PRINTED: 07/11/2023 FORM APPROVED OMB NO. 0938-0391

	DF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495299	B. WING_		1	C 28/2023
	ROVIDER OR SUPPLIER TH ADAM CRUMP HEALT	H AND REHAB		STREET ADDRESS, CITY, STATE, ZIP CODE 3600 MOUNTAIN ROAD GLEN ALLEN, VA 23060		20,2020
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFII TAG	PROVIDER'S PLAN OF CORRECTION ((EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
	INITIAL COMMENTS An unannounced Me standard survey was through 6/28/2023. Compliance with 42 C Term Care Requirement investigated during the substantiated with desubstantiated for consisted of two currections (a) Notice Requirements (FR(s): 483.15(c)(3) Notice Before a facility transfersident, the facility must resident the reasons for the melanguage and manner facility must send a correpresentative of the Cong-Term Care Omb (ii) Record the reason discharge in the residuaccordance with paragant	dicare/Medicaid abbreviated conducted 6/27/2023 corrections are required for FR Part 483 Federal Long ents. Three complaints were esurvey (VA00058072-ficiency, VA00057340-ficiency, and VA00059047-ficiency). Dicertified bed facility was survey. The survey sample ent resident reviews and four in the survey sample ent resident reviews and four in the survey. The survey sample ent resident reviews and four in the survey is a survey. The survey sample ent resident reviews and four in the survey is a survey. The survey sample ent resident reviews and four in the survey is a survey. The survey sample ent resident reviews and four in the survey is a survey. The survey sample ent resident reviews and four in the survey is a survey. The survey sample ent resident reviews and four in the survey is a survey. The survey sample ent resident reviews and four in the survey is a survey. The survey sample ent resident reviews and four in the survey is a survey. The survey sample ent resident reviews and four in the survey is a survey. The survey sample ent resident reviews and four in the survey is a survey. The survey sample ent resident reviews and four in the survey is a survey. The survey sample ent resident reviews and four in the survey is a survey. The survey sample ent resident reviews and four in the survey is a survey. The survey sample ent resident reviews and four in the survey sample ent resident reviews and four in the survey sample ent resident reviews and four in the survey sample ent resident reviews and four in the survey sample ent resident reviews and four in the survey sample ent resident reviews and four in the survey sample ent resident reviews and four in the survey sample ent resident reviews and four in the survey sample ent resident reviews and four in the survey sample ent resident reviews and four in the survey sample ent resident reviews and four in the survey sample ent resident reviews and four in the survey sample ent resident reviews and four in the survey sample ent resident reviews and four i	TAG	CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	longer is oital	
AROBAGO	§483.15(c)(4) Timing (i) Except as specified (c)(8) of this section, t			TITLE	1	(X6) DATE

Any determs statement unding with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other saleggad as 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.

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			A BOILDIN		c
		495299	B. WING		06/28/2023
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
 ELIZABET	H ADAM CRUMP HEALT	H AND REHAB		3600 MOUNTAIN ROAD	
				GLEN ALLEN, VA 23060	
(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	
			-	1 The Administrator or	
F 623	Continued From page	. 1	F 62	9esignee will audit reside	nts
1 020		der this section must be	'0'	that have left the facility i	4MA
		least 30 days before the		and/or transferred to the	
	resident is transferred			hospital in the last 30 day	S
	 (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would 			^C ompleted to ensure	
				appropriate notification t	o the
13				resident, ombudsman and	d/or
				APS.	
		r paragraph (c)(1)(i)(D) of			
	this section; (C) The resident's health improves sufficiently to			3) The Administrator or	
		te transfer or discharge,		Designee provided re-edu	
	under paragraph (c)(1 (D) An immediate trar)(i)(B) of this section;		to the Social Services tear	n
		nt's urgent medical needs,		^r egarding notice requiren	nents
)(i)(A) of this section; or		to resident, ombudsman	and/or
	(E) A resident has not days.	resided in the facility for 30		ላPS on transfers to the ho	ospital
				and residents that leave A	MA.
		ts of the notice. The written ragraph (c)(3) of this section		4) =1 41	
	must include the follow			4) The Administrator or	
	(i) The reason for training			Designee will audit transf	
	(ii) The effective date (iii) The location to wh	of transfer or discharge; iich the resident is		weekly for 8 weeks to ens	
	transferred or dischar	ged;	*	there is evidence of notifi	
		resident's appeal rights,		to the Ombudsman, writt	
	and telephone number	ddress (mailing and email), r of the entity which		notification to the Reside	
	receives such request	s; and information on how		APS notification for reside	
	to obtain an appeal fo	rm and assistance in nd submitting the appeal		that leave AMA. Results v	
	hearing request;	and appar		presented to QAPI month	ly.
		s (mailing and email) and		Any noted trends will be	
	telephone number of t Long-Term Care Omb			corrected immediately.	
	•	residents with intellectual		5) Compliance Date: 7/27	/2023

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495299	B WING				C (28/2023
	ROVIDER OR SUPPLIER	TH AND REHAB		3	STREET ADDRESS, CITY, STATE, ZIP CODE 600 MOUNTAIN ROAD SLEN ALLEN, VA 23060		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC (DENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 623	and developmental di disabilities, the mailin telephone number of the protection and addevelopmental disabilic of the Development and Bill of Rights Act codified at 42 U.S.C. (vii) For nursing facilit disorder or related disemail address and tel agency responsible for advocacy of individual established under the for Mentally III Individual established under the erion under the information in the effecting the transfer of the witten notification one the comes available. §483.15(c)(8) Notice is the administrator of the written notification prictor the State Survey Act State Long-Term Care the facility, and the rewell as the plan for the relocation of the residual 483.70(i). This REQUIREMENT by: Based on clinical recand facility document that the facility staff facility document that the facility staff fac	sabilities or related g and email address and the agency responsible for vocacy of individuals with lities established under Part tal Disabilities Assistance of 2000 (Pub. L. 106-402, 15001 et seq.); and y residents with a mental sabilities, the mailing and ephone number of the or the protection and ls with a mental disorder Protection and Advocacy unals Act. Les to the notice. Les to the notice as soon the updated information In advance of facility closure closure, the individual who is the facility must provide or to the impending closure gency, the Office of the combudsman, residents of sident representatives, as transfer and adequate	F	623			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT	IPLE CONSTRUCTION		(X3) DATE COMF	SURVEY
		495299	B. WING				C
NAME OF P	ROVIDER OR SUPPLIER	435253	15.44.16	STREET ADDRESS, CITY, STATE, ZIP CODE		06/	28/2023
I WANTE OF T	NOVIDEN ON OUT FIEN			3600 MOUNTAIN ROAD			
ELIZABET	TH ADAM CRUMP HEALT	H AND REHAB		GLEN ALLEN, VA 23060			
(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 COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE		(X5) COMPLETION DATE
F 623	Ombudsman for two sample, Resident #1 The findings include: 1. For Resident #1 (Reprovide a written notice resident and the ombon 2/3/2023 where the return to the facility upon the facility	and #3. 1), the facility staff failed to be of discharge to the budsman for a hospitalization beywere not allowed to boon hospital discharge. itted to the facility on a lon 1/8/2023, and pital on 2/3/2023. For R1 documented in part, and and pital on 2/3/2023. For R1 documented in part, and pital on 2/3/2023. For R1 documented in part, and pital on 2/3/2023. For R1 documented in part, and pital on 2/3/2023. For R1 documented in part, and pital on 2/3/2023. For R1 documented in part, and pital on 2/3/2023. For R1 documented in part, and pital on 2/3/2023. For R1 documented in part, and and least the same of hospital), and and see the same of the same	F 6	523			
		ary dated 2/3/23-2/17/23 for spital) documented in part,					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495299	B WING				C 28/2023
	ROVIDER OR SUPPLIER	TH AND REHAB		STREET ADDRESS, CITY, STATE, ZIP COD 3600 MOUNTAIN ROAD GLEN ALLEN, VA 23060	E		
(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)	N SHOULD BE		(X5) COMPLETION DATE
F 623	- "(Name of hospital 10:08 AM EST: Form different from the orig reviewed chart. Upda via (patient navigatior facility) Health and re resident at facility. Or discharge plan is to re Confirmation from facility and the confirmation from facility. Or discharge plan is to re Confirmation from facility. Or discharge plan is to re Confirmation from facility. Or discharge plan is to re Confirmation from facility. It is a support of the confirmation from the orig reviewed chart. Dischiback to SNF/(Name of surgical intervention arequire insurance aut therapy/occupational for auth (authorization have been sent via (phealth." - "(Name of hospital 2:39 PM EST: Formadifferent from the orig orders today to SNF, (authorization). (Nam would accept patient they cannot accept be been in communication stating they can accept of administrator (Name of facility) SNF given 30 day notice of Christmas and she dipatient she said she his stay and never received former administrator and about her payme	case manager) - 02/06/2023 atting of this note might be inal. CM (case manager) ted clinicals have been sent in service) health to (Name of hab (SNF/LTC). Patient is note medically stable,	F 6				

CENTER	S FUR WEDICARE &	MEDICAID SERVICES				CIVID IV	7. 0330-0331
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
			B 14#NG			I	С
		495299	B. WING			06/	28/2023
	ROVIDER OR SUPPLIER TH ADAM CRUMP HEALT	TH AND REHAB		30	TREET ADDRESS, CITY, STATE, ZIP CODE 600 MOUNTAIN ROAD SLEN ALLEN, VA 23060		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAC		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 623	my supervisor to see from their admin (Nar Explain to patient she admin and we need to she has been there so used her Medicare da Medicaid since we do stated yes. Brought possible gave me copy of card Medicaid and sent to Explained we will hav Referral sent through services) for placemee - "(Name of hospital of 9:21 AM EST: Format different from the orig (skilled nursing facility patient back, now say documents from facility patient back placement. Requeste instrument) from (Naraugust, Will upload on plan SNF. 1150 (11:5 (Name of facility) to s (administrator) (Name again due to not prov Message left. Escalath hotline (phone number back." On 6/27/2023 at 12:4 to ASM (administrativ)	if he could get more info me of former administrator). It cannot go back there per to look else where. She said ince November, likely has ays. Asked if she had It not have it on file. She atient her purse and she It. Copy made of her public benefits to upload. It is upload. It is to upload. It is upload	F	623			
		provided to resident and					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A BUILD	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		495299	B. WING			1	C / 28/2023
	ROVIDER OR SUPPLIER TH ADAM CRUMP HEALT			STREET ADDRESS, CITY, STATE, ZIP 3600 MOUNTAIN ROAD GLEN ALLEN, VA 23060	CODE	1 00	20/2020
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		CTION SHOULD B THE APPROPRI		(X5) COMPLETION DATE
F 623	ombudsman, evidence discharge notices, ev for 2/4/2023 hospitaliz resident was not eligii On 6/27/2023 at 2:10 conducted with ASM: nursing. ASM #3 stat would break the nonso they had issued the notice by the former a social worker. ASM # appointment for dialysthe vascular physicial hospital so they had istated that R1 was act due to the 30 day discallowed to come back. On 6/27/2023 at 4:30 director of clinical ser have evidence of a bethe hospitalization on president of operation unable to find the 30 time but were still loothat they had contact they knew if the resid discharge but they discharge but they discharge notice wou was not eligible to ret. On 6/28/2023 at 9:12 conducted with OSM director of social servithey had started work of 2023 and were away for the social servithey had started work of 2023 and were away	the of any appeal to the idence of bed hold offered station and evidence that the ble to return to the facility. p.m., an interview was #3, assistant director of sted that R1 smoked and smoking policy at the facility em a 30 day discharge administrator and the former #3 stated that R1 went to an sis and had been advised by in the day before to go to the open sent afterwards. She dimitted to the hospital and charge notice she was not at to the facility. p.m., ASM #5, the regional vices stated that they did not ed hold notice provided for 2/3/2023. ASM #6, the vice is stated that they were day discharge notice at that king for it. ASM #6 stated ed the ombudsman to see if ent had appealed the dinot have anything about an see He stated that the 30 day lid be the evidence that R1	F	623			

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		495299	B. WING			C 06/28/2023	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 3600 MOUNTAIN ROAD GLEN ALLEN, VA 23060		06/28/2023	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		IOULD BE	(X5) COMPLETION DATE	
F 623	at the facility. OSM # social worker had ser facilities and had not for them but they did evidence that. OSM is dialysis and afterward room and was admitte administrator told their take her back into the if the resident did not the facility should have come back to the first. The facility policy, "Di undated, documented Discharges and Trans Medicare & Medicaid requirements for facility transfers in the follow Transfers while resident while the resident is some requires that the facility decided while the resident is some requires that the facility discharge to the reside representative and midischarge notice to a Ombudsman. B. Notic occur at the same timprovided to the reside representative, even the mergency transfer, some transfer notice to the occur as soon as practice to the oc	2 stated that the former at in paperwork to other secured an alternate facility and have documentation to \$2 stated that R1 went to the swent to the emergency and so the former and that they did not have to facility. OSM \$2 stated that have a notice of discharge the offered the resident to available bed. Scharge and Transfers and Transfers are still hospitalized is the notice ty-initiated discharges or ing circumstances: 1. The still hospitalized: A set to discharge the resident till hospitalized, CMS ty send a notice of the ent and resident the states of the offeres o	F	623			

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l	IPLE CONSTRUCTION			(3) DATE SURVEY COMPLETED	
		495299	B WING_			06/2	: !8/2023	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIF	CODE			
ELIZABE1	TH ADAM CRUMP HEALT	H AND REHAB		3600 MOUNTAIN ROAD GLEN ALLEN, VA 23060				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A) CROSS-REFERENCED TO DEFICIE	CTION SHOULD BI D THE APPROPRIA		(X5) COMPLETION DATE	
F 623	of transfer or discharge On 6/28/2023 at 12:2 administrator, ASM # nursing, ASM #3, the nursing, ASM #5, the services and ASM #6 operations were made No further information 2. For Resident #3 (F evidence notification Protective Services (AMA (against medical On the most recent for the significant change as (assessment reference resident scored 15 or interview for mental sersident was cognitive decisions. A "Notice of Involuntate dated 10/19/2022 doe constitutes notice that discharged from (bland 10/17/22. Your design responsible party or I will be provided a cop for Transfer or Discharge welfare and needs ca as documented by yor record. (Emergency for category). Evidence	2 p.m., ASM #1, the interim 2, the interim director of assistant director of regional director of clinical , the vice president of e aware of the concern. In was provided prior to exit. R3), the facility staff failed to of the ombudsman and Adult APS) when R3 left the facility I advice) on 2/10/2023. IDS (minimum data set), a sessment with an ARD the date) of 6/8/2023, the aut of 15 on the BIMS (brief tatatus), indicating the ely intact for making daily ary Transfer or Discharge" cumented in part, "This letter t you will be transferred or not in the following date:	F€	523			at Page 9 of 18	

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		495299	B. WING				C 28/2023
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, S 3600 MOUNTAIN ROAD GLEN ALLEN, VA 2306		1 00,	20,2020
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	(EACH CORRE	'S PLAN OF CORRECTION ECTIVE ACTION SHOULD E ENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 623	dated 2/10/2023 docu refusing to sign the for witnesses of the refusing to sign the refusing the refusing the refusion of the long term care protective services of 2/10/2023. On 6/28/2023 at 9:12 On 6/28/2023 at 9:12	Advice (AMA Form)" for R3 Imented the resident Imm with signatures of Sal by ASM #3, the assistant PN (licensed practical nurse) Inember. The AMA form Intermedical risks/benefits It ome by a member of the Identified derstand those Death, Risks to health, Intermedical risks/benefits It ome by a member of the Identified derstand those Death, Risks to health, Intermedical risks/benefits Intermedical risks/benefits Intermedical risks/benefits Intermedical risks/benefits Intermedical risks/benefits Intermedical risks Intermedical risks/benefits Intermedical ris	F	523			

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 07/11/2023 FORM APPROVED 391

CENTERS FOR MEDICARE 8	MEDICAID SERVICES		OMB NO. 0938-03
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING.	(X3) DATE SURVEY COMPLETED
			C
	495299	B. WING	06/28/2023
NAME OF PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD	E

3600 MOUNTAIN ROAD

ELIZABET	TH ADAM CRUMP HEALTH AND REHAB		3600 MOUNTAIN ROAD GLEN ALLEN, VA 23060			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC (DENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE		
F 623	Continued From page 11 belongings were still at that hotel. She stated that she was not sure what the police did because she had left the facility at that point. She stated that the former administrator stated that they would notify APS and the ombudsman that day and they did not know if there was evidence of that or not. She stated that APS would typically send them a letter acknowledging the notification and it would be scanned into the medical record. On 6/28/2023 at 11:04 a.m., a follow up interview was conducted with ASM #3, the assistant director of nursing. ASM #3 stated that they believed the AMA form refusal for R3 dated 2/10/2023 was witnessed in his room prior to him leaving for the appointment. ASM #3 stated that they had notified R3 that he could go to (Name of other facility) and he refused, started packing his belongings and stated that he was leaving the facility so they presented the AMA form and he refused to sign it. She stated when she went back to check on R3 he stated he was no longer going to leave the facility. She stated that R3 left with a CNA on 2/10/2023 with transportation and she and the unit manager had gone to pick up the CNA because she was scared where he took her. She stated that R3 had become upset with them and sped off in the motorized wheelchair when they tried to talk to him and bring him back to the facility. She stated that R3 then got the transport service to bring him back to the facility and was told by the former administrator that he could not come back in. She stated that R3 told the police that he did not receive a 30 day discharge notice and they had provided it to the police for	F 623	DEFICIENCY)			
	reference. She stated that R3 had used someone's phone to get transport and was still outside of the facility when she left.					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL	TPLE CONST	TRUCTION	(X3) DATE SURVEY COMPLETED	
		495299	B WING			1	C 28/2023
	ROVIDER OR SUPPLIER	TH AND REHAB		3600 MC	ADDRESS, CITY, STATE, ZIP CODE DUNTAIN ROAD ALLEN, VA 23060		
(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 623	On 6/28/2023 at 11:11 conducted with LPN (LPN #2 stated that or to go to (Name of othe to one due to overdos when going out of the agreed to have some facility to appointment appointments and traistated that she understated that the CNA was to be the facility without an made an appointment downtown (Name of owent out with the CNA CNA called for them to city) because she did deferred from his app she and the assistant pick the CNA up and when they were in (Naup. She stated that R form and then came to stated that when R3 of former administrator stated that facility and talked to he because he had initial that they had restricte room. She stated that they just waited until he stated that the former and assistant director resident was left outsil	5 a.m., an interview was licensed practical nurse) #2. in 2/10/2023 R3 had agreed er facility) and was on one sing on drugs he obtained facility. She stated that R3 one escort him out of the ts and was making insportation himself. She stood that R3 was advised be initiated if he went out of escort and that R3 had to with the dentist in city) on 2/10/2023 when they A. LPN #2 stated that the opick her up in (Name of not feel safe [the resident ointment]. She stated that director of nursing went to witnessed the AMA form ame of city) picking the CNA is refused to sign the AMA back to the facility later. She came back to the facility the restricted him from coming is had come in the door after red that the former	F	523			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		495299	B. WING		l .	28/2023
NAME OF PROVIDER OR SUPPLIER ELIZABETH ADAM CRUMP HEALTH AND REHAB			STREET ADDRESS, CITY, STATE, ZIP CODE 3600 MOUNTAIN ROAD GLEN ALLEN, VA 23060			
(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
	transportation to the hown pocket for the hodidn't ask for her monomodidn't ask for her monomodidn't ask for her monomodidn't ask for her monomodification and adult notification for the AV. The facility policy, "Discription of the facility policy, "Discription of the AV. The facility policy, "Discription of the facility transfer the facility transfer the resident goes on the facility transfer the facil	notel and she paid out of her tel and transportation and ley back. In was provided from facility ace of ombudsman protective services IA discharge on 2/10/2023. Is scharge and Transfers'' and in part, "2. If resident against medical advice afe discharge can be must sign the AMA form dications are to be supplied esident refuses to sign AMA are must witness the refusal. budsman, and APS must be " 2 p.m., ASM #1, the interim 2, the interim director of regional director of regional director of clinical, the vice president of aware of the concern. In was provided prior to exit. Dicy Before/Upon Trnsfr (2) bed-hold policy and return-before transfer. Before a ers a resident to a hospital or therapeutic leave, the provide written information to	F6		bed	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		495299	B. WING		06/2	28/2023	
	ROVIDER OR SUPPLIER	H AND REHAB		STREET ADDRESS, CITY, STATE, ZIP CODE 3600 MOUNTAIN ROAD GLEN ALLEN, VA 23060			
(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 APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 625	specifies- (i) The duration of the any, during which the return and resume restacility; (ii) The reserve bed pplan, under § 447.40 (iii) The nursing facility bed-hold periods, whith paragraph (e)(1) of the resident to return; and (iv) The information set of this section. §483.15(d)(2) Bed-houst the time of transfer of the hospitalization or therefacility must provide the tresident representative specifies the duration described in paragraph This REQUIREMENT by: Based on clinical rectand facility staff fanotice provided to the representative for one survey sample, Resident #1 (R1), provide a bed hold not transferred to the hose Resident #1 was discovered.	state bed-hold policy, if resident is permitted to sidence in the nursing ayment policy in the state of this chapter, if any; y's policies regarding ch must be consistent with its section, permitting a dispecified in paragraph (e)(1). Id notice upon transfer. At a resident for apeutic leave, a nursing of the resident and the rewritten notice which of the bed-hold policy of (d)(1) of this section. It is not met as evidenced ord review, staff interview review it was determined uiled to evidence bed hold resident and resident when pital on 2/3/2023. The facility staff failed to the facility staff failed to record documented R1 was	F 62	2) The Administrator or designee will audit hospital transfers in the last 30 day ensure bed hold notice was provided. 3) The Administrator or designee provided re-educe to the Social Service, Busin Office and Licensed nurses regarding the Transfer to Hospital policy related to evidence of bed holds. 4) The Administrator or Designee will audit transfer weekly for 8 weeks to ensure evidence of bed hold policy provided. Results will be presented to QAPI month Any noted trends will be corrected immediately. 5) Compliance Date: 7/27	cation ness s ers sure cy was		

	DF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	IPLE CONSTRUCTION IG		E SURVEY IPLETED C
		495299	B. WING		06	5/28/2023
	ROVIDER OR SUPPLIER	TH AND REHAB		STREET ADDRESS, CITY, STATE, ZIP CODE 3600 MOUNTAIN ROAD GLEN ALLEN, VA 23060		
(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)	IOULD BE	(X5) COMPLETION DATE
F 625	hospitalization on 2/3. The progress notes for - "2/4/2023 04:33 (4:3 from the hospital. Re Was informed resider gangrene." - "2/4/2023 00:01 (12 informed from previous went to dialysis earlie Started calling hospital Called (Name of hospital Galled (Name of hospital Galled (Name of hospital Hospital Galled (Name of ho	or R1 documented in part, 33 a.m.) No return call back called (Name of hospital). In the was being admitted for contained in the was being admitted for contained in the was being admitted for contained in the was shift report that resident in today and did not return also near dialysis center. Solitally, resident was not there solitally and was informed that the ER (emergency room), are having phone issues and a nurse to return my	F 6	225		

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' /	PLE CONSTRUCTION G	0	(X3) DATE SURVEY COMPLETED	
		495299	B WING_			06/2	28/2023
	ROVIDER OR SUPPLIER I'H ADAM CRUMP HEALT	H AND REHAB		STREET ADDRESS, CITY, STATE, ZIP CODE 3600 MOUNTAIN ROAD GLEN ALLEN, VA 23060			
(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 AI DEFICIENCY)	SHOULD BE	E	(X5) COMPLETION DATE
F 625	have been sent via (phealth." - "(Name of hospital 2:39 PM EST:(Nam would accept patient they cannot accept been in communicatic stating they can acce to administrator (Nam (Name of facility) SNI given 30 day notice of Christmas and she dipatient she said she histay and never receiv of former administrator and about her payme paid and they will not my supervisor to see from their admin (Nar Explain to patient she admin and we need to she has been there is used her Medicare da Medicaid since we distated yes. Brought pave me copy of card Medicaid and sent to Explained we will hav Referral sent through services) for placeme. On 6/27/2023 at 12:4 to ASM (administrativ regional director of cliof bed hold offered for hospitalization. On 6/27/2023 at 4:30	case manager) - 02/09/2023 e of facility) stated they until today. Was informed ack, even though they have on with us since day one pt back. Called and spoke ne of former administrator) at and he stated she was f discharge back before d not appeal. Spoke to had paid this months fee to ed any form. Asked (Name or) to fax copy/proof of form int, He stated she has not accept back. Spoke with if he could get more info ine of former administrator). Cannot go back there per o look else where. She said ince November, likely has as a sked if she had in not have it on file. She attent her purse and she i. Copy made of her public benefits to upload. e to find other placement. (patient navigation int." 1 p.m., a request was made e staff member) #5, the inical services, for evidence	F 6	25			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495299	B WING	-	06/:	28/ 2023
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
ELIZABET	H ADAM CRUMP HEALT	TH AND REHAB	3600 MOUNTAIN ROAD GLEN ALLEN, VA 23060			
	CHMMARYST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE
F 625	have evidence of a betthe hospitalization on On 6/28/2023 at 9:12 conducted with OSM director of social servithey had started work of 2023 and were awa a 30 day discharge mat the facility. OSM # social worker had ser facilities and had not for them but they did evidence that. OSM dialysis and afterward room and was admitt administrator told the take her back into the if the resident did not the facility should have come back to the first that she did not send thought that admission have been offered. On 6/28/2023 at 1:24 conducted with ASM nursing. ASM #2 star bed hold notices whe hospital but if a residifrom an outside apposocial services would on 6/28/2023 at 1:53 facility bed hold policic clarified the process social services was resident on the conducted with ASM for an outside apposocial services would on 6/28/2023 at 1:53 facility bed hold policic clarified the process social services was resident and the conducted with a services would on the conducted with a service of the conducted with a service	a.m., an interview was (other staff member) #2, the ices. OSM #2 stated that king at the facility in January are that R1 had been issued otice prior to them working #2 stated that the former it in paperwork to other secured an alternate facility not have documentation to #2 stated that R1 went to dis went to the emergency ed so the former in that they did not have to a facility. OSM #2 stated that have a notice of discharge we offered the resident to at available bed. She stated bed hold notices and she ons did that and it should 4 p.m., an interview was #2, the interim director of ted that nursing provided the on they sent a resident to the ent was sent to the hospital internet they would think that	F 6.	25		

STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495299	B WING		06/2	28/2023
	ROVIDER OR SUPPLIER H ADAM CRUMP HEALT		;	STREET ADDRESS, CITY, STATE, ZIP CODE 6600 MOUNTAIN ROAD GLEN ALLEN, VA 23060		
(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 APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 625	Policy" undated, docu facility is required by inform you of our bed transferred to a hospi leave, the following b Medicaid, If Medicaid state Medicaid prograbed for a limited time or on therapeutic leav will hold your bed for indicated below or un have the bed held, will hospitalization or their number of days indicated you to the first availal room if you wish to be require the services of the facility is able to cand you are eligible for services" On 6/28/2023 at 12:2 administrator, ASM # nursing, ASM #3, the nursing, ASM #5, the services and ASM #6.	rginia Notice of Bed Hold Imented in part, "Our state and federal law to hold policy. When you are tal or go on therapeutic ed hold policy takes effect: is paying for your care, the im may pay us to hold your while you are in the hospital re. In this state, Medicaid the number of days til you waive your right to nichever occurs first If your rapeutic leave exceeds the rated above, we will readmit tole bed in a semi-private re readmitted and: You brovided by the facility and otherwise meet your needs; or Medicaid nursing facility 2 p.m., ASM #1, the interim 2, the interim director of	F 625	1) Resident #1 no longer res in the facility.	ides	
F 626 SS=D	Permitting Residents CFR(s): 483,15(e)(1) §483.15(e)(1) Permit facility. A facility must establi	-	F 620	2) The Administrator or Designee will audit the last 3 days of hospital transfers to ensure they were permitted return to the facility.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A_BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	495299	B WING		1	C 28/2023
NAME OF PROVIDER OR SUPPLIER	453255		STREET ADDRESS, CITY, STATE, ZIP CODE	1 06/	28/2023
		;	3600 MOUNTAIN ROAD		
ELIZABETH ADAM CRUMP HEALT	H AND REHAB		GLEN ALLEN, VA 23060		
PREFIX (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 CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
following. (i) A resident, whose I leave exceeds the been State plan, returns to room if available or impressed and availability of a bed in resident- (A) Requires the service and (B) Is eligible for Mediservices or Medicaid nursing facility services (ii) If the facility that downwas transferred were turning to the facility facility, the facility facility, the facility facility, the facility facility facility, the facility facility according to the facility facility, the facility facility facility, the facility facility facility, the facility facility facility in the facility facility of paraged distinct part. When the returns is a composite § 483.5), the resident to an available bed in composite distinct paragree facility of a bed the theoretical the time of return, the option to return to availability of a bed the This REQUIREMENT by: Based on clinical recording facility document that the facility staff facility affered in the facility affered in	lized or placed on e policy must provide for the hospitalization or therapeutic d-hold period under the the facility to their previous neediately upon the first a semi-private room if the ices provided by the facility; icare skilled nursing facility es. etermines that a resident with an expectation of y, cannot return to the st comply with the graph (c) as they apply to dission to a composite the facility to which a resident e distinct part (as defined in must be permitted to return the particular location of the rt in which he or she resided not available in that location that location upon the first	F 626	3) The Administrator or Designee provided re-educate to Admission Director and Social Services on permitting residents to return to the facility. 4) The Administrator or Designee will audit transfers weekly for 8 weeks to ensure residents were permitted to return to facility. Results will presented to QAPI monthly. Any noted trends will be corrected immediately. 5) Compliance Date: 7/27/202	be	

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495299	B WING		1	28/2023
	ROVIDER OR SUPPLIER	TH AND REHAB		STREET ADDRESS, CITY, STATE, ZIP CODE 3600 MOUNTAIN ROAD GLEN ALLEN, VA 23060	•	
(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 E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 626	Continued From page	e 20	F 620	5		
	The findings include:					
	For Resident #1 (R1) allow them to return t hospitalization on 2/3					
	Resident #1 was adm 11/3/2022, readmitted on 2/3/2023.	nitted to the facility on d on 1/8/2023, and discharge				
		ocumented R1 being under the time of hospitalization on				
	- "2/4/2023 04:33 (4:3 from the hospital. Re Was informed resider gangrene." - "2/4/2023 00:01 (12 informed from previous went to dialysis earlied Started calling hospit Called (Name of hospitaled (Name of hospitaled)."	or R1 documented in part, 33 a.m.) No return call back scalled (Name of hospital). In the was being admitted for 2:01 a.m.) Note Text: Was us shift report that resident for today and did not return. als near dialysis center. In pital), resident was not there. In pital) and was informed that the ER (emergency room). There having phone issues and a nurse to return my				
	notice of discharge o to R1 for the 2/3/202: The encounter summ R1 from (Name of ho	iled to evidence a written r a bed hold notice provided 3 hospitalization. hary dated 2/3/23-2/17/23 for espital) documented in part, case manager) - 02/06/2023				

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I i i i i i i i i i i i i i i i i i i i		(X3) DATE SURVEY COMPLETED	
		405000			C	
		495299	B WING		06/28/2023	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
ELIZABET	H ADAM CRUMP HEALT	TH AND REHAB		3600 MOUNTAIN ROAD GLEN ALLEN, VA 23060		
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID.	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		
F 626	Continued From page	e 21	F 62	6		
. 525	' "	ils have been sent via				
		rvice) health to (Name of				
		hab (SNF/LTC). Patient is				
	resident at facility. Or	ice medically stable,				
	discharge plan is to re					
		cility that they will accept				
	back"	case manager) - 02/08/2023				
		(case manager) reviewed				
		s are to return back to SNF/				
	(Name of facility). No					
		ne. Per facility, they require				
	insurance authorization					
	therapy/occupational	therapy) ordered to submit				
	for auth (authorization	n). All other updated clinicals				
		patient navigation services)				
	health."	case manager) - 02/09/2023				
		nt with discharge orders				
		es insurance auth. (Name of				
		ould accept patient until				
		they cannot accept back,				
		e been in communication				
		stating they can accept				
		oke to administrator (Name				
		or) at (Name of facility) SNF				
		s given 30 day notice of e Christmas and she did not				
		tient she said she had paid				
		y and never received any				
		of former administrator) to				
	fax copy/proof of form	and about her payment.				
		t paid and they will not				
		with my supervisor to see if				
		o from their admin (Name of				
		Explain to patient she	1			
		per admin and we need to				
		said she has been there	1			
	since November, like	ly has used her Medicare				

	G WEDIGHID CERTICES				
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C		(X3) DATE SURVEY COMPLETED	
	19			С	
	495299	B. WING		06/28/2023	
NAME OF PROVIDER OR SUPPLIER			REET ADDRESS, CITY, STATE, ZIP CODE		
ELIZABETH ADAM CRUMP HE	ALTH AND REHAB		0 MOUNTAIN ROAD EN ALLEN, VA 23060		
	CONTRACTOR DESIGNATION		PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX (EACH DEFICIE	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	E COMPLETION	
have it on file. She purse and she gay of her Medicaid ar upload. Explained placement. Referr navigation service - "(Name of hospit 9:21 AM EST: For different from the conference from the conference with A administrator, he so dually certified befor 2/9/2023 documents. On 6/27/2023 at 1 to ASM (administration of discharge notice evidence of any and evidence of bed hospitalization and not eligible to return they had issued notice by the form.	had Medicaid since we do not stated yes. Brought patient her the me copy of card. Copy made and sent to public benefits to have will have to find other all sent through (patient s) for placement. " all case manager) - 02/10/2023 matting of this note might be original. Issues with SNF cility). Stated they would take saying they cannot. Requested will they showing she cannot ded patient Medicaid into did not have" 30 a.m., during entrance SM #1, the interim stated that the facility had 180 ds. Review of the facility census mented an active inpatient list of 2:41 p.m., a request was made ative staff member) #5, the ficlinical services, for evidence the sprovided to resident, opeal to the discharge notices, old offered for 2/4/2023 devidence that the resident was	F 626			

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
					С	
		495299	B. WING		06/28/2023	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
ELIZABET	H ADAM CRUMP HEALT	'H AND REHAB		GLEN ALLEN, VA 23060		
(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 APPROPRIA DEFICIENCY)		
F 626	appointment for dialys the vascular physician hospital so they had be stated that R1 was acdue to the 30 day disc allowed to come back that she thought that was working to find all smoking facility for R1 On 6/27/2023 at 4:30 director of clinical senhave evidence of a bethe hospitalization on president of operation unable to find the 30 ditime but were still lool that they had contact they knew if the residischarge but they diappeal in their recordischarge notice wou was not eligible to ret On 6/28/2023 at 9:12 conducted with OSM director of social servithey had started work of 2023 and were awa a 30 day discharge notice work of 2023 and were awa a 30 day discharge notice work of 2023 and were awa a 30 day discharge notice work of 2023 and were awa a 30 day discharge notice work of 2023 and were awa a 30 day discharge notice work of 2023 and were awa a 30 day discharge notice work of 2023 and were awa a 30 day discharge notice work of 2023 and were awa a 30 day discharge notice work of 2023 and was admitted administrator told their discharge notice work of 2023 and was admitted administrator told their	sis and had been advised by in the day before to go to the been sent afterwards. She dimitted to the hospital and charge notice she was not at to the facility. She stated the current social worker ternate placement in a prior to the hospitalization. p.m., ASM #5, the regional vices stated that they did not end hold notice provided for 2/3/2023. ASM #6, the vice has stated that they were day discharge notice at that king for it. ASM #6 stated and the ombudsman to see if ent had appealed the did not have anything about an see. He stated that the 30 day lid be the evidence that R1 urn to the facility. a.m., an interview was (other staff member) #2, the ices. OSM #2 stated that the former are that R1 had been issued office prior to them working 2 stated that the former are in paperwork to other secured an alternate facility not have documentation to the swent to the emergency	F 626			

STATEMENT OF DEFICIENCIES (AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495299	B WING _			C / 28/2023	
NAME OF PROVIDER OR SUPPLIER ELIZABETH ADAM CRUMP HEALTH AND REHAB			STREET ADDRESS, CITY, STATE, ZIP CODE 3600 MOUNTAIN ROAD GLEN ALLEN, VA 23060				
(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 DEFIGIENCY)	D BE	(X5) COMPLETION DATE	
F 626	if the resident did not the facility should have come back to the first. The facility policy, "Di undated, documented Discharges and Trans Medicare & Medicaid requirements for facility transfers in the follow Transfers while reside When a facility decide while the resident is a requires that the facilidischarge to the reside representative and midischarge notice to a Ombudsman. B. Notific occur at the same timprovided to the reside representative, even emergency transfer, stransfer notice to the occur as soon as prabelow" The policy in "Reasons for Dischart Documentation. The documentation. The documentation of the discharge. This docubefore, or as close as of transfer or discharge. On 6/28/2023 at 12:2 administrator, ASM #nursing, ASM #3, the nursing, ASM #5, the services and ASM #6	have a notice of discharge we offered the resident to available bed. ischarge and Transfers" d in part, "Facility-Initiated sfers, CMS (Centers for Services) clarifies the notice ity-initiated discharges or ing circumstances: 1. ent is still hospitalized: A. es to discharge the resident still hospitalized, CMS ity send a notice of lent and resident ust also send a copy of the representative of the ce to the Ombudsman must he the notice of discharge is ent and resident though, at the time of initial sending a copy of the Ombudsman only needed to circiable, as described further documented, rige and Required medical record must show basis for transfer or timentation must be made s possible to the actual time ge"	F 6	26			

STATEMENT (OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A, BUILDING		(X3) DATE SURVEY COMPLETED	
		495299	B. WING			
	ROVIDER OR SUPPLIER TH ADAM CRUMP HEALT		36	REET ADDRESS, CITY, STATE, ZIP CODE 500 MOUNTAIN ROAD LEN ALLEN, VA 23060	06/28/2023	
(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 BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		
F 626 F 656 SS=D	No further information Develop/Implement CCFR(s): 483.21(b)(1) §483.21(b) Comprehe §483.21(b)(1) The fact implement a comprehe care plan for each resident rights set for §483.10(c)(3), that incobjectives and timeframedical, nursing, and needs that are identificassessment. The condescribe the following (i) The services that a or maintain the reside physical, mental, and required under §483. (ii) Any services that under §483.24, §483 provided due to the runder §483.10, including factorial provide as a result or recommendations. If findings of the PASAI rationale in the reside (iv) In consultation wit resident's representa (A) The resident's prefuture discharge, Facwhether the resident's representa whether the resident's prefuture discharge, Facwhether the resident's	n was provided prior to exit. Comprehensive Care Plan (3) ensive Care Plans cility must develop and densive person-centered sident, consistent with the th at §483.10(c)(2) and cludes measurable ames to meet a resident's amental and psychosocial ded in the comprehensive densive care plan must are to be furnished to attain ant'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 ding the right to refuse 8.10(c)(6). ervices or specialized as the nursing facility will PASARR a facility disagrees with the RR, it must indicate its ant's medical record. the the resident and the tive(s)-	F 656	1) Residents #2 and #3 no longer reside in the facility. 2) The Director of Nursing of Designee will audit current Residents comprehensive caplans to ensure discharge goand planning were developed and are being implemented. 3) The Administrator or Designee provided re-educated to Social Services on develoand implementing care plane. 4) The Administrator or designee will audit new admissions weekly for 8 westo ensure comprehensive caplans are being developed a implemented for discharge goals and planning. Results be presented to QAPI mont Any noted trends will be corrected immediately. 5) Compliance Date: 7/27/2	are pals ed . ation ping ss. eks are and will hly.	

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		495299	B. WING		06/28/2023	
	ROVIDER OR SUPPLIER	TH AND REHAB		STREET ADDRESS, CITY, STATE, ZIP CODE 3600 MOUNTAIN ROAD GLEN ALLEN, VA 23060		
(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 F CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 656	local contact agencie entities, for this purpo (C) Discharge plans i plan, as appropriate, requirements set forti section. §483.21(b)(3) The se by the facility, as outl care plan, must-(iii) Be culturally-com This REQUIREMENT by: Based on responsiblinterview, clinical recidocument review it with facility staff failed to care plan for two of sample, Resident #2 The findings include: 1. For Resident #2 (develop the compredischarge goals and from the facility on 5/ On the most recent Minimal quarterly assessment reference date) of 4//9 out of 15 on the Blistatus), indicating the impaired for making assessment docume planning occurring and R2 not wanting the possibility of leaving live and receive services.	s and/or other appropriate use. In the comprehensive care in accordance with the in in paragraph (c) of this rivices provided or arranged ined by the comprehensive petent and trauma-informed. It is not met as evidenced be party interview, staff ord review and facility as determined that the develop the comprehensive ix residents in the survey and Resident #3. R2), the facility staff failed to be planning. R2 was discharged 18/2023. MDS (minimum data set), a twith an ARD (assessment 17/2023, the resident scored MS (brief interview for mental eresident was moderately	F 68			et Page 27 of 46

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495299	B WING		C 06/28/2023	
	ROVIDER OR SUPPLIER TH ADAM CRUMP HEALT			STREET ADDRESS, CITY, STATE, ZIP CODE 3600 MOUNTAIN ROAD GLEN ALLEN, VA 23060	, 00/	20/2023
(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 APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 656	participation. On 6/28/2023 at 3:45 conducted with R2's or R2 was discharged for resided with her. She guardian for medical (Name of non-profit or conservator for funds discharge from the fathat the facility did not to discharge other that to do a home assessing happened. She state up a discharge plannihad canceled it when and never discussed stated that she wanted to brifelt that she would be home. She stated that written prescriptions in discuss any care instituted for now but would postacility for more thera. The comprehensive cevidence documental preference and potent to return to the comm. The progress notes for "05/18/2023 12:10 (Resident was discharge) paperwork and docte.	p.m., an interview was guardian. She stated that om the facility and currently a stated that she was R2's care and decisions but rganization) was the . When asked about R2's cility, R2's guardian stated to discuss any planning prior and they were going to come ment which never do that one time they had set any meeting at the facility but she arrived at the facility anything afterwards. She all the former administrator ing R2 home because she able to get stronger at the facility only sent home with R2 and did not ructions with them prior to do that R2 was still at home sibly go into another rehability go into another rehability in the near future. The plan for R2 failed to did not ruction of the resident's tial for discharge or desire unity. The R2 documented in part, 12:10 p.m.) Note Text: 12:10 p.m.) Note Text: 13:10 god to home. Transported that the given to attendants.	F 656			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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		495299	B WING_		<u> </u>	28/2023	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 3600 MOUNTAIN ROAD			
ELIZABET	TH ADAM CRUMP HEALT	TH AND REHAB		GLEN ALLEN, VA 23060			
(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 CORRECTIC ((EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 656	medicines." - "05/17/2023 11:14 (Late Entry. Note Text Date of Service: May R2) (date of birth for I Evaluation for hospita Illness: Asked to see appropriateness of a has been preparing for report that DME (dura Company is requestir documentation indica bed along with other a patient has a history of along with depression for her to discharge h seen this morning res poor historian but app - "05/12/2023 15:15 (Late Entry. Note Text Date of Service: May R2) (date of birth for I History Of Present Illn for evaluation of disci is presently residing a history of dementia, v hypothyroidism, depr weakness. She is pla with family and home afternoon, sitting up i be a poor historian bu Staff was interviewed patient concerns As patient): 1) Hypothyro Synthroid. Will need of for management and Dementia - Ongoing, nursing and medicati	11:14 a.m.) Physician Note, : Provider Documentation 17, 2023. Patient: (Name of R2) CC (chief complaint): all bed. History of Present patient for evaluation for the hospital bed. This patient or discharge to home. Staff able medical equipment) in gror specific ting the needs for a hospital assistive equipment. This of dementia and debility in and dysphagia. The plan is some with family. She was sting in bed, noted to be a pears in no distress" 3:15 p.m.) Physician Note: Provider Documentation 12, 2023. Patient: (Name of R2) CC: Discharge planning. Theses: Asked to see patient harge planning. This patient at (Name of facility) with vitamin D deficiency,	F6	956			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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NAMEOED	ROVIDER OR SUPPLIER	170200		TREET ADDRESS, CITY, STATE, ZIP CODE	1 06/	2012023
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	CUMMA DV CT	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
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F 656	Continued From page	29	F 656			
	Patient is stable. To c	ontinue on current dose of				
	antidepressant and be	e monitored, she will need				
	continued outpatient f	•				
		Muscle weakness - Ongoing.				
		supportive and assistive				
		Skilled therapy/home health harge. Up with wheelchair				
	for mobility."	marge. Op with wheelondin				
	The physician orders	documented in part.				
	- "Home health: PT(pl					
	therapy)/OT(occupation	onal therapy)/Nursing				
	services to evaluate a	ind treat. Order Date:				
	05/15/2023."					
	Review of the clinical	record failed to evidence a				
	discharge care plan, o					
		scharge, documentation of				
	the intent to discharge					
	discharge planning ar post-discharge care.	nd arrangements for				
	post-discharge care.					
	On 6/28/2023 at 8:13	a.m., a request was made				
	to ASM (administrativ	e staff member) #1, the		14		
	interim administrator f	for evidence of R2's				
	discharge care plan.					
	On 6/28/2023 at 8:20	a.m., an interview was				
		egistered nurse) #1, MDS				
		tated that a paper care plan				
		mission for a baseline and				
	then when the admiss					
		ehensive care plan was				
	completed in the com					
	goals were normally a	N #1 stated that discharge				
		did not know if they put				
		RN #1 stated that they				
		er the resident was long				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A BUILDING			(X3) DATE SURVEY COMPLETED	
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NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	00/	
ELIZA DE 1	ELIZABETH ADAM CRUMP HEALTH AND REHAB			3600 MOUNTAIN ROAD		
ELIZABEI	H ADAW CROWP HEALS	H AND REHAB		GLEN ALLEN, VA 23060		
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F 656	term or short term in to term or short term in to On 6/28/2023 at 9:12 conducted with OSM services. OSM #2 stated termined if a reside short term and plans. She stated that when the facility in January asked what needed to discharged home. She stated that she was a for her. She stated the meetings twice a weet to make any changes not develop any care stated that the MDS shand initiated the care. On 6/28/2023 at 8:41 director of nursing procare plan for R2. ASI and stated that they or regarding discharge for the facility policy, "Diffundated, documented resident-initiated transport of intent to lear facility The medical documentation or evice of intent to lear facility The medical documentation or evice of intent to lear facility care plan, a discussions with the resident with the resident on with the resident or some plans and the state of the same plans and the same plans and the same plans are	a.m., an interview was #2, the director of social ated that on admission they ent was staying long term or to return to the community. she first started working at of 2023 R2's sister had be done to get them he stated that R2's sister dding a room onto the home hat they have care plan k and go over the care plan or updates but that she did plans or create them. She staff or the nurse created plans. a.m., ASM #2, the interim evided the comprehensive M #2 reviewed the care plan did not see anything or them. sischarge and Transfers" d in part, "1. A sfer or discharge means the riate, the resident ovided verbal or written we the long-term care record must contain dence of: A. The resident's ative's verbal or written we the facilityB. A and documented resident or, if appropriate, e, containing details of	F 65			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A, BUILDING			(X3) DATE SURVEY COMPLETED		
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		495299	B WING_			1	28/2023
NAME OF P	ROVIDER OR SUPPLIER			S.	TREET ADDRESS, CITY, STATE, ZIP CODE		
ELIZABET	H ADAM CRUMP HEALT	TH AND REHAB	- 1		600 MOUNTAIN ROAD		
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F 656	plan should contain the admission and desired be in alignment with the resident-initiated" On 6/28/2023 at 12:23 administrator, ASM #3, the nursing, ASM #3, the nursing, ASM #5, the services and ASM #6, operations were made. No further information. 2. For Resident #3 (Failed to develop the conclude discharge good discharged from the failed to develop the conclude discharge good discharged from the failed to develop the conclude discharge good discharged from the failed to develop the conclude discharge good discharged from the failed to develop the conclude discharge good discharged from the failed to develop the conclude discharge good discharged from the failed to develop the conclude discharged from the failed to develop the consideration of the good discharged from the failed to develop the consideration of the good discharged from the failed to develop the consideration of the good discharged from the failed to develop the consideration of the good failed from the failed to develop the consideration of the good failed from the failed failed from the failed fr	i. The comprehensive care he resident's goals for doutcomes, which should he discharge if it is 2 p.m., ASM #1, the interim 2, the interim director of assistant director of regional director of clinical, the vice president of e aware of the concern. In was provided prior to exit. R3), the facility staff failed to comprehensive care plan to als and planning. R3 was acility on 2/10/2023. IDS (minimum data set), a sessment with an ARD see date) of 6/8/2023, the stof 15 on the BIMS (brief tatus), indicating the ely intact for making daily is ment documented no uiring extensive assistance of the property of the prop	Fé	356			
	A "Notice of Involunta	ry Transfer or Discharge"					

NAME OF PROVIDER OR SUPPLIER ELIZABETH ADAM CRUMP HEALTH AND REHAB KA-IID PREPIX SUMMARY STATEMENT OF DEPICIENCES Solo MOUNTAIN ROAD GLEN ALLER, VA 20060 KA-IID PREPIX SUMMARY STATEMENT OF DEPICIENCES SOLO MOUNTAIN ROAD GLEN ALLER, VA 20060 KA-IID PREPIX TAGE TO A CONTROLL SUPPLIANCE FEB CANADA CONTROLL SECOND PRINT TAGE CANADA CONT		MENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION LAN OF CORRECTION IDENTIFICATION NUMBER: A, BUILDING		(X3) DATE SURVEY COMPLETED				
MANE OF PROVIDER OR SUPPLIER ELIZABETH ADAM CRUMP HEALTH AND REHAB (X4)ID PRIERTX SUMMARY STATEBURY OR SUPPLIER SUPPLIER SUMMARY STATE AND REHABILITY AND SUMMARY STATE AND SUPPLIES SUMMARY STATE AND					1		С	
BELIZABETH ADAM CRUMP HEALTH AND REHAB SIMMARY STATEMENT OF DEPOCIENCIES (RACH DEPOCIENCY NUST BE PRECEDED BY PULL TAG. F 658 Continued From page 32 dated 10/19/2022 documented in part, "This letter constitutes notice that you will be transferred or discharged from (Marik space) on the following date: 10/17/22. Your designated family member, responsible party or legal representative, (blank space), will be provided a copy of this Notice. A Reason for Transfer or Discharge. The reason for your transfer or discharge is indicated below: Your welfare and needs cannot be met in this facility, as documented by your physician in your clinical record. (Emergency hospitalization falls in this category). Evidence that this notice was provided to the long term care ombudsman was reviewed. The comprehensive care plan failed to evidence a discharge care plan, documentation of a 30 day notice given to the resident, discharge planning or evidence care planning to find alternate placement for R3. The clinical record failed to evidence documentation of attempts to find alternate placement for R3 or care planning related to discharge/transfer planning. On 6/28/2023 at 8:20 a.m., an interview was conducted with RN (registered nurse) #1, MDS coordinator, RN #1 stated that a paper care plan was completed on admission for a baseline and then when the admission assessment was completed in the computer building on the baseline care plan. RN #1 stated that discharge goals were normally addressed in the MDS			495299	B, WING _		06/	28/2023	
CENALER ADAM CRUMP HEALTH AND REHAB GLEN ALLEN, WA 23060	NAME OF P	ROVIDER OR SUPPLIER						
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F 656 Continued From page 32 dated 10/19/2022 documented in part, "This letter constitutes notice that you will be transferred or discharged from (dank space) on the following date: 10/17/22. Your designated family member, responsible party or legal representative, (blenk space), will be provided a copy of this Notice. A. Reason for Transfer or Discharge. The reason for your transfer or discharge is middled to evidence a discharge care plan failed to evidence a discharge care plan, documentation of a 30 day notice given to the resident, discharge planning or evidence care planning to find alternate placement for R3. The clinical record failed to evidence documentation of attempts to find alternate placement for R3 or care planning related to discharge/fransfer planning. On 6/28/2023 at 8:20 a.m., an interview was conducted with RN (registered nurse) #1, MDS coordinator, RN #1 stated that a paper care plan was completed the computer building on the baseline care plan, RN #1 stated that discharge goals were normally addressed in the MDS			TELEPIS OF DEFIDITIONS			N	(75)	
dated 10/19/2022 documented in part, "This letter constitutes notice that you will be transferred or discharged from (blank space) on the following date: 10/17/22. Your designated family member, responsible party or legal representative, (blank space), will be provided a copy of this Notice. A. Reason for Transfer or Discharge. The reason for your transfer or discharge is indicated below: Your welfare and needs cannot be met in this facility, as documented by your physician in your clinical record. (Emergency hospitalization falls in this category). Evidence that this notice was provided to the long term care ombudsman was reviewed. The comprehensive care plan failed to evidence a discharge care plan, documentation of a 30 day notice given to the resident, discharge planning or evidence care planning to find alternate placement for R3. The clinical record failed to evidence documentation of attempts to find alternate placement for R3 or care planning related to discharge/transfer planning. On 6/28/2023 at 8:20 a.m., an interview was conducted with RN (registered nurse) #1, MDS coordinator. RN #1 stated that a paper care plan was completed on admission for a baseline and then when the admission assessment was completed in the comprehensive care plan was completed in the computer building on the baseline care plan. RN #1 stated that discharge goals were normally addressed in the MDS	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	BE	COMPLETION	
them in the care plan. RN #1 stated that they discussed whether the resident was long term or short term in the care plan meetings.	F 656	dated 10/19/2022 doc constitutes notice that discharged from (blar date: 10/17/22. Your oresponsible party or lespace), will be provide Reason for Transfer or your transfer or disch Your welfare and nee facility, as documented clinical record. (Emerthis category). Evider provided to the long to reviewed. The comprehensive of discharge care planning placement for R3. The clinical record fait documentation of atterplacement for R3 or of discharge/transfer plate. On 6/28/2023 at 8:20 conducted with RN (recoordinator, RN #1 s was completed on ad then when the admission completed in the your assessment but they them in the care plandiscussed whether the	cumented in part, "This letter t you will be transferred or nk space) on the following designated family member, egal representative, (blank ed a copy of this Notice. A. or Discharge. The reason for arge is indicated below: ds cannot be met in this ed by your physician in your gency hospitalization falls in nce that this notice was erm care ombudsman was care plan failed to evidence a documentation of a 30 day sident, discharge planning or ng to find alternate empts to find alternate care planning related to anning. a.m., an interview was egistered nurse) #1, MDS tated that a paper care plan emission for a baseline and sion assessment was ehensive care plan was eputer building on the RN #1 stated that discharge addressed in the MDS did not know if they put . RN #1 stated that they e resident was long term or	F 6	56			

STATEMENT OF DEFIC AND PLAN OF CORREC		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495299	B, WING		C 06/28/2023	
NAME OF PROVIDER		TH AND REHAB	3	STREET ADDRESS, CITY, STATE, ZIP CODE 1600 MOUNTAIN ROAD GLEN ALLEN, VA 23060		
(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 B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		
On 6/conduservice meeting to man anot destated care produced facility that we care produced f	acted with OSM #2 strings twice a weeke any changes welop any care of that the MDS solans. She state ischarge notice y and they had by yould accept the 28/2023 at 8:41 or of nursing prolan for R3. AS tated that they oding discharge of the discharge of the extension were made actions were made action them to position of factors lettions of factors lettions of factors lettion of factors lettion of factors lettion of factors lettions were made action them to position of factors lettions were settion of factors lettions are part of the extension of factors lettions are part of the extension of factors lettion them to position of factors lettions are part of the extension of factors lettions are part of the extension of factors lettion them to position of factors letting the extension of f	a.m., an interview was #2, the director of social ated that they have care plan so or updates but that she did plans or create them. She staff or the nurse initiated the ed that R3 was issued the 30 prior to them working at the cried to find another facility em. a.m., ASM #2, the interim ovided the comprehensive M #2 reviewed the care plan did not see anything or transfer planning for them. 22 p.m., ASM #1, the interim easistant director of expression and director of expression and director of expression and director of the ware of the concern. In was provided prior to exit. Process	F 660	1) Resident #2 no longer res	to tive	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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F 660	rights set forth at 483 (i) Ensure that the dis resident are identified development of a dis resident. (ii) Include regular re identify changes that discharge plan. The updated, as needed, (iii) Involve the interd by §483.21 (b) (2) (ii), developing the disch (iv) Consider caregiv and the resident's or person(s) capacity a required care, as partischarge needs. (v) Involve the residerepresentative in the discharge plan and in resident representative (vi) Address the resident representative in the discharge plan and in resident representative in the discharge turning to (A) If the resident incompression to calcon appropriate entities in (B) Facilities must up comprehensive care appropriate, in responsable propriate entities. (C) If discharge to the	sistent with the discharge 5.15(b) as applicable and- scharge needs of each d and result in the charge plan for each -evaluation of residents to require modification of the discharge plan must be to reflect these changes. isciplinary team, as defined in the ongoing process of arge plan. er/support person availability caregiver's/support and capability to perform to of the identification of ent and resident development of the inform the resident and ve of the final plan. dent's goals of care and es. I resident has been asked in receiving information to the community. dicates an interest in returning the facility must document any tact agencies or other made for this purpose. Total and discharge plan, as the plan and discharge plan and all contact agencies or other	F 66	3) The Administrator or Designee provided re-educati to Social Services on developi and implementing effective interdisciplinary discharge planning. 4) The Administrator or Designee will audit upcoming discharges weekly for 8 week to ensure an effective interdisciplinary discharge pl was developed and implemented. Results will be presented to QAPI monthly. Any noted trends will be corrected immediately. 5) Compliance Date: 7/27/20	ng	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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NAME OF P	ROVIDER OR SUPPLIER			FREET ADDRESS, CITY, STATE, ZIP CODE		
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(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		
F 660	made the determinati (viii) For residents wh SNF or who are disch LTCH, assist resident representatives in sel provider by using data limited to SNF, HHA, patient assessment d measures, and data of the data is available. the post-acute care si assessment data, data data on resource use the resident's goals o preferences, (ix) Document, compl on the resident's need record, the evaluation needs and discharge evaluation must be di resident's representati information must be in discharge plan to faci to avoid unnecessary discharge or transfer. This REQUIREMENT by: Based on responsible interview, clinical reco document review it we facility staff failed to effective discharge pl the survey sample, R The findings include: For Resident #2 (R2) evidence ongoing inte	on and why. o are transferred to another larged to a HHA, IRF, or and their resident ecting a post-acute care a that includes, but is not IRF, or LTCH standardized ata, data on quality on resource use to the extent The facility must ensure that tandardized patient a on quality measures, and is relevant and applicable to f care and treatment ete on a timely basis based ds, and include in the clinical of the resident's discharge plan. The results of the scussed with the resident or tive. All relevant resident moorporated into the litate its implementation and delays in the residenced e party interview, staff or review and facility as determined that the levelop and implement an an for one of six residents in	F 660			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
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NAME OF P	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE		
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				GLEN ALLEN, VA 23060		
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F 660	considering their capa required care for a de accordance with the ridocumented in the plant of their guardian's how their guardian for medical (Name of non-profit of their guardian's how the possible of their guardian's how their guardian for medical (Name of non-profit of their guardian's how the possible of their guardian's how their guardia	ability to perform the spendent resident in resident's needs as an of care om the facility on 5/18/2023 me. IDS (minimum data set), a swith an ARD (assessment 7/2023, the resident scored MS (brief interview for mental resident was moderately daily decisions. Section G irring extensive assistance son for bed mobility, and toilet use and extensive person for walking and he assessment documented andent on two or more hormally using a wheelchair incontinent of bowel and ment further documented no ming occurring at the time of R2 not wanting to speak to seibility of leaving the facility and receive services in the essment documented R2 is sessment and no family or pating. Is p.m., an interview was guardian. She stated that on the facility and currently a stated that she was R2's care and decisions but	F 660			
	discharge from the fa	icility, R2's guardian stated				

		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUIT	IPLE CONSTRUCTION	(X3) DATE	SURVEY
	DEFICIENCIES CORRECTION	IDENTIFICATION NUMBER:	1 ' '	NG		PLETED
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				3600 MOUNTAIN ROAD		
ELIZABET	H ADAM CRUMP HEALT	TH AND REHAB		GLEN ALLEN, VA 23060		
(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)	DULD BE	(X5) COMPLETION DATE
F 660	to discharge other that to do a home assessi happened. She state up a discharge plann had canceled it when and never discussed stated that she had to that she wanted to briefly that she would be home. She stated this written prescriptions is discuss any care instituted discuss any care instituted access to R2's funds conservator so there getting the prescription services had assisted. She stated that there from not getting medifrustrating. She state therapy to come in an teaching them exercialso. R2's guardian supposed to set up a in personal care but that the home health did not have home he she never told the far personal aide and tol hour care. She state administrator had call they discharged R2 a send someone out to one ever showed up asked about the hom that they would not caway. She stated the	t discuss any planning prior an they were going to come ment which never do that one time they had set ing meeting at the facility but she arrived at the facility anything afterwards. She old the former administrator ing R2 home because she able to get stronger at at the facility only sent home with R2 and did not ructions with them prior to do that she did not have because she was not the was a 20 day delay in one filled and adult protective do them in getting them filled, were no adverse effects ications however it was do that the facility set up not they had been coming in sets and a nurse came in stated that the facility was home health aide to assist hey did not do it. She stated nurse came but said they ealth aides. She stated that coility that she already had a dot them that R2 needed 24	F	360		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495299	B. WING				C 28/2023
	ROVIDER OR SUPPLIER TH ADAM CRUMP HEALT			360	REET ADDRESS, CITY, STATE, ZIP CODE 00 MOUNTAIN ROAD LEN ALLEN, VA 23060	00/	28/2023
(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 B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 660	in part, - "I am incontinent of 04/11/2022! require more activity of daily 03/06/2023" - "Pressure ulcer actu. Assistance required it incontinence. Date In The care plan failed tof the resident's prefedischarge or desire to The progress notes for "05/18/2023 12:10 (Resident was dischard via (Name of transpole paperwork and docted DNR (do not resuscit Resident medicated with medicines." The progress notes for documentation of one discharge planning in discharge instructions R2's guardian. Review of the clinical discharge care plan, guardian regarding dithe intent to discharge interdisciplinary dischargements for posconsidering R2's guathe required care for accordance with the	py in the near future. care plan for R2 documented urine. Date Initiated: assistance with one or living. Date Initiated: all or at risk due to: n bed mobility, Bowel itiated: 04/11/2022" o evidence documentation erence and potential for or return to the community. or R2 documented in part, 12:10 p.m.) Note Text: red to home. Transported rtation service). All rs [sic] order and copy of ate) given to attendants. with am (morning) alled to evidence going interdisciplinary including R2's guardian, sor education provided to record failed to evidence a discussions with R2's ischarge, documentation of e, documentation of e, documentation of ischarge planning and st-discharge care rdian's capability to perform a dependent resident in	F	660			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT	IPLE CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
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		495299	B WING			06/:	28/2023
	ROVIDER OR SUPPLIER TH ADAM CRUMP HEALT	TH AND REHAB		STREET ADDRESS, CITY, STATE, ZIP CODE 3600 MOUNTAIN ROAD GLEN ALLEN, VA 23060			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFII TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD B		(X5) COMPLETION DATE
F 660	at discharge with edu On 6/27/2023 at 12:4 to ASM (administrativ regional director of cli discharge planning no resources set up prio of communication reg guardian and the con On 6/27/2023 at appr #2, the interim directo packet of documents Management Dischar R2 which contained R physician. The check The "Interdisciplinary documented a dischar documented in part," family requestDisch will require 24 (hour) documented, "Specia planned for discharge Other: Nsg (nursing) eval. (evaluation) & to required: N/A (not ap Physician Services w Under "Additional Co documented "Pt d/c (sister. Requires 24 (family 24 (hour) care provided, SW (socia (with) (Name of home (wheelchair) order (w medical equipment p dated 05/23 (5/23/20 documented a skilled	1 p.m., a request was made e staff member) #5, the inical services, for all otes, evidence of all outside r to discharge and evidence garding discharge with the servator. Toximately 3:00 p.m., ASM or of nursing provided a containing a "Care rge Planning Checklist" for R2's name and attending dist was blank and undated. Discharge Summary" for R2 targe date of 5/17/2023 and 'Reason for discharge: Per harge potential: Pt (patient) care" It further the treatments or procedures e: PT/ST (speech therapy) Hm (home) Hlth (health) ox (treatment). Drug therapy plicable)" The area for ras not signed or dated. mments/Concerns it discharge) hm (home) (with) thour) care & (services). Per & (services) will be I worker) has set up hm hlth the health agency) & w/c with) (Name of durable rovider)." A fax confirmation 23) at 10:20 a.m. I home health patient der for services, current	F	560			

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	FIPLE CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		495299	B WING_				28/2023
	ROVIDER OR SUPPLIER TH ADAM CRUMP HEALT	TH AND REHAB		STREET ADDRESS, CITY, STATE, ZIP CODE 3600 MOUNTAIN ROAD GLEN ALLEN, VA 23060			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		SHOULD BI		(X5) COMPLETION DATE
F 660	home health agency. order for home health Pt. d/c home (with) H (with) personal care personal care svs" of initialed by OSM (oth director of social serv for a standard wheeld and hospital bed date the durable medical eincluded in the documinstructions or educated on 6/28/2023 at 8:13 to ASM #1, the interir of the discharge care that the guardian rectant deducation regard. On 6/27/2023 at 3:05 conducted with LPN #1 stated that the discharge planning. On 6/27/2023 at 4:03 conducted with OSM manager. She stated have been set up with process and the facilitate guardian on that she did not think that with setting people up supposed to set thing was not sure what the knew R2 really needs	agnosis codes sent to the Review of the physicians in documented, "5/22/2023 m Hlth, PT/OT eval & tx svs (services)." The " oserved to be struck out was er staff member) #2, the ices. The physicians orders chair, wheelchair cushion ad 5/17/2023 addressed to equipment provider was also ments. No discharge ction were provided. a.m., a request was made in administrator for evidence plan for R2 and evidence evived discharge instructions ling the discharge. p.m., an interview was (licensed practical nurse) #1. ey were not involved in any or R2. LPN #1 stated that is normally involved with	F	660			

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
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		495299	B, WING			06/	28/2023
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CLIZADE	TIADAM ONOMI TIERE	TIAND RELING		GL	EN ALLEN, VA 23060		
(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 BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 660	On 6/28/2023 at 9:12 conducted with OSM services. OSM #2 sta started working at the R2's sister had asked get them discharged sister stated that she home for her. She st have a home evaluatic could not be done exitange and she was nipolicy or a therapy postaff went out to do the that when they get or evaluations they get the evaluation, physical therapy to evaluate a she added nursing if medication managem stated that if the hom provide the services that they (facility staff money and she said savailable. When ask dated 5/22/2023 with struck out and initiale health agency must he them they didn't proviso they scratched it onot set anything else made it seem like she asked about discharge summary asked stated that typical discharge summary asked services and she stated that typical discharge summary asked services and services and she did that they didn't proviso they scratched it on the set anything else made it seem like she asked about discharge summary asked services and serv	a.m., an interview was #2, the director of social ated that when she first facility in January of 2023 what needed to be done to home. She stated that R2's was adding a room onto the ated that they had wanted to on, but a home evaluation cept within a certain mileage of sure if it was a facility dicy. She stated that therapy as assessments. She stated ders for home health hem for the home health herapy and occupational and treat. She stated that she felt that they needed it, hent, and wound care. She he health agency could not hely let them know. She told her that she had 24 d not question it. She stated) told her that she had	F	660			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
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NAMEOED	ROVIDER OR SUPPLIER	495299	B. WING _	STREET ADDRESS, CITY, STATE, ZIP CODE	1 06/	28/2023
IVAIVIE OF F	ROVIDER OR SUPPLIER			3600 MOUNTAIN ROAD		
ELIZABE1	TH ADAM CRUMP HEALT	TH AND REHAB		GLEN ALLEN, VA 23060		
(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 660	record. She stated the conversations with accounty. She stated the had a safe discharge sister could take care. The facility policy, "Di Documentation" date part, "1. An initial excompleted upon admiplanning record will be days after admission. Be reviewed after sixt according to the level discharge, a discharge instructions are provideresident's care giver in following: A. Current in potential; C. Summar Physician's orders for Pertinent social information for the facility policy another type of reside board-and-care home necessary, home visithat community service being provided accorde. Documentation of the will be made on the sand labeled "Post-Distribution," Distribution, and the resident-initiated transpection, if appropriate appropriate transpection, if appropriate in the control of the facility policy, "Dundated, documented resident-initiated transpection, if appropriate in the control of the facility policy, "Dundated, documented resident-initiated transpection, if appropriate in the control of the control of the facility policy, "Dundated, documented resident-initiated transpection, and the control of the facility policy, and the control of the facility policy, and the facility policy and the facility policy and the facility policy and the facility policy and the facility policy.	at she did not have any dult protective services in the hat she did not feel like she and did not feel like her of her. scharge Planning did 11/2020 documented in valuation of a resident is ission. 2. Discharge e completed within seven (7) 3. All discharge plans will by (60) to ninety (90) days, of care. 4. At the time of the summary and home-going ded to the resident or the which will include the diagnosis; B. Rehabilitation by of prior treatment; D. rimmediate care; E. mation; F. Community e.g., home health, mental e.g., etc.). 5. Within twenty-four on hours (or next day) after nother nursing facility or to certial facility such as a e.g., a follow-up phone call, or if the will be made to ascertain cest/referrals are indeed ding to the discharge plan. The after discharge contact ocial service progress note scharge Note.""	F6	560		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
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NAME OF P	ROVIDER OR SUPPLIER	435233	D. WING	STREET ADDRESS, CITY, STATE, ZIP CODE	06/28/2023	
		THAND DELLAD		3600 MOUNTAIN ROAD		
ELIZABET	H ADAM CRUMP HEALT	H AND REHAB		GLEN ALLEN, VA 23060		
(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 APPROPRIA DEFICIENCY)		
F 661 SS=D	documentation or evicor resident representation of intent to leave discharge care plan, a discussions with their his/her representative discharge planning and post-discharge planning and post-discharge care, iplan should contain the admission and desire be in alignment with the resident-initiated" On 6/28/2023 at 12:2 administrator, ASM # nursing, ASM #3, the nursing, ASM #3, the nursing, ASM #5, the services and ASM #6 operations were made. No further information Discharge Summary CFR(s): 483.21(c)(2) General When the facility anticomust have a discharge but is not limited to, the findless/treatment or radiology, and consult (ii) A final summary of include items in paragethe time of the discharge to the discharge of the d	we the long-term care al record must contain dence of: A. The resident's ative's verbal or written we the facilityB. A and documented resident or, if appropriate, containing details of a darrangements for in the comprehensive care are resident's goals for doutcomes, which should the discharge if it is 2 p.m., ASM #1, the interim 22, the interim director of assistant director of regional director of clinical the vice president of a ware of the concern. In was provided prior to exit. (i)-(iv) In ge Summary that includes, the resident's stay that includes, the resident's stay that inited to, diagnoses, course of the repy, and pertinent lab,	F6		o te	

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBÉR:	(X2) MULTIPI A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			A BOILDING		С
		495299	B, WING		06/28/2023
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
ELIZABET	H ADAM CRUMP HEALT	H AND REHAB		3600 MOUNTAIN ROAD GLEN ALLEN, VA 23060	· ·
(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 APPROPRIA DEFICIENCY)	
F 661	medications (both preover-the-counter). (iv) A post-discharge developed with the parand, with the resident representative(s), which adjust to his or her nepost-discharge plan of the individual plans to that have been made care and any post-discharge and staff intention the facility staff failed discharge summary for survey sample, Resident #4 (R4) evidence a discharge recapitulation of the resummary of the residence in the discharge, reconciliate medications with the medications and a pothe discharge on 2/5/R4 was admitted to the discharged home on	all pre-discharge resident's post-discharge resident's post-discharge resident's post-discharge resident and plan of care that is articipation of the resident 's consent, the resident ich will assist the resident to rew living environment. The ff care must indicate where reside, any arrangements for the resident's follow up recharge medical and is not met as evidenced ord review, facility document riew, it was determined that to evidence a complete or one of six residents in the lent #4. In the facility staff failed to summary that included a resident's stay, a final rent's status at the time of ion of all pre-discharge resident's post discharge st discharge plan of care for 2023. The facility on 1/29/2023 and	F 66	3) The Administrator or Designee provided re-education to Social Services on completing discharge summary. 4) The Administrator or Designee will audit upcoming discharges weekly for 8 weeks to ensure discharge summary was completed. Results will be presented to QAPI monthly. Any noted trends will be corrected immediately. 5) Compliance Date: 7/27/2023	ng
	discharged home on	2/5/2023.			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` ′	TIPLE CONSTRUCTION	(2	X3) DATE	
		495299	B. WING			06/3	28/2023
NAME OF P	ROVIDER OR SUPPLIER	493233	Ī	STREET ADDRESS, CITY, STATE, ZIP CODE		00/2	20/2023
ELIZABE	TH ADAM CRUMP HEALT	TH AND REHAB		3600 MOUNTAIN ROAD GLEN ALLEN, VA 23060			
(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 CORR	HOULD BE	E	(X5) COMPLETION DATE
F 661	"2/5/2023 14:04 (2:04 transport) present to thome, res was admitt transfer/ discharge ar with resident and trans and verbal and denie Review of the clinical discharge summary to fithe resident's stay, resident's status at the reconciliation of all privity of the resident's stay, resident's status at the reconciliation of all privity of the resident's pound a post discharge discharge on 2/5/202 On 6/27/2023 at 12:4 to ASM (administrative regional director of clinicy of discharge instruction and the discharge surecapitulation of the reconsident of operation have any discharge of stated that R4 came is respite care before go received hospice sensitated that there should the record. On 6/28/2023 at apprivation of the record.	A p.m.) Note Text: (Name of transport res (resident) ted to facility for respite care, and personal items were sent asport staff. res was alert a pain." record failed to evidence a that included a recapitulation a final summary of the te time of discharge, re-discharge medications at discharge medications plan of care for the 3. A p.m., a request was made the staff member) #5, the inicial services for evidence ons provided to the resident mmary that included a resident's stay for the 3. In p.m., ASM #6, the vice ons stated that they did not discouments for R4. ASM #6 in for a short period on oning back home and vices at the facility. He all the a discharge summary the formulation of the provided the 2/5/2023 documented tioner admission review	F	561			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
		495299	B. WING _			28/2023
	ROVIDER OR SUPPLIER	TH AND REHAB		STREET ADDRESS, CITY, STATE, ZIP CODE 3600 MOUNTAIN ROAD GLEN ALLEN, VA 23060	•	
(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	(X5) COMPLETION DATE
F 661	contained hospice do information report, ho 1/9/2023-1/24/2023, a dated 1/24/2023, a Hospice group) Comprehensiv Care Update Report orders dated 1/24/202 notes documented Reof town during the reservance of the resident's stay 2/5/2023. The facility policy "Dis Documentation" date part, "At the time of summary and home-comprovided to the resident's discharged information, F. Comm (e.g., home health, metc.)" The facility policy "Int Summary" dated 11/2 resident's discharged interdisciplinary Disclesic] as part of the Metal Con 6/28/2023 at 12:2	e documents provided also cuments including a Patient spice notes dated a client medication report Aide Care Plan Report dated IDG (interdisciplinary re Assessment and Plan of dated 1/24/2023, hospice 23. ASM #2 stated that the 4's family member being out spite stay at the facility in the documents provided recipity discharge to the resident and the hat included a recapitulation for the facility discharge on scharge Planning discharge, a discharge going instructions are ent or the resident's neclude the following: A. Rehabilitation potential; C. atment; D. Physician's care; E. Pertinent social nunity referrals as needed tental health, adult day care, serdisciplinary Discharge 2020 documented in part, "All I from the facility will have an harge Summary competed	F 6	61		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495299	B WING			00/2022	
	ROVIDER OR SUPPLIER		S 36	TREET ADDRESS, CITY, STATE, ZIP CODE 600 MOUNTAIN ROAD GLEN ALLEN, VA 23060	1 06/	28/2023	
(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)		(X5) COMPLETION DATE	
F 661	services and ASM #6 operations were made		F 661				