professional's progres							
		logy and other diagnostic equired under §483.50.						
	-	is not met as evidenced						
	by:							
		iew, facility document review			F842 Resident Records			
		view, it was determined the			1Residents # 117 was discharged.			
		naintain an accurate clinical esidents in the survey			2-All current residents with a colostomy have the potential to be affected. The L			
	sample, Resident #11				Manager, or designee will audit the ADI			
		··· \····/·			clinical record to ensure there is a place			
	The findings include:				document colostomy care.			
					3-The ADON nurse or designee will			
	For R117, the facility	staff failed to accurately			educate all licensed nurses and CNA	s		

Event ID: V8T511

Facility ID: VA0392

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ID PLAN OF	CORRECTION		(/2) 10211	PLE CONSTRUCTION		DATE SURVEY
		IDENTIFICATION NUMBER:	A. BUILDING	G		COMPLETED
495391		B. WING			C	
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP		02/08/2023	
GLENBURNIE REHAB & NURSING CENTER			1901 LIBBIE AVE			
GLENBUR	NIE REHAB & NURSING	G CENTER		RICHMOND, VA 23226		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLETIO DATE
F 842	Continued From page	> 204	F 84	12		
1 012	document the care for		F 04	on the requirement for the	a documentation	
		a colosionty.		of colostomy care in resid		
	On the most recent M	IDS (minimum data set)		4-The Unit Manager or de		
	assessment, a Medic	are five-day assessment,		complete weekly audits x	8 weeks, then	
		eference date of 1/29/2022,		monthly x2 to of residents		
		ed in Section H - Bladder		colostomy to ensure that	•	
	and Bowel, as having	a colostomy.		care is documented in the		
	The ADL (activities of	daily living) documentation		5- Results of the audits w to the QAPI Committee for		
	for January 2022, doc			recommendation.		
	movements of a resid			The Administrator or Dire	ctor of Nursing	
	Movements," the follo	wing was documented:		are responsible for impler	•	
		to 11:00 p.m. shift (3-11)- M		plan of correction.		
		nent, 4 - total dependence		6- Date of completion 3/2	1/23.	
	on staff, 2 - one-perso					
		n. to 7:00 a.m. (11-7)- M, 3 I due to Ostomy, 2 - limited				
	assistance, 2 - one-pe	3				
		to 3:00 p.m. (7-3) - 97				
		tegories, according to the				
	legend at the bottom	of the documentation, a 97				
	indicates "not applica					
		arge), 0 - continent, 4 - total				
	•	2 - one-person physical				
	assist. 1/27/2022 - 11-7 M -	1 - Incontinent, 2 - limited				
	assistance, 2 - one-pe	-				
	1/27/2022 - 7-3 - 97 -					
	1/27/2022 - 3-11 - 97					
	1/28/2022 - 11-7 - 97	- not applicable				
	1/28/2022 - 7-3 - blan					
		- 1 - incontinent, 4 - total				
	dependence on staπ, assist.	2- one-person physical				
		- 1 - incontinent, 4 - total				
		2- one-person physical				

Facility ID: VA0392

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		ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 03/14/2023 M APPROVED D. 0938-0391	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION					E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
	495391		B. WING			C 02/08/2023		
NAME OF PF	ROVIDER OR SUPPLIER			ŝ	STREET ADDRESS, CITY, STATE, ZIP CODE	-		
GLENBUR	NIE REHAB & NURSING	G CENTER						
					RICHMOND, VA 23226			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE	
F 842	G REGULATORY OR LSC IDENTIFYING INFORMATION)		F	842				
	documented in part, " and CNAs will docum	ursing Documentation" POLICY: Licensed Nurses ent all pertinent nursing terventions, and follow up I record."						
	nursing, and ASM #3	2, the interim director of , the regional director of e made aware of the above						

Facility ID: VA0392

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		MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495391	B. WING				C / 08/2023	
NAME OF PROVIDER OR SUPPLIER		•	ST	REET ADDRESS, CITY, STATE, ZIP CODE				
GLENBUR	RNIE REHAB & NURSING	GCENTER			01 LIBBIE AVE CHMOND, VA 23226			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 842	Continued From page	e 206	F	842				
F 880 SS=D			F	880			3/21/23	
	infection prevention a designed to provide a comfortable environm	blish and maintain an and control program a safe, sanitary and nent and to help prevent the nsmission of communicable						
	program. The facility must esta	prevention and control blish an infection prevention (IPCP) that must include, at ving elements:						
	reporting, investigatin and communicable di staff, volunteers, visit providing services un arrangement based u	ipon the facility assessment to §483.70(e) and following						
	procedures for the pribut are not limited to: (i) A system of survei possible communication infections before they persons in the facility	llance designed to identify ble diseases or / can spread to other ;						
		m possible incidents of se or infections should be						

Facility ID: VA0392

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391	
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
495391		495391	B. WING			C 02/08/2023		
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE			
GLENBUF	GLENBURNIE REHAB & NURSING CENTER				901 LIBBIE AVE RICHMOND, VA 23226			
(X4) ID PREFIX TAG				ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)				
F 880	 (iii) Standard and trant to be followed to prev (iv)When and how iscoresident; including bu (A) The type and durat depending upon the ininvolved, and (B) A requirement that least restrictive possilic circumstances. (v) The circumstances must prohibit employed disease or infected secontact with residents contact with residents contact will transmit th (vi)The hand hygiene by staff involved in dir §483.80(a)(4) A systemidentified under the factorrective actions take §483.80(e) Linens. Personnel must hand transport linens so as infection. §483.80(f) Annual reverties and the facility will conduct the factor of the factor	ent spread of infections; ent spread of infections; lation should be used for a t not limited to: ation of the isolation, infectious agent or organism t the isolation should be the ole for the resident under the s under which the facility ees with a communicable in lesions from direct is or their food, if direct he disease; and procedures to be followed rect resident contact. em for recording incidents acility's IPCP and the en by the facility. le, store, process, and to prevent the spread of riew. ct an annual review of its r program, as necessary. i is not met as evidenced ms, staff interview, resident ord review and facility as determined the facility a effective infection control B residents in the survey	F	880	F880 Infection Control and Prevention 1-Residents #4 is receiving medication a sanitary manner and Resident #95 at receiving care has the respiratory equipment stored appropriately. LPN # was re-educated on proper handwashi 2-All current residents with respiratory	s in re 2		

Facility ID: VA0392

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DA	NO. 0938-039 TE SURVEY MPLETED
		495391	B. WING		0	C 2/08/2023
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COL			
GLENBURNIE REHAB & NURSING CENTER			1901 LIBBIE AVE			
GLENBUR	INIE REHAD & NORSII	G CENTER	1	RICHMOND, VA 23226		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 880	Continued From pa	ge 208	F 880			
	The findings include			equipment and receiving me have the potential to be affect deficient practice with handw	ted by	
	wash or sanitize ha medications to the i	nds before administering resident.		staff during medication admir The Unit Manager or designer residents with respiratory equ	ee will audit uipment to	
	#5 was observed as room after administ	p.m., RN (registered nurse) s she came out of a resident's ering medications. RN #5 was	ensure that it is stored corre in use and that nursing staft proper handwashing proced		are using	
	medication cart, rer another pair of glov	#5 approached the noved the gloves, put on es, and prepared medications		administering medications 3-The ADON, or designee wi Licensed Nursing staff on pro	oper	
	medications to the the medications as	to R4. RN #5 delivered the resident, and the resident took instructed by RN #5. RN #5		handwashing during care and respiratory equipment when 4-The Unit Manager or desig	not in use. nee will	
		itize her hands after removing itting on new gloves just prior iedications.		conduct observations of Nurs medication administration to proper handwashing is provid ensure that respiratory equip	ensure that ded and	
	nurse) #2 was inter	.m., LPN (licensed practical viewed. When asked what a er administering medications		stored appropriately when no weekly x 8 weeks, then mont 5- Results of the audits will b	ot in use thly x2.	
	to one resident and medications to a ne	before administering other w resident, she stated: "The wash their hands or sanitize		to the QAPI Committee for re recommendation. The Administrator or Director	eview and	
	them with hand san	itizer." When asked why this 2 stated: "Infection control. To		 are responsible for implement plan of correction. 6- Date of completion 3/21/23 	ntation of the	
		a.m., ASM (administrative ne administrator, ASM #2, the				
	director of nursing,	and ASM #3, the regional ervices, were informed of				
	Control Policy, "Har	ity Infection Prevention and ndwashing Requirements," mployees will wash hands at				

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391	
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
495391		B. WING			C 02/08/2023			
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE			
GLENBU	RNIE REHAB & NURSING	CENTER			901 LIBBIE AVE RICHMOND, VA 23226			
(X4) ID PREFIX TAG	REFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE					(X5) COMPLETION DATE		
F 880	transmission and acq hygiene can consist of and water, or use of a rubThe following is require hand hygiene aprons." No further information 2. Resident #95's trac for nebulizer treatmer bedrail and uncovered Resident #95 was add 9/20/22 with diagnose limited to: trach (track The most recent MDS assessment, a quarte ARD (assessment ref coded the resident as the BIMS (brief intervi indicating the residen impaired. A review of the compr 10/22/22 documented risk for complications tracheostomy second INTERVENTIONS: A orderedObserve for respiratory complicati or respiratory blockag MD as indicated"	uisition of infectionsHand of handwashing with soap an alcohol based hand a list of some situations that After removing gloves or a was provided prior to exit. Theostomy collar mask, used of a was attached to the d 2/5/23 through 2/7/23. mitted to the facility on es that included but were not heostomy). (minimum data set) rty assessment, with an ference date) of 12/28/22, a scoring a 15 out of 15 on iew for mental status) score, t was not cognitively rehensive care plan dated i in part, "the resident is at	F	880				

Facility ID: VA0392

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		D HUMAN SERVICES MEDICAID SERVICES				FORM	D: 03/14/2023 MAPPROVED D. 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING _		(X3) DATE SURVEY COMPLETED			
		495391	B. WING		_		C 108/2023
NAME OF PF	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STA	ATE, ZIP CODE		
GLENBUR	NIE REHAB & NURSING	CENTER		901 LIBBIE AVE RICHMOND, VA 23226			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BI ICED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE
F 880 F 947 SS=E	when not in use, Resi hanging on the bedrai On 2/6/23 at 10:00 AM observed not in use, h uncovered. On 2/6/23 at 10:15 AM nurse) #1 was asked i room. When asked h should be cared for w stated, it should be co On 2/7/23 at 5:15 PM member) #1, the adm director of nursing, we findings. A review of the facility policy dated 11/1/19 r mask/collar over patie mask/collar in storage No further information Required In-Service T CFR(s): 483.95(g)(1)- §483.95(g)(1) Be suffic continuing competence be no less than 12 ho	ch collar is covered in a bag dent #95 stated, no, it is just il. M, the trach collar mask was hanging on the bed rail, and M, LPN (licensed practical to come to Resident #95's ow the trach collar mask hen not in use, LPN #1 overed. , ASM (administrative staff inistrator and ASM #2, the ere made aware of the 's "Respiratory Equipment" evealed, "Place trach ent's stoma/trach. Store e bag when not in use." was provided prior to exit. Training for Nurse Aides (4) in-service training for nurse st- icient to ensure the ee of nurse aides, but must urs per year.	F 880				3/21/23
		dementia management abuse prevention training.					

Facility ID: VA0392

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	MENT OF HEALTH AN S FOR MEDICARE & I	D HUMAN SERVICES			FOF	ED: 03/14/2023 RM APPROVED IO. 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING	(X3) DAT	E SURVEY IPLETED		
		495391	B. WING		0	C 2/08/2023
NAME OF P	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE		2,00,2020
			19	901 LIBBIE AVE		
GLENBUR	RNIE REHAB & NURSING	CENTER	R	ICHMOND, VA 23226		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 947	Continued From page	211	F 947			
	determined in nurse a and facility assessme address the special n determined by the face §483.95(g)(4) For nur to individuals with cog address the care of th This REQUIREMENT by: Based on staff intervir review it was determin failed to ensure CNAs assistants) received a of dementia and abus records reviewed (CN The findings include: On 02/07/2023 an em conducted for five CN evidence the annual r following CNAs: 1. CNA #1 - hire date dementia and abuse t and 01/01/2022. 2. CNA #6 - hire date abuse training betwee 01/01/2022. 3. CNA #9- hire date dementia and abuse t and 01/01/2022.	ility staff. se aides providing services gnitive impairments, also the cognitively impaired. is not met as evidenced we and employee record hed that the facility staff s (certified nursing innual retraining in the areas the for four of five CNA lAs #1, #6, #9, and #10). ployee record review was As. This review failed to equired training for the e 01/01/2020, no evidence of training between 01/01/2021 e 01/01/2020, no evidence of training between 01/01/2021 e 01/01/2020, no evidence of training between 01/01/2021 e 01/20/2020, no evidence of training between 01/01/2021		F947 Required in service trainin Nurse Aides 1-CNA staff have now been iden completion of their required train 2-All CNA staff have the potentia affected by this practice. An aud been completed on the required for CNAs to ensure the required has been completed. 3-The DON or designee will prov in-service education to the ADON on the monitoring of staff training ensure requirements are met. 4-An audit will be completed by to or designee monthly X 3 months ensure that required in-service e is completed. Any variances will corrected with additional training corrective action. 5- Results of the audits will be pr to the QAPI Committee for review recommendation. The Administrator or Director of I are responsible for implementation plan of correction. 6- Date of completion 3/21/23	tified for ing. I to be it has training training vide N and HR of to to ducation be and/or resented w and Nursing	

Event ID: V8T511

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	03/14/2023 APPROVED 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			SURVEY ETED
		495391	B. WING		_	C 02/0	8/2023
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	TATE, ZIP CODE		
GLENBUF	RNIE REHAB & NURSING	CENTER		1901 LIBBIE AVE RICHMOND, VA 23226			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		S PLAN OF CORRECTION		(X5)
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRE CROSS-REFERE	CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE
F 947	interview was conduct member) #10, human asked for the evidence training for the CNAs stated that they did no unable to locate them On 02/08/2023 at app (administrative staff n was made aware of th	proximately 4:10 p.m. an ted with OSM (other staff resource director. When we of dementia and abuse listed above OSM #10 bt have them and were h. proximately 10:30 a.m., ASM hember) #1, administrator,	F 9	47			

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