PRINTED: 10/20/2023 FORM APPROVED OMB NO. 0938-0391

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION	(.	X3) DATE COMPI	
		495283	B. WING _			09/2	21/2023
	ROVIDER OR SUPPLIER	TATION		STREET ADDRESS, CITY, STATE, ZIP CODE 1719 BELLEVUE AVENUE RICHMOND, VA 23227			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	E	(X5) COMPLETION DATE
E 000	Initial Comments		E 0	00			
F 000	survey was conducte 9/21/2023. The facilir compliance with 42 C Requirement for Long emergency prepared investigated during the The census in this 12 106 at the time of the	ty was in substantial FR Part 483.73, g-Term Care Facilities. No ness complaints were le survey. 8 certified bed facility was survey. The survey sample nt resident reviews and five s.	FO	00			
	survey was conducte Significant corrections compliance with the f Federal Long Term C complaint was investi (VA00059236-substa The Life Safety Code The census in this 12 106 at the time of the	ollowing 42 CFR Part 483 are requirements. One gated during the survey ntiated with deficiency). survey/report will follow. 8 certified bed facility was survey. The survey sample nt resident reviews and five					
F 557 SS=D	Respect, Dignity/Right CFR(s): 483.10(e)(2) §483.10(e) Respect a The resident has a rigand dignity, including §483.10(e)(2) The rig possessions, including	and Dignity. ght to be treated with respect	F 5	57			11/3/23
ABORATORY		SUPPLIER REPRESENTATIVE'S SIGNATURE	1	TITLE			(X6) DATE

Electronically Signed 10/16/2023

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

PRINTED: 10/20/2023 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
		495283	B. WING			C 09/21/2023
NAME OF PI	ROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CODE	· ·	
				1719 BELLEVUE AVENUE		
ROSEDAL	E HEALTH & REHABILI	TATION		RICHMOND, VA 23227		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 557	Continued From page	e 1	F 55	57		
		alth and safety of other				
	This REQUIREMENT by:	is not met as evidenced				
	Based on staff interv	iew, facility document review		This plan of correction is resp	-	
		view, it was determined the		submitted and is an affirmation		
	one of 40 residents in	ensure residents dignity for		corrections to the areas cited I made and the facility is in com	•	
	Resident #120.	i tile survey sample,		participation requirements.	pliance with	
	The findings include:			Resident #120 has had thei catheter bag covered to ensur		
		d to ensure a resident's 120 as his urinary catheter		dignity.		
		overing during observations		2. An audit has been performe		
		M, 9/20/23 8:10 AM and		residents who have a urinary of		
	9/20/23 at 4:15 PM.			bag. Any residents found to no		
	Resident #120 was a	dmitted to the facility on		urinary catheter bag covered h corrected.	ias been	
		es that included but were not		corrected.		
	_	gn prostatic hypertrophy).		3. The Director of Nursing/Des reeducate CNAs, LPNs, and F		
		ine care plan dated 9/14/23,		importance of ensuring urinary		
	· ·	CUS: The resident has		bags are covered to maintain		
	Indwelling Catheter:	TOVENTIONS TO STATE		dignity. This education will incl		
	· ·	RVENTIONS: The resident tion catheter bag and tubing		be limited to, how to cover a u catheter bag and how to help		
	below	tion catheter bag and tubing		to keep their urinary catheter b		
		er and away from entrance		to Reep their unitary datheter t	ag covered.	
		ag to cover drainage bag		4. The Director of Nursing/Des	signee will	
	content.			perform an audit to ensure all	residents	
				who have urinary catheter bag	-	
		M, 9/20/23 8:10 AM and		privacy covering weekly for 4		
		Resident #120 was observed		then monthly for 2 months. Th		
		uncovered urinary drainage		of Nursing/Designee will identi		
		urine in it, was visible from		issues, patterns or trends and the Quality Assurance and Pe		
	doorway.			Improvement Committee at lea		
	On 9/20/23 at 8:10 A	M an interview was		guarterly.	331	

Facility ID: VA0154

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION IG	(X:	3) DATE SURVEY COMPLETED
		495283	B. WING _			C 09/21/2023
	ROVIDER OR SUPPLIER	TATION		STREET ADDRESS, CITY, STATE, ZIP CODE 1719 BELLEVUE AVENUE RICHMOND, VA 23227		00/21/2020
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 557		registered nurse) #2. When heter bag has no privacy ent's dignity being	F 5	5. The date of compliance is: 11/3	3/23	
	Asked if a resident's	(licensed practical nurse) #3. dignity is maintained if their rivacy covering, LPN #3				
	member) #1, the adn director of nursing ar	M, ASM (administrative staff ninistrator, ASM #2, the nd ASM #4, the regional is made aware of the findings.				
	"Each resident shall promotes and enhan well-being, level of sa feelings of self-worth Demeaning practices compromise dignity i expected to promote	s and standards of care that s prohibited. Staff are dignity and assist residents; the resident to keep urinary				
F 580 SS=E		n was provided prior to exit. njury/Decline/Room, etc.) 1)(i)-(iv)(15)	F 5	80		11/3/23
	consult with the resid consistent with his or representative(s) who (A) An accident invol	nediately inform the resident; lent's physician; and notify, her authority, the resident				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	PLE CONSTRUCTION G	COM	E SURVEY PLETED
		495283	B. WING _			C / 21/2023
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1719 BELLEVUE AVENUE RICHMOND, VA 23227	1 03	12 112023
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 580	mental, or psychosod deterioration in health status in either life-th clinical complications (C) A need to alter to a need to discontinue treatment due to adv commence a new for (D) A decision to tran resident from the fact §483.15(c)(1)(ii). (ii) When making not (14)(i) of this section all pertinent informati is available and proving physician. (iii) The facility must resident and the resident	n; age in the resident's physical, bial status (that is, a n, mental, or psychosocial reatening conditions or c); eatment significantly (that is, e an existing form of erse consequences, or to m of treatment); or isfer or discharge the dility as specified in diffication under paragraph (g) the facility must ensure that on specified in §483.15(c)(2) ded upon request to the dent representative, if any, a or roommate assignment 10(e)(6); or ent rights under Federal or ons as specified in paragraph derivative and periodically mailing and email) and	F 5	80		

AND DI AN OF CORRECTION INTERPRETATION NUMBERS		` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495283	B. WING		C 09/21/2023
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 09/21/2023
				1719 BELLEVUE AVENUE	
ROSEDAL	E HEALTH & REHABILIT	TATION		RICHMOND, VA 23227	
(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)	
F 580	Continued From page	e 4	F 580		
	under §483.15(c)(9). This REQUIREMENT by: Based on staff intervi	en its different locations is not met as evidenced iew, facility document review view, the facility staff failed		This plan of correction is respectfully submitted, and it is an affirmation that	
		of a significant change in		corrections to the areas cited have; be	<u>on</u>
		ed to alter treatment in a		made and the facility is in compliance	
		of 40 residents in the		participation requirements.	With
	survey sample, Resid			1. Residents #106 and #96 no longer	
	The findings include:			reside at the facility.	
		(R106), the facility staff sician of a pressure injuries		2. An audit has been performed on all residents who have a pressure injury to ensure timely notification to the physic was completed. A MAR to Cart audit h	ian
	documented R106 probilateral heel pressure Further review of R10 reveal the physician v	aluation dated 5/19/23 esented with unstageable e areas (injuries) (1). 16's clinical record failed to was notified of the pressure A physician note dated		been completed for all current medicat carts. Any physician notifications for resident pressure injuries and medicat not available have now been made and are documented.	ion
	patient has dark area	SKIN: (Name) indicated that on both heels. Wound care a and dry. No induration, ion"		3. The Director of Nursing/Designee w reeducate LPNs, and RNs on the importance of notifying the physician o significant change in condition and/or need to alter treatment in a timely	
	LPN #3 stated nurses	licensed practical nurse) #3. s should notify the physician orders when a resident is e injuries and when a		manner. This education will include, but not limited to notifying the physician of pressure injury in a timely manner and notifying the physician if 3 consecutive doses of a vital medication are not available.	а
	On 9/21/23 at 11:28 a conducted with OSM (R106's physical thera	•		4. The Director of Nursing/Designee w perform an audit on 25% of residents weekly for 4 weeks and then monthly f months to ensure timely notification of	or 2

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		495283	B. WING			C 09/21/2023	
	ROVIDER OR SUPPLIER LE HEALTH & REHABILI	TATION		STREET ADDRESS, CITY, STATE, ZIP CODE 1719 BELLEVUE AVENUE RICHMOND, VA 23227		33/21/2023	
(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 COR (EACH CORRECTIVE ACTION OF CROSS-REFERENCED TO THE ADDITIONAL DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 580	staff member) #1 (the (the director of nursin above concern. The facility policy title Prevention And Mana Observations of new a. Reported to the ph further evaluation and Reference: (1) "A pressure injury skin and underlying shony prominence or device. The injury ca open ulcer and may has a result of intense or pressure in combin Unstageable Pressur full-thickness skin an Full-thickness skin an extent of tissue dama be confirmed because eschar (dead tissue). obtained from the we https://cdn.ymaws.cogr/online_store/npiap 2. For Resident #96 (to notify the physician Nubeqa (1) was not a on multiple dates in A review of R96's clir physician's order date.	am., ASM (administrative administrator) and ASM #2 ag) were made aware of the ad, "Pressure Injury agement" documented, "3. pressure ulcer/injury will be: sysician/practitioner for ditreatment." This localized damage to the soft tissue usually over a related to a medical or other in present as intact skin or an one painful. The injury occurs and/or prolonged pressure nation with shear are Injury: Obscured ditissue loss. In the dissue loss in which the age within the ulcer cannot be it is obscured by slough or" This information was bisite: Im/npiap.com/resource/resm injury_stages.pdf (R96), the facility staff failed in when the medication available for administration	F 58	resident pressure injuries and medications that are not availated administration. The Director of Nursing/Designee will identify a patterns or trends and report to Quality Assurance and Perforn Improvement Committee at least quarterly. 5. The date of compliance is: 1	able for any issues, the nance ast		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIP	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495283	B. WING		C 09/21/2023
	ROVIDER OR SUPPLIER	TATION		STREET ADDRESS, CITY, STATE, ZIP CODE 1719 BELLEVUE AVENUE RICHMOND, VA 23227	03/2/1/2023
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROFIDERICIENCY)	D BE COMPLETION
F 580	2023 MAR (medication revealed the same plon 8/26/23 (a.m. and and p.m. doses), 8/20 (p.m. dose), 8/30/23 (a.m. dose), the the control of the Mark (p.m. dose), the control of the Mark (p.m. dose), and the control of the Control of the Mark (p.m. dose), and the control of the Mark (p.	cer. A review of R96's August on administration record) hysician's order for Nubeqa. If p.m. doses), 8/27/23 (a.m. 8/23 (p.m. dose), 8/29/23 (p.m. dose) and 8/31/23 code, "9=Other / See Nurse is dated 8/26/23 documented, in med arrive from pharmacy" of stock, resident made it of monitor" was documented in med arrive from pharmacy." If y from pharmacy." A nurse's add documented, "Medication on 8/24/23." A nurse's note ocumented, "Medication on 8/24/23." A nurse's note ocumented, "Medication on 8/24/23." A nurse's note ocumented, "Medication of y unavailable [sic]." A "30/23 had documented, "On it." A nurse's note dated inted, "Will administer when imacy." Further review of the August 2023 MAR failed to in that Nubeqa was on the above dates, and interview was (licensed practical nurse) #3. In a medication is not available and interview and interview are supposed to see what he recommends. In a medication is not available and this should be	F 58		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION G		E SURVEY IPLETED
		7 20.23	<u> </u>		С
	495283	B. WING _		09	9/21/2023
NAME OF PROVIDER OR SUPPLIER ROSEDALE HEALTH & REHABIL	LITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 1719 BELLEVUE AVENUE RICHMOND, VA 23227		
PREFIX (EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE- (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
staff member) #1 (the director of nursiabove concern. The facility pharmace Guidelines for Medication are with face medication are with the physician is not inotification and physician in the solution of the season of physician is not inotification and physician in the facility in the physician is not inotification and physician in the facility in the reasons for the planguage and mannafacility must send a representative of the Long-Term Care On (ii) Record the reason discharge in the resident in the facility in the resident in the facility must send a representative of the Long-Term Care On (ii) Record the reason discharge in the resident in the facility in the facility must send a representative of the Long-Term Care On (ii) Record the reason discharge in the resident in the facility in the f	o.m., ASM (administrative ne administrator) and ASM #2 ing) were made aware of the by policy titled, "General cation Administration" onsecutive doses, or in illity policy, of a vital neld, refused, or not available, fied. Nursing documents the sician response." Nubeqa) is used to treat state cancerDo not stop without talking to your nation was obtained from the gov/druginfo/meds/a619045.h as Before Transfer/Discharge b)-(6)(8) be before transfer. sfers or discharges a mustant and the resident's the transfer or discharge and move in writing and in a ter they understand. The copy of the notice to a coffice of the State	F 5			11/3/23

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING		' '	(X3) DATE SURVEY COMPLETED			
		495283	B. WING			C 09/21/2023
	ROVIDER OR SUPPLIER	ITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 1719 BELLEVUE AVENUE RICHMOND, VA 23227	<u> </u>	33/21/2023
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 623	paragraph (c)(5) of the \$483.15(c)(4) Timing (i) Except as specific (c)(8) of this section, discharge required to made by the facility resident is transferred (ii) Notice must be must be must be must be reduced this section; (B) The health of incident endangered under this section; (C) The resident's health of allow a more immediated under paragraph (c) (D) An immediate transferred by the residunder paragraph (c) (E) A resident has not days. §483.15(c)(5) Content notice specified in paragraph (c) (ii) The reason for the (iii) The location to water transferred or discharge (iv) A statement of the including the name, and telephone number receives such requestion.	tice the items described in his section. g of the notice. ed in paragraphs (c)(4)(ii) and the notice of transfer or under this section must be at least 30 days before the ed or discharged. hade as soon as practicable scharge when-ividuals in the facility would be paragraph (c)(1)(i)(C) of dividuals in the facility would be paragraph (c)(1)(i)(D) of ealth improves sufficiently to iate transfer or discharge, (1)(i)(B) of this section; ansfer or discharge is lent's urgent medical needs, (1)(i)(A) of this section; or of the notice. The written aragraph (c)(3) of this section owing: ansfer or discharge; e of transfer or discharge; which the resident is	F 62	23		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' ·	PLE CONSTRUCTION G	' '	TE SURVEY MPLETED
		495283	B. WING			C 09/21/2023
	ROVIDER OR SUPPLIER LE HEALTH & REHABIL	ITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 1719 BELLEVUE AVENUE RICHMOND, VA 23227		33/21/2020
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 623	hearing request; (v) The name, addrestelephone number of Long-Term Care Om (vi) For nursing facility and developmental disabilities, the mailitelephone number of the protection and adevelopmental disabilities, the mailitelephone number of the protection and adevelopmental disabilities of the Developmental disabilities and Bill of Rights Accodified at 42 U.S.C. (vii) For nursing facilities of the control of the mail address and the agency responsible advocacy of individual established under the for Mentally III Individual established under the for Mentally III Individual established under the formation in the effecting the transfer must update the recast practicable once becomes available. §483.15(c)(8) Notice In the case of facility the administrator of written notification protection to the State Survey of State Long-Term Cathe facility, and the recombination of the state plan for the state survey of the facility, and the recombination of the state survey of the facility, and the recombination of the state survey of the facility, and the recombination of the state survey of the facility, and the recombination of the state survey of the facility, and the recombination of the state survey of the facility, and the recombination of the state survey of the facility, and the recombination of the state survey of the facility, and the recombination of the state survey of the facility, and the recombination of the state survey of the facility and the recombination of the state survey of the facility and the recombination of the state survey of the facility and the recombination of the state survey of the facility and the recombination of the state survey of the facility and the recombination of the state survey of the facility and the recombination of the state survey of the state s	and submitting the appeal ass (mailing and email) and if the Office of the State abudsman; ity residents with intellectual disabilities or related ang and email address and if the agency responsible for dvocacy of individuals with bilities established under Part antal Disabilities Assistance at of 2000 (Pub. L. 106-402, . 15001 et seq.); and lity residents with a mental isabilities, the mailing and belephone number of the for the protection and als with a mental disorder als with a mental disorder are Protection and Advocacy duals Act.	F 62	23		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X2) MULTIPLE CONSTRUCTION (X3) MULTIPLE CONSTRUCTION (X4) BUILDING		COMPLETED		
	495283	B. WING		C 09/21/2023
	LITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 1719 BELLEVUE AVENUE RICHMOND, VA 23227	03/21/2023
(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD	O BE COMPLETION
483.70(I). This REQUIREMEN by: Based on staff interand facility document the facility staff faile written RP (responsion notification was provided from the hospital, Residents in the sunt to the hospital, Resident #11. The findings included for the findings included from	IT is not met as evidenced rview, clinical record review nt review, it was determined d to provide evidence that iible party) and ombudsman vided when three of 40 vey sample were transferred idents #49, Resident #33, and E: ailed to evidence provision of fication was provided to the tty) and ombudsman at the r Resident #49. Resident #49 he hospital on 7/19/23. Idmitted to the facility on is that included but were not congestive heart failure, tructive pulmonary disease) ry failure. Resident # It #49's eINTERACT fluce acute care transfer) form aled, "COPD, shortness of pital." Inducted on 9/20/23 at 2:30 sed practical nurse) #2. When is written notification to the RP PN #2 stated, "We call the rvices sends them something	F 62	This plan of correction is respectfully submitted and it is an affirmation that corrections to the areas cited have and the facility is in compliance participation requirements. 1. The facility has provided written notification for hospital transfer to the Responsible Parties and Ombudsman Residents #49, #33 and #11. 2. An audit has been performed on a residents who have been transferred the hospital in the last 30 days to enswritten notification has been provided the Responsible Parties and Ombudsman. Any residents found to not had written notification sent to the Responsible Parties and Ombudsman have been completed. 3. The Administrator/Designee will reeducate Social Services Director of importance of providing written notifito Responsible Parties and Ombuds when residents are transferred to the hospital. 4. The Administrator/Designee will perform an audit on all residents transferred to the hospital weekly for weeks and then monthly for 2 month ensure written notification has been provided to Responsible Parties and	t been e with e with e with e with e with e an for all l to sure d to have eir an en the cation man e e e 4 s to
An interview was co	onducted on 9/21/23 at 9:48			any
	ROVIDER OR SUPPLIER E HEALTH & REHABIL SUMMARY S (EACH DEFICIEN REGULATORY OF SUPPLIER OF SUPPLIER OF SUMMARY S (EACH DEFICIEN REGULATORY OF SUPPLIER OF SUPPLIER OF SUMMARY S (EACH DEFICIEN REGULATORY OF SUPPLIER OF SUMMARY S (EACH DEFICIEN REGULATORY OF SUMMARY S (EACH DEFICIEN REGULATORY OF SUMMARY S (EACH DEFICIEN REGULATORY OF SUMMARY S (II) This REQUIREMEN S (II) Based on staff interested in the sum to the facility staff faile written RP (responsion to the hospital, Resident #11. The findings included 1. The findings included 1. The facility staff for required written noting RP (responsible partime of discharge for was transferred to the summar of discharge for was transferred to the summar of discharge for was transferred to the Resident #49 was a 5/9/23 with diagnos limited to: diabetes, COPD (chronic obstand acute respirator) A review of Resider (interventions to reduced 7/19/23 reveals breath. Sent to hose saked who provides and ombudsman, Lifamily, but social send ombudsman, Lifa	A95283 ROVIDER OR SUPPLIER E HEALTH & REHABILITATION SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 10 483.70(I). This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review and facility document review, it was determined the facility staff failed to provide evidence that written RP (responsible party) and ombudsman notification was provided when three of 40 residents in the survey sample were transferred to the hospital, Residents #49, Resident #33, and	A BUILDING 495283 ROVIDER OR SUPPLIER E HEALTH & REHABILITATION SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 10 483.70(I). This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review and facility document review, it was determined the facility staff failed to provide evidence that written RP (responsible party) and ombudsman notification was provided when three of 40 residents in the survey sample were transferred to the hospital, Residents #49, Resident #33, and Resident #11. The findings include: 1. The facility staff failed to evidence provision of required written notification was provided to the RP (responsible party) and ombudsman at the time of discharge for Resident #49. Resident #49 was transferred to the hospital on 7/19/23. Resident #49 was admitted to the facility on 5/9/23 with diagnosis that included but were not limited to: diabetes, congestive heart failure, COPD (chronic obstructive pulmonary disease) and acute respiratory failure. Resident # A review of Resident #49's eINTERACT (interventions to reduce acute care transfer) form dated 7/19/23 revealed, "COPD, shortness of breath. Sent to hospital." An interview was conducted on 9/20/23 at 2:30 PM with LPN (licensed practical nurse) #2. When asked who provides written notification to the RP and ombudsman, LPN #2 stated, "We call the family, but social services sends them something I believe. They also contact the ombudsman."	ROWIDER OR SUPPLIER E HEALTH & REHABILITATION SUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECTIVE ACTION SHOULD) (EACH DEFICIENCY MIST BE PIECEDED BY FULL REGULATORY OR LSC IDENTIFYMG INFORMATION) Continued From page 10

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING			PLETED				
		495283	B. WING _				C 21/2023
	ROVIDER OR SUPPLIER	ITATION		17	REET ADDRESS, CITY, STATE, ZIP CODE 19 BELLEVUE AVENUE ICHMOND, VA 23227	1 03/	21/2023
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 623	Continued From page AM with OSM (other director of social ser- provides written RP of OSM #4 stated, "The every month is sent takes the list and reventhe original list. I mai give it to the residenthave not found a bladischarge form that I where and why they form are mailed out to On 9/21/23 at 1:20 F member) #1, the addr director of nursing at nurse consultant was A review of the facility or Discharge" policy transfers or discharge notify the resident ar representative(s) of the language and manne written notice will increason for transfer or date of transfer or dis which the resident is	staff member) #4, the vices. When asked who and ombudsman notification, a complete list of discharges to the ombudsman and she views it. I keep a binder of it it to the resident's house or trif they are responsible. I nk copy of the notice of can use. Date of transfer, were sent out and date of to the RP." PM, ASM (administrative staff ministrator, ASM #2, the and ASM #4, the regional is made aware of the findings. Ty's "Facility Initiated Transfer revealed "Before a facility will and the resident's the transfer or discharge and move in writing and in a cer they understand. The stude the following: The redischarge; The effective scharge; The location to transferred or discharged; it email), and telephone		623			
	requests; and inform appeal form and ass form and submitting The name, address telephone number of Long-Term Care Omfacility residents with	ation on how to obtain an istance in completing the the appeal hearing request; (mailing and email) and fithe Office of the State budsman; For nursing					

AND DLAN OF CORRECTION IDENTIFICATION NUMBER				2) MULTIPLE CONSTRUCTION BUILDING		(X3) DATE SURVEY COMPLETED	
		495283	B. WING	B WING		C 09/21/2023	
	ROVIDER OR SUPPLIER LE HEALTH & REHABILIT			S 1	TREET ADDRESS, CITY, STATE, ZIP CODE 719 BELLEVUE AVENUE RICHMOND, VA 23227	1 097	21/2023
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	Х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 623	number of the agency protection and advoce developmental disabilisend a copy of the notate of the Office of the State Ombudsman. The combudsman will be sis provided to the resire presentative. Copie transfers will be sent may be sent when provided to the residents on a month. No further information. 2. For Resident #33 (to provide evidence the transfer was provided responsible party, or ombudsman for a factory 7/29/2023. A review of R33's clin following progress nounded, and reside department) r/t (related (fracture)." - "8/2/2023 15:30 (3:3 to facility from Acute (treatment of right hip was performed to right intact, no bleeding" Further review of the reveal evidence that was provided to the reveal of the reveal evidence that was provided to the reveal evidence to the reveal evidence that was provided to the reveal evidence to the reveal evidence that was provided to the reveal evidence to the reveal evidence that was provided to the reveal evidence that wa	address and telephone responsible for the acy of individuals with lities and the facility will stice to a representative of a Long-Term Care topy of the notice to the tent at the same time notice dent and resident tes of notices for emergency to the ombudsman, but they to the ombudsman, but they acticable, such as in a list of ly basis. In was provided prior to R33), the facility staff failed that written notification of I to the resident and/or the long-term care ility-initiated transfer on	F	623			

STATEMENT OF DEFICIENCIES (X: AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		495283	B. WING _			C 09/21/2023	
	ROVIDER OR SUPPLIER	LITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 1719 BELLEVUE AVENUE RICHMOND, VA 23227		03/21/2023	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 623	request was made member) #1, the accomplete member and/or resplong-term care ombounded from the member of the memb	proximately 4:00 p.m., a to ASM (administrative staff Iministrator for evidence of of transfer provided to the consible party and the cudsman for the transfer on proximately 8:00 a.m., ASM did not have any evidence of of transfer provided to the consible party and the cudsman for the transfer on 23 p.m., an interview was N (licensed practical nurse) #2. the nursing staff did not notification of transfer to the consible party when they went extated that they notified the of the transfer and was not consible for ombudsman and the aphone call to the family was transferred to the hospital written notification of transfer. Thought that the social worker iffication of transfer and the ation of transfer.	F6	23			
		M (other staff member) #4, the rvices. OSM #4 stated that					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP	PLE CONSTRUCTION B	(X3) DATE SURVEY COMPLETED	
		495283	B. WING		09/21/20	123
	ROVIDER OR SUPPLIER LE HEALTH & REHABILI	TATION		STREET ADDRESS, CITY, STATE, ZIP CODE 1719 BELLEVUE AVENUE RICHMOND, VA 23227	1 03/21/20	20
(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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE COM	(X5) IPLETION DATE
F 623	followed was to send ombudsman by emai this since they started that they had been un from the former social they were sending the she had been unable transfer. She stated kept a binder with the discharge or transfer home addresses but an original of the notion that the facility used. On 9/21/2023 at apprecent that the facility used. On 9/21/2023 at apprecent that the facility used. No further information 3. For Resident #11 to provide evidence to transfer was provided responsible party for 6/11/2023 and 6/27/22. A review of R11's clin following progress note: "6/11/2023 08:50 (8 (emergency medical (patient) being transposition which hospital atm (a - "6/14/2023 17:58 (5 was admitted from Ac Seizures. Per Reside	facility and the process they a list of discharges to the land they had been doing dat the facility. She stated hable to find some notices il worker but it looked like the monthly. She stated that to find any written notices of that at their former job they copies of the notice of and mailed them to the they had been unable to find they had been unable to find they had been unable to find the they had been unable to find the regional nurse to aware of the concern. In was provided prior to exit. (R11), the facility staff failed that written notification of the to the resident and/or facility-initiated transfers on 1023. ical record revealed the tes: 50 a.m.) Note Text: EMS services) arrived on site, Pt to orted to hospital, unknown	F 62	23		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			COMPLETED		
		495283	B. WING			C 09/21/2023		
	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP CODE 1719 BELLEVUE AVENUE RICHMOND, VA 23227		09/2 1/2023		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE		
F 623	came to me stating in Nurse entered the rolleft side with full bod 8 mins. Resident not seizure with abnorm saturation) 88% on radded. Resident serfor full code status. (and family notified." - "7/4/2023 19:17 (7: was admitted from A seizures activity. Perwas admitted for Lor Further review of the reveal evidence that was provided to the party for the transfer. On 9/20/2023 at apprequest was made to member) #1, the admitten notification or resident and/or respon 6/11/2023 and 6/2000 or 9/20/2023 at 2:2000 conducted with LPN LPN #2 stated that the provide any written in resident or the response.	4:32 p.m.) At 11:10 nurse resident having a seizure. From and resident laying on any shaking. Activity lasted for the verbally responsive after the sall breathing. Sats (oxygen room air. Non-rebreather of the to ER (emergency room) name of provider), Hospice, 117 p.m.) Admit Info: (R11) recute hospital via Stretcher for resident/Family the patient regident and/or responsible on 6/11/2023 and 6/27/2023. Froximately 4:00 p.m., a proximately 8:00 a.m., ASM	F 6	23				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495283	B. WING				C 21/2023
	ROVIDER OR SUPPLIER	ration		1	TREET ADDRESS, CITY, STATE, ZIP CODE 719 BELLEVUE AVENUE RICHMOND, VA 23227		
(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 625 SS=D	conducted with LPN anursing staff made a when the resident was but did not send a wrishe stated that she the sent the written notifice. On 9/21/2023 at 9:48 conducted with OSM director of social servishe had been unable transfer. She stated to kept a binder with the discharge or transfer home addresses but an original of the notification that the facility used. On 9/21/2023 at apprraising and ASM #4, consultant were made. No further information Notice of Bed Hold Pocential Certain Certain Certain Servision (1) with the same stated of the servision of the ser	a.m., an interview was 3. LPN #3 stated that the phone call to the family s transferred to the hospital itten notification of transfer. hought that the social worker cation of transfer. a.m., an interview was (other staff member) #4, the ices. OSM #4 stated that to find any written notices of that at their former job they copies of the notice of and mailed them to the they had been unable to find de of discharge or transfer a.m., an interview was (other staff member) #4, the ices. OSM #4 stated that to find any written notices of that at their former job they copies of the notice of and mailed them to the they had been unable to find the regional nurse to aware of the concern. a was provided prior to exit. bolicy Before/Upon Trnsfr (2) bed-hold policy and return- before transfer. Before a ters a resident to a hospital or therapeutic leave, the provide written information to		623			11/3/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MULI IDENTIFICATION NUMBER: A. BUILD		IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		495283	B. WING _		0	C 9/21/2023	
	ROVIDER OR SUPPLIER	ITATION		STREET ADDRESS, CITY, STATE, ZIP C 1719 BELLEVUE AVENUE RICHMOND, VA 23227			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 625	any, during which the return and resume refacility; (ii) The reserve bed plan, under § 447.40 (iii) The nursing facily bed-hold periods, with paragraph (e)(1) of the resident to return; and	pe state bed-hold policy, if e resident is permitted to esidence in the nursing payment policy in the state of of this chapter, if any; ity's policies regarding nich must be consistent with this section, permitting a	F6	525			
	§483.15(d)(2) Bed-h the time of transfer of hospitalization or the facility must provide resident representat specifies the duratio described in paragra This REQUIREMEN by: Based on staff inter and facility documer the facility staff failer hold notification was and/or responsible p 40 residents in the s transferred to the ho Resident #33, and F The findings include 1. For Resident #49 evidence provision of	erapeutic leave, a nursing to the resident and the ive written notice which nof the bed-hold policy aph (d)(1) of this section. T is not met as evidenced view, clinical record review at review, it was determined do to provide evidence that bed a provided to the resident earty (RP), when three out of curvey sample were spital; Residents #49, Resident #11.		This plan of correction is r submitted and it is an affirr corrections to the areas cit made and the facility is in coparticipation requirements. 1. Residents #49, #33 and returned to the facility from 2. An audit has been performent who are currently facility at the hospital to en information has been proving resident or resident representation of the provided to them or their resident	mation that ed have; been compliance with #11 have all the hospital. primed on all y out of the sure written ded to the entative about esidents found primation		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		I DENTIFICATION NUMBER:		PLE CONSTRUCTION	, ,	(X3) DATE SURVEY COMPLETED	
		495283	B. WING			C 09/21/2023	
NAME OF P	ROVIDER OR SUPPLIER	400200	<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CODE		9/21/2023	
NAME OF T	TOVIDER OR GOLF EIER			1719 BELLEVUE AVENUE	-		
ROSEDAL	E HEALTH & REHABILI	TATION					
				RICHMOND, VA 23227			
(X4) ID PREFIX TAG	(EACH DEFICIENC	FATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 625	Continued From page	e 18	F 62	25			
		uce acute care transfer) form ed, "COPD, shortness of		have been completed and doc	cumented.		
	breath. Sent to hosp	ital."		3. The Director of Nursing/Des reeducate LPNs and RNs on t	he		
		al record revealed there was		importance of providing writter			
		ten bed-hold notice was		information to the resident or r			
	•	ent and/or RP when Resident		representative about the bed-h			
	#49 was transferred	to the hospital on 7/19/23.		Administrator will provide educ			
	A it	ducted as 0/20/22 at 2:20		Social Servies Director on bed			
		nducted on 9/20/23 at 2:30		The education will include but			
		ed practical nurse) #2. When bed hold notification upon		to documenting that the bed-h notification was provided.	old		
		ed, there is a form they are		notification was provided.			
		d if there is a form they are		4. The Administrator/Designee	will		
		PN #2 stated, no, they do		perform an audit of all discharge			
	not keep a copy of th			residents weekly x 4 weeks ar	-		
	, ,,			monthly for 2 months to ensure			
	An interview was con	nducted on 9/21/23 at 9:48		or resident representatives ha			
	AM with OSM (other	staff member) #4, the		provided with written information	on about the		
	director of social serv	vices. When asked who		bed-hold policy. The			
	•	d notification, OSM #4		Administrator/Designee will ide			
		be blank copies of the form		issues, patterns or trends and	•		
		that are filled out with the		the Quality Assurance and Per			
	•	that is sent out with the		Improvement Committee at lea	ast		
		e family calls admission to		quarterly.			
		. OSM #4 they did not know		F. The data of compliance is:	11/2/22		
	if nursing keeps a co	py.		5. The date of compliance is:	11/3/23		
		M, ASM (administrative staff					
		ninistrator, ASM #2, the					
		nd ASM #4, the regional					
	nurse consultant was	s made aware of the findings.					
	A review of the facility						
	revealed "Prior to init						
	therapeutic leaves, re						
		be informed in writing of the					
		policy. Prior to a transfer, ill be given to the residents					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	PLE CONSTRUCTION G	COMPLETED		
		495283	B. WING		09/21/2023	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1719 BELLEVUE AVENUE RICHMOND, VA 23227	03/21/2023	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE COMPLETI	ON
F 625	detail: The rights an regarding bed-holds as indicated by the seresidents); The facilithold a bed (non-Medbed beyond the state residents); and The notice of transfer)." No further informations. For Resident #33 to provide evidence provided to the reside for a facility-initiated of a facility-initiated of a facility-initiated of the reside for a facility-initiated of the reside for a facility-initiated of the reside for a facility from Acute (fracture)." - "8/2/2023 15:30 (3:10 to facility from Acute treatment of right hip was performed to riginated, no bleeding Further review of the reveal evidence that provided to the reside for the transfer on 7/ On 9/20/2023 at apprequest was made to member) #1, the additional provided hold notice provided-hold notice provided-	resentatives that explains in ad limitations of the resident; reserve bed payment policy state plan (Medicaid ty per diem rate required to dicaid residents), or to hold a se bed-hold period (Medicaid details of the transfer (per the on was provided prior to exit. (R33), the facility staff failed that bed-hold notice was lent and/or responsible party transfer on 7/29/2023. Inical record revealed the otes: 7:52 a.m.) N.O. (new order) ident to ED (emergency ted to) r (right) femur fx 1:30 p.m.) Note Text: Readmit Care Hospital for repair and of fracture. Surgical procedure the party and " 2: clinical record failed to bed-hold notice was lent and/or responsible party	F 62	25		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION G	(X3	COMPLETED	
		495283	B. WING			C 09/21/2023	
	NAME OF PROVIDER OR SUPPLIER ROSEDALE HEALTH & REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 1719 BELLEVUE AVENUE RICHMOND, VA 23227	I	09/21/2023	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 625	#1 stated that they bed-hold notice progresponsible party for R33. On 9/20/2023 at 2: conducted with LPI LPN #2 stated that bed-hold notice with upon transfer and to the progress notes. On 9/21/2023 at 9: conducted with LPI nursing staff sent at resident at the time in the progress not. On 9/21/2023 at ap #1, the administration that the progress not. No further informat. 4. For Resident #1 to provide evidence provided to the resident at the resident #1.	oproximately 8:00 a.m., ASM did not have any evidence of ovided to the resident and/or or the transfer on 7/29/2023 for 23 p.m., an interview was N (licensed practical nurse) #2. the nursing staff sent a h the resident to the hospital hat it should be documented in 207 a.m., an interview was N #3. LPN #3 stated that the bed hold notice with the e of transfer and documented it	F 6				
	6/27/2023. A review of R11's of following progress - "6/11/2023 08:50 (emergency medical)	linical record revealed the					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495283	B. WING		C 09/21/2023		
	ROVIDER OR SUPPLIER	ITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 1719 BELLEVUE AVENUE RICHMOND, VA 23227	03/21/2020		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	D BE COMPLETION		
F 625	which hospital atm (- "6/14/2023 17:58 (was admitted from A Seizures. Per Resid admitted for: Seizure - "6/27/2023 16:32 (came to me stating of the side with full book mins. Resident not seizure with abnorm saturation) 88% on a sadded. Resident ser for full code status. (and family notified." - "7/4/2023 19:17 (7) was admitted from A seizures activity. Per was admitted for Low was admitted for Low Further review of the reveal evidence that provided to the reside for the transfer on 6, On 9/20/2023 at apprequest was made to the member) #1, the additional bed-hold notice was and/or responsible profile for the stated that they of the stated that the stated that the st	at this moment)." 5:58 p.m.) Admit Info: (R11) cute hospital via Stretcher for ent/Family the patient was es; Long Term Placement" 4:32 p.m.) At 11:10 nurse resident having a seizure. com and resident laying on ly shaking. Activity lasted for t verbally responsive after the al breathing. Sats (oxygen com air. Non-rebreather int to ER (emergency room) (Name of provider), Hospice, 1:17 p.m.) Admit Info: (R11) cute hospital via Stretcher for r Resident/Family the patient ing Term Placement" e clinical record failed to bed-hold notice was lent and/or responsible party 11/2023 and 6/27/2023. broximately 4:00 p.m., a c ASM (administrative staff ministrator for evidence that provided to the resident party for the transfer on 2023 for R11.	F 62	5			

` '		IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		495283	B. WING		C 09/21/2023	
	ROVIDER OR SUPPLIER	11 11		STREET ADDRESS, CITY, STATE, ZIP CODE 1719 BELLEVUE AVENUE RICHMOND, VA 23227	09/21/2023	
(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 E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		
F 625	On 9/20/2023 at 2:23 conducted with LPN (LPN #2 stated that the bed-hold notice with the upon transfer and that the progress notes. On 9/21/2023 at 9:07 conducted with LPN in nursing staff sent a bresident at the time of in the progress notes. On 9/21/2023 at appring the progress notes.	p.m., an interview was dicensed practical nurse) #2. The nursing staff sent at the resident to the hospital at it it should be documented in a.m., an interview was #3. LPN #3 stated that the ed hold notice with the firansfer and documented it a Toximately 1:40 p.m., ASM ASM #2, the director of the regional nurse aware of the concern. The was provided prior to exit. The is not met as evidenced as accurately reflect the accurately reflect the accurately reflect the accurate and facility was determined that the maintain a complete and num data set) assessment as in the survey sample,	F 6		with has to i3 tal	

	OF DEFICIENCIES CORRECTION	IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
			A. BUILDI	NG _		C		
		495283	B. WING				21/2023	
NAME OF P	ROVIDER OR SUPPLIER			S ⁻	TREET ADDRESS, CITY, STATE, ZIP CODE			
				17	719 BELLEVUE AVENUE			
ROSEDAL	E HEALTH & REHABIL	ITATION		R	CICHMOND, VA 23227			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)	
PRÉFIX TAG	,	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE	
F 641	Continued From pag	je 23	F	641				
		/IDS assessment for current			has been modified to reflect their use o	ıf		
	tobacco use.				oxygen.			
	On the most recent I	MDS assessment, an annual			2. An audit has been performed on all			
		ARD (assessment reference			current resident □s MDS assessments			
		he resident scored 15 out of			ensure residents current tobacco use,	ĺ		
	15 on the BIMS (brie	ef interview for mental status)			mental status and use of oxygen has			
		ng they were cognitively			been reflected correctly. Any resident□			
		ly decisions. Section J			assessment information found to have			
	documented no curre	ent tobacco use.			accurately reflected the resident□s sta	ius		
					has been modified.			
		6 p.m., an interview was						
	conducted with R62. R62 stated that they had smoked for years and had been smoking at the				3. The Regional Revenue Integrity			
		ion. R62 stated that the			Specialist/Designee will reeducate MD Coordinators and IDT team on the	5		
		igarettes and lighter in a box			importance of completing accurate			
		ing the smoking times.			assessments to reflect the resident s			
	liat they took at dan	ing the smoking times.			status. This education will include, but	not		
	The comprehensive	care plan for R62			be limited to, coding current tobacco us			
		"History of smoking and			assessing the mental status of resident			
	current smoker	, ,			and use of oxygen.	,		
	Date Initiated: 12/06	/2019. Revision on:						
	08/09/2023."				4. The Director of Nursing/Designee wi	II		
					perform an audit of 25% of resident			
		lent Safety Evaluation" for			assessments weekly x 4 weeks and the	en		
	R62 dated 2/9/2023	•			monthly for 2 months to ensure			
		n: 1. Does the resident use			assessments accurately reflect the			
		es. Does the facility allow			resident □s status. The Director of			
	Smoking? Yes. Tobal Cigarettes/Cigars"	cco products utilized:			Nursing/Designee will identify any issue	<i>‡</i> 5,		
	Olgarelles/Olgars				patterns or trends and report to the Quality Assurance and Performance			
	On 9/20/2023 at 2:34	4 p.m., an interview was			Improvement Committee at least	ĺ		
		registered nurse) #5, MDS			quarterly.	ĺ		
	,	stated that when completing			4			
		tion on the MDS assessment			5. The date of compliance is: 11/3/23	ĺ		
		are plan and clinical record to						
	· ·	noked. She reviewed R62's						
	care plan and stated	that there was a care plan						
	for smoking and stat	ed that she was not sure why						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			IPLE CONSTRUCTION	, ,	(X3) DATE SURVEY COMPLETED	
		495283	B. WING _			C 09/21/2023
NAME OF PROVIDER OR SUPPLIER ROSEDALE HEALTH & REHABILITATION				STREET ADDRESS, CITY, STATE, ZIP CODE 1719 BELLEVUE AVENUE RICHMOND, VA 23227		J972 172023
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES DY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF ((EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
it v Accins 20 as us loc or 7-c Or stadir nu co No 2. to (m Or as da He un Se int sta Th 8/2 or to Or or to	strument) Manual, 18, section J1300 sessment, "1. Ask ed tobacco in any ok-back period. 2. she used tobacco day look-back perion 9/20/2023 at 3:38 aff member) #1, the ector of nursing all rise consultant well nurse consultant well nurse. The further information of further information for Resident #33 assess the mental inimum data set) at the most recent I sessment with an ate) of 8/10/2023, For a sessment with an ate of 8/10/2023, For a sessment well assessment well assessm	(resident assessment Version 1.16, dated October documented in the steps for the resident if he or she form during the 7-day If the resident states that he in some form during the od, code 1, yes" 8 p.m., ASM (administrative administrator, ASM #2, the nd ASM #4, the regional re made aware of the made aware of the made aware of the status on the MDS assessment. MDS, a significant change ARD (assessment reference R33 was coded in Section B - d Vision as usually and being understood. In a Patterns, the resident ampleted. The resident and/or re blank.	F6			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	LE CONSTRUCTION G	COMPLETED	
		495283	B. WING		C 09/21/2023
	NAME OF PROVIDER OR SUPPLIER ROSEDALE HEALTH & REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 1719 BELLEVUE AVENUE RICHMOND, VA 23227	1 09/21/2023
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE COMPLETION
F 641	MDS was normally worker but they had social worker position that she interviewed to complete the ass She stated that if she assessment on the assessment was consignificant change at 8/10/2023 and state have been responsionable looked like it was not conducted with OSI director of social set they were responsible the MDS assessment was due, she typical and completed it with transferred it to the resident was able to the resident working at the facilith have been them conweck but it should have been them conw	stated that Section C of the completed by the social completed at times when the on was not filled. She stated at the resident and attempted essment on all residents. The was unable to complete the resident then the staff impleted. She reviewed R33's assessment with the ARD of each that the social worker would ble for completing it and that it of done. 18 a.m., an interview was will do the staff member) #4, the revices. OSM #4 stated that one for completing Section C of int. She stated that when it ally printed out a paper copy the the resident and then in MDS. She stated that if the complete one or the other should be sone. She reviewed R33's MDS with the ARD of each that they had started by that week and it may not impleting assessments that have been completed. 18 (resident assessment to documented in Coding Tips, in the interview with ALL or it will be conducted during the the Assessment Reference	F 64	1	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		495283	B. WING _			C 09/21/2023
	ROVIDER OR SUPPLIER	TATION		STREET ADDRESS, CITY, STATE, ZIP CODE 1719 BELLEVUE AVENUE RICHMOND, VA 23227	<u> </u>	03/21/2023
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 641	On 9/20/2023 at 3:38 staff member) #1, the director of nursing ar nurse consultant wer concern. No further information 3. For Resident #49, complete an accurate a quarterly assessment assessment, a quarter ARD (assessment recoded the resident ast the BIMS (brief intervindicating the resident indicating the resident indicating the resident indicating supervision and locomotion. A requiring supervision and locomotion. A reprocedures/treatment oxygen- No. A review of the comp 5/9/23, which revealed has altered respirator and COPD. INTERVINGS: Bi-pap at revening and night she revealed, "Bi-pap at revening and night she reconstruction of the physical revening and night she reconstructions are supplied to the physical revening and night she reconstructions."	akes Self Understood" B p.m., ASM (administrative end ASM #4, the regional ende aware of the end was provided prior to exit. The facility staff failed to end end MDS (minimum data set), ent for the use of oxygen. S (minimum data set) end assessment, with an end ference date) of 8/8/23, as scoring a 15 out of 15 on wiew for mental status) score, at was not cognitively end was not cognitively end	F 6	41		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495283	B. WING			C 21/2023	
	NAME OF PROVIDER OR SUPPLIER ROSEDALE HEALTH & REHABILITATION			17	TREET ADDRESS, CITY, STATE, ZIP CODE 719 BELLEVUE AVENUE ICHMOND, VA 23227	,	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 641	MDS coordinator. As #49's MDS Section Of for bi-pap, RN #5 statincorrectly, I will modi (resident assessment standard." On 9/21/23 at 1:20 PI member) #1, the adm director of nursing an nurse consultant was According to the RAI instrument) MDS Section therapy: "Code continuation administered via mas a resident to relieve hoxygen used in Bi-lev Pressure/Continuous (BiPAP/CPAP) here. If oxygen for wound the may be coded if the rehis/her own oxygen medians."	AM, an interview was egistered nurse) #5, the ked to review Resident dated 8/8/23 and the orders red, "Yes, this is coded fy this. We use the RAI instrument) as our M, ASM (administrative staff rinistrator, ASM #2, the dASM #4, the regional made aware of the findings. (resident assessment tion O: 0100C, Oxygen reducus or intermittent oxygen k, cannula, etc., delivered to repoxia in this item. Code rel Positive Airway Pressure Do not code hyperbaric rapy in this item. This item resident places or removes reask, cannula."	F	641			
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)- §483.21 Comprehens Planning §483.21(a) Baseline (§483.21(a)(1) The faci implement a baseline that includes the instr	sive Person-Centered Care	F	655			11/3/23

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		495283	B. WING		C 09/21/2023	
	ROVIDER OR SUPPLIER	ITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 1719 BELLEVUE AVENUE RICHMOND, VA 23227	03/2 1/2023	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROFIDERICIENCY)	D BE COMPLETION	
F 655	that meet profession The baseline care p (i) Be developed wit admission. (ii) Include the minin necessary to proper including, but not lin (A) Initial goals base (B) Physician orders (C) Dietary orders. (D) Therapy service (E) Social services. (F) PASARR recom §483.21(a)(2) The factomprehensive care care plan if the com (i) Is developed with admission. (ii) Meets the require (b) of this section (e) this section). §483.21(a)(3) The factomities are limited to: (i) The initial goals (ii) A summary of the dietary instructions. (iii) Any services are administered by the on behalf of the faci (iv) Any updated info of the comprehensiv This REQUIREMEN by: Based on resident if	anal standards of quality care. Ilan must- hin 48 hours of a resident's num healthcare information ly care for a resident hited to- ed on admission orders. S. mendation, if applicable. acility may develop a e plan in place of the baseline prehensive care plan- hin 48 hours of the resident's ements set forth in paragraph excepting paragraph (b)(2)(i) of facility must provide the presentative with a summary plan that includes but is not of the resident. he resident to be facility and personnel acting	F 68	This plan of correction is respectfull submitted, and it is an affirmation the		

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495283	495283 B. WING			09/21/2023		
NAME OF PI	ROVIDER OR SUPPLIER			STF	REET ADDRESS, CITY, STATE, ZIP CODE	1 03/	21/2020	
					9 BELLEVUE AVENUE			
ROSEDALE HEALTH & REHABILITATION					CHMOND, VA 23227			
(X4) ID PREFIX TAG			ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 655	Continued From page		F 6	655				
		nined the facility staff failed to			corrections to the areas cited have; be			
		ment a baseline care plan			made and the facility is in compliance v	vith		
	for three of 40 reside Residents #119, #120	nts in the survey sample, 0 and #96.			participation requirements.			
				1. Residents #119 and #96 are no long	er			
	1. For Resident #119				residing at the facility. Resident #120 I	nas		
	implement the baseli			had their urinary catheter bag covered				
	dialysis weights.			and a care plan has been developed for				
					the use of the anticoagulant medication	١,		
		dmitted to the facility on			Warfarin.			
		that included but were not			0.5			
		d stage renal disease) and			2. Rosedale has identified that all new			
	dialysis.				residents are at risk from this deficient			
	A ravious of the basel	ing care plan dated 0/0/22			practice. A process has been develope			
		ine care plan dated 9/9/23 The resident has ESRD and			and implemented to identify resident canneeds in the daily interdisciplinary team			
	receives Hemodialys				meeting, and to update the care plans			
	Tuesday/Thursday/S				reflect the needs identified.			
		Pre-Post dialysis weights.			Teneer the fields identified.			
		n of the AV fistula (pulse,			3. The Director of Nursing/Designee wi	II		
		ure adequate blood flow per			reeducate LPNs, and RNs on the			
	protocols."	are adequate grove new per			importance of completing an admission	1		
					assessment on each new admission			
		cian's order dated 9/12/23 very T-TH-SA. Obtain			which initiates the baseline care plan.			
	_	s, and weight - input weight			4. The Director of Nursing/designee wi	I		
		nication forms every evening			audit the baseline care plans of any ne			
	-	Sat. Obtain post-dialysis			admissions 5x per week for 4 weeks ar			
		nt - input weight from dialysis			monthly for 2 months to ensure that a			
		s every evening shift every			baseline care plan has been developed	t		
	Tue, Thu, Sat."	-			and interventions are appropriate and			
					reflect the individual needs of each			
		#119's TAR (treatment			resident. Any issues identified will be			
	administration record) for September 2023			addressed immediately by the Director	of		
	revealed, pre-dialysis	s weights were not obtained			Nursing/designee and appropriate action	ons		
	on 9/19/23 and post-	dialysis weights were not			will be taken to update the resident			
	obtained on 9/12/23,	9/14/23 and 9/16/23.			baseline care plans. The Director of			
					Nursing/Designee will identify any issu-	es,		
	An interview was con	ducted on 9/20/23 at 8:40			patterns or trends and report to the			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495283	B. WING _			1	C / 21/2023
	ROVIDER OR SUPPLIER	ITATION		17	REET ADDRESS, CITY, STATE, ZIP CODE 19 BELLEVUE AVENUE CHMOND, VA 23227	1 03	12 112023
(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 E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 655	was weighed before #119 stated, no, not An interview was co AM with RN #2. Wh dialysis communicat purpose is to share the dialysis center, i medications and any review Resident #11 dialysis weights, RN not there and the thimplemented. On 9/20/23 at 3:30 Rmember) #1, the addirector of nursing a nurse consultant, we findings. A review of the facility Centered" revealed, the resident's immediately im	119, and when asked if he and after dialysis, Resident always. Inducted on 9/20/23 at 8:00 then asked the purpose of the stion form, RN #2 stated, the and receive information with including vital signs, weights, y lab results. When asked to 19's TAR for pre and post 1 #2 stated the weights were the care plan was not PM, ASM (administrative staff ministrator, ASM #2, the ind ASM #4, the regional there made aware of the industrial to the ty's "Care Planning-Person" A baseline care plan to meet	F6	655	Quality Assurance and Performance Improvement Committee at least quarterly. 5. The date of compliance is: 11/3/23		
	admission orders. F	Physician orders." on was provided prior to exit.					
	implement the base dignity bag (cover) f	0, the facility failed to line care plan for the use of a or an indwelling urinary to develop a baseline care					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '		(X3) DATE SURVEY COMPLETED
	495283	B. WING		09/21/2023
	LITATION		1719 BELLEVUE AVENUE	1 03/2 1/2020
(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPE DEFICIENCY)	OULD BE COMPLETION
plan for the use of the Warfarin. Observations of Rebag revealed there 9/19/23 at 1:40 PM AM and 9/20/23 at bag was visible from A review of the basincluded, FOCUS: Catheter: history of BPH. INThas 16 FR/10cc Pobelow the level of the blad room door. Dignity content. A review of the physincluded, Foley Cat Size: (10 milliliters) shift. A review of the physincluded, Warfarin S (MG) Give 1 tablet treating/preventing On 9/20/23 at 8:10 conducted with RN asked if a urinary category.	he anticoagulant medication, sident #120's urinary catheter was no privacy covering on and 2:45 PM, 9/20/23 at 8:10 4:15 PM. The urinary catheter in the resident's doorway. eline care plan dated 9/14/23 The resident has Indwelling rerventlent bag and tubing lder and away from entrance bag to cover drainage bag sician orders dated 6/13/23 heter: (16 French) Balloon For Diagnosis of BPH every sician orders dated 6/13/23 Sodium Tablet 2.5 milligram by mouth one time a day for blood clots. AM an interview was (registered nurse) #2. When atheter bag has no privacy	F 655		
	Continued From particle plants of the bas included, FOCUS: Catheter: history of BPH. IN has 16 FR/10cc Pobelow the level of the blact room door. Dignity content. A review of the physical plants of the phys	ROVIDER OR SUPPLIER LE HEALTH & REHABILITATION SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 31 plan for the use of the anticoagulant medication, Warfarin. Observations of Resident #120's urinary catheter bag revealed there was no privacy covering on 9/19/23 at 1:40 PM and 2:45 PM, 9/20/23 at 8:10 AM and 9/20/23 at 4:15 PM. The urinary catheter bag was visible from the resident's doorway. A review of the baseline care plan dated 9/14/23 included, FOCUS: The resident has Indwelling Catheter: history of BPH. INTERVENTIONS: The resident has 16 FR/10cc Position catheter bag and tubing below the level of the bladder and away from entrance room door. Dignity bag to cover drainage bag content. A review of the physician orders dated 6/13/23 included, Foley Catheter: (16 French) Balloon Size: (10 milliliters) For Diagnosis of BPH every shift. A review of the physician orders dated 6/13/23 included, Warfarin Sodium Tablet 2.5 milligram (MG) Give 1 tablet by mouth one time a day for treating/preventing blood clots. On 9/20/23 at 8:10 AM an interview was conducted with RN (registered nurse) #2. When asked if a urinary catheter bag has no privacy	ROVIDER OR SUPPLIER LE HEALTH & REHABILITATION SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 31 plan for the use of the anticoagulant medication, Warfarin. Observations of Resident #120's urinary catheter bag revealed there was no privacy covering on 9/19/23 at 1:40 PM and 2:45 PM, 9/20/23 at 8:10 AM and 9/20/23 at 4:15 PM. The urinary catheter bag was visible from the resident's doorway. A review of the baseline care plan dated 9/14/23 included, FOCUS: The resident has Indwelling Catheter: history of BPH. INTERVENTIONS: The resident has 16 FR/10cc Position catheter bag and tubing below the level of the bladder and away from entrance room door. Dignity bag to cover drainage bag content. A review of the physician orders dated 6/13/23 included, Foley Catheter: (16 French) Balloon Size: (10 milliliters) For Diagnosis of BPH every shift. A review of the physician orders dated 6/13/23 included, Warfarin Sodium Tablet 2.5 milligram (MG) Give 1 tablet by mouth one time a day for treating/preventing blood clots. On 9/20/23 at 8:10 AM an interview was conducted with RN (registered nurse) #2. When asked if a urinary catheter bag has no privacy	ROWIDER OR SUPPLIER LE HEALTH & REHABILITATION SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 31 plan for the use of the anticoagulant medication, Warfarin. Observations of Resident #120's urinary catheter bag revealed there was no privacy covering on 9/19/23 at 1:40 PM and 2:45 PM, 9/20/23 at 8:10 AM and 9/20/23 at 4:15 PM. The urinary catheter bag was visible from the resident's doorway. A review of the baseline care plan dated 9/14/23 included, FOCUS: The resident has Indwelling Catheter: history of BPH. INTERVENTIONS: The resident has 16 FR/10cc Position catheter bag and tubing below the level of the bladder and away from entrance room door. Dignity bag to cover drainage bag content. A review of the physician orders dated 6/13/23 included, Foley Catheter: (16 French) Balloon Size: (10 millilliters) For Diagnosis of BPH every shift. A review of the physician orders dated 6/13/23 included, Warfarin Sodium Tablet 2.5 milligram (MG) Give 1 tablet by mouth one time a day for treating/preventing blood clots. On 9/20/23 at 8:10 AM an interview was conducted with RN (registered nurse) #2. When

		(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTI IDENTIFICATION NUMBER: A. BUILDIN		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495283	B. WING		09/21/2023
	ROVIDER OR SUPPLIER	ITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 1719 BELLEVUE AVENUE RICHMOND, VA 23227	1 03/21/2020
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION
F 655	stated, yes, it should be included, LPN #3 and symptoms of ble (prothrombin time) a normalized ratio) and On 9/21/23 at 1:20 flemember) #1, the addirector of nursing a nurse consultant was No further informatic 3. For Resident #96 to implement the bainjury assessment, the documentation. R96 was admitted to diagnosis of a stage sacral region (1). Redocumented, "I have integrity r/t (related to Administer medication treatments as orderedAssess/Modepth, margins: periundermining, exuda infection, necrosis, exprogress in wound here facility protocols. A review of R96's cliphysician's order da sacral wound with we calcium alginate (us bed and cover with a review of R96's Secretary of R96's	nticoagulant warfarin, LPN #3 d. When asked what should d stated, to assess for signs deeding, labs like PT and INR (international d monitoring their diet. PM, ASM (administrative staff ministrator, ASM #2, the and ASM #4, the regional s made aware of the findings. On was provided prior to exit. (R96), the facility staff failed seline care plan for pressure reatment, and On the facility on 8/24/23 with a three pressure injury of the go's care plan dated 9/6/23 de actual impairment to skin do (Sacrum) Immobility. Dons, supplements and Onitor/Document wound: size, wound skin, sinuses, tes, edema, granulation, deschar, gangrene. Document dealing on an ongoing basis	F 655		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIF	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
		495283	B. WING			C 09/21/2023
	ROVIDER OR SUPPLIER	TATION		STREET ADDRESS, CITY, STATE, ZIP CODE 1719 BELLEVUE AVENUE RICHMOND, VA 23227	·	3372112023
(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 CORRECTIVE ACTION SHOUTH ACTION SHOUTH APPORT OF THE	OULD BE	(X5) COMPLETION DATE
F 655	documentation that the on 9/8/23, 9/10/	ne treatment was completed (11/23, 9/14/23 and 9/15/23. It is to sign off the treatments blank. A review of nurse's to failed to reveal the treatments were So failed to reveal the treatments are admited to the pressure injury the treatments, presence or the pressure and type of the treatments are admitted, the presence of the treatment of the color, the presence of the	F 65	55		
	completion of treatmenurses evidence trea	n regard to evidencing the ents, LPN #3 stated the tments are done by signing the electronic treatment				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
					С		
		495283	B. WING		09/	21/2023	
	ROSEDALE HEALTH & REHABILITATION			17	TREET ADDRESS, CITY, STATE, ZIP CODE 719 BELLEVUE AVENUE ICHMOND, VA 23227		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 655	conducted with LPN # purpose of the care p while they [the reside care plan implemental nurses have access to mds (minimum data is nurses have question) On 9/21/23 at 1:28 p. staff member) #1 (the (the director of nursin above concern.) Reference: (1) "Stage 3 Pressure loss. Full-thickness loss of is visible in the ulcer at epibole (rolled wound This information was https://cdn.ymaws.co.gr/online_store/npiap. Develop/Implement CCFR(s): 483.21(b)(1) The fact implement a compreh 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	m., another interview was #3. LPN #3 stated, "The lan is the action of the care ints] are here." In regard to tion, LPN #3 stated the of the care plans and the eet) staff is available if is about the care plan. m., ASM (administrative administrator) and ASM #2 g) were made aware of the # Injury: Full-thickness skin skin, in which adipose (fat) and granulation tissue and edges) are often present." obtained from the website: m/npiap.com/resource/resm pressure_injury_stages.pdf 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 mental and psychosocial fed in the comprehensive inprehensive care plan must		655 656			11/3/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495283	B. WING		С	
		495263	B. WING		09/21/2023	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
ROSEDAL	ROSEDALE HEALTH & REHABILITATION			1719 BELLEVUE AVENUE		
ROSEDALE REALIT & REHABILITATION				RICHMOND, VA 23227		
(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 APPROPRI	BE COMPLÉTION	
				DEFICIENCY)		
F 656	Continued From page	e 35	F 65	6		
	or maintain the reside	ent's highest practicable				
		psychosocial well-being as				
		would otherwise be required				
	under §483.24, §483.	.25 or §483.40 but are not				
	provided due to the re	esident's exercise of rights				
	under §483.10, includ	ling the right to refuse				
	treatment under §483	3.10(c)(6).				
	(iii) Any specialized s	ervices or specialized				
	rehabilitative services	the nursing facility will				
	provide as a result of	PASARR				
	recommendations. If	a facility disagrees with the				
	findings of the PASAF	RR, it must indicate its				
	rationale in the reside	ent's medical record.				
	(iv)In consultation wit	h the resident and the				
	resident's representa	` ,				
	(A) The resident's go	als for admission and				
	desired outcomes.					
		eference and potential for				
	_	ilities must document				
		s desire to return to the				
	_	ssed and any referrals to				
		s and/or other appropriate				
	entities, for this purpo					
		n the comprehensive care				
		in accordance with the				
		n in paragraph (c) of this				
	section.					
	by the facility, as outli	rvices provided or arranged ined by the comprehensive				
	care plan, must-					
		petent and trauma-informed.				
		is not met as evidenced				
	by:					
		n, resident interview, staff		This plan of correction is respectfully		
		ument review and clinical		submitted, and it is an affirmation that		
		cility staff failed to develop		corrections to the areas cited have; be		
		comprehensive care plan		made and the facility is in compliance	with	
	for eight of 40 resider	nts in the survey sample,		participation requirements.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495283	B. WING			00	C 0/21/2023	
NAME OF P	ROVIDER OR SUPPLIER	100200	1	S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 08	1/2 1/2023	
TO WILL OF T	NOVIDEN ON OUT FIEN				719 BELLEVUE AVENUE			
ROSEDAL	E HEALTH & REHABI	LITATION			CICHMOND, VA 23227			
	I			- 1	 			
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 656	Continued From pa	age 36	F 6	556				
	1	08, #52, #219, #62, #76, #11,						
	and #16.	55, 1162, 11216, 1162, 1116, 1111,			Residents #48, #108, #52, #219, #62,			
					#76, #11 and #16 were assessed by			
	The findings includ	e:			nursing staff and their medical records			
					were reviewed. The residents care pla	ns		
		8 (R48), the facility staff failed			have been updated to reflect current			
		ehensive care plan for the			individualized plans of care and the			
	resident's larynged	tomy tube (1).			results of implementation are being			
	D40 1 111 11				tracked and addressed appropriately.			
		to the facility on 6/6/23 with a			December to the state of the st	.4.		
		esence of an artificial larynx (a). A review of R48's			Rosedale has identified that all resider are at risk from this deficient practice.			
		re plan initiated on 6/6/23 failed			process has been developed and	^		
		tation regarding the resident's			implemented in the daily interdisciplina	irv		
	laryngectomy tube.				team meeting to identify resident care	y		
	, , ,				needs, ensure a care plan has been			
	On 9/20/23 at 8:34	a.m., R48 was observed			developed to meet individualized need	s		
	sitting on the bed a	nd the resident was observed			and the results of implementation are			
		omy tube. At this time, an			being tracked and addressed			
		ucted with R48. The resident			appropriately.			
		ally communicate but						
		non-verbal gestures and by			The Director of Nursing/designee has			
	_	unication board. R48 was			in-serviced nursing leadership, interdisciplinary team members and			
		clean and provide care for his The resident nodded his			licensed nursing staff (LPN and RN)			
		ndicating, "No" and pointed to			regarding updating and implementing	he		
		ed if he provides the care,			care plan. The in-service includes, but			
		ad up and down indicating,			not limited to, the importance of care p			
		d if the nurses check to make			reviews and updates with any changes			
	sure he is cleaning	and caring for his			each resident and care plans being			
	laryngectomy tube,	R48 nodded his head side to			reflective of individualized care needs.			
	side, indicating, "No	0."						
					The Director of Nursing/designee will			
		a.m., an interview was			conduct an audit of 25% of resident ca			
		N (licensed practical nurse) #3.			plans weekly for 4 weeks and monthly			
		e purpose of the care plan is			2 months to ensure that interventions	are		
		re while they [the residents]			appropriate and reflect the individual	oina		
		stated residents' care plans			needs of each resident and they are be	-		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING			(X3) DATE SURVEY COMPLETED			
		495283	B. WING			C 09/21/2023
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1719 BELLEVUE AVENUE RICHMOND, VA 23227		33/21/2023
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 656	documents what ne (as needed), make the physician of any infection, and monit and oxygen level. On 9/21/23 at 1:28 staff member) #1 (the director of nurs above concern. The facility policy tit Comprehensive Per "13. The compreher a. Incorporate ident b. Incorporate ident b. Incorporate risk fidentified problems; c. Build on the resid d. Be culturally com as applicable e. Reflect treatment objectives in measure f. Identify the profess responsible for each g. Aid in preventing resident's functional levels; h. Promote resident i. Enhance the optim by focusing on a refige. Reflect currently repractice for problem. Reference: (1) A laryngectomy of the larynx (the voinformation was obtime larynx (the voinformation was obtime larynx).	and usually the care plan eds to be done, suction prosure care is provided, notify a secretions or signs of or the resident's temperature p.m., ASM (administrative ne administrator) and ASM #2 ing) were made aware of the led, "Care Planning - reson-Centered" documented, naive care plan will: iffed problem areas; actors associated with dent's strengths; petent and trauma-informed a goals, timetables and trable outcomes; scional services that are nelement of care; or reducing declines in the I status and/or functional	F 65	identified will be addressed imme by the Director of Nursing/design appropriate actions will be taken the resident care plans. The Director Nursing/designee will identify any and/or patterns and provide eductraining to staff on an ongoing bath Findings will be discussed with the committee on at least a quarterly. Date of Compliance: 11/3/23	ee and to update ctor of / trends cation and sis. ne QAPI	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495283	B. WING		09/21/2023
	ROVIDER OR SUPPLIER LE HEALTH & REHABIL	ITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 1719 BELLEVUE AVENUE RICHMOND, VA 23227	1 03/21/2020
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE COMPLÉTIC
F 656	Continued From pag	ge 38	F 656	6	
	failed to implement to care for pressure injudocumentation.	8 (R108), the facility staff he resident's comprehensive ury assessment and to the facility on 5/27/23 with			
	a diagnosis of a stag sacral region (1). R plan dated 6/4/23 do impairment to skin ir ischium (inaccurate Assess/Monitor/Doc	ge four pressure injury on the 108's comprehensive care ocumented, "I have actual attegrity r/t (related to) right documentation of location). ument wound: size, depth, skin, sinuses, undermining,			
	exudates, edema, g	ranulation, infection, necrosis, Document progress in wound			
	thorough assessmel progress in wound h September 2023. T regarding the reside observation dated 8, open areas, a weekl 8/15/23 that docume buttock, a weekly sk regarding another sk contain any docume pressure injury, a we 8/29/23 that docume weekly skin observa	clinical record failed to reveal ants of the pressure injury and lealing in August 2023 and the only documentation int's skin was a weekly skin (7/23 that documented no y skin observation dated ented an open area on the left in observation dated 8/21/23 kin concern but did not intation regarding the leekly skin observation dated ented no open areas and a tion dated 9/6/23 that in area on the left buttock.			
	On 9/20/23 at 9:37 a conducted with LPN LPN #3 stated asses	a.m., an interview was (licensed practical nurse) #3. ssments of pressure injuries scription of the wound, the			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION B	(X3) DATE SURVEY COMPLETED	
		495283	B. WING		C 09/21/2023	
	PROVIDER OR SUPPLIER	LITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 1719 BELLEVUE AVENUE RICHMOND, VA 23227	1 00/2 //2020	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPROFICIENCY)	D BE COMPLETION	
F 656	measurement of the presence of drainage is a RN (registered) On 9/21/23 at 9:16 conducted with LPN purpose of the care while they [the residence plan implement nurses have access MDS (minimum data nurses have question) On 9/21/23 at 1:28 staff member) #1 (the director of nurses above concern.) Reference: (1) "Stage 4 Pressurand tissue loss. Full-thickness skin are or directly palpable ligament, cartilage of and/or eschar may was obtained from the https://cdn.ymaws.org/online_store/npiass. Resident #52 was are 6/19/23 with diagnol limited to: hemipleg obesity and congess	e size, any odor, the color, the ge, and the stage if the nurse nurse). a.m., another interview was I #3. LPN #3 stated, "The plan is the action of the care dents] are here." In regard to tation, LPN #3 stated the sto the care plans and the a set) staff is available if ons about the care plan. p.m., ASM (administrative ne administrator) and ASM #2 ing) were made aware of the are Injury: Full-thickness skin and tissue loss with exposed fascia, muscle, tendon, or bone in the ulcer. Slough the visible." This information the website: com/npiap.com/resource/resm ap_pressure_injury_stages.pdf admitted to the facility on sis that included but were not ia, hemiparesis, morbid	F 65	56		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495283	B. WING		C 09/21/2023
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1719 BELLEVUE AVENUE RICHMOND, VA 23227	09/21/2023
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETION
F 656	is at risk for falls rela INTERVENTIONS: E light is within reach a use it for assistance needs prompt respondassistance." A review of the physorder for bed rails. Resident #52 was of 9/19/23 at 1:20 PM, 9/21/23 at 8:00 AM varised on bed. A review of the facilitientrapment form da "Recommendations: independent bed moduse: to assist with b An interview was con PM with Resident #5 the rails, Resident #5 to turn in bed and to An interview was con AM with LPN (licens asked the purpose of stated, the purpose of the care while the should be on the car need to use them for On 9/21/23 at 1:20 F member) #1, the add director of nursing an	aled, "FOCUS: The resident ated to limited mobility. Be sure the resident's call and encourage the resident to as needed. The resident make to all requests for a lician orders revealed no a lician order	F 65	6	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED
		495283	B. WING		C 09/21/2023
	ROVIDER OR SUPPLIER LE HEALTH & REHABIL	ITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 1719 BELLEVUE AVENUE RICHMOND, VA 23227	1 00/2 //2020
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETION
F 656	Continued From pag	ge 41	F 656	3	
	4. For Resident #21 implement the comp medication administ Resident #219 was the diagnoses of hig atrial fibrillation (Afibnon-pressure chronion A review of the comp 9/19/23 revealed the "(Resident #219) is problems" Interve 9/19/23 for "Meds an "I have actual impair Interventions include "Administer medicat treatments as ordere "(Resident #219) had Interventions include "Give anti hypertens ordered"	admitted on 9/8/23 and had th blood pressure (HTN), b), lymphedema and c ulcer of the skin. prehensive care plan dated e following: at risk for potential nutritional entions included one dated and Labs as ordered." The ment to skin integrity" ed one dated 9/19/23 for ions, supplements and ed" s hypertension (HTN)." ed one dated 9/19/23 for			
	following: (1) Aspirin an 81 mg daily. Order dated 9 (2) Valsartan an 80 dated 9/8/23. (3) Vitamin D3 a 25 Give two tablets one (4) Zinc a 220 mg tahealing. Order date	mcg (milligrams) tablet once 0/8/23. mg tablet once daily. Order mcg (micrograms) tablet. se daily. Order dated 9/9/23. blet once daily for wound d 9/13/23.			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIP A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495283	B. WING		09/21/2023
	ROVIDER OR SUPPLIER LE HEALTH & REHABILI	TATION		STREET ADDRESS, CITY, STATE, ZIP CODE 1719 BELLEVUE AVENUE RICHMOND, VA 23227	1 03/21/2023
(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 CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLÉTION
F 656	#219. Upon review of the Medication Admin September 2023 revolvalsartan, Vitamin Dawere not prepared an observation. On 9/20/23 at 1:10 P conducted with LPN thought she pulled an medications. She state how she missed ther On 9/20/23 at 1:50 P interview was conducted asked if the care plar medications as order were missed, was the she stated that it was the purpose of the care everyone knows how. The facility policy "Ca Comprehensive Personal This policy document comprehensive care measurable objective resident2. The facilimplement a comprehensive resident a comprehensive resident a comprehensive resident and provided in the purpose of the care plan for each remeasurable objective resident's medical, no psychosocial needs are plan for each remeasurable objective resident's medical, no psychosocial needs are ps	Practical Nurse), for Resident of the physician's orders and histration Record (MAR) for ealed that the Aspirin, and Zinc were ordered but and administered on the administered on the administered that she are administered that she are did not known. My an interview was the above atted that she did not known. My a second follow up of the above atted with LPN #10. When a documented to administer red, and the medications of care plan being followed, and. When asked what was are plan, she stated so that the to care for the resident. Agree Planning - the above atted, " A person-centered plan that includes on and the area and timetables to meet the cursing, mental and shall be developed for each allity will develop and the ansive person-centered	F 65	6	

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
		495283	B. WING		C 09/21/2023
	ROVIDER OR SUPPLIER	ITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 1719 BELLEVUE AVENUE RICHMOND, VA 23227	1 00/2 112020
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROVIDENCY)	D BE COMPLETION
F 656	Staff Member) the A Director of Nursing, Nurse Consultant, w findings. No further the end of the survey References: (1) Aspirin - Is used strokes, and reduce attack or stroke. Information obtained https://medlineplus.g tml (2) Valsartan - Is us with other medicatio pressure. Information obtained https://medlineplus.g tml (3) Vitamin D3 - Is u when the amount of enoughis also use prevent and treat bo Information obtained https://medlineplus.g tml (4) Zinc - Is an esse commonly found in r is necessary in small growth, and sense of	PM, ASM #1 (Administrative dministrator, ASM #2 the and ASM #4, the Regional ere made aware of the information was provided by y. to prevent heart attacks, the risk of death from a heart of the information was provided by y. I from gov/druginfo/meds/a682878.h ed alone or in combination of the insection of th	F 65	56	
	excess zinc, so it mu It's needed for immu	ust be obtained from the diet. ne function, wound healing, d function, and much more. It			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED					
		495283	B. WING				21/2023
	ROVIDER OR SUPPLIER LE HEALTH & REHABILIT	TATION		1719	EET ADDRESS, CITY, STATE, ZIP CODE 9 BELLEVUE AVENUE CHMOND, VA 23227		
(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 656	might have effects ag Information obtained https://medlineplus.go 5. For Resident #62 to implement the com a cigarette extender a smoking. On the most recent M assessment, an annu (assessment, an annu (assessment reference resident scored 15 ou interview for mental sindicating they were obtained as observed so to bacco use. On 9/19/2023 at 2:30 made of R62 in the far R62 was observed so the supervised smoked cigarette extender or On 9/19/2023 at 3:56 conducted with R62. Smoked for years and facility since admission facility stored their cigarette that they took at during stated that they had a kept in their room and "sometimes." R62 star require them to use subut they were not require they wer	in maintaining vision and ainst viruses. from by/druginfo/natural/982.html) (R62), the facility staff failed aprehensive care plan to use and smoking apron while (R62) (minimum data set) all assessment, with an ARD be date) of 6/20/2023, the at of 15 on the BIMS (brief tatus) assessment, cognitively intact for making ion J documented no current p.m., an observation was icility courtyard smoking. Inoking two cigarettes during the break without using a smoking apron. p.m., an interview was R62 stated that they had I had been smoking at the parettes and lighter in a boxing the smoking times. R62 in cigarette extender that they are they took it outside atted that the facility used to moking aprons at one time uired anymore.	F	656			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495283	B. WING		C 09/21/2023
	ROVIDER OR SUPPLIER	LITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 1719 BELLEVUE AVENUE RICHMOND, VA 23227	1 03/21/2020
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETION
F 656	during the supervise use of a cigarette extended in part, current smoker Date Initiated: 12/06/08/09/2023." Under documented in part, extender is used du Date Initiated: 03/29/01/11/2023 Provid assist to put on. Dat Revision on: 01/11/2/2 The "Smoking-Residented 2/9/2023"Tobacco Utilization tobacco products? Smoking? Yes. Tobacco Utilization tobacco products? Yes. To	R62 was observed smoking and smoke break without the ktender or smoking apron. It care plan for R62 "History of smoking and solution on: In "Interventions" it properties and west and service with a smoking apron and the Initiated: 02/19/2020. 2023" In the smoking apron and the Initiated: 02/19/2020. 2023" In the smoking apron and the Initiated: 02/19/2020. 2023" In the smoking apron and the Initiated: 02/19/2020. 2023" In the smoking apron and the Initiated: 02/19/2020. 2023" In the smoking apron and the Initiated: 02/19/2020. 2023" In the smoking apron and the Initiated: 02/19/2020. 2023" In the smoking apron and the Initiated: 02/19/2020. 2023" In the smoking apron and the Initiated: 02/19/2020. 2023" In the smoking allow accoproducts utilized: Resident adaptive equipment apron, b. Cigarette holder, c. In the smoking apron and the smoke and were supposed to put prior to going out to smoke the smoking aprons because she to often. She stated that she and cigarette extender that they	F 656		
		3 p.m., an interview was I (licensed practical nurse) #2.			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G		OATE SURVEY OMPLETED
		495283	B. WING _			C 09/21/2023
	ROVIDER OR SUPPLIER	ITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 1719 BELLEVUE AVENUE RICHMOND, VA 23227	,	30/21/2020
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 656	was to keep track of facility and contained. She stated that the complemented to mak getting the proper car. On 9/21/2023 at 9:0 conducted with LPN purpose of the care of care and document there. She stated the implemented by the care plan if they need available if they had plan. On 9/20/2023 at 3:3 staff member) #1, the director of nursing, an urse consultant we concern. No further information. 6. For Resident #76 to implement the concern. On the most recent leasessment, a quart ARD (assessment rethe residents cognitions Section G document for walking in the roof state of the residents of	the purpose of the care plan the residents care in the dall aspects of their care. Care plan should be e sure the resident was are and treatment. 7 a.m., an interview was #3. LPN #3 stated that the plan was to provide an action need why the resident was at the care plan was nurses having access to the ded it and having MDS any questions about the care 8 p.m., ASM (administrative e administrator, ASM #2, the and ASM #4, the regional re made aware of the on was provided prior to exit. 6 (R76), the facility staff failed apprehensive care plan to was within reach. MDS (minimum data set) terly assessment, with an eference date) of 8/15/2023, on status was not assessed. The dall apprehension was supervision and the care plan to was within set at the care plan to was within reach.	F 6	56		

		IDENTIFICATION NUMBER:		JLTIPLE CONSTRUCTION DING		(X3) DATE SURVEY COMPLETED	
		495283	B. WING _			C 09/21/2023	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 1719 BELLEVUE AVENUE RICHMOND, VA 23227	•	09/21/2023	
(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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE	
F 656	made of R76's bathrositting on the side of a front of them. The was contained a call light attached. The call ligaccessible to the resineeded. At that time with R76. R76 states of the wall over a west the cord up to the nurthe nurse on duty at thave maintenance reused the bathroom at they would not be about the that they would cord on the light but of the wall observation made on 9/20/2023 at 1:45 p.m. The call ligwithout a pull cord and the floor if needed. The comprehensive of documented in part, 'falls r/t (related to) lim 05/30/2023. Revision "Interventions" it docuresident's call light is the resident to use it	A p.m., an observation was som. R76 was observed their bed with a walker in all beside R76's commode panel with no pull cord put was observed to not be dent from the floor if an interview was conducted that the cord had come out the ago and they had taken reses station and given it to the time and asked them to pair it. R76 stated that they not was scared that if they fell le to call anyone because the to reach the call light. R76 g staff had told them several have someone come fix the no one had come. Ins of R76's bathroom were at 8:55 a.m. and 9/20/2023 at 19th in the bathroom remained becessible to the resident from the care plan for R76 (Name of R76) is at risk for 19th in the pathroom remained becessible to the resident from 19th in the pathroom remained because the mobility. Date Initiated: 19th on: 06/07/2023." Under 19th on: 06/07/2023.	F 6	56			
	On 9/20/2023 at 2:13	p.m., an interview was					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
	495283		B. WING			C 09/21/2023		
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	1 03/	21/2023	
DOOEDAL	- U-ALTU A DEUADU	ITATION		1	719 BELLEVUE AVENUE			
ROSEDAL	E HEALTH & REHABII	LITATION		F	RICHMOND, VA 23227			
(X4) ID PREFIX TAG			ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 656	Continued From pa	-	F	656				
		A (certified nursing assistant) that they were not aware of						
		any resident call lights on the						
	• •	at all residents should have						
		ght and if there were any						
		all light they put in requisitions						
		e come to repair them.						
		23 p.m., an interview was						
	conducted with LPN LPN #2 stated that							
	was to keep track o							
	facility and containe							
	She stated that the							
		ke sure the resident was						
	getting the proper c							
	conducted with OSI director of maintena utilized a computer able to enter work of stated that he check day and added complete his maintenance realight and stated that him. He observed to with no pull cord and cord in place for the it if needed. On 9/21/2023 at 1:2 staff member) #1, the	61 p.m., an interview was M (other staff member) #6, the ance. OSM #6 stated that they system which all staff were orders into for repairs. He ked the system at least once a aments for repairs needed or ed repairs. OSM #6 checked quests for R76's bathroom call to the call light in R76's bathroom d stated that there should be a expression resident to be able to access a expression. ASM (administrative ne administrator, ASM #2, the and ASM #4, the regional						
	nurse consultant we concern.	ere made aware of the						
	No further informati	on was provided prior to exit.						

1 '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495283	B. WING				21/2023
	ROVIDER OR SUPPLIER LE HEALTH & REHABILI	TATION	1	1	STREET ADDRESS, CITY, STATE, ZIP CODE 719 BELLEVUE AVENUE RICHMOND, VA 23227		
(X4) ID PREFIX TAG			ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 656	Continued From page	e 49	F	656			
		R11), the facility staff failed ehensive care plan for					
	assessment, an annu (assessment reference	MDS (minimum data set) ual assessment, with an ARD ce date) of 8/5/2023, the us receiving hospice services e facility.					
	The comprehensive of evidence hospice ser	care plan for R11 failed to vices.					
		for R11 documented in part, phone number of hospice).					
		31 a.m.) Note Text : (age and sex of R11) LTC r hospice services recently					
	conducted with LPN of LPN #2 stated that the was to keep track of facility and contained She stated that MDS developed the care p was not sure if hospic not because hospice	p.m., an interview was (licensed practical nurse) #2. e purpose of the care plan the residents care in the all aspects of their care. staff and nursing both lans. She stated that she ce was on the care plan or residents at the facility were the ones they normally					
		p.m., an interview was egistered nurse) #5, MDS					

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495283	B. WING			C 09/21/2023		
	NAME OF PROVIDER OR SUPPLIER ROSEDALE HEALTH & REHABILITATION			s 1	TREET ADDRESS, CITY, STATE, ZIP CODE 719 BELLEVUE AVENUE RICHMOND, VA 23227	1 097	21/2023	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 656	She stated that the Manything that triggere and the nursing staff, activities added addit the care plan purpose care and hospice resiplan addressing hosp R11's care plan and sanything regarding hosp R1	tated that MDS was imprehensive care plan. IDS staff care planned defrom the MDS assessment dietician, social worker and ional things. She stated that was to guide the residents idents should have a care dice services. She reviewed stated that she did not see ionice services. She reviewed stated that she did not see ionice services. In p.m., ASM (administrative administrator, ASM #2, the ind ASM #4, the regional are made aware of the in was provided prior to exit. In (R16), the facility staff failed aprehensive care plan to interpret as a "no or unknown" for the formula or unknown" for the months. The resident dieving a therapeutic diet.	F	656				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING			COMPLETED	
		495283	B. WING			C	
	ROVIDER OR SUPPLIER	100000		STREET ADDRESS, CITY, STATE, ZIP CODE 1719 BELLEVUE AVENUE RICHMOND, VA 23227	09/21/2023		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 656	documented in part physician and response weight change. Dat The physician order "No labs, no vitals. Order Date: 3/3/202 The weight of 179.0 lbs weight of 179.4 lbs summary failed to educate 4/2023, 5/2023, 6/2 Review of the clinic refusals of weights On 9/20/2023 at 2:2 conducted with LPN LPN #2 stated that was to keep track of facility and contained She stated that the implemented. She weighed at least more frequently and if the documented in the On 9/20/2023 at 2:2 conducted with CNA #8. CNA #8 stated weighed at least more nurses told them it if the resident refusal ter that day and if nurse know.	ry for R16 documented in part, Continue monthly weights. ry for R16 documented in part, Continue monthly weights. ry for R16 documented a (pounds) on 3/6/2023 and a on 9/6/2023. The weight evidence weights obtained for 023, 7/2023 or 8/2023. all record failed to evidence between 4/1/2023-8/31/2023. It is purpose of the care plan of the residents care in the ed all aspects of their care. care plan should be stated that residents were onthly unless ordered more by refused weights it was	F 65	56			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
	495283	B. WING _			C 09/21/2023	
NAME OF PROVIDER OR SUPPLIER ROSEDALE HEALTH & REHABILIT	TATION		STREET ADDRESS, CITY, STATE, ZIP CO 1719 BELLEVUE AVENUE RICHMOND, VA 23227	DDE	00/21/2020	
PREFIX (EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		ON SHOULD BE		
director of nursing, ar nurse consultant were concern.	administrator, ASM #2, the ad ASM #4, the regional a made aware of the	F	656			
SS=D Care Plan Timing and CFR(s): 483.21(b)(2)(2)(2)(3) §483.21(b) Comprehe §483.21(b)(2) A complete (i) Developed within 7 the comprehensive as (ii) Prepared by an intincludes but is not liminally (A) The attending phy (B) A registered nurse resident. (C) A nurse aide with resident. (D) A member of food (E) To the extent practive the resident and their An explanation must liminally medical record if the pand their resident repinot practicable for the resident's care plan. (F) Other appropriate disciplines as determinally or as requested by the (iii) Reviewed and revite team after each assess comprehensive and quassessments.	ensive Care Plans brehensive care plan must I days after completion of essessment. Berdisciplinary team, that endited to resician. It with responsibility for the I and nutrition services staff. Beticable, the participation of esident's representative(s). I be included in a resident's participation of the resentative is determined and edvelopment of the staff or professionals in ined by the resident's needs are resident. I seed by the interdisciplinary essment, including both the	F	657		11/3/23	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495283	B. WING			C 09/21/2023	
NAME OF P	ROVIDER OR SUPPLIER	100200	 	STREET ADDRESS, CITY, STA		09/21/2023	
NAME OF T	TOVIDER OR GOLT EIER			,	ATE, ZII OODE		
ROSEDAL	E HEALTH & REHABILI	TATION		1719 BELLEVUE AVENUE			
				RICHMOND, VA 23227			
(X4) ID PREFIX TAG			ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BE ICED TO THE APPROPRIATE IEFICIENCY)	(X5) COMPLETION DATE	
F 657	F 657 Continued From page 53		F 6	57			
	and facility document that the facility staff fa	cord review, staff interview is review, it was determined ailed to review and revise the of 40 residents in the survey 13, 108 and #83.			an affirmation that reas cited have; been by is in compliance with		
	The findings include: 1. For Resident #13 (R13), the facility staff failed to review and revise the comprehensive care plan after a resident to resident altercation on 8/21/2023.				to include a physical ther resident. The care 3 was updated to ne anti-anxiety		
	assessment, a quarter (assessment reference resident scored 6 of a interview for mental sindicating the resident making daily decision no behaviors other the	status) assessment, at was severely impaired for as. Section E documented an rejection of care.		and implemented in interdisciplinary tea resident care needs has been revised to needs and the resu are being tracked a	from this deficient has been developed the daily m meeting to identify s, ensure a care plan meet individualized lts of implementation		
	- "8/21/2023 13:23 (1) Resident got into a planother resident in rethis resident received the right eye. Resident Tylenol for pain. Resimake all his needs knowheelchair visiting. Notice distress at this time." - "8/21/2023 13:50 (1) (social worker) spoke incident in facility, resident came into his face. SW explained to	hysical altercation with sident's room. As a result		in-serviced nursing interdisciplinary tea licensed nursing staregarding revising the in-service includes, updates with any chartest and care production in the Director of National conduct an audit of plans weekly for 4 visite interdisciplinary teaching interdiscip	m members and aff (LPN and RN) he care plan. The but is not limited to, nanges for each lans being reflective of needs. lursing/designee will 25% of resident care weeks and monthly for that interventions are		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	IPLE CONSTRUCTION IG	(X	(X3) DATE SURVEY COMPLETED	
	495283	B. WING			C 09/21/2023	
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DDE	03/21/2020	
ROSEDALE HEALTH & REHAE	RII ITATION		1719 BELLEVUE AVENUE			
ROSEDALE REALIN & RENAL	BILITATION		RICHMOND, VA 23227			
PREFIX (EACH DEFICI	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
completed skin chappropriate follow called regarding in complete. Mother (administrator), Do SW about incident charges made." Review of the facis 8/21/2023 docume incident, resident social services now The comprehensive vidence a review resident to resident to resident to resident to resident to resident to a social services and was to document care while at the finurses and MDS in plan. On 9/21/2023 at 9 conducted with LF purpose of the callof care for the resident comprehensive callong. She stated revised after a resident to 9/21/2023 at 9 conducted with Os	ility at any time. Nursing neck and injuries sustained, oup concluded. Mother was natter, resident interview spoke with admin ON (director of nursing), and t, police were called and no elity investigation dated ented a summary of the statements, nursing notes, and	F 6	reflect the individual needs resident and they are being appropriately. Any issues id addressed immediately by the Nursing/designee and approvial be taken to update the replans. The Director of Nursi will identify any trends and/oprovide education and train an ongoing basis. Findings discussed with the QAPI colleast a quarterly basis. 5. Date of Compliance: 11/3	implemented lentified will be the Director of opriate actions resident care ing/designee or patterns and ing to staff on will be ommittee on at	e f s	

	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA ID PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTII A. BUILDIN	PLE CONSTRUCTION G	COMPLETED		
		495283	B. WING		09/21/202	23	
	NAME OF PROVIDER OR SUPPLIER ROSEDALE HEALTH & REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 1719 BELLEVUE AVENUE RICHMOND, VA 23227			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRODEFICIENCY)	ILD BE COMP	X5) PLETION ATE	
F 657	did a physical asses change if needed to were kept safe. She may update the care physical because of She stated that the of for both residents. The facility policy, "Comprehensive Perdocumented in part, care plan will: a. Incomprehensive plan wi	residents, made sure nursing sment and discussed a room make sure the residents estated that social services plan if the altercation was the aggressive behaviors. Eare plan would be updated Care Planning-son-Centered" undated, " 13. The comprehensive proporate identified problem in Intervention Plan (BIP) may a resident exhibits behaviors int, other residents, or staff at their rights. a. The BIP will aboration with the resident, in, and mental health propriate. b. The BIP will be resident's comprehensive P will be reviewed and to address change in the c. The BIP will clearly identify	F 65	57			
	should the resident respectations" On 9/21/2023 at 1:20 staff member) #1, the director of nursing at	oction that may be taken not comply with the agreed of p.m., ASM (administrative e administrator, ASM #2, the not ASM #4, the regional re made aware of the					
		on was obtained prior to exit. 3 (R108), the facility staff					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		495283	B. WING_			C 9/21/2023	
	NAME OF PROVIDER OR SUPPLIER ROSEDALE HEALTH & REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CO 1719 BELLEVUE AVENUE RICHMOND, VA 23227	•	9/21/2023	
(X4) ID PREFIX TAG	EIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFI TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 657	A review of R108's progress note date "Resident was involuter altercation this after the other resident upper shoulder/chealtercation took plathe other resident minor scratches, during the scuffle. scratch on his left wounds were clear dressed. His RP (r Contact (mother) with the situation was eno concerns at the observed to help per A review of R108's revised on 8/29/23 was reviewed and altercation. On 9/21/23 at 9:16 conducted with LP LPN #3 stated, "The the action of the care here." LPN #3 should be reviewer altercation, so emphave a behavior.	age 56 d revise the resident's re plan after a physical other resident on 8/21/23. c clinical record revealed a d 8/21/23 that documented, olved in a resident on resident ernoon. According to (R108), involved slapped him on his est area after a verbal ace and, in relation, (R108) hit in the face. (R108) obtained elivered by other resident, He was bleeding from one forearm and had a 2-3 inch upper arm. The superficial ned but did not need to be esponsible party)/Emergency vas contacted by this nurse and explained to her. She expressed t time. Both residents are being revent further issues." a comprehensive care plan failed to reveal the care plan revised regarding the physical a a.m., an interview was N (licensed practical nurse) #3. The purpose of the care plan is are while they [the residents] a stated residents' care plans d and revised after a physical bloyees know the residents	F	657			
		p.m., ASM (administrative the administrator) and ASM #2					

AND PLAN OF CORRECTION IDENTIFICAT		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED		
		495283	B. WING _			C 09/21/2023	
	NAME OF PROVIDER OR SUPPLIER ROSEDALE HEALTH & REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP COD 1719 BELLEVUE AVENUE RICHMOND, VA 23227		35/21/2023	
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 657	above concern. 3. For Resident #83 (to review and revise to comprehensive care the anti-anxiety media. A review of R83's clir physician's order data mg (milligrams)- one hours as needed for review of R83's Augu 2023 MARs (medicat revealed the resident needed diazepam 28 24 times in Septembe comprehensive care failed to reveal the carevised for the reside medication. On 9/21/23 at 9:16 a. conducted with LPN LPN #3 stated, "The the action of the care are here." LPN #3 st should be reviewed a anti-anxiety medicatic behaviors and chang. On 9/21/23 at 1:28 p. staff member) #1 (the	R83), the facility staff failed the resident's plan for the resident's use of cation, diazepam. Inical record revealed a ed 8/4/23 for diazepam (1) 5 tablet by mouth every eight 180 days for anxiety. A st 2023 and September ion administration records) was administered as times in August 2023 and er 2023. A review of R83's plan revised on 8/15/23 are plan was reviewed and nt's use of anti-anxiety m., an interview was (licensed practical nurse) #3. purpose of the care plan is while they [the residents] ated residents' care plans and revised for the use of on so staff can monitor for	F 6	557			
		to treat anxiety. This ined from the website:					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIP A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495283	B. WING		C 09/21/2023	
	NAME OF PROVIDER OR SUPPLIER ROSEDALE HEALTH & REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 1719 BELLEVUE AVENUE RICHMOND, VA 23227	09/21/2023	
(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 I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION	
F 657	https://medlineplus.g	ov/druginfo/meds/a682047.h	F 65			
F 658 SS=D	CFR(s): 483.21(b)(3) §483.21(b)(3) Compositive services provide as outlined by the comustive in Meet professional This REQUIREMENT by: Based on observation document review and facility staff failed to of practice for two of sample, Residents # The findings include: 1.a. For Resident #11 failed to obtain a phy injury treatments that A review of R106's claurses' notes that do -5/22/23 "It was repo has large ulcers on hunstageable ulcers (if and stage 1 (1) ulcer ankle. Wiped down vinding -6/7/23 "Resident was unstageable ulcer (promositive in the center and surrous in the center and surrous in the center and surrous in the center in the ce	rehensive Care Plans d or arranged by the facility, mprehensive care plan, standards of quality. It is not met as evidenced on, staff interview, facility d clinical record review, the follow professional standards 40 residents in the survey 106 and #219. D6 (R106), the facility staff sician's order for pressure at were completed. inical record revealed cumented the following: rted by therapy that resident eels. On arrival resident has njuries) (1) on both heels on both side of the foot and with skin prep."	F 65	This plan of correction is respectfully submitted, and it is an affirmation that corrections to the areas cited have ¿be made and the facility is in compliance participation requirements. 1. Residents #106 and #219 no longer reside at the facility. 2. An audit has been performed on all current residents to identify residents to pressure injuries to ensure physician orders for pressure injury treatments a obtained and resident skin assessment have been accurately documented up admission. An audit has been perform on all current residents to ensure medications are being administered as ordered by the physician. Any discrepancies have been corrected. 3. The Director of Nursing/designee he educated licensed nursing staff on meeting professional standards of quather in-service includes, but is not limit to, obtaining a physician □s order for	een with r Il with s are nts on ned s as	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPI A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495283	B. WING		C 09/21/2023
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 00/21/2020
				1719 BELLEVUE AVENUE	
ROSEDAL	E HEALTH & REHABIL	ITATION		RICHMOND, VA 23227	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECT	
PREFIX TAG	•	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	
F 658	Continued From pag		F 65	8	
		ed bruises on the left lower		pressure injury treatments, accurat	ely
	•	and left hip wound were		documenting a resident⊡s skin	
		d cleanser and dry dressing		assessment upon admission, and	
	applied."			administering medications as order	red by
	Further review of R1	06's clinical record failed to		the physician.	
		otained physician's orders for		4. The Director of Nursing/designed	e will
		s that were completed.		conduct an audit of all residents we	
		·		for 4 weeks and monthly for 2 mon	
	On 9/20/23 at 10:10	a.m., an interview was		ensure that any resident with a pre	ssure
		registered nurse) #4. RN #4		injury has a physician order for pre	ssure
		s to give orders for how to		injury treatments. The Director of	
	clean wounds.			Nursing/designee will also audit an	-
	0 0/04/00 14.00	AON4 / 1		admissions weekly for 4 weeks and	
	-	o.m., ASM (administrative		monthly for 2 months to ensure ski	
		e administrator) and ASM #2 ng) were made aware of the		assessments are accurately docun upon admission. The Director of	nented
	above concern.	ng) were made aware or the		Nursing/designee will also audit 25	% of
	above concern.			resident □s medication administrati	
	The facility policy title	ed, "Medication and		records weekly for 4 weeks and mo	onthly
	Treatment Orders" d	ocumented, "1. Medications		for 2 months to ensure medications	s are
	will be administered	only upon the written order of		being administered as ordered by t	he
	a person duly license			physician. Any issues identified wil	
	prescribe such medi-	cations in this state."		addressed immediately by the Dire	
				Nursing/designee and appropriate	actions
	Reference:	, in In anima d dance are to the		will be taken. The Director of	
	, , , , , , , , , , , , , , , , , , ,	y is localized damage to the		Nursing/designee will identify any t	
		soft tissue usually over a related to a medical or other		and/or patterns and provide educa	
		n present as intact skin or an		training to staff on an ongoing basi Findings will be discussed with the	
		be painful. The injury occurs		committee on at least a quarterly b	
		e and/or prolonged pressure		destination of at loads a quarterly b	40.0.
	or pressure in combi			5. The date of compliance is: 11/3/	23
	Stage 1 Pressure Inj			, , , , , , , , , , , , , , , , , , , ,	
	erythema of intact sk				
	· ·	alized area of non-blanchable			
	erythema, which may	y appear differently in darkly			
	pigmented skin				
	Stage 2 Pressure Inj	ury: Partial-thickness skin			

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	PLE CONSTRUCTION IG		DATE SURVEY COMPLETED
		495283	B. WING _			C
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1719 BELLEVUE AVENUE RICHMOND, VA 23227	ı	09/21/2023
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOWN CROSS-REFERENCED TO THE APPLICATION OF THE APPLICAT	OULD BE	(X5) COMPLETION DATE
F 658	dermis. The wound is moist, and may also ruptured serum-filled Unstageable Pressu full-thickness skin an Full-thickness skin a extent of tissue dama be confirmed because eschar (dead tissue) obtained from the we https://cdn.ymaws.co.gr/online_store/npian 1.b. For Resident #1 failed to accurately dof a skin assessmen the nurse documented with no skin issues. R106's admission so 5/18/23 documented issues. A physical the documented R106 p pressure injuries (1) On 9/20/23 at 10:10 conducted with RN # documented the admassessment). RN #4 assessment on the coreport she received for the resident did not he documented no skin assessment. RN #4 documenting no skin services and services are serviced for the resident did not he documented no skin assessment. RN #4 documenting no skin	ermis. Is of skin with exposed bed is viable, pink or red, present as an intact or a libister It is lister It is lister	F6	58		

			(X3) DATE COMP	SURVEY LETED			
		495283	B. WING			l	21/2023
	ROVIDER OR SUPPLIER	TATION	•	1	STREET ADDRESS, CITY, STATE, ZIP CODE 719 BELLEVUE AVENUE RICHMOND, VA 23227	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 658	staff member) #1 (the (the director of nursin above concern. The facility policy title Wound Treatments" assessments are documented in the confirmed because each are (dead tissue) obtained from the weak https://cdn.ymaws.co.gr/online_store/npiage. For Resident #21 administer four mediphysician. A review of the physical following: (1) Aspirin an 81 mg daily. Order dated 9 (2) Valsartan an 80 m dated 9/8/23.	.m., ASM (administrative e administrator) and ASM #2 ng) were made aware of the ed, "Documentation of documented, "1. Wound cumented upon admission" essure Injury: Obscured at tissue loss. In the loss in which the lage within the ulcer cannot se it is obscured by slough or" This information was ebsite: om/npiap.com/resource/resm opressure_injury_stages.pdf 9 the facility staff failed to cations as ordered by the discin's orders revealed the (milligrams) tablet once	F	658			
	(4) Zinc a 220 mg tal healing. Order dated On 9/20/23 at 9:05 A administration was c						

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	LE CONSTRUCTION	(X3	ODATE SURVEY COMPLETED
		495283	B. WING			C 09/21/2023
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 1719 BELLEVUE AVENUE RICHMOND, VA 23227		03/21/2023	
(X4) ID PREFIX TAG	(EACH DEFICIEI	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 658	Medication Administration of drin accordance with manufacturer speciprofessional (s) proof medications errodrug is ordered but unauthorized drug without a physician wrong route of administed but unauthorized of drug is ordered but unauthorized of drug route of administration of drin accordance with manufacturer speciprofessional (s) proof medications errodrug is ordered but unauthorized drug without a physician wrong route of administration of administration of drin accordance with manufacturer speciprofessional standard professional standard p	physician's orders and the stration Record (MAR) for evealed that the Aspirin, D3 and Zinc were ordered but and administered on were signed out as being PM, an interview was N #10. She stated that she and administered the above swhy they were signed out as . She stated that she did not sed them. PM, a second follow up ucted with LPN #10. She sess for medication added the five rights of making right dose, right time, right and the right medication. See there were medications that we rights were not followed. Adverse Consequences and documented, ""Medication the preparation or rugs or biological which is not	F 65	8		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
		495283	B. WING		C 09/21/2023
	ROVIDER OR SUPPLIER	ITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 1719 BELLEVUE AVENUE RICHMOND, VA 23227	03/21/2023
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE COMPLETION
F 658	was conducted with Member) the Admini of Nursing, and ASM Consultant, were ma further information wasurvey. References: (1) Aspirin - Is used strokes, and reduce attack or stroke. Information obtained https://medlineplus.gtml (2) Valsartan - Is us with other medication pressure. Information obtained https://medlineplus.gtml (3) Vitamin D3 - Is us when the amount of enoughis also use prevent and treat bo Information obtained https://medlineplus.gtml (4) Zinc - Is an essecommonly found in ris necessary in small growth, and sense of	PM, an end-of-day meeting ASM #1 (Administrative Staff strator, ASM #2 the Director #4, the Regional Nurse ade aware of the findings. No was provided by the end of the to prevent heart attacks, the risk of death from a heart from gov/druginfo/meds/a682878.h ed alone or in combination ins to treat high blood. I from gov/druginfo/meds/a697015.h esed as a dietary supplement vitamin D in the diet is not d along with calcium to ne diseases I from gov/druginfo/meds/a620058.h	F 6:	58	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	IPLE CONSTRUCTION IG		(X3) DATE COMPI	
		495283	B. WING _			09/2	21/2023
	ROVIDER OR SUPPLIER	TATION		STREET ADDRESS, CITY, STATE, ZIP COD 1719 BELLEVUE AVENUE RICHMOND, VA 23227	E		
(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 CO ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE		(X5) COMPLETION DATE
F 658 F 684 SS=G	It's needed for immun blood clotting, thyroid also plays a key role might have effects ag Information obtained https://medlineplus.go	et be obtained from the diet. e function, wound healing, function, and much more. It n maintaining vision and ainst viruses.	F 6				
	applies to all treatment facility residents. Bas assessment of a resident residents receive accordance with profes practice, the compreheare plan, and the resident resident resident resident review, and the resident review, clinical recodocument review, it was facility staff failed to for transporting a resident resi	andamental principle that and care provided to sed on the comprehensive lent, the facility must ensure treatment and care in essional standards of tensive person-centered sidents' choices. The is not met as evidenced on, resident interview, staff ord review, and facility as determined that the follow the plan of care for the which resulted in an injury in the survey sample, sident sustained a fracture which constituted harm, pliance.		Past noncompliance: no plat correction required.	n of		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII		STRUCTION	(X3) DATE COMP	SURVEY
		495283	B. WING _				C 21/2023
	ROVIDER OR SUPPLIER LE HEALTH & REHABILI	TATION		1719 B	T ADDRESS, CITY, STATE, ZIP CODE BELLEVUE AVENUE MOND, VA 23227	1 00.	
(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 I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE
F 684	a fractured femur. On R33's most recent a significant change at (assessment reference resident was not assed to documented R33 to having range of motion the upper and lower and documented R33 beit using a manual wheet documented R33 have related to a fall in the commented R33 have related to a fall in the commented R33 using a manual wheet documented R33 using the resident was asset independent in making documented R33 using range of motion impart and lextremities. Section non-ambulatory and lextremities. Section non-ambulatory and lextremities of feet with two a corridor or similar section documented R33 not on 9/21/2023 at 8:34 conducted with R33. Not really been told we remembered that the	and subsequently sustained It MDS (minimum data set), assessment with an ARD be date) of 8/10/2023, the assed for cognition. Section asing a wheelchair and on impairment on one side in extremity. Section GG ang non-ambulatory and alchair. Section J ring a fall with fracture past 6 months. Sprior to the injury, a t with an ARD of 5/25/2023, assed as being modified and daily decisions. Section G and a wheelchair and having irment on one side in the both side in the lower GG documented R33 being using a manual wheelchair. I R33 being dependent to to turns and wheel 150 feet in pace. Section J	F	684			
	- "7/28/2023 12:29 (1	or R33 documented in part, 2:29 p.m.) Note Text: CNA istant) propelling resident to					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G	(X3	COMPLETED
		495283	B. WING _			C
	ROVIDER OR SUPPLIER	1	STREET ADDRESS, CITY, STATE, ZI 1719 BELLEVUE AVENUE RICHMOND, VA 23227		09/21/2023 P CODE	
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 684	the shower room in 1030am when reside to the floor and cau w/c in the hallway. In the hallway. In the hallway members. Denies properties and the properties of the floor and cau w/c in the hallway. In the hallway. In the hallway members. Denies properties of the properties of the floor and the properties of the floor	her w/c (wheelchair) at dents feet with sneakers on fell seed resident to fall out of the Assisted from floor by 3 staff pain. States she feels fine. Scion) performed without any staff pain. RP (responsible party) and derived the will cont (continue) to (3:22 p.m.) Note Text: plains of) pain 6/10 (six out of at groin and thigh. Voltaren gele (nurse practitioner) called and co. (new order) Right hip and STAT (now) s/p (status post) are party) aware. X-ray called in l." (10:47 p.m.) Note Text: X-ray called this shift, Resident complained of level ving in the bed was medicated good relief." (7:00 a.m.) Note Text: ult finding sub capital fracture amoral neck without dislocation can) message via on call, at report given to oncoming (7:52 a.m.) Note Text: N.O. sident to ED (emergency atted to) r (right) femur fx 3:30 p.m.) Note Text: Readmit are Care Hospital for repair and its fracture. Surgical procedure ght hip, dressing dry and	F 6	84		
	- "7/29/2023 07:52 received to send re department) r/t (relature)." - "8/2/2023 15:30 (3 to facility from Acut treatment of right his was performed to ri intact, no bleeding. (temperature),98 (p. 10.5)	sident to ED (emergency ated to) r (right) femur fx 3:30 p.m.) Note Text: Readmit e Care Hospital for repair and ip fracture. Surgical procedure ght hip, dressing dry and				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION IG	(XX	3) DATE SURVEY COMPLETED	
		495283	B. WING _			C 09/21/2023	
	ROVIDER OR SUPPLIER	LITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 1719 BELLEVUE AVENUE RICHMOND, VA 23227		1 03/21/2023	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 684	pedal pulses." The comprehensive documented in part living) Self care defi weakness, femur fra 05/18/2019. Revision plan further docume actual fall due to we 05/18/2019. Revision Review of the fall in dated 7/28/2023 do Description: Nursing resident to the show when residents feet floor and caused resthe hallway. Assiste members. Denies promote actual fall did not hit her head done. No visible inj and ROM WNL (wit back to w/c. Complement order STAT x-ray of notified. Pain mediarests provided on whospital? N (no)N incident." On 9/20/2023 at 3:3 staff member) #1, the CNA who was particular fractions.	e care plan for R33 , "ADL (activities of daily icit as evidenced by related to acture. Date Initiated: on on: 08/02/2023." The care ented, "At risk for falls, had an eakness. Date Initiated: on on: 08/02/2023." vestigation completed for R33 cumented in part, "Incident g Description: CNA propelling ver room in her w/c at 1030am with sneakers on fell to the sident to fall out of the w/c in ed from floor by 3 staff ain. States she feels fine. Hout any new limitation or obtified. Will cont to monitor aken: Description: Resident to Head to toe assessment ury noted. V/S (vital signs) hin normal limits). Assisted aining of right hip, leg pain. received and carried out to right hip and right femur. RP cation administered. Leg heelchair. Resident taken to lo injuries observed post	F	84			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	PLE CONSTRUCTION IG		DATE SURVEY COMPLETED
		495283	B. WING			C 09/21/2023
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1719 BELLEVUE AVENUE RICHMOND, VA 23227	!	09/21/2023
(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 COR ((EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 684	Continued From page interviewed. ASM #4		F 6	84		
	consultant stated tha	t the facility had an action ut in place after R33's injury				
	conducted with LPN LPN #3 stated that th	a.m., an interview was (licensed practical nurse) #3. ley were unsure if they were 33's injury or not. She stated				
	that the team had dis their morning meeting out to the hospital. S	cussed the fall and injury in g after they had been sent the stated that R33 was				
	staff to push them are that any residents that	or to the injury and required bund the halls. She stated at were unable to propel seelchair should have leg				
	rests on the chairs to	•				
	conducted with ASM ASM #2 stated that the 7/28/2023. She stated that they were calling	8 a.m., an interview was #2, the director of nursing. ney were in the building on ed that the staff notified them the nurse practitioner and				
	stated that the staff re taking the resident fo and they had put the	for the stat x-ray. She eported to her that they were r their scheduled shower, ir feet down with their shoes				
	one person assist, who required staff to proper prior to the incident.	el them in the wheelchair She stated that from their				
	rests on the wheelch	nvestigation they had CNA did not have the leg air and had the resident She stated that this led				
	them to put an action	plan in place. She stated for staff was to make sure e in place prior to				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495283	B. WING		09/21/2023	
	ROVIDER OR SUPPLIER	LITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 1719 BELLEVUE AVENUE RICHMOND, VA 23227	1 03/21/2023	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUND CROSS-REFERENCED TO THE APPRODEFICIENCY)	JLD BE COMPLETION	
F 684	conducted with CNA anytime they needed required them to pure sure they had leg restant if the resident of went to the therapy. She stated that they did not drag because breakdown and was conducted with CNA residents had leg resi	35 a.m., an interview was A #9. CNA #9 stated that d to transport a resident who sh their wheelchair they made ests on the chair. She stated lid not have leg rests, they department to obtain some. If did this so the resident's feet we it could cause skin as also a safety issue. 241 a.m., an interview was A #10. CNA #10 stated that lests on the wheelchair for use staff unless therapy resident needed to be extremities by a stated that R33 was able to opel themselves in the	F 68	,		
	R33 did not hit their pain, or have any al the head-to-toe ass monitored them at t was in the wheelchafeet hanging down a on them and they the down on the carpet	front of her. She stated that head, did not complain of any conormalities in vital signs or essment so they had just hat time. She stated that R33 air without leg rests with their and had sneaker on with grips lought when their foot dropped it had gripped the carpet and lard out of the chair. She				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION G		DATE SURVEY COMPLETED
		495283	B. WING			C 00/24/2023
	ROVIDER OR SUPPLIER	LITATION	STREET ADDRESS, CITY, STATE, ZIP COD 1719 BELLEVUE AVENUE RICHMOND, VA 23227		09/21/2023 E	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 684	room to get the leg could not be located fine until later in the complain of pain, so practitioner and ord R33 normally was a wheelchair by staff had only seen them hallway. On 9/21/2023 at ap #1, the administrate R33 with a complet of the action plan deplan for R33, identif potentially affected, quality assurance performance and a plan. On 9/21/2023 at ap request was made of for evidence of common one education regarding application residents that are dependent wheelch leg rests were avail	advised the CNA to go to the rests for the chair, but they d. She stated that R33 was a shift when they started to to they had contacted the nurse ered the x-ray. She stated that always propelled in the prior to the incident and they a propel only a few steps in the proximately 8:00 a.m., ASM or provided an action plan for ion date of 8/4/2023. Review ocumented corrective action fication of other residents measures the facility will take, lans to monitor facility completion date for the action proximately 8:20 a.m., a to ASM #1, the administrator apletion of the action plan. 40 a.m., ASM #1 provided a ere of completion of the action plan documented: 1) on to the CNA involved on of leg rest/footrest on any ependent with locomotion. 2) of all residents in the facility sidents potentially affected. 3) in 8/11/2023, 8/18/2023, 3, 9/8/2023 and 9/15/2023 of lair residents to determine if able and 25% care plan cumented education provided	F 6	84		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
		495283	B. WING			C 09/21/2023	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 1719 BELLEVUE AVENUE RICHMOND, VA 23227	•		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 684	rests are available for rests if not available nursing on 8/3/2023. assurance performar agenda/summary dathe administrator, MI and director of nursir "Management of tranwheelchair residents wheelchair depender Review of the plan of #1 for R33's injury or date of compliance of the facility plan of coobservations, staff in facility audits, staff en No concerns were id Observations of currotransported by facility the survey dates. The concerns identified. On 9/21/2023 at 12:0 administrator and AS consultant were made harm. No further inforto exit. Based on the accept components of the pridentified during the sis cited at past non-concerns.	ent residents- ensure leg r chair & place order for leg conducted by the director of 4) An ad hoc QAPI (quality nee improvement) meeting ted 8/3/2023 documenting DS coordinator, unit managering meeting regarding isporting dependent in wheelchairs and where nee is documented." If correction provided by ASM of 7/28/2023 documented a f 8/4/2023. Verification of correction was completed by terviews and review of the ducation and resident audits. The entified. The entified of the concern for remation was provided prior able plan of correction, all an verified, and no concerns sourcey, this deficient practice	F 6	84			

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
		495283	B. WING _		C 09/21/2023
	ROVIDER OR SUPPLIER	TATION		STREET ADDRESS, CITY, STATE, ZIP CODE 1719 BELLEVUE AVENUE RICHMOND, VA 23227	03/21/2023
(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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE COMPLETION
F 684 F 686 SS=G	leg. It is also called the needed surgery to replace and surgery called an fixation. In this surger cut to open your fract obtained from the we https://medlineplus.go 00166.htm. Treatment/Svcs to Pr	e thigh bone. You may have pair the bone. You may have open reduction internal y, your surgeon will make a paire. This information was posite: by/ency/patientinstructions/0 event/Heal Pressure Ulcer	F 6		11/3/23
	resident, the facility m (i) A resident receives professional standard pressure ulcers and of ulcers unless the individemonstrates that the (ii) A resident with professional star promote healing, previous new ulcers from deverthis REQUIREMENT by: Based on resident in facility document revious, the facility star services to prevent at three of 40 residents Residents #106, #108 #106, the facility staff for risk for pressure in pressure in juries, failed orders for the treatments.	re ulcers. hensive assessment of a nust ensure that- s care, consistent with s of practice, to prevent loes not develop pressure vidual's clinical condition by were unavoidable; and essure ulcers receives and services, consistent adards of practice, to vent infection and prevent loping. The is not met as evidenced terview, staff interview, ew and clinical record of failed to provide care and and treat pressure injuries for		This plan of correction is respectful submitted, and it is an affirmation the corrections to the areas cited have a made and the facility is in compliant participation requirements. 1. Residents #106 and #96 no long reside at the facility. Resident #108 received care and services to prevente treat pressure injuries.	er has

l ` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	IDENTIFICATION NUMBER:		MULTIPLE CONSTRUCTION JILDING		(X3) DATE SURVEY COMPLETED	
							С	
		495283	B. WING _			0	9/21/2023	
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE			
DOCEDAL	FUEALTH & DEHAL	DII ITATION		17	719 BELLEVUE AVENUE			
RUSEDAL	E HEALTH & REHA	BILITATION		R	CICHMOND, VA 23227			
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR	BE	(X5) COMPLETION DATE	
IAG	THE GOLF IT OTHER	CRESS BERTIL TING III GRAWATION,	IAG		DEFICIENCY)			
F 686	Continued From p	nage 73		686				
1 000	-	_		000	2 December 1			
	turtner pressure ir	njuries, which constituted harm.			Rosedale has identified that all residents are at risk from this deficient	t		
	The findings inclu			practice. An audit has been conducted identify any pressure injuries and to	d to			
	1. For Resident#	106 (R106), upon admission on			ensure treatment and services are bei	ing		
		y staff failed to assess the			provided. A process has been develop	•		
		or pressure injuries, failed to			and implemented to provide treatment			
	document pressu			and services to prevent/heal pressure				
	hip, right heel and			ulcers.				
	physician's orders	for treatments for those						
	pressure injuries,	and failed to implement			3. The Director of Nursing/designee h			
		revent further pressure injuries.			educated licensed nursing staff (RNs	and		
		ound care physician identified			LPNs) on providing treatment and			
	_	e (1) pressure injuries on the			services to Prevent/Heal Pressure Uld			
	right great toe and	d left great toe.			The in-service includes, but is not limit			
					to, completing thorough assessments			
		ed to the facility on 5/18/23. The			assess the resident for risk of pressur	е		
		er assessment dated 5/18/23			injuries, documentation of pressure			
		6 presented with no skin issues;			injuries, care planning pressure injurie			
		n interview with RN (registered			obtaining physician orders to impleme	nt		
	· '	rse who documented the			interventions to prevent and treat			
		er assessment, RN #4 stated			pressure injuries, providing treatments	-		
		kin assessment on 5/18/23 and			physician⊡s orders, assessing self-ca	re		
		ete a skin assessment until			of pressure injuries and providing			
		tated that during the 5/19/23			oversight of self-care to ensure			
		she identified multiple pressure			treatments are being completed.			
		were later documented in a skin			4 Th - Din4f Noi/i			
		. The pressure injuries			4. The Director of Nursing/designee w	111		
		N #4's skin note dated 6/7/23 able pressure injury on the			conduct an audit of residents with a	٨		
	_	geable pressure injury on the			pressure injury weekly for 4 weeks an monthly for 2 months to ensure that the			
		tageable pressure injury on the			are receiving care and services to pre			
	_	age two (1) pressure injury on			and treat the areas. The Director of	v Ciil		
	the left hip.	age two (1) pressure injury on			Nursing/designee will also audit any n	ω.ν.		
	uie ieit ilip.				admissions weekly for 4 weeks and	CVV		
	The facility staff fo	ailed to assess the resident's			monthly for 2 months to ensure skin			
		njuries (until 5/23/23 when the			assessments are accurately documen	ted		
		essed as being at moderate risk			upon admission and any pressure inju			
		es), failed to develop a care			provided with treatment and services.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
	495283	B. WING			C 9/21/2023	
NAME OF PROVIDER OR SUPPL			STREET ADDRESS, CITY, STATE, ZIP		9/2 1/2023	
			1719 BELLEVUE AVENUE			
ROSEDALE HEALTH & REI	HABILITATION		RICHMOND, VA 23227			
PREFIX (EACH DE	MARY STATEMENT OF DEFICIENCIES FICIENCY MUST BE PRECEDED BY FULL DRY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
failed to obtain interventions to injuries (until 6, physician evaluate treatments for 17 These pressure injuries skin note; an usacrum, an unsileft hip, an unsinght heel and a and two new properties. A hospital discipated to reveal pressure injuries facility on 5/18, pressure injuries admission. R1 (assessment) or resident had not plan triggers set focus, goals, or skin integrity. R106's care pladocument any and pressure in the documented R mobility and properties.	m page 74 Ire injuries (until 6/27/23), and physician's orders to implement or prevent and treat pressure /8/23). On 6/8/23, the wound cauted R106 and ordered six different pressure injuries. e injuries included the four es documented in RN #4's 6/7/23 instageable pressure injury on the stageable pressure injury on the stageable pressure injury on the ressure injuries which were an ressure injury on the ressure injury on the ressure injury on the left harge summary dated 5/18/23 any documentation regarding es. R106 was admitted to the /23. No assessment for risk for es was completed on the date of 06's admission screener dated 5/18/23 documented the oskin issues. The baseline care ection of the screener revealed restriction of the screener revealed restriction in the regarding skin integral injuries, until 6/27/23. Tapy evaluation dated 5/19/23 failed to information regarding skin integral injuries, until 6/27/23. Tapy evaluation dated 5/19/23 failed to information regarding skin integral injuries, until 6/27/23. Tapy evaluation dated 5/19/23 failed to record failed to reveal any further record failed to reveal any further record failed to reveal any further regarding the bilateral heel	are 3 seel, oe rity ped ral of	issues identified will be ac immediately by the Directon Nursing/designee and appear will be taken. The Directon Nursing/designee will ider and/or patterns and provious training to staff on an ong Findings will be discussed committee on at least a question of the staff of the s	or of propriate actions r of ntify any trends de education and oing basis. d with the QAPI uarterly basis.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		495283	B. WING _			C 09/21/2023
	ROVIDER OR SUPPLIER LE HEALTH & REHABIL	ITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 1719 BELLEVUE AVENUE RICHMOND, VA 23227	•	03/21/2023
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 686	pressure injuries unidated 5/22/23 docur therapy that residen On arrival resident h (injuries) on both he both side of the foot skin prep." A review medication administration administration treatment administration failed to reveal any tinjuries. A review of nurse prepromotes dated 5/19/23 through documentation reganotes dated 5/19/23 5/24/23 documented cyanosis. Warm and nodules, or discoloral A Braden scale for prepromotes administration reconsultation reconsultat	til 5/22/23. A nurse's note mented, "It was reported by thas large ulcers on heels. as unstageable ulcers els and stage 1 (1) ulcer on and ankle. Wiped down with of physician's orders, the ration record and the ation record for May 2023 treatments for the pressure actitioner and physician notes in 5/24/23 failed to reveal any rding pressure injuries. The 5/22/23, 5/23/23 and 1, "SKIN: No rash, ulcer or d dry. No induration, ation" Predicting pressure sore 23/23 had documented that ate risk for pressure injuries. In's orders, the medication d, and the treatment d for May 2023 and June I any treatments for any til 6/8/23. End 6/2/23 and 6/7/23 (Name) indicated that a on both heels. Wound care m and dry. No induration,	Fé	986		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDIN	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
	495283	B. WING		09/21/2023	
OVIDER OR SUPPLIER	TATION		STREET ADDRESS, CITY, STATE, ZIP CODE 1719 BELLEVUE AVENUE RICHMOND, VA 23227	1 09/21/2023	
(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	OULD BE COMPLETION	
was noted to have ar (pressure injury) mea 10 cm in circumferen cm stage II (1) ulcer of left upper thigh, fluid surrounding tissues rom unstageable ulce bruises on the left low left hip wound were of cleanser and dry dress. A progress note signification on 6/8/23 of Exam. Constitutional	n unstageable ulcer asuring 7 cm (centimeters) x ce in the sacrum. 5 cm x 7 on the lateral aspect of the filled in the center and ed and irritated. 4 cm x 4.5 r on both heels. Scattered wer leg and foot. Sacral and eleansed with wound essing applied." ed by the wound care locumented, "Physical l: The pulse has a regular	F 68	36		
patient appears well weightWound Asse -Wound #1 Sacral is Injury Obscured full-t loss Pressure Ulcer a Not Healed. Initial w measurements are 8 no measurable depth (square) cm. There is serous drainage note wound margin is flat 76-100% escharWound #2 Left Hip is Injury Obscured full-t loss Pressure Ulcer a Not Healed. Initial w measurements are 6 no measurable depth There is a None amo has no odor. The wo Wound #3 Right Healed. Wound #3 Right Healed.	nourished and has a normal ssments(s) an Unstageable Pressure hickness skin and tissue and has received a status of ound encounter cm length x 9 cm width with a, with an area of 72 sq s Moderate amount of and which has no odor. The and intact. Wound bed has as an Unstageable Pressure hickness skin and tissue and has received a status of ound encounter cm length x 3 cm width with a, with an area of 18 sq cm. Funt of drainage noted which and margin is flat and intact.				
O /O : O O O O O O O O O	SUMMARY ST (EACH DEFICIENCE REGULATORY OR Continued From page was noted to have ar (pressure injury) mea 10 cm in circumferen cm stage II (1) ulcer of left upper thigh, fluid surrounding tissues r cm unstageable ulcer bruises on the left low left hip wound were of cleanser and dry dres A progress note signe physician on 6/8/23 of Exam. Constitutiona rate and rhythm. The patient appears well if weightWound Asse -Wound #1 Sacral is Injury Obscured full-t loss Pressure Ulcer a Not Healed. Initial we measurements are 8 no measurable depth (square) cm. There i serous drainage note wound margin is flat a 76-100% escharWound #2 Left Hip is Injury Obscured full-t loss Pressure Ulcer a Not Healed. Initial we measurements are 6 no measurable depth closs Pressure Ulcer a Not Healed. Initial we measurements are 6 no measurable depth do and the serous linjury Obscured full-t loss Pressure Ulcer a Not Healed. Initial we measurements are 6 no measurable depth of the serous and the serous linjury Obscured full-t loss Pressure Ulcer a Not Healed. Initial we measurements are 6 no measurable depth of the serous and the serous linjury Obscured full-t loss Pressure Ulcer a Not Healed. Initial we measurements are 6 no measurable depth of the serous linjury Obscured full-t loss Pressure Ulcer a Not Healed. Initial we measurements are 6 no measurable depth of the serous linjury Obscured full-t loss Pressure Ulcer a Not Healed. Initial we measurements are 6 no measurements are 6 no measurements are 6 no measurements are 1 loss Pressure Ulcer a Not Healed. Initial we measurements are 1 loss Pressure Ulcer a Not Healed. Initial we measurements are 1 loss Pressure Ulcer a loss Pressu	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 76 was noted to have an unstageable ulcer (pressure injury) measuring 7 cm (centimeters) x 10 cm in circumference in the sacrum. 5 cm x 7 cm stage II (1) ulcer on the lateral aspect of the left upper thigh, fluid filled in the center and surrounding tissues red and irritated. 4 cm x 4.5 cm unstageable ulcer on both heels. Scattered bruises on the left lower leg and foot. Sacral and left hip wound were cleansed with wound cleanser and dry dressing applied." A progress note signed by the wound care physician on 6/8/23 documented, "Physical Exam. Constitutional: The pulse has a regular rate and rhythm. The patient is afebrile. The patient appears well nourished and has a normal weightWound Assessments(s) Wound #1 Sacral is an Unstageable Pressure Injury Obscured full-thickness skin and tissue loss Pressure Ulcer and has received a status of Not Healed. Initial wound encounter measurements are 8 cm length x 9 cm width with no measurable depth, with an area of 72 sq (square) cm. There is Moderate amount of serous drainage noted which has no odor. The wound margin is flat and intact. Wound bed has	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 76 was noted to have an unstageable ulcer (pressure injury) measuring 7 cm (centimeters) x 10 cm in circumference in the sacrum. 5 cm x 7 cm stage II (1) ulcer on the lateral aspect of the left upper thigh, fluid filled in the center and surrounding tissues red and irritated. 4 cm x 4.5 cm unstageable ulcer on both heels. Scattered bruises on the left lower leg and foot. Sacral and left hip wound were cleansed with wound cleanser and dry dressing applied." A progress note signed by the wound care physician on 6/8/23 documented, "Physical Exam. Constitutional: The pulse has a regular rate and rhythm. The patient is afebrile. The patient appears well nourished and has a normal weightWound Assessments(s) -Wound #1 Sacral is an Unstageable Pressure Injury Obscured full-thickness skin and tissue loss Pressure Ulcer and has received a status of Not Healed. Initial wound encounter measurements are 8 cm length x 9 cm width with no measurable depth, with an area of 72 sq (square) cm. There is Moderate amount of serous drainage noted which has no odor. The wound margin is flat and intact. Wound bed has 76-100% eschar -Wound #2 Left Hip is an Unstageable Pressure Injury Obscured full-thickness skin and tissue loss Pressure Ulcer and has received a status of Not Healed. Initial wound encounter measurements are 6 cm length x 3 cm width with no measurable depth, with an area of 18 sq cm. There is a None amount of drainage noted which has no odor. The wound margin is flat and intact. Wound bed has 76-100% eschar -Wound #3 Right Heel is an Unstageable Pressure Injury Obscured full-thickness and	STREET ADDRESS, CITY, STATE, ZIP CODE 1719 BELLEVUR AVENUE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 76 was noted to have an unstageable ulcer (pressure injury) measuring 7 cm (centimeters) x 10 m in circumference in the sacrum. 5 cm x 7 cm stage II (1) ulcer on the lateral aspect of the eft upper thigh, fluid filled in the center and surrounding tissues red and irritated. 4 cm x 4.5 cm unstageable ulcer on both heels. Scattered bruises on the left lower leg and foot. Sacral and eft hip wound were cleansed with wound cleanser and dry dressing applied." A progress note signed by the wound care physician on 6/8/23 documented, "Physical Exam. Constitutional: The pulse has a regular rate and rhythm. The patient is afebrile. The patient appears well nourished and has a normal weight. Wound Assessments(s) Wound #1 Sacral is an Unstageable Pressure injury Obscured full-thickness skin and tissue loss Pressure Ulcer and has received a status of Not Healed. Initial wound encounter measurements are 8 cm length x 9 cm width with no measurable depth, with an area of 72 sq (square) cm. There is Moderate amount of serous drainage noted which has no odor. The wound margin is flat and intact. Wound bed has 76-100% eschar "Wound #2 Left Hip is an Unstageable Pressure injury Obscured full-thickness skin and tissue loss Pressure Ulcer and has received a status of Not Healed. Initial wound encounter measurements are 8 cm length x 9 cm width with no measurable depth, with an area of 18 sq cm. There is a None amount of drainage noted which has no odor. The wound margin is flat and intact. Wound #3 Right Heel is an Unstageable Pressure Injury Obscured full-thickness and	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		495283	B. WING			C 9/21/2023
	ROVIDER OR SUPPLIER	TATION		STREET ADDRESS, CITY, STATE, ZIP COD 1719 BELLEVUE AVENUE RICHMOND, VA 23227	•	
(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 686	measurements are 6 no measurable depth There is a None amount has no odor. The wow Wound bed has 76-1 -Wound #4 Left Heel Pressure Injury Persired, maroon or purplulicer and has receiv Initial wound encountength x 6 cm width with an area of 30 sq amount of drainage in The wound margin is has 76-100% epithel -Wound #5 Right Green Pressure Injury Obscitissue loss Pressure status of Not Healed measurements are 1 no measurable depth There is a None amount has no odor. The wow Wound bed has 76-1 -Wound #6 Left Green Pressure Injury Obscitissue loss Pressure status of Not Healed measurements are 1 no measurable depth There is a None amount has no odor. The wow Wound bed has 76-1 Weekly Wound Evaluof 6/8/23 and signed nurse) #3 on 6/9/23,	Initial wound encounter cm length x 6 cm width with a, with an area of 36 sq cm. aunt of drainage noted which bund margin is flat and intact. 00% eschar is a Deep Tissue (1) stent non-blanchable deep ed discoloration Pressure ed a status of Not Healed. Iter measurements are 5 cm with no measurable depth, cm. There is a None noted which has no odor. If and intact. Wound bed italization is at Toe is an Unstageable eured full-thickness skin and Ulcer and has received a linitial wound encounter cm length x 1 cm width with a, with an area of 1 sq cm. Funct of drainage noted which bund margin is flat and intact. 100% eschar it Toe is an Unstageable eured full-thickness skin and Ulcer and has received a linitial wound encounter cm length x 1 cm width with a linitial	F 68	36		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPL AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING		FIPLE CONSTRUCTION NG	(X3	B) DATE SURVEY COMPLETED		
		495283	B. WING _			C 09/21/2023
	ROVIDER OR SUPPLIER	ITATION		STREET ADDRESS, CITY, STATE, ZIP 1719 BELLEVUE AVENUE RICHMOND, VA 23227	CODE	33/21/2323
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN O X (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 686	Continued From pag	e 78	F	686		
	provider, and docum as new skin concern	obtained by the wound care ented the pressure injuries s and facility acquired.				
	were not obtained ur 1. Bactrim DS (doub 800-160 mg (milligra times a day for wour	all of the pressure injuries ntil 6/8/23 and included: le strength) (an antibiotic) ms)- one tablet by mouth two nd infection for 14 days.				
	hip topically every ex Cleanse area with w cover with foam dres	cal grade honey)- Apply to left vening shift for skin alteration. ound cleanser, apply honey, ssing. to sacrum topically every				
	evening shift for skin	alteration. Cleanse area , apply medihoney, cover				
	(antiseptic used to treevening shift for skin	eat skin infections) every alteration. Is with betadine every				
	On 9/20/23 at 9:37 a conducted with LPN	.m., an interview was (licensed practical nurse) #3				
	wound evaluations). assessment, and a handle be completed	mented the 6/8/23 weekly LPN #3 stated a Braden nead-to-toe skin assessment If for all residents upon				
	present with a pressi staff have to make si	stated if a resident does ure injury on admission, then ure the resident has an air ırses should check the				
	orders. LPN #3 state instructions do not co then nurses should of	structions for wound care ed that if the discharge ontain wound care orders, call the doctor or nurse wound care orders. LPN #3				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495283	B. WING			C 09/21/2023
	ROVIDER OR SUPPLIER	TATION	•	STREET ADDRESS, CITY, STATE, ZIP COD 1719 BELLEVUE AVENUE RICHMOND, VA 23227		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 686	in case the first nurse stated nurses are surplan on admission are include a risk for skir and include pressure pressure injuries. Libraria tresidents are admitted should be conducted are required to look a #3 stated if a new are should assess the preassessment, notify the initiate a treatment of plan. LPN #3 stated injuries should include the measurement of the presence of drain nurse is a RN (regist evidencing the compostated the nurses evidencing the treatment administration on 9/20/23 at 10:10 conducted with RN # documented the administration of the presence of th	hours of admission, a second skin assessment emissed something. LPN #3 poposed to develop a care and the care plan should a alteration for all residents injuries if the resident has PN #3 stated that after and, weekly skin observations on all residents and nurses at every resident's skin. LPN are a is observed, the nurse essure injury, document the ne doctor, notify the family, and update the care assessments of pressure a description of the wound, the size, any odor, the color, hage, and the stage if the ered nurse). In regard to letion of treatments, LPN #3 dence treatments are done ents off on the electronic tion record. a.m., an interview was 4, the nurse who hission screener assessment 's note. RN #4 stated R106	F 68	36		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CC A. BUILDING A. BUILDING		FIPLE CONSTRUCTION NG		DATE SURVEY COMPLETED		
		495283	B. WING			C 09/21/2023
	ROVIDER OR SUPPLIER	ITATION		STREET ADDRESS, CITY, STATE, ZIP O 1719 BELLEVUE AVENUE RICHMOND, VA 23227	CODE	00/21/2020
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG		TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 686	doctor has to give of wounds. (Note: RN progress note regard until 6/7/23 and physician evaluated On 9/20/23 at 10:26 conducted with LPN documented the 5/2 did not remember R R106. On 9/20/23 at 3:19 pconducted with ASN member) #3 (the wostated he could not R106's pressure injuries. A highly non-complian understand why staff determining what the pressure injuries be pressure injuries. A to call him anytime a visit. On 9/20/23 at 3:37 pstaff member) #1 (the director of nursicabove concerns and	tor involved because the orders for how to clean the #4 did not document a ding R106's pressure injuries sician's orders were not after the wound care the pressure injuries). a.m., an interview was #9, the nurse who 2/23 nurse's note. LPN #9 106 or any information about and care physician). ASM #3 provide information about uries before he observed the SM #3 stated R106 was the with care, and he could for could have a tough time eatments to use for R106's cause of the amount of SM #3 stated he tells the staff and not wait until his weekly one., ASM (administrative are administrator) and ASM #2 ang) were made aware of the the concern for harm.	F	686		
	conducted with OSN (R106's physical the not responsible for cassessments, but he	a.m., an interview was I (other staff member) #7 rapist). OSM #7 stated he is conducting total body skin c completes range of motion sts residents' strength and				

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				DATE SURVEY COMPLETED
		495283	B. WING			C
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1719 BELLEVUE AVENUE RICHMOND, VA 23227	I	09/21/2023
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 686	unusual or pain, he olimited mobility or pain 5/19/23, R106 comphe removed the residunstageable pressur looked blackish blue stated he reported the nursing staff on 5/19. On 9/21/23 at 12:18 R106's nurse practitical available for interview. The facility policy title Prevention And Manintent of this organizmaintain systems and the resident does not ulcers/injuries, (PU/Funavoidable and that and services consist standards of practice of pressure ulcer/injurealing of existing profice (including prevention possible); and prevention possible); and prevention possible); and prevention possible). Pressure ulcer/injury PROCEDURES/GUI 1. Pressure ulcer/injury PROCEDURES/GUI 1. Pressure ulcer/injury procession admission admission admission admission admission. Pressure ulcersed/registered in the resident's medical format/tool.	ent complains of something checks to see the cause of in. OSM #7 stated on lained of pain in both feet so dent's socks and saw e injuries that were closed, but not yet eschar. OSM #7 the pressure injuries to the /23. p.m., a call was placed to oner but she was not w. ed, "Pressure Injury agement" documented, "The lation is to develop and d processes to ensure that the develop pressure ent with professional ento: -Promote the prevention ary development; promote the ressure ulcers/injuries of infection to the extent and development of additional ento: SPECIFIC DANCE: Risk Assessments-bury risk assessments will be sion/re-admission, a risk completed weekly for the first sure ulcer/injury risk conducted by a nurse and will be documented lical record using the facility	F 6	86		

OLITIC	OT OIL MEDIO, ILL A	MEDIO/ ND CEITVIOLO				<u> </u>	7. 0000 000 1
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
			7 20.25			، ا	c
		495283	B. WING				21/2023
NAME OF PE	ROVIDER OR SUPPLIER	100200			STREET ADDRESS, CITY, STATE, ZIP CODE	09/	21/2023
TO WILL OF TH	TO VIDERY OF YOUR TELETY				719 BELLEVUE AVENUE		
ROSEDAL	E HEALTH & REHABILI	TATION			RICHMOND, VA 23227		
					·		I
(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		(X5) COMPLETION DATE
IAO		,	1710		DEFICIENCY)		
F 686	Continued From page	e 82	F	686			
	incorporated into the	resident's plan of care.					
	Preventative Measure	es- 1. Preventative					
	interventions will be in	mplemented based on the					
	pressure ulcer/injury	risk assessment, other					
	related factors, and re	esident					
	preferencesIdentific	cation- 1. Staff will be					
	encouraged to promp	tly report any observation of					
	a change in the reside	5 ,					
	_	ions will be conducted by a					
		ndings will be documented in					
	the resident's medical record. 3. Observations of						
		ijury will be: a. Reported to					
		oner for further evaluation					
		ferred to the designated					
	wound nurse as appr	-					
	Evaluation/Assessme						
		nt of pressure ulcer/injury					
		ekly and with significant					
	change in condition o						
	licensed nurse and/or	•					
		e evaluations/assessment of					
		ury will [sic] maintained in					
		I record. Documentation					
	•	ion of ulcer/injury. b. Date					
		as acquired [when known].					
		ulcer/injury to include stage,					
	measurements [lengt	ny tunneling or undermining,					
		ial, granulation, slough,					
		nce/absence and type of					
		g tissue description, and					
		pain with the ulcer/injury. d.					
	Treatment and interven						
		Protocols- 1. Treatments will					
		ysician/practitioner3. The					
	effectiveness of the p	•					
		uated weekly during the					
		sessment of the wound. If					
		ound is not seen within two					
		Same to hot booth within two	1				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	PLE CONSTRUCTION G	, ,	(X3) DATE SURVEY COMPLETED	
		495283	B. WING			C 09/21/2023
	ROVIDER OR SUPPLIER	ITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 1719 BELLEVUE AVENUE RICHMOND, VA 23227		03/21/2020
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 686	with the assessmen measures obtained including preventative documented in the recordCare Plansplan will be develop address the resident pressure ulcer/injury resident has a pressure ulcer/injury resident has a pressure injury skin and underlying bony prominence or device. The injury copen ulcer and may as a result of intensor pressure in comb Stage 1 Pressure in comb Stage 1 Pressure in erythema of intact skin with a loce erythema, which may pigmented skin Stage 2 Pressure In loss with exposed dermis. The wound moist, and may also ruptured serum-filled Unstageable Pressure full-thickness skin a Full-thickness skin a extent of tissue dam be confirmed becau eschar (dead tissue Deep Tissue Pressure)	n/practitioner will be contacted t and alternative treatment as indicated5. Treatments, we interventions, will be resident's medical - 1. A resident centered care red and implemented to t's risk for development of a y and to promote healing if the sure ulcer/injury" Ty is localized damage to the soft tissue usually over a related to a medical or other an present as intact skin or an be painful. The injury occurs reand/or prolonged pressure ination with shear jury: Non-blanchable kin. ralized area of non-blanchable ray appear differently in darkly individually i	F 68			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULT A. BUILDII	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED		
		495283	B. WING _			C 09/21/2023	
	ROVIDER OR SUPPLIER	TATION		STREET ADDRESS, CITY, STATE, 1719 BELLEVUE AVENUE RICHMOND, VA 23227	ZIP CODE	00.2.1.2020	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD			
F 686	persistent non-blanch purple discoloration or revealing a dark wour blister" This information was https://cdn.ymaws.col gr/online_store/npiap. 2. For Resident #108 failed to complete the resident's stage four particles 2023 and September for self-care of the preprovide oversight to ebeing completed for the 2023 and September. R108 was admitted to a diagnosis of a stage sacral region. R108's dated 6/4/23 docume impairment to skin intischium (inaccurate dassess/Monitor/Documargins: periwound sexudates, edema, graeschar, gangrene. Dehealing on an ongoing Notify MD (medical documents) of 6/80 on the most recent Madmission assessments and service and servic	cin with localized area of hable deep red, maroon, or epidermal separation and bed or blood filled sobtained from the website: m/npiap.com/resource/resm_pressure_injury_stages.pdf (R108), the facility staff frough assessments of the pressure injury (1) in August 2023, failed to assess R108 persure injury, and failed to ensure treatments were the pressure injury in August 2023. To the facility on 5/27/23 with the four pressure injury on the secomprehensive care plan and the four pressure in	F	686			
	cognitively intact for n	naking daily decisions.					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	PLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED		
		495283	B. WING _			C 09/21/2023
	ROVIDER OR SUPPLIER	ITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 1719 BELLEVUE AVENUE RICHMOND, VA 23227	I	03/21/2023
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHO		(X5) COMPLETION DATE
F 686	Continued From pag	e 85	F 6	86		
	documented R108 p pressure injury on th documentation of loc admission, and mea in length by 4 cm in v On 9/20/23 at 1:10 p conducted with R108 wound on his buttoo stated the nurses on asks, and the nurses wound, "In a while." treatment for the wo treatment consists o putting the gauze in	luation dated 7/21/23 resented with a stage four e right ischial (inaccurate cation), present on suring 4.5 cm (centimeters) width by 2 cm in depth. a.m., an interview was a. R108 stated he has had a k for over three years. R108 ly look at the wound when he be have not measured the R108 stated he completes und twice a day and the f soaking gauze in saline, the wound, applying an men covering that with another				
	thorough assessment August 2023 and Set documentation regal a weekly skin observed documented no oper observation dated 8/ open area on the left observation dated 8/ concern but did not or regarding the pressuration dated 8/ open areas, and a weekly open areas, and a weekly document a descript (including stage, meabsence of any tunning a weekly document of any tunning stage, meabsence of any tunning stage, meabsence of any tunning stage, means weekly document and second or second o	linical record failed to reveal ats of the pressure injury in ptember 2023. The only rding the resident's skin was vation dated 8/7/23 that a areas, a weekly skin 15/23 that documented an at buttock, a weekly skin 21/23 regarding another skin contain any documentation are injury, a weekly skin 29/23 that documented no eekly skin observation dated ated an open area on the left a skin observations failed to ion of the pressure injury assurements, presence or eling or undermining, type of or absence and type of				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
			7 ti Boilebi	_		, ا	C	
		495283	B. WING				21/2023	
NAME OF P	ROVIDER OR SUPPLIER		-	S	TREET ADDRESS, CITY, STATE, ZIP CODE			
DOSEDAL	E UEALTH O DEHADI	LITATION		17	719 BELLEVUE AVENUE			
KUSEDAL	E HEALTH & REHABI	LHAHON		R	RICHMOND, VA 23227			
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC 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 686	Continued From pa	ge 86	F	686				
	reveal the resident the pressure injury capable of caring for failed to reveal over the resident was prinjury per the physicorder dated 6/28/23 wound to the right the apply normal saline area, and cover with every shift for wourned August 2023 and South (treatment administ same physician's or documentation that completed each daspaces for nurses the treatments were notes for August 202 to reveal document R108's pressure injudocumentation of reand September 202 8/3/23 that docume seen by the wound note dated 8/26/23 refused wound treat physician. On 9/20/23 at 9:37 conducted with LPN LPN #3 stated that weekly skin observall residents and nuevery resident's skil assessments of presidents.	108's clinical record failed to was assessed for self-care of to ensure the resident was or the pressure injury, and resight was provided to ensure oviding care for the pressure cian's order. A physician's documented to cleanse the outtock with normal saline, a soaked gauze to the open the adry adhesive dressing and care. A review of R108's eptember 2023 TARs ration records) revealed the order but failed to reveal the treatments were y for both months. The consign off the completion of the blank. Review of nurses' 223 and September 2023 failed ation that treatments for ury were completed. The only efusal of care in August 2023 23 was a nurse's note dated anted R108 declined to be care physician and a nurse's that documented R108 them twith the wound a.m., an interview was that documented R108 them twith the wound a.m., an interview was that documented R108 them twith the wound a.m., an interview was that documented R108 them twith the wound						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					(X3) DATE SURVEY COMPLETED		
		495283	B. WING _			1	C 21/2023		
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRE	ESS, CITY, STATE, ZIP CODE	1 00/			
ROSEDAL	E HEALTH & REHABILIT	TATION		1719 BELLEV	UE AVENUE				
ROOLDAL	LE HEAETH & REHABIEN			RICHMOND,	VA 23227				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI) TAG	,	PROVIDER'S PLAN OF CORRECTION EACH CORRECTIVE ACTION SHOULD E DSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE		
F 686	Continued From page	e 87	F 6	86					
	drainage, and the sta (registered nurse). In completion of treatmenurses evidence treat	e color, the presence of ge if the nurse is a RN regard to evidencing the ents, LPN #3 stated the timents are done by signing the electronic treatment							
	conducted with LPN # evaluation should be resident is safe and a pressure injury care. should make sure the he needs for wound of aware the resident per nurses should offer at #3 stated this should wound care is due per #3 stated she had not R108's pressure injur or July 2023 but she of wound care on the pr stated she observed and spread out and of LPN #3 stated she the to dry dressing and a pressure injury treatm not document this observed and spread out and complete a late entry. On 9/21/23 at 1:28 p. staff member) #1 (the	completed to make sure a ble to perform his own LPN #3 stated nurses resident has the supplies are, make sure the doctor is erforms his wound care, and assistance if needed. LPN be done each time the rethe physician's order. LPN to personally assessed y on the buttock since June abserved R108 perform evious Monday. LPN #3 the resident lay on his side lean and pack the wound. aught R108 was using a wet border gauze for his ment. LPN #3 stated she did servation and needed to							
	Reference: (1) "Stage 4 Pressure and tissue loss.	Injury: Full-thickness skin							

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDII	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED		
		495283	B. WING _			C 09/21/2023	
	OVIDER OR SUPPLIER	TATION		STREET ADDRESS, CITY, STATE, ZIP CO 1719 BELLEVUE AVENUE RICHMOND, VA 23227	DE	09/21/2023	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO X (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
	or directly palpable filigament, cartilage of and/or eschar may be was obtained from the https://cdn.ymaws.cogr/online_store/npiagr/online_store/npiagr/online_store/npiagr/online_store/npiagr/online_store/npiagr/online_store/npiagr/online_store/npiagr/online_store/npiagr/online_store/npiagr/online_store/npiagr/online_store/npiagr/online_store/npiagr/online_store/npiagr/online_stage three August 2023 and Seprovide treatments provide treatments provide treatments provide treatments provide treatments of a stage sacral region (1). Adated 8/24/23 documented alginated with an open measuring 1.5 cm (ccm (width). A weekly 9/4/23 documented, an open area to sacrover with some discover with foam dress observation dated 9/madmitted with open skin observations fail description of the present control of t	and tissue loss with exposed ascia, muscle, tendon, robne in the ulcer. Slough e visible." This information he website: bom/npiap.com/resource/resm oppressure_injury_stages.pdf (R96), the facility staff failed in assessments of the expressure injury (1) in prember 2023, and failed to er physician's orders on other 2023. The facility on 8/24/23 with a three pressure injury of the in admission evaluation mented an open pressure. A weekly skin observation occumented R96 was in area to the sacrum entimeters) (length) by 1.5 by skin observation dated "Resident was admitted with rum (1.5cm x 1.5cm)." A stion dated 9/11/23 area" and "Cleanse sacral deanser. Apply calcium at wounds) to wound bed sing." A weekly skin 19/23 documented, area to sacrum." The weekly led to document a sesure injury (including stage, //23, 9/11/23 and 9/19/23],	F	686			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			SURVEY PLETED	
		495283	B. WING			1	C 21/2023
	ROVIDER OR SUPPLIER E HEALTH & REHABILI			1719	EET ADDRESS, CITY, STATE, ZIP CODE BELLEVUE AVENUE HMOND, VA 23227	1 09/	21/2023
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PREFIX (EACH CORRECTIVE ACTION SHO			(X5) COMPLETION DATE
F 686	absence and type of Further review of R96 the following physicia 8/24/23- clean the sa and cover with form to (discontinued 9/8/23) 9/8/23- cleanse the so cleanser. Apply calco and cover with foam A review of R96's Se (treatment administrat same physician's ord documentation that the completed on 9/1/23, 9/11/23, 9/14/23 and nurses to sign off the were blank. A review dates also failed to re treatments were come On 9/20/23 at 9:37 ac conducted with LPN LPN #3 stated that ar weekly skin observat all residents and nurs every resident's skin assessments of pres a description of the w the size, any odor, the drainage, and the stat (registered nurse). In completion of treatmen nurses evidence treat the treatments off on administration record	drainage). S's clinical record revealed in's orders: cral area with normal saline coard gauze daily. acral wound with wound it it is a strength of the result of the res	F	586			
		e administrator) and ASM #2					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		495283	B. WING				21/2023
	ROVIDER OR SUPPLIER E HEALTH & REHABILIT			1	TREET ADDRESS, CITY, STATE, ZIP CODE 719 BELLEVUE AVENUE RICHMOND, VA 23227	1 031	21/2023
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 689 SS=D	above concern. Reference: (1) "Stage 3 Pressure loss. Full-thickness loss of is visible in the ulcer a epibole (rolled wound This information was https://cdn.ymaws.cogr/online_store/npiap. Free of Accident Haza CFR(s): 483.25(d)(1)(1)(1)(1)(1)(1)(1)(1)(2)(1)(1)(1)(1)(1)(1)(1)(1)(1)(1)(1)(1)(1)	g) were made aware of the Injury: Full-thickness skin skin, in which adipose (fat) and granulation tissue and edges) are often present." obtained from the website: m/npiap.com/resource/resm _pressure_injury_stages.pdf ards/Supervision/Devices (2)		686	This plan of correction is respectfully submitted, and it is an affirmation that corrections to the areas cited have; between made and the facility is in compliance of participation requirements. 1. Facility has secured the smoking materials for Resident #13 and #101. Resident #62 has been using a cigarett extender and smoking apron while smoking. 2. An audit has been performed on all	with	11/3/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495283	B. WING _				C 21/2023
NAME OF PR	ROVIDER OR SUPPLIER		1	S	STREET ADDRESS, CITY, STATE, ZIP CODE	1 03/	21/2020
					719 BELLEVUE AVENUE		
ROSEDAL	E HEALTH & REHABIL	TATION			RICHMOND, VA 23227		
				•	·		
(X4) ID PREFIX TAG	(EACH DEFICIENC	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 689	Continued From pag	e 91	F 6	689			
	On the most recent I	MDS (minimum data set)			current residents who smoke to ensure	!	
	assessment, a quart	erly assessment with an ARD			that all their smoking material is stored	in	
		ce date) of 6/24/2023, the			a safe place in the facility. Any resident		
	resident scored 6 of	15 on the BIMS (brief			found to have smoking materials on the	eir	
	interview for mental:	status) assessment,			person when not smoking during		
	indicating the resider	nt was severely impaired for			scheduled smoking time will be		
	making daily decision	ns.			reeducated on resident smoking policy		
					An audit has been performed on all		
		p.m., an observation was			current residents who have been		
		acility courtyard smoking.			evaluated to need adaptive/protective		
		ghting their cigarette using a			equipment to smoke safely to ensure the	nat	
	•	oved from their pocket of the			the equipment is being used. Any		
		re wearing and returning the			residents found to not be using		
		The supervising staff			adaptive/protective equipment will be		
		asking R13 if they needed a			reevaluated and/or reeducated on the		
		in which R13 stated that			need for adaptive/protective equipment	t to	
		vas observed returning into			smoke.		
		of the break with the lighter			2. The Advantage Application and Advantage Application and App		
	in their shorts pocket				3. The Administrator/Designee will		
	On 0/40/2022 at 4:20) n m an additional			reeducate staff on implementing a safe		
	On 9/19/2023 at 4:30	ducted of R13 in the facility			smoking environment. This education vinclude, but not be limited to, proper	VIII	
		R13 was observed smoking			1		
		d smoke break using a			storage of residents□ smoking materia and the proper use of adaptive/protecti		
		oved from their shorts pocket			equipment while smoking. A smoking	VC	
		naring the lighter with another			evaluation will be completed for newly		
		cigarette and returning the			identified smokers.		
	_	pocket. R13 was observed			deritined emotore.		
		y at the end of the break with			4. The Administrator/Designee will		
		orts pocket. The supervising			conduct an audit of residents smoking		
	•	served directly in front of			weekly for 4 weeks and monthly for 2		
		sidents during the smoke			months to ensure smoking material is		
	break.	Ŭ			stored properly and adaptive/protective	;	
					equipment is utilized by residents who		
	On 9/20/2023 at 9:09	a.m., an interview was			have been assessed to need it. The		
		R13 stated that they			Administrator/Designee will identify any	/	
	currently smoked. W	/hen asked about their			issues, patterns or trends and report to		
	cigarettes and lighter	r, R13 stated that the nurses			the Quality Assurance and Performanc	е	
	kept everything at the	e desk.			Improvement Committee at least		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	DING			(X3) DATE SURVEY COMPLETED	
		495283	B. WING _				21/2023
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00.	
BOSEDAL	E UEALTU O DEUADILI	FATION		17	719 BELLEVUE AVENUE		
KUSEDAL	E HEALTH & REHABILI	IATION		R	CICHMOND, VA 23227		
(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 APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 689	Continued From page	92	F 6	889			
	The comprehensive of	care plan for P13			quarterly.		
	documented in part, "	(R13) is a smoker. Date Revision on: 08/09/2023."			5. The date of compliance is: 11/3/23		
	The clinical record do resident safety evalua 3/22/2023 which documents smoke with supervision	ation for R13 dated umented the resident able to					
	On 9/19/2023 at 2:50 conducted with RN (r stated that the CNA's assistants) normally sbreaks at the facility a 2:30 p.m. break becastated that he did not supposed to have cigand he thought that a supposed to be kept nurses station that the breaks. He stated the residents he observebreak why they had thand was not sure of the	p.m., an interview was egistered nurse) #1. RN #1 (certified nursing supervised the smoke and they were filling in for the use they were busy. He think that residents were tarettes or lighters on them all smoking materials were in the smoking box at the ey brought out during at he had asked some of the doutside at the 2:30 p.m. the cigarettes and lighters he process. He stated that ng box process was new					
	conducted with CNA: there were scheduled residents met in the r the staff took them ou stated that they kept and cigarettes and th as the residents went lit them for the reside been the process for	p.m., an interview was #11. CNA #11 stated that I smoking times and the oom by the courtyard and utside for breaks. She a locked box for the lighters ey passed out the cigarettes tout the door and then they ints. She stated that this had the past two years she had tated that she was aware of					

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	IPLE CONSTRUCTION NG	COMPLETED	
		495283	B. WING _			C 09/21/2023
	ROVIDER OR SUPPLIER LE HEALTH & REHABILI	TATION	1	STREET ADDRESS, CITY, STATE, ZIP COI 1719 BELLEVUE AVENUE RICHMOND, VA 23227	DE	33/2 112020
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CO ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIA	
F 689	and if they saw them confiscate them becato keep them on their residents in the facilitiany smoking materia. On 9/19/2023 at 4:51 conducted with CNA residents were not straighters on them at have all smoking mathat was locked at the that she was aware to lighters and they were them. The facility policy "Sr 10/20/22 documente implement processes right to smoke and we safe smoking in a mathate on any resident's right smoke may not keep [i.e. cigarettes, electrobacco, lighter, light person when not smosafety purposes, all sedevices and tobacco.	eak in lighters and cigarettes , they were supposed to ause they were not allowed r person. She stated that ty were not allowed to keep	F6	689		
	smoking will be offer resident assessment encouraged and assi the protective device On 9/20/2023 at 3:38	p.m., ASM (administrative				
	staff member) #1, the	e administrator, ASM #2, the				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		495283	B. WING			1	C 21/2023	
	ROVIDER OR SUPPLIER	ITATION		1	TREET ADDRESS, CITY, STATE, ZIP CODE 719 BELLEVUE AVENUE RICHMOND, VA 23227	1 00/	21/2020	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 689	F 689 Continued From page 94 director of nursing and ASM #4, the regional		F	689				
	_	re made aware of the						
	No further informatio	n was obtained prior to exit.						
		(R62), the facility staff failed e extender and smoking smoking.						
	assessment, an anni (assessment referen resident scored 15 o interview for mental indicating they were	MDS (minimum data set) ual assessment, with an ARD ice date) of 6/20/2023, the ut of 15 on the BIMS (brief status) assessment, cognitively intact for making tion J documented no current						
	made of R62 in the f R62 was observed s	D p.m., an observation was acility courtyard smoking. moking two cigarettes during the break without using a smoking apron.						
	conducted with R62. smoked for years an facility since admissi facility stored their ci that they took at duri stated that they had kept in their room an "sometimes." R62 si	6 p.m., an interview was R62 stated that they had d had been smoking at the on. R62 stated that the garettes and lighter in a box ng the smoking times. R62 a cigarette extender that they d they took it outside tated that the facility used to smoking aprons at one time quired anymore.						
	On 9/19/2023 at 4:30 observation was con	D p.m., an additional ducted of R62 in the facility						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	IPLE CONSTRUCTION IG	' '	(X3) DATE SURVEY COMPLETED		
		495283	B. WING _			C 09/21/2023	
	ROVIDER OR SUPPLIER	11.11		STREET ADDRESS, CITY, STATE, ZIP CODE 1719 BELLEVUE AVENUE RICHMOND, VA 23227		09/21/2023	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (CEACH CORRECTIVE ACTION SHOOTH CROSS-REFERENCED TO THE APPLICATION OF THE APPLIC	IOULD BE	(X5) COMPLETION DATE	
F 689	during the supervise a cigarette extender The comprehensive documented in part, current smoker Date Initiated: 12/06, 08/09/2023." Under documented in part, extender is used dur Date Initiated: 03/29, 01/11/2023 Providassist to put on. Date Revision on: 01/11/2 The "Smoking-Resid R62 dated 2/9/2023"Tobacco Utilizatio tobacco products? Ysmoking? Yes. Tobac Cigarettes/Cigars In needs: a. Smoking a Supervision" On 9/19/2023 at 2:50 conducted with RN (stated that the CNA's assistants) normally breaks at the facility 2:30 p.m. break becaused on 9/19/2023 at 3:45 conducted with CNA residents met in the to going out if they required.	R62 was observed smoking d smoke break without using or smoking apron. care plan for R62 "History of smoking and /2019. Revision on: "Interventions" it "Assist/ensure cigarette ing designated smoke times. /2022. Revision on: e with a smoking apron and e Initiated: 02/19/2020. 023" ent Safety Evaluation" for documented in part, in: 1. Does the resident use ies. Does the facility allow ecco products utilized: Resident adaptive equipment pron, b. Cigarette holder, c.	F 6	89			

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	PLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED	
		495283	B. WING _			C 09/21/2023	
	ROVIDER OR SUPPLIER	ITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 1719 BELLEVUE AVENUE RICHMOND, VA 23227		09/21/2023	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR ((EACH CORRECTIVE ACTION SHORT) CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 689	She stated that she cigarette extender the bring with them. She offer to apply smoking who required them at the nurse. On 9/20/2023 at 3:3 staff member) #1, the director of nursing, a nurse consultant we concern. No further information in the state of the state o	worked with them so often. knew that R62 had a nat they kept in their room to be stated that the staff shoulding aprons to any residents and if they refused report it to a part of the staff shoulding aprons to any residents and if they refused report it to a part of the staff shoulding aprons to any residents and if they refused report it to a part of the staff should remade aware of the staff	F 6	89			
	8/9/23, which reveal a smoker.	ed, "FOCUS: The resident is					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	TIPLE CONSTRUCTION NG	, ,	DATE SURVEY COMPLETED	
		495283	B. WING _			C 09/21/2023	
	ROSEDALE HEALTH & REHABILITATION (X4) ID PREFIX TAG COntinued From page 97 INTERVENTIONS: Instruct resident about the facility policy on smoking: locations, times, safety concerns. Instruct resident about smoking risks and hazards and about smoking cessation. aids that are available." A review of the "Resident Safety Evaluation" dated 8/25/23, revealed "Smoking Safety Evaluation: Poor vision or blindness-no, Balance		STREET ADDRESS, CITY, STATE, ZIP CODE 1719 BELLEVUE AVENUE RICHMOND, VA 23227)E	, 33/2//23	
PRÉFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 689	INTERVENTIONS: I facility policy on smo concerns. Instruct re and hazards and ab that are available." A review of the "Res dated 8/25/23, revea Evaluation: Poor vis problems while sittin limited ROM in arms motor skills needed / falls asleep easily of Burns skin, clothing, ashes on self-no, Folocation and time of Unable to light a cigarette safely-no, extinguish a cigarette safe cigarette safely-no, extinguish a cigarett the resident a safe supervision." On 9/19/23 at 2:25 Foloserved leaving he self-propelled, with a foot sock. Resident obtained the cigaret sock and would not information. An interview was copen with RN (registed describe the smokin "You heard me asking their cigarettes and (certified nursing asking do not think that the	ident Safety Evaluation" aled "Smoking-no, Total or or hands-no, Insufficient fine to securely hold-no, Lethargic during tasks or activities-no, furniture or other-no, Drops of Smoking-yes. Concerns: arette safely-no, Unable to Ily-no, Unable to use ashtray to e-no. Review and Plan: Is moker? Safe to smoke with	F	589			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		405000	P. WING			С	
		495283	B. WING _			09/	21/2023
NAME OF PR	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
ROSEDAL	E HEALTH & REHABILIT	TATION			719 BELLEVUE AVENUE		
				K	RICHMOND, VA 23227		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 689	given they have to sign about smoking. The shave had it a couple of smoking prior to them. We have this box for not all the residents proposed to and I do should have their cigar. On 9/19/23 at 3:55 Pth of Resident #101 smoking area with a county and another resident.	d they have a form they are in and the doctor has to sign smoking box is new, we of weeks. I never monitored putting the box in place. the cigarettes and lighters, ut them in here. They are not believe that any resident	F	689			
	PM with CNA #1. Asl process, CNA #1 stat replaced the older bot to have their lighters at They do not always for then kept in the locked nurse's station. On 9/21/23 at 1:20 Pt member) #1, the admits a station of the control of the	ducted on 9/19/23 at 4:00 ked to describe the smoking ed, this is a new box. It x we had. The residents are and cigarettes in this box. bllow the rules. The box is d med room behind the M, ASM (administrative staff inistrator, ASM #2, the					
F 692 SS=E	director of nursing and nurse consultant was No further information Nutrition/Hydration St CFR(s): 483.25(g)(1)- §483.25(g) Assisted r (Includes naso-gastric	d ASM #4, the regional made aware of the findings. was provided prior to exit. atus Maintenance	Fé	692			11/3/23

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495283	B. WING _				21/2023
	ROVIDER OR SUPPLIER	TATION		1	TREET ADDRESS, CITY, STATE, ZIP CODE 719 BELLEVUE AVENUE RICHMOND, VA 23227		
(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 692	enteral fluids). Based comprehensive assessensure that a resident \$483.25(g)(1) Mainta of nutritional status, significantly desirable body weight balance, unless the redemonstrates that this preferences indicate \$483.25(g)(2) Is offer maintain proper hydrates \$483.25(g)(3) Is offer there is a nutritional provider orders a their This REQUIREMENT by: Based on resident in clinical record review review, it was determ failed to monitor weight the survey sample, Resident #53 (to monitor weights before the most recent Massessment, an annual (assessment reference resident scored 14 out interview for mental sindicating the resident making daily decision	copic jejunostomy, and don a resident's asment, the facility must attract as usual body weight or a trange and electrolyte esident's clinical condition is is not possible or resident betherwise; and the health care apeutic diet. The is not met as evidenced atterview, staff interview, and facility document in and the facility staff that the facility staff that the facility staff the for two of 40 residents in esidents #53 and #16. R53), the facility staff failed tween 6/9/2023-9/20/2023. RS53), the facility staff failed tween 6/9/2023-9/20/2023. RS53), the facility staff failed tween 6/9/2023-9/20/2023. RS53), the facility staff failed tween 6/9/2023-9/20/2023, the attorious facility (brief	F	592	This plan of correction is respectfully submitted, and it is an affirmation that corrections to the areas cited have; because and the facility is in compliance of participation requirements. 1. Resident #53 and #16 have a current weight documented. 2. An audit was performed to ensure all residents with an order to obtain a weigh has a current weight documented. Any residents found not to have a current weight have been corrected. 3. The Director of Nursing/designee has in-serviced licensed nurses (RNs and LPNs) and C.N.A□s on importance of obtaining resident weights as ordered by	vith I ght s	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN		CONSTRUCTION	COM	E SURVEY PLETED	
		495283	B. WING _				C / 21/2023	
	ROVIDER OR SUPPLIER	TATION			STREET ADDRESS, CITY, STATE, ZIP CODE 1719 BELLEVUE AVENUE RICHMOND, VA 23227		03/21/2023	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 692	8/3/2023 documenter assessment for (age care) female w/hx (w tract infection), PNA (hypertension), anem paraplegia, depression (bipolar disorder), DNHt (height) 66", last woon significant weight weight pending No recommendations at monitor PO (by mout status" The comprehensive documented in part, alteration in nutritional multiple medical dx (major depressive disorder depressi	assessment for R53 dated d in part, " Annual and sex) LTC (long term ith history) of UTI (urinary (pneumonia), HTN nia, GERD, hypothyroidism, on, chronic pain, BPD /T (deep vein thrombosis). It (weight) obtained 6/2023 change at that time; 8/2023 nutrition-related this time, continue to h) and weight change care plan for R53 (R53) has the potential for al status r/t (related to) diagnoses), paraplegia, MDD sorder), bipolar disorder, ageal reflux disorder, BMI obese, will eat meals nstead of facility meals at 09/23/2021. Revision on: a for R53 failed to evidence a 6/9/2023. a R53 failed to evidence usal of weights between .	F 6	692	physician. 4. The Director of Nursing/designee wi conduct an audit weekly for 4 weeks at monthly for 2 months of resident's weig to ensure they are obtained and monitored according to physician order. The Director of Nursing/designee will identify any trends and/or patterns and additional education and training will be provided to staff on an ongoing basis. Findings will be discussed with the QA committee on at least a quarterly basis. 5. Date of Compliance: 11/3/23	nd ghts rs. e		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G	, ,	OMPLETED
		495283	B. WING _			C 09/21/2023
	ROVIDER OR SUPPLIER	1	STREET ADDRESS, CITY, STATE, ZIP COD 1719 BELLEVUE AVENUE RICHMOND, VA 23227		<u> </u>	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 692	if the resident refuse later that day and if to nurse know. On 9/20/2023 at 2:2: conducted with LPN LPN #2 stated that reside they documented it in the procedure distribution. They were procedured to the fact of the facility policy in the facility policy in the facility policy in the facility policy in the fact of the procedure at the fact of the facility policy in the fac	d they waited and attempted they still refused they let the grant process of process of the proc	F 6	92		

	OF DEFICIENCIES CORRECTION			(X3) DATE SURVEY COMPLETED C			
		495283	B. WING			; 21/2023	
	ROVIDER OR SUPPLIER	TATION		STREET ADDRESS, CITY, STATE, ZIP CODE 1719 BELLEVUE AVENUE RICHMOND, VA 23227	1 00/2	03/21/2020	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 692	Continued From pag	e 102	F 69	2			
		n was provided prior to exit.					
		(R16), the facility staff failed 4/2023, 5/2023, 6/2023,					
	assessment, a quart ARD (assessment re the resident was cod weight loss in the pa	MDS (minimum data set) erly assessment, with an eference date) of 6/7/2023, ed as no or unknown for st 6 months. The resident eliving a therapeutic diet.					
		s for R16 documented in part, continue monthly weights. 3."					
	weight of 179.0 lbs () weight of 179.4 lbs o summary failed to ev	of for R16 documented a counds) on 3/6/2023 and a n 9/6/2023. The weight ridence weights obtained for 23, 7/2023 or 8/2023.					
	hydration/nutrition im therapeutic diet, h/o mass index), and mu hx (history) of lymph	care plan for R16 "(Name of R16) is at risk for abalance in setting of (history of) obese BMI (body altiple chronic disease states, edema, h/o significant wt hitiated: 11/06/2017. Revision					
	Review of the clinica evidence refusals of 4/1/2023-8/31/2023.	I record failed for R16 to weights between					
		3 p.m., an interview was (certified nursing assistant)					

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G		E SURVEY IPLETED
		495283	B. WING _		0.0	C 9/21/2023
	ROVIDER OR SUPPLIER	ITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 1719 BELLEVUE AVENUE RICHMOND, VA 23227		312 112023
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 692	weighed at least monurses told them it wif the resident refuse later that day and if the nurse know. On 9/20/2023 at 2:20 conducted with LPN LPN #2 stated that nobtained on admissistated that if a reside they documented it in the conducted with OSN registered dietician. In monitored residents weight loss and/or gresident triggered for weight was monitored a resident refused to notified but they were procedure at the factor of nursing, at the factor of nursing, at the staff member) #1, the director of nursing, at the staff member in the sta	hat all residents were hithly and more often if the ras needed. She stated that d they waited and attempted hey still refused they let the 3 p.m., an interview was (licensed practical nurse) #2. esidents weights were on and then monthly. She ent refused to be weighed in the nurses notes. 14 a.m., an interview was 1 (other staff member) #5, OSM #5 stated that they for changes in weight status, ain. She stated that unless a r weight loss or gain the d monthly. She stated that if be weighed they should be e not sure of the policy and/or	F 6	92		
F 695 SS=E		n was provided prior to exit. stomy Care and Suctioning	F 6	95		11/3/23
		ory care, including nd tracheal suctioning. sure that a resident who				

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495283	B. WING		C 09/21/2023	
NAME OF PE	ROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CODE	09/21/2023	
	10 115211 011 001 1 21211			1719 BELLEVUE AVENUE		
ROSEDAL	E HEALTH & REHABILIT	TATION		RICHMOND, VA 23227		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION	
F 695	Continued From page	e 104	F 69	95		
		e, including tracheostomy				
		ctioning, is provided such				
		professional standards of				
		nensive person-centered				
		nts' goals and preferences,				
	and 483.65 of this sul					
		is not met as evidenced				
	by:					
	_	n, resident interview, staff		This plan of correction is respectfu	lly	
		ument review and clinical		submitted, and it is an affirmation the		
		cility staff failed to provide		corrections to the areas cited have	been	
	respiratory care and s	•		made and the facility is in complian	ce with	
		y sample, Residents #270		participation requirements.		
	and #48.					
				1. Resident #270 is no longer resid	ing at	
	The findings include:			the facility. Resident #48 does not I	nave a	
				physician order for an incentive		
		(R270), the facility staff		spirometer, and it has been remove	ed from	
		cian's orders for the care of		his room.		
		ctomy tube (1), failed to				
		care of the laryngectomy		An audit was performed to identi		
		ovide oversight to ensure the		residents with a laryngectomy tube		
	resident's care of the	laryngectomy tube.		ensure a physician⊡s order for the		
		IDO /		the laryngectomy tube has been ob		
		IDS (minimum data set), a		assess if resident can self-care and		
		with an ARD (assessment		oversight of the resident □s care of		
	-	7/23, the resident scored 14		laryngectomy tube is being comple		
		6 (brief interview for mental		audit was performed to identify resi		
		resident was cognitively		using an incentive spirometer to en		
	intact for making daily	/ uccisions.		physician ☐s order was obtained an incentive spirometer is being stored		
	A review of P270's ali	inical record failed to reveal				
		nical record failed to reveal the care of the resident's		sanitary manner. Any discrepancies immediately corrected.	> WOLC	
	· •	R270's comprehensive care		ininediately confected.		
	plan revised on 9/1/23			3. The Director of Nursing/designed	has	
	documentation regard			in-serviced licensed nurses (RNs a		
		Further review of R270's		LPNs) regarding laryngectomy tube		
		e resident's readmission on		incentive spirometers. The in-service		
	8/14/23, failed to reve			includes, but is not limited to, the		
	5	100140111 1140		siados, sacio not inintod to, tilo		

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		40.5000	D WING				
		495283	B. WING			09/	21/2023
NAME OF PR	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
DOCEDAL	E UEALTU O DELIABILI	TATION		17	719 BELLEVUE AVENUE		
KUSEDAL	E HEALTH & REHABILI	TATION		R	CICHMOND, VA 23227		
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI TAG	X	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE
F 695	Continued From page	e 105	F	695			
		e of the laryngectomy tube,			importance of obtaining physician orde	re	
		versight was provided to			for laryngectomy tubes and spirometers		
		was performing care of the			the need to evaluate resident to assess		
		except for 9/8/23 and 9/9/23).			they are able to self-care laryngectomy		
	laryingectoring tube (e	except for 9/0/23 and 9/9/23).			tubes and storing an incentive spirome		
	On 0/20/23 at 8:34 a	.m., R270 was observed			in a sanitary manner.	Tei	
		d the resident was observed					
	_	my tube. At this time, an			4. The Director of Nursing/designee wil	1	
		cted with R270. The resident			conduct an audit weekly for 4 weeks ar		
	was unable to verbal				monthly for 2 months of residents with	Iu	
		on-verbal gestures and by			laryngectomy tubes to ensure physicial	n⊟s	
		ication board. R270 was			order for the care of the laryngectomy	100	
	•	lean and provide care for his			tube has been obtained, assess if resid	lent	
		The resident nodded his			can self-care and oversight of the	One	
		icating, "No" and pointed to			resident⊡s care of the laryngectomy tu	be	
		d if he provides the care,			is being completed. The Director of		
		ad up and down indicating,			Nursing/designee will conduct an audit		
		if the nurses check to make			weekly for 4 weeks and monthly for 2		
	sure he is cleaning a	nd caring for his			months of residents with incentive		
	_	R270 nodded his head side to			spirometers to ensure a physician⊡s		
		" R270 pointed to his supply			order was obtained and the incentive		
		rote on his communication			spirometer is being stored in a sanitary		
	board that he needed	d more neck bands and a			manner. Any issues identified will be		
	brush to clean the tul	be.			addressed immediately by the Director	of	
					Nursing/designee and appropriate action	ons	
	On 9/21/23 at 9:16 a	.m., an interview was			will be taken. The Director of		
		(licensed practical nurse) #3.			Nursing/designee will identify any trend	s	
	LPN #3 stated an eva	aluation should be completed			and/or patterns and additional education	'n	
	to make sure a reside	ent is safe and able to			and training will be provided to staff on	an	
	perform his own track	h/laryngectomy tube care.			ongoing basis. Findings will be discuss	ed	
	LPN #3 stated the nu	ırses can provide assisted to			with the QAPI committee on at least a		
	R270, but the resider	nt really takes care of his			quarterly basis.	ĺ	
		LPN #3 stated the resident				ĺ	
		en he needs supplies and the			5. Date of Compliance: 11/3/23	ĺ	
		assistance, document that				ĺ	
		ed, document that supplies				ĺ	
	were provided, and d	locument if R270 accepts or					
	declines assistance.	LPN #3 stated this should					
	occur at least once a	day or per whatever the					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495283	B. WING _			C 09/21/2023
	ROVIDER OR SUPPLIER	TATION		STREET ADDRESS, CITY, STATE, ZIP CODE 1719 BELLEVUE AVENUE RICHMOND, VA 23227		09/21/2023
(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 CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 695		e 106 s. LPN #3 stated that if s order then the nurses need	F6	95		
	to call the doctor and On 9/21/23 at 1:28 p. staff member) #1 (the					
	Medications and Trea "POLICY: Residents self-administer medic interdisciplinary team clinically appropriate do so. SPECIFIC PROCED 1. As part of their ove practitioner will asses and physical abilities whether self-administ treatments is clinicall resident.	cations / treatments if the has determined that it is and safe for the resident to URES / GUIDANCE crall evaluation, the staff and as each resident's mental and choice to determine tering medications and/or				
	who are identified as medications/treatmer so. 3. In addition to gene decision-making capa practitioner will perfor assessment, which m to) the resident's: a. Ability to read and labels / treatment ins b. Comprehension of administration for his medications/treatmer	being able to self-administer of the whether they wish to do the valuation of the acity, the staff and the arm a more specific skill the properties of the purpose and properties or her on the purpose and properties.				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED			
		495283	B. WING		09/21/2023
	ROVIDER OR SUPPLIER	LITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 1719 BELLEVUE AVENUE RICHMOND, VA 23227	03/21/2020
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE COMPLETION
F 695		ze risks and major adverse	F 69	5	
	safely self-administ nursing staff will ad medications. 5. The staff and pra- findings and the ch- able to self-administ 6. For self-administ staff will determine resident or the nurs those medications of treatments were ad 12. Nursing staff wi medication/treatme shift, and they will to the medication/trea	ents. mines that a resident cannot er medications/treatments, the minister the resident's actitioner will document their bices of residents who are ter medications/treatments. ering residents, the nursing who will be responsible (the ing staff) for documenting were taken and/or that ministered Il review the self-administered nt record on each nursing ransfer pertinent information to tment administration record riately noting that the doses			
	of the larynx (the voinformation was obthettps://medlineplus. 2. For Resident #48 to obtain a physicial incentive spirometer incentive spirometer admission assessmented as to other the most recent admission assessmented as the status of th	tube is used after the removal pice box in the throat). This sained from the website: gov/ency/article/007398.htm 8 (R48), the facility staff failed n's order for the use of an r and failed to store the r in a sanitary manner. MDS (minimum data set), an ment with an ARD (assessment 8/28/23, the resident scored 12 MS (brief interview for mental the resident was moderately of for making daily decisions.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495283	B. WING _			09/2	: :1/2023	
	ROVIDER OR SUPPLIER E HEALTH & REHABILI	TATION		STREET ADDRESS, CITY, STATE, ZIP COL 1719 BELLEVUE AVENUE RICHMOND, VA 23227	DE .	00/2		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	=	(X5) COMPLETION DATE	
F 695	Continued From pag	e 108	F 6	95				
E 608	physician's order for R48's care plan date information regarding. On 9/19/23 at 11:34 sitting in a wheelchai incentive spirometer resident's overbed ta spirometer was uncowas exposed to air. On 9/21/23 at 8:19 a sitting in a wheelchai incentive spirometer bed, uncovered, with air. At this time, an in R48. The resident st spirometer once or to provided a bag or comprovided a bag or co	.m., R48 was observed r in the bedroom. The was observed sitting on the the mouthpiece exposed to nterview was conducted with ated he uses the incentive vice a day and staff had not ver for the device. .m., an interview was (licensed practical nurse) #3. Into should have a the use of an incentive everything has to have a #3 stated an incentive e stored in a little baggie for	F 6				11/3/23	
F 698 SS=E	Dialysis CFR(s): 483.25(l)		F 6	30			11/3/23	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
				_		(С	
		495283	B. WING _			09/21/2023		
NAME OF P	ROVIDER OR SUPPLIER	•	•	ST	REET ADDRESS, CITY, STATE, ZIP CODE			
DOSEDAL	E HEALTH & REHABI	ITATION		17	19 BELLEVUE AVENUE			
KOSEDAL	E REALIN & RENADI	LHAHON		RI	ICHMOND, VA 23227			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFII TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 698	require dialysis reco with professional st comprehensive per the residents' goals This REQUIREMEN by: Based on resident interview, clinical re- document review, it staff failed to provid for two of 40 reside Resident #119 and The findings include 1. For Resident #11 a bagged lunch to tappointments for for communicate with the four days. Resident #119 was 9/9/23 with diagnos limited to: ESRD (edialysis and acute por The most recent MI assessment, an unassessment, with a date) of 9/16/23, con 13 out of 15 on the mental status) scor- not cognitively impassection G-was incompared.	sure that residents who eive such services, consistent andards of practice, the son-centered care plan, and and preferences. Note is not met as evidenced and staff interview, resident accord review and facility as was determined the facility are dialysis care and services and in the survey sample, Resident #83. E: 9, the facility failed to provide the ake to the dialysis ur of four days and to failed to the dialysis facility for three of admitted to the facility on is that included but were not and stage renal disease),	F	698	This plan of correction is respectfully submitted, and it is an affirmation that corrections to the areas cited have; be made and the facility is in compliance of participation requirements. 1. Resident #119 is no longer residing the facility. Resident #83 has a dialysis communication book that reflects communication and collaboration with the resident shemodialysis center. 2. An audit has been performed on all residents receiving dialysis care to ensugged nutrition is sent with the reside to dialysis and that they have a dialysis communication book that reflects communication and collaboration with the resident shemodialysis center. Any discrepancies have been corrected. 3. The Food Service Director will reeducate Cooks and Dietary Aides on importance of providing nutrition to dialysis residents prior to them leaving dialysis. The Director of Nursing/Design will reeducate LPNs, and RNs on the importance of the communication proceeds the facility and the dialysis to the test the facility and the dialysis.	vith at the the for nee esss		
	A review of the phy	sician's order dated 9/12/23			center. This education will include, but be limited to, the dialysis residents hav			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		
		495283	B. WING		C 09/21/2023	
	ROVIDER OR SUPPLIER	TATION		STREET ADDRESS, CITY, STATE, ZIP CODE 1719 BELLEVUE AVENUE RICHMOND, VA 23227	1 00/2 1/2020	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	OULD BE COMPLETION	
F 698	sheet for 9/12/23, ho communication shee 9/19/23. An interview was cor AM with Resident #1 items he took with hi stated, there was not takes a bagged mea Resident #119 stated lunch and I do not had an interview was cor AM with RN #2. Who dialysis communication purpose is to share at the dialysis center, ir medications any lab review Resident #11 book, RN #2 stated, but he should have hand 9/19/23. He is nasked if Resident #1 him, RN #2 stated, "other places, but the here. He leaves early an interview was cor AM with OSM (other director. When asked bagged lunch to take yes, they are. When process of dietary be needing the bagged	#119's dialysis revealed a communication wever there were no ts for 9/14/23, 9/16/23 and Inducted on 9/20/23 at 8:40 19 and when asked what Im to dialysis, Resident #119 Ithing. When asked if he I or a communication binder, Id, "No, there is no bagged ave binder." Inducted on 9/20/23 at 8:00 Inducted on 9/2	F 698	a dialysis communication book that be sent with them to the dialysis of the sent with them to the dialysis of the sent with the resident to dialysis. The sent of Nursing/Designee will conduct weekly for 4 weeks and monthly for months to ensure that residents he dialysis communication book sent dialysis center and that it reflects communication and collaboration resident he hemodialysis center. Director of Nursing/Designee will any issues, patterns or trends and to the Quality Assurance and Performance Improvement Commileast quarterly. 5. The date of compliance is: 11/3	center. conduct monthly sent Director an audit or 2 ave a to with the The identify d report	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		495283	B. WING _			C 09/21/2023
	ROVIDER OR SUPPLIER	ITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 1719 BELLEVUE AVENUE RICHMOND, VA 23227	· · · · · · · · · · · · · · · · · · ·	03/21/2023
(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 CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AIDEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 698	instance, if the resid morning, we make son the Resident's suthe refrigerator. If the we send the bagged We do not have this dialysis resident." We seident #119 is be OSM #1 stated, no have the days and times of dialysis and times of the facilialysis and times of the facilial	lysis schedule and time. For ent leaves early in the ure the bagged lunch is sent apper tray so it can be put in ley leave mid-morning, then I lunch on the breakfast tray. resident on our list as a When asked to review if ling sent a bagged lunch, the is not and they have not e is a dialysis resident and the alysis. PM, ASM (administrative staff ministrator, ASM #2, the and ASM #4, the regional ere made aware of the leaves and the cility will include all aspects of lare will be managed including of a comprehensive and	F 6			
	nursing facility and t reflect ongoing comi collaboration. c. timely medication d. advance directive e. nutritional and flui f. provision and doci access care g. hemodialysis trea	he dialysis center that will munication, coordination, and administration s and code status				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495283	B. WING			C 19/21/2023	
	ROVIDER OR SUPPLIER	TATION		STREET ADDRESS, CITY, STATE, ZIP CODE 1719 BELLEVUE AVENUE RICHMOND, VA 23227	•	372 172023	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 698	to ensure adequate of collaboration for care hemodialysis center. A review of R83's clir physician's order date Monday, Wednesday. On the most recent Madmission assessme reference date) of 6/5 out of 15 on the BIMS status), indicating the intact for making daily. Further review of R83 reveal communication hemodialysis center of dated 6/28/23 that do placed on a fluid rest dated 7/17/23 and 9/dialysis center was carefused to go to dialy. On 9/19/23 at 3:58 p. nurse's station failed communication folder employee stated the room. At that time, a was conducted. No of folder/book was observed to make the communication book. On 9/21/23 at 9:16 at conducted with LPN of the content of the conducted with LPN of the content of the conducted with LPN of the conducted of the conducted of the conducted with LPN of the conducted of the	RR83), the facility staff failed communication and with the resident's mical record revealed a ed 6/5/23 for dialysis every and Friday at 11:45 a.m. MDS (minimum data set), an int with an ARD (assessment ed) 23, the resident scored 14 ed) (b) (brief interview for mental ed) resident was cognitively ed) decisions. B's clinical record failed to en and collaboration with the except for a dietary note educated R83 was to be riction, and nurses' notes 11/23 that documented the alled to inform staff that R83 sis those days. m., observation of the to reveal a dialysis r/book for R83. An book was probably in R83's no observation of R83's room dialysis communication erved and R83 stated she ided a dialysis m., an interview was (licensed practical nurse) #3.	F 69	98			
	LPN #3 stated that us receives dialysis has	sually a resident who a folder with his or her name					

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495283	B. WING		C 09/21/2023
	ROVIDER OR SUPPLIER .E HEALTH & REHABILI	TATION		STREET ADDRESS, CITY, STATE, ZIP CODE 1719 BELLEVUE AVENUE RICHMOND, VA 23227	00/2 1/2020
(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)	DATE
F 698 F 727 SS=F	communication sheet time the resident goe the dialysis communinformation such as the documentation about since the last treatment changes in the resident's computed about the resident's computed on 9/21/23 at 1:28 p. staff member) #1 (the director of nursing above concern. RN 8 Hrs/7 days/Wk, CFR(s): 483.35(b)(1): §483.35(b) Registere §483.35(b)(1) Except paragraph (e) or (f) or must use the services least 8 consecutive h	to the dialysis facility each to the dialysis facility each so to dialysis. LPN #3 stated cation sheet contains he resident's vital signs, anything that has changed int, any recent labs, any int's diet, and documentation lialysis access. In ASM (administrative administrator) and ASM #2 g) were made aware of the Full Time DON (3) If a nurse when waived under this section, the facility is of a registered nurse for at ours a day, 7 days a week.	F 69	8	11/3/23
	must designate a reg director of nursing on §483.35(b)(3) The dir as a charge nurse on average daily occupa This REQUIREMENT by: Based on staff interv review, it was determensure there was an	f this section, the facility istered nurse to serve as the		This plan of correction is respectfully submitted, and it is an affirmation that corrections to the areas cited have; be made and the facility is in compliance participation requirements.	

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	' '	TE SURVEY MPLETED
		495283	B. WING			C 9/21/2023
	ROVIDER OR SUPPLIER	TATION		STREET ADDRESS, CITY, STATE, ZIP CODE 1719 BELLEVUE AVENUE RICHMOND, VA 23227		3/2 1/2020
(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 CORRECTIVE ACTION SHOUS CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 732 SS=C	was conducted. There RN was on duty for e 9/16/23. The Nursing Staffing blanks in the spaces each shift on 9/16/20. An interview was con (administrative staff in nursing, on 9/20/2023 the process for ensur eight hours each day usually has RNs on ditime and part time RN on that day, they had and they canceled the She stated she could asked should there be eight consecutive houstated, yes. A request was made to coverage. On 9/20/23 at 11:21 a administrator, stated policy, they just follow ASM #1 and ASM #2	D days as-worked schedule a was no evidence that an ight consecutive hours on Data for 9/16/2023 had for the number of RNs for 23. ducted with ASM nember) #2, the director of 3 at 10:25 a.m. When asked ing an RN is on duty for ASM #2 stated the facility uty as they have both full ls. ASM #2 explained that two agency RNs scheduled air shifts around 6:00 a.m. in't get coverage. When an RN on duty for at least airs each day, ASM #2 for the policy regarding RN a.m., ASM #1, the that they did not have a very the regulations. were made aware of the 1/20/2023 at 10:25 a.m. in Information	F 72	 There has been an RN on duty consecutive hours since 9/17/23. An audit has been performed of as-worked schedule since 9/17/2 has been an RN on duty for eight consecutive hours since 9/17/23. The Director of Nursing/Design reeducate Scheduler on the important ensuring there is a RN on duty for consecutive hours each day. The Director of Nursing/Design conduct an audit weekly for 4 were monthly for 2 months to ensure the RN on duty for eight consecutive each day. The Director of Nursing/Designee will identify any patterns or trends and report to the Quality Assurance and Performar Improvement Committee at least quarterly. The date of compliance is: 11/3 	of the 3. There are will artance of are eight are will are is a a hours by issues, are	11/3/23
	§483.35(g) Nurse Sta					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495283	B. WING			C 09/21/2023	
	ROVIDER OR SUPPLIER	TATION		1	TREET ADDRESS, CITY, STATE, ZIP CODE 719 BELLEVUE AVENUE RICHMOND, VA 23227	1 001	172020
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 732	must post the followin basis: (i) Facility name. (ii) The current date. (iii) The total number by the following category unlicensed nursing stresident care per shift (A) Registered nurses (B) Licensed practical vocational nurses (as (C) Certified nurse aid (iv) Resident census. §483.35(g)(2) Posting (i) The facility must prospecified in paragraph daily basis at the begin (ii) Data must be post (A) Clear and readab (B) In a prominent plaresidents and visitors §483.35(g)(3) Public staffing data. The fact written request, make available to the public exceed the communit §483.35(g)(4) Facility requirements. The fact posted daily nurse staffs months, or as requising greater. This REQUIREMENT by: Based on observation	and the actual hours worked gories of licensed and aff directly responsible for t: s. I nurses or licensed addefined under State law). des. g requirements. gost the nurse staffing data th (g)(1) of this section on a inning of each shift. ded as follows: le format. acce readily accessible to access to posted nurse cility must, upon oral or enurse staffing data to for review at a cost not to the standard. a data retention accility must maintain the affing data for a minimum of uired by State law, whichever is not met as evidenced n, staff interview and facility	F	732	This plan of correction is respectfully		
	Based on observatio	n, staff interview and facility vas determined the facility			This plan of correction is respectfully submitted, and it is an affirmation that		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII		CONSTRUCTION		E SURVEY PLETED
		495283	B. WING			C 09/21/2023	
	ROVIDER OR SUPPLIER	TATION		17	TREET ADDRESS, CITY, STATE, ZIP CODE 719 BELLEVUE AVENUE IICHMOND, VA 23227	,	
(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 732	' '	e 116 nurse staffing information	F 7	732	corrections to the areas cited have; be	en	
	on 9/20/2023.	3			made and the facility is in compliance very participation requirements.		
	receptionist desk was	9 a.m. an observation of the conducted. On the desking, however the paper in the 1/2023.			The Direct Care Staffing posting was corrected immediately on 9/20/23. The Direct Care Staffing has been posted each day since 9/20/23.	5	
	member) #2, the rece 10:31 a.m. When ask putting up the staff po stated the scheduler asked if the schedule	ducted with OSM (other staff optionist, on 9/20/2023 at ed who is responsible for esting each day, OSM #2 usually does it. OSM #2 was r isn't here, then who puts it e DON (director of nursing)			3. The Administrator will reeducate the Scheduler, Receptionist and Managem team on the importance of posting the direct care staffing information each da 4. The Administrator will conduct an au weekly for 4 weeks and monthly for 2 months to ensure the direct care staffin is posted. The Administrator will identif	nent ny. ndit	
	nursing, on 9/20/2023 who is responsible for each day, ASM #2 sta	ducted with ASM nember) #2, the director of 3 at 10:32 a.m. When asked r posting the staff posting for ated the scheduler was out the back up and she didn't			any issues, patterns or trends and report to the Quality Assurance and Performance Improvement Committee least quarterly. 5. The date of compliance is: 11/3/23	ort	
	Staffing" documented will post on a daily ba number of nursing pe providing direct care to Procedures/Guidance each shift, the numbergistered nurses, LF nurses) and the numbersonnel (CNAs -cel directly responsible for	rsonnel responsible for					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION NG		(X3) DATE COMP	SURVEY LETED
		495283	B. WING _				21/2023
	ROVIDER OR SUPPLIER LE HEALTH & REHABILIT	TATION		STREET ADDRESS, CITY, STATE, ZIP CO 1719 BELLEVUE AVENUE RICHMOND, VA 23227	ODE	1 03/	21/2023
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE CROSS-REF	ON SHOULD BI HE APPROPRIA		(X5) COMPLETION DATE
F 732 F 755 SS=E	Continued From page resident and visitors) format." ASM #1, the administ made aware of the at 10:35 a.m. No further information Pharmacy Srvcs/Proc CFR(s): 483.45(a)(b)(s) §483.45 Pharmacy S The facility must prov drugs and biologicals them under an agree §483.70(g). The facil personnel to administ permits, but only under a licensed nurse. §483.45(a) Procedure pharmaceutical service that assure the accurrence.	e 117 and in a clear and readable trator and ASM #2 were bove finding on 9/20/2023 at n was provided prior to exit. cedures/Pharmacist/Records (1)-(3) ervices ride routine and emergency to its residents, or obtain ment described in lity may permit unlicensed ter drugs if State law er the general supervision of es. A facility must provide ces (including procedures ate acquiring, receiving,	F 7	DEFICIENC			11/3/23
	\$483.45(b) Service C must employ or obtain pharmacist who- §483.45(b)(1) Provide aspects of the provisi the facility.	on of pharmacy services in shes a system of records of n of all controlled drugs in					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCT (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCT (X3) PROVIDER/SUPPLIER/CLIA (X3) MULTIPLE CONSTRUCT (X3) PROVIDER/SUPPLIER/CLIA (X3) MULTIPLE CONSTRUCT (X3) MULTIPLE CONSTRUCT (X3) PROVIDER/SUPPLIER/CLIA (X4) MULTIPLE CONSTRUCT (X4) PROVIDER/SUPPLIER/CLIA (X5) MULTIPLE CONSTRUCT (X5) PROVIDER/SUPPLIER/CLIA (X6) MULTIPLE CONSTRUCT (X6) PROVIDER/SUPPLIER/CLIA (X6) MULTIPLE CONSTRUCT (X6) PROVIDER/SUPPLIER/CLIA (X6) PROVIDER/SUPPLIER/S			(X3) DATE SURVEY COMPLETED			
		495283	B. WING		C 09/21/2023	
	ROVIDER OR SUPPLIER	LITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 1719 BELLEVUE AVENUE RICHMOND, VA 23227		09/21/2023	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION	
F 755	Continued From pa	ge 118	F 75	5		
	order and that an act is maintained and provide pharmac residents in the sum. The findings included For Resident #96 (Fensure the medicate for administration of 2023. A review of R96's of physician's order damag (milligrams) two day for prostate car 2023 MAR (medica revealed the same On 8/26/23 (a.m. ar and p.m. doses), 8/30/23 (a.m. dose), the MA "9=Other / See Nurs 8/26/23 documente arrive from pharmace	rmines that drug records are in account of all controlled drugs reriodically reconciled. Note in the property of the property		This plan of correction is respectfully submitted, and it is an affirmation that corrections to the areas cited have; be made and the facility is in compliance participation requirements. 1. Residents #96 no longer resides at facility. 2. A MAR to Cart audit has been completed for all current medication of Any missing Medications are now available. 3. The Director of Nursing/Designee we reeducate LPNs, and RNs on the importance of following general guidel for medication administration. This education will include, but not be limite to, the steps to take when a medication not available. 4. The Director of Nursing/Designee we perform an audit on 25% of residents weekly for 4 weeks and then monthly months to ensure medication with a current, active order is available to be administered. The Director of	een with the arts. vill ines ed n is	
	administer when me "Awaiting delivery fr note dated 8/28/23	d 8/27/23 documented, "Will ed arrive from pharmacy" and rom pharmacy." A nurse's documented, "Medication not 8/24/23." A nurse's note		administered. The Director of Nursing/Designee will identify any issupatterns or trends and report to the Quality Assurance and Performance Improvement Committee at least quarterly.	les,	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		, ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495283	B. WING		0	C 9/21/2023	
	ROVIDER OR SUPPLIER	FATION		STREET ADDRESS, CITY, STATE, ZIP CODE 1719 BELLEVUE AVENUE RICHMOND, VA 23227	1 -	<u> </u>	
(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 CORREI (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 755	dated 8/29/23 docum reordered as currently nurse's note dated 8/order from pharmacy, 8/31/23 documented, arrive from pharmacy, 9/1/23 documented, "regards to Nubeqa ta writer medication compharmacy, MD (Medinew orders noted: Okfrom resident family. (Responsible Party) vnursing staff 9/2/23." A review of the facility list revealed Nubeqa supply. On 9/21/23 at 9:16 a. conducted with LPN (LPN #3 stated that if for administration, the notify the doctor and call the pharmacy to I medication is not at the will be before the medication is not available, and this shiclinical record. On 9/21/23 at 1:28 p. staff member) #1 (the	ented, "Medication y unavailable [sic]." A 30/23 documented, "On" A nurse's note dated "Will administer when med" A nurse's note dated Writer called pharmacy in blet. Pharmacy informed nes from a special cal Doctor) made aware with any to receive medication writer call [sic] resident RP who will bring medication to who will bring medication to was not available in the	F 75	5. The date of compliance is: 11/3	3/23		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE COMP	SURVEY
			7 50.125.	_		(c
		495283	B. WING			09/	21/2023
	ROVIDER OR SUPPLIER E HEALTH & REHABILIT	TATION		17	TREET ADDRESS, CITY, STATE, ZIP CODE 719 BELLEVUE AVENUE ICHMOND, VA 23227		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	Х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 758 SS=E	active order cannot be cart/drawer, other are medication room, and are searched, if possi cannot be located after pharmacy is contacter from the emergency known and the emergency known are searched, if possi cannot be located after pharmacy is contacter from the emergency known are searched. Reference: (1) "Darolutamide (Nucertain types of prostataking darolutamide with doctor." This information website: https://medlineplus.gottml Free from Unnec Psy CFR(s): 483.45(c)(3)(3)(3)(4)(4)(3)(4)(4)(4)(4)(4)(4)(4)(4)(4)(4)(4)(4)(4)	ation Administration" dication with a current, e located in the medication as of the medication cart, I facility (e.g., other units) ble. If the medication er further investigation, the d or medication removed cit." Abeqa) is used to treat ate cancerDo not stop without talking to your tion was obtained from the abov/druginfo/meds/a619045.h chotropic Meds/PRN Use (e)(1)-(5) pic Drugs. notropic drug is any drug that associated with mental ior. These drugs include, drugs in the following		755			11/3/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING A. BUILDING		(X3) DATE SURVEY COMPLETED			
		495283	B. WING		C 09/21/2023
	ROVIDER OR SUPPLIER	TATION		STREET ADDRESS, CITY, STATE, ZIP CODE 1719 BELLEVUE AVENUE RICHMOND, VA 23227	03/21/2020
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION
F 758	specific condition as in the clinical record; §483.45(e)(2) Reside drugs receive gradual behavioral interventic contraindicated, in an drugs; §483.45(e)(3) Reside psychotropic drugs punless that medicatic diagnosed specific or in the clinical record; §483.45(e)(4) PRN or are limited to 14 days; §483.45(e)(5), if the prescribing practition appropriate for the Proposition beyond 14 days, he or rationale in the reside indicate the duration §483.45(e)(5) PRN or drugs are limited to 1 renewed unless the appropriateness. This REQUIREMENT by: Based on staff intervand clinical record reto ensure a resident unnecessary psycho	ents who use psychotropic al dose reductions, and ons, unless clinically in effort to discontinue these ents do not receive ursuant to a PRN order on is necessary to treat a condition that is documented and entered in the second in attending physician or er believes that it is RN order to be extended or she should document their ent's medical record and for the PRN order. Firders for anti-psychotic 4 days and cannot be attending physician or er evaluates the resident for of that medication. Figure is not met as evidenced entered in the facility staff failed was free from an tropic medication for one of urvey sample, Resident #83.	F 75	This plan of correction is respectfully submitted, and it is an affirmation that corrections to the areas cited have; be made and the facility is in compliance participation requirements. 1. Resident #83 has been evaluated to the physician/nurse practitioner to	een with

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPI A. BUILDING	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		495283	B. WING			C 9/21/2023	
NAME OF P	ROVIDER OR SUPPLIER		- 	STREET ADDRESS, CITY, STATE, ZIP CODE		3/2 1/2023	
				1719 BELLEVUE AVENUE			
ROSEDAL	E HEALTH & REHABILI	TATION					
				RICHMOND, VA 23227			
(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 CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 758	Continued From pag	e 122	F 75	8			
	For Resident #83 (R	83), the facility staff failed to		determine use of the anti-anxiety			
		or nurse practitioner		medication, diazepam.			
		nt for continued use of the as		modication, diazoparii.			
		medication diazepam (1).		2. An audit has been performed of	n all		
	Troodod arta armaoty	modication diazopain (1).		residents with physician orders for			
	A review of R83's cli	nical record revealed a		anti-anxiety medications to ensur			
		ed 8/4/23 for diazepam 5 mg		physician/nurse practitioner has			
	1 * *	let by mouth every eight		the resident for continued use of			
		180 days for anxiety. A		anti-anxiety medication after bein			
		ust 2023 and September		administered for 14 days and if no			
		tion administration records)		there is documented rationale for			
	revealed the resident was administered as			extended use of the medication.	Any		
	needed diazepam 28	times in August 2023 and		discrepancies have been correcte	-		
		er 2023. Further review of					
	R83's clinical record	failed to reveal the physician		3. The Director of Nursing/Design	ee will		
	or nurse practitioner	documented a rationale for		reeducate Physicians and Nurse			
	extended use and fa	iled to reveal the physician or		Practitioners on the importance o	f		
	nurse practitioner ev	aluated the resident for		evaluating residents for continued	d use of		
	continued use of the	medication after the		the anti-anxiety medication after			
	medication had beer	administered for 14 days.		medication has been administere			
				days. This education will include,			
	''	kimately 12:20 p.m., a call		be limited to, documenting a ratio	nale for		
	I	nurse practitioner. She was		extended use of the medication.			
	not available for inter	rview.					
				4. The Director of Nursing/Design			
		.m., an interview was		conduct an audit weekly for 4 weekly			
	conducted with ASM	•		monthly for 2 months to ensure th			
	, ,	ector of nursing). ASM #1		physician/nurse practitioner has e			
		prescription for as needed		the resident for continued use of			
	-	ons is for 14 days then the		anti-anxiety medication after bein			
		or she wants to continue the		administered for 14 days and if no			
	medication or not.			there is documented rationale for			
	0= 0/04/00 : 1.4.00	ACM #4 #1		extended use of the medication.			
	On 9/21/23 at 1:28 p			Director of Nursing/Designee will			
		SM #2 were made aware of		any issues, patterns or trends and	a report		
	the above concern.			to the Quality Assurance and	-:444		
	The feetile	ad IIA matina ayala adic BA - di - edi -		Performance Improvement Comm	iiilee at		
		ed, "Antipsychotic Medication I4. The need to continue		least quarterly.			

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING COMPLE		(X3) DATE SURVEY COMPLETED			
		495283	B. WING		C 09/21/2023
	ROVIDER OR SUPPLIER	TATION		STREET ADDRESS, CITY, STATE, ZIP CODE 1719 BELLEVUE AVENUE RICHMOND, VA 23227	39/2 H2929
(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 758	practitioner document extended order." Reference: (1) Diazepam is used information was obtai https://medlineplus.go	ers for psychotropic 4 days requires that the the rationale for the to treat anxiety. This	F 758	5. The date of compliance is: 11/3/23	
F 759 SS=D	CFR(s): 483.45(f)(1) §483.45(f) Medication The facility must ensu §483.45(f)(1) Medicat percent or greater; This REQUIREMENT by: Based on observation record review and fact determined that the famedication error rate 40 residents in the su #219. During the Medication of 29 opportunities administer four medicate of 13.79%. The findings include: For Resident #219 the four medications durin administration task. On 9/20/23 at 9:05 Af	ion error rates are not 5 is not met as evidenced n, staff interview, clinical ility document review, it was acility staff failed to ensure a of less than 5% for one of rvey sample; Resident dication Administration task, s, the facility failed to ations, resulting in an error e facility failed to administer ng the medication M, the medication	F 759	This plan of correction is respectfully submitted, and it is an affirmation that corrections to the areas cited have; be made and the facility is in compliance of participation requirements. 1. Resident #219□s physician and RP was notified of medication errors. Resident had no adverse reaction as a result of medication errors. 2. A medication pass audit has been performed on LPNs and RNs to ensure the medication error rate is less than 5 Any discrepancies have been corrected.	with % . d.
		vi, the medication inducted with LPN #10		reeducate LPNs and RNs on medication	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495283	B. WING				C 0/21/2023
NAME OF P	ROVIDER OR SUPPLIER	100200		STR	REET ADDRESS, CITY, STATE, ZIP CODE	1 09	0/21/2023
ROSEDAL	E HEALTH & REHABILI	TATION		171	9 BELLEVUE AVENUE		
KOSEDAL	E HEALTH & REHABILI	IATION		RIC	CHMOND, VA 23227		
(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 I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE
F 759	Continued From page	e 124	F 7	59			
F 759	(Licensed Practical N Upon review of the pl the Medication Admir September 2023 reve were ordered but wer administered on obse out as being administ A review of the physic following: (1) Aspirin an 81 mg daily. Order dated 9/(2) Valsartan an 80 m dated 9/8/23. (3) Vitamin D3 a 25 m Give two tablets once (4) Zinc a 220 mg table healing. Order dated On 9/20/23 at 1:10 Pl conducted with LPN at thought she pulled ar medications, and is we being administered. Iknow how she missed On 9/20/23 at 1:50 Pl interview was conducted with the process administration includes sure you have the rig route, right resident at She stated that since were missed, the five	lurse), for Resident #219. hysician's orders (below) and histration Record (MAR) for healed that four medications re not prepared and hervation. They were signed hered. cian's orders revealed the (milligrams) tablet once 8/23. hy tablet once daily. Order heg (micrograms) tablet. he daily. Order dated 9/9/23. helet once daily for wound hy 13/23. My an interview was hy they were signed out as he stated that she had administered the above hy they were signed out as he stated that she did not had them. My a second follow up he stated with LPN #10. She has for medication hed the five rights of making ht dose, right time, right hand the right medication. There were medications that he rights were not followed.	F 7		administration. This education will include but not limited to, adverse consequent of medication errors. 4. The Director of Nursing/Designee was perform a medication pass audit week for 4 weeks and then monthly for 2 months to ensure the medication error rate is less than 5%. The Director of Nursing/Designee will identify any issupatterns or trends and report to the Quality Assurance and Performance Improvement Committee at least quarterly. 5. The date of compliance is: 11/3/23	vill	
		lverse Consequences and ocumented, ""Medication ne preparation or					

, ,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495283	B. WING		C 09/21/2023
	ROVIDER OR SUPPLIER LE HEALTH & REHABIL	ITATION	1	TREET ADDRESS, CITY, STATE, ZIP CODE 719 BELLEVUE AVENUE RICHMOND, VA 23227	1 30/21/2020
(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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION
F 759	in accordance with professional standar professiona	ings or biological which is not obysician's orders, cations, or accepted dis and principles of the ding services5. Examples include: a. omission - a not administered; b. a drug is administered is order; c. wrong dose d. inistration e. wrong dosage g. wrong time; and/or; h. ufacturer instructions and/or al standards" PM, an end-of-day meeting ASM #1 (Administrative Staff strator, ASM #2 the Director M #4, the Regional Nurse adde aware of the findings. No was provided by the end of the director of the risk of death from a heart of the gov/druginfo/meds/a682878.h	F 759		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE COMP	SURVEY
		495283	B. WING _			C 09/21/2023	
	ROVIDER OR SUPPLIER LE HEALTH & REHABILIT	TATION		17	TREET ADDRESS, CITY, STATE, ZIP CODE 719 BELLEVUE AVENUE ICHMOND, VA 23227		21/2025
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 759	prevent and treat bon Information obtained https://medlineplus.go tml (4) Zinc - Is an esse	l along with calcium to ne diseases from ov/druginfo/meds/a620058.h ential trace element	F	759			
F 760 SS=E	3		F.	760			11/3/23
	medication errors. This REQUIREMENT by: Based on staff interv and clinical record rev to ensure a resident v medication error for o survey sample, Resid The findings include: For Resident #96 (R9 administer the medical	rits are free of any significant is not met as evidenced iew, facility document review view, the facility staff failed was free of a significant one of 40 residents in the			This plan of correction is respectfully submitted, and it is an affirmation that corrections to the areas cited have; been made and the facility is in compliance we participation requirements. 1. Residents #96 no longer resides at the facility. 2. A MAR to Cart audit has been completed for all current medication can Any missing Medications are now	vith he	

STATEMENT OF DEFICIENCIES (X'AND PLAN OF CORRECTION	1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION	(X3) DATE COMP	
		7 50.25				
	495283	B. WING _			09/	21/2023
NAME OF PROVIDER OR SUPPLIER ROSEDALE HEALTH & REHABILITAT	TION		STREET ADDRESS, CITY, STATE, ZIP CODE 1719 BELLEVUE AVENUE RICHMOND, VA 23227			
PREFIX (EACH DEFICIENCY M	MENT OF DEFICIENCIES UST BE PRECEDED BY FULL IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
day for prostate cancer. 2023 MAR (medication a revealed the same phys On 8/26/23 (a.m. and p. and p.m. doses), 8/28/23 (p.m. dose), 8/30/23 (p.m. dose), 8/30/23 (p.m. dose), the MAR do "9=Other / See Nurse Not 8/26/23 documented, "Warrive from pharmacy" a stock, resident made aware monitor." Nurses' notes documented, "Will admin from pharmacy" and "Avapharmacy." A nurse's note documented, "Medicatio 8/24/23." A nurse's note documented, "Medicatio unavailable [sic]." A nur documented, "On order nurse's note dated 8/31/20 administer when med ar nurse's note dated 9/1/2 called pharmacy in rega Pharmacy informed write from a special pharmacy made aware with new or receive medication to nurs On 9/21/23 at approximated approximated approximated as a proximated and proximated approximated and proximated approximated and proximated approximated and proximated approximated and proximated and proximated approximated approximated and proximated approximated and proximated approximated and proximated approximated and proximated and prox	al record revealed a 8/24/23 for Nubeqa 300 dets by mouth two times a A review of R96's August administration record) ician's order for Nubeqa. m. doses), 8/27/23 (a.m. 3 (p.m. dose), 8/29/23 m. dose) and 8/31/23 ocumented the code, otes" Nurses' notes dated Will administer when med and "Medication out of vare, will continue to dated 8/27/23 mister when med arrive vaiting delivery from ote dated 8/28/23 on not in stock, reorder on a dated 8/29/23 on reordered as currently rive from pharmacy." A 23 documented, "Will rive from pharmacy." A 23 documented, "Writer rds to Nubeqa tablet. For medication comes by MD (Medical Doctor) orders noted: Okay to resident family. Writer esponsible Party) who will sing staff 9/2/23."	F	760	available. 3. The Director of Nursing/Designee wireeducate LPNs, and RNs on the importance of following general guideling for medication administration. This education will include, but not be limited to, the steps to take when a medication not available and the importance of residents being free of significant med errors. 4. The Director of Nursing/Designee wiperform an audit on 25% of residents weekly for 4 weeks and then monthly formonths to ensure medications with a current, active order are available to be administered. The Director of Nursing/Designee will identify any issue patterns or trends and report to the Quality Assurance and Performance Improvement Committee at least quarterly. 5. The date of compliance is: 11/3/23	nes d n is II or 2	

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE COMP	SURVEY
				_		С	
		495283	B. WING			09/	21/2023
	ROVIDER OR SUPPLIER	- Table			TREET ADDRESS, CITY, STATE, ZIP CODE 719 BELLEVUE AVENUE		
RUSEDAL	E HEALTH & REHABILIT	ATION		R	ICHMOND, VA 23227		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 760	conducted with OSM quality assurance phathat based on the mainformation, Nubeqa is cancer. In regard to treceiving Nubeqa as that this was patient swhat other medication receiving but, "Gener something you want to On 9/21/23 at 1:28 p. staff member) #1 (the director of nursin above concern. The facility policy title and Medication Errors Examples of medication mission-a drug is orgadministered"	c.m., an interview was (other staff member) #8 (the armacist). OSM #8 stated nufacturer's package s usually used for prostate the importance of a resident prescribed, OSM #8 stated specific and depended on the sthe resident was ally chemotherapy is not to miss as a general rule." m., ASM (administrative the administrator) and ASM #2 g) were made aware of the d, "Adverse Consequences s" documented, "5. ons errors include: a.	F	760			
F 770 SS=D	The website further d NUBEQA EXACTLY A YOU." https://www.nubeqa-u ng-nubeqa Laboratory Services CFR(s): 483.50(a)(1)(1)(1)(1)(2)(1)(2)(1)(2)(1)(2)(1)(2)(1)(2)(2)(2)(2)(2)(2)(2)(2)(2)(2)(2)(2)(2)	AS YOUR DOCTOR TELLS us.com/what-is-nubeqa#taki	F	770			11/3/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		495283	B. WING			C 9/21/2023	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD		372 172020	
				1719 BELLEVUE AVENUE			
ROSEDAL	E HEALTH & REHABILI	TATION		RICHMOND, VA 23227			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX		EFIX (EACH CORRECTIVE ACTION SHOULD BE		
				32110.21101)			
F 770	Continued From page	e 129	F 77	70			
	and timeliness of the	services.					
		les its own laboratory					
	• •	s must meet the applicable					
		pratories specified in part 493					
	of this chapter.						
	•	Γ is not met as evidenced					
	by:						
		iterview, staff interview,		This plan of correction is res	pectfully		
		and facility document		submitted, and it is an affirma			
	review, it was determined that the facility staff			corrections to the areas cited			
		ed laboratory testing for one		made and the facility is in cor	-		
		survey sample, Resident		participation requirements.	•		
	#53 .						
				1. Resident #53□s physician	discharged		
	The findings include:			order for stool culture.	-		
	For Resident #53 (R5	53), the facility staff failed to		2. An audit has been perform	ed on all		
	obtain a stool culture	as ordered on 9/14/2023.		residents with current physici			
				laboratory services to ensure			
		IDS (minimum data set)		laboratory testing has been o	•		
		ual assessment, with an ARD ce date) of 8/5/2023, the		discrepancies have been corr	rected.		
		ut of 15 on the BIMS (brief		3. The Director of Nursing/De			
	interview for mental s	status) assessment,		reeducate LPNs and RNs on			
	indicating they were	cognitively intact for making		importance of obtaining labor			
	daily decisions.			ordered by the physician. Thi			
				will include, but not be limited			
		4 p.m., an interview was		importance of notifying the ph			
		R53 stated that they had		and/or the nurse practitioner			
		for about 16 days with		laboratory test is not obtained	d .		
		nd abdominal pain. R53					
	•	an x-ray done and had seen		4. The Director of Nursing/De	-		
		the nurse practitioner a		conduct an audit weekly for 4			
		stated that they were		monthly for 2 months to ensu	•		
		were being brushed off		testing ordered by the physic	ian is		
		d times when they felt bad		obtained. The Director of			
	and didn't know what	the next step was.		Nursing/Designee will identify			
				patterns or trends and report			
	The physician orders	for R53 documented in part.		Quality Assurance and Perfor	rmance		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		ı	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		495283	B. WING _				C 21/2023	
	ROVIDER OR SUPPLIER	TATION		17	TREET ADDRESS, CITY, STATE, ZIP CODE 719 BELLEVUE AVENUE ICHMOND, VA 23227	1 03/	21/2023	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD			(X5) COMPLETION DATE	
F 770	' •	e 130 one time only for c-diff (1) for	F	770	Improvement Committee at least			
	2 days. Order Date: 0 The eTAR (electronic record) for R53 dated	treatment administration 9/1/2023-9/30/2023 failed of the stool specimen			quarterly. 5. The date of compliance is: 11/3/23			
	progress note. Memb abdominal pain and 2 practitioner) ordered (x-ray). NP encourage	0 p.m.) Physician/NP er c/o (complains of) loose stools. NP (nurse stool culture and KUB						
	or sent to the lab. The failed to evidence door	stool culture being obtained e clinical record further cumentation of notification of the nurse practitioner of the						
	conducted with LPN (LPN #3 stated that th of the ordered stool c	a.m., an interview was licensed practical nurse) #3. ey had looked for the results ulture and did not find re going to follow up with the nurse practitioner.						
	they had spoken with she had canceled the due to the resident no She stated that the or and she would have e	7 a.m., LPN #3 stated that the nurse practitioner and order for the stool culture lo longer having any diarrhea. The was canceled 9/21/2023 expected nursing to have sulture not having been y.						

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE COMP	
		495283	B. WING		00/	21/2023
	ROVIDER OR SUPPLIER E HEALTH & REHABILI			STREET ADDRESS, CITY, STATE, ZIP CODE 1719 BELLEVUE AVENUE RICHMOND, VA 23227	1 097.	21/2023
(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 APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 770	Continued From page	e 131	F 77	70		
	conducted with ASM member) #5, nurse p that they had examinand reviewed the x-ra She stated that she h that for complaints of diarrhea when she had culture. She stated the examination R53 had and had not reported staff. The facility policy, "La Results" documented physician/practitioner diagnostic and lab ted diagnostic and monitored.	ractitioner. ASM #5 stated ed R53 last on 9/15/2023 ay results with them then. ad examined them prior to abdominal pain and ad ordered an x-ray and stool nat as of the last not complained of any pain any new concerns to the				
		2, the director of nursing, onal nurse consultant were				
F 840 SS=D	No further information Use of Outside Resor CFR(s): 483.70(g)(1)		F 84	0		11/3/23
	qualified professional service to be provided must have that service person or agency out	tside resources. acility does not employ a person to furnish a specific d by the facility, the facility se furnished to residents by a side the facility under an ed in section 1861(w) of the				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	IPLE CONSTRUCTION	(X	3) DATE SURVEY COMPLETED
		495283	B. WING _			C 09/21/2023
	ROVIDER OR SUPPLIER	TATION	•	STREET ADDRESS, CITY, STATE, 1719 BELLEVUE AVENUE RICHMOND, VA 23227	ZIP CODE	00.2.1.2020
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE CROSS-REFERENCED	N OF CORRECTION E ACTION SHOULD BE) TO THE APPROPRIATE CIENCY)	(X5) COMPLETION DATE
F 840	(2) of this section. §483.70(g)(2) Arrang section 1861(w) of the pertaining to services resources must speciassumes responsibil (i) Obtaining services standards and princip professionals providing and (ii) The timeliness of This REQUIREMENT by: Based on staff interview, it was determ have a written dialys residents in the survey and #83. The findings include: 1. For Resident #119	gements as described in the Act or agreements as furnished by outside sify in writing that the facility sity forth at the professional poles that apply to the services in such a facility; the services. To is not met as evidenced when and facility staff failed to its agreement for two of 40 bey sample, Resident #119	F	This plan of correction submitted, and it is an corrections to the areas made and the facility is participation requirement. 1. Resident #119 no lost facility. A dialysis agreed #83 so dialysis center here. 2. An audit has been presidents receiving dial	is respectfully affirmation that s cited have; been in compliance with ents. nger resides at the ement with Residen has been obtained.	h nt
	9/9/23 with diagnosis	admitted to the facility on that included but were not d stage renal disease), and		ensure the facility has a agreement with each o dialysis centers. Any di been corrected.	f the resident□s	
	9/9/23 which reveale has ESRD and recei Tuesday/Thursday/S INTERVENTIONS: I Auscultation/palpatic			3. The Regional Director will reeducate the Admimportance of having wagreements with residencenters. 4. The Regional Directors.	inistrator on the vritten dialysis ent⊡s dialysis	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	LE CONSTRUCTION	, ,	(X3) DATE SURVEY COMPLETED	
			7. BOILDING			С	
		495283	B. WING		09	/21/2023	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	•		
DOOFDAL	E LIEALTIL O DELLA DILL	TATION		1719 BELLEVUE AVENUE			
ROSEDAL	E HEALTH & REHABIL	ITATION		RICHMOND, VA 23227			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 840	Continued From pag	e 133	F 84	0			
	protocols." A review of the physicevealed, "Dialysis ended plants of the physicevealed, "Dialysis ended plants of the physicevealed, "Dialysis ended plants of the physiceveal plants of the physiceves of the physic	ician's order dated 9/12/23 very T-TH-SA." conference to the facility on as made for the dialysis		Operations/Designee will conweekly for 4 weeks and monmonths to ensure written dia agreements with resident senters are in place. The Di Nursing/Designee will identif patterns or trends and report Quality Assurance and Perfolmprovement Committee at I quarterly. 5. The date of compliance is	thly for 2 lysis dialysis rector of y any issues, t to the ormance east		
	member) #1, the adradirector of nursing ar nurse consultant, we findings. A review of the facilit Disease-Care of the "Agreements betwee contracted ESRD fact how the resident's cabut not limited to: a. the development of integrated care plan b. the communication nursing facility and the						

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		495283	B. WING		C 09/21/2023	
	ROVIDER OR SUPPLIER	TATION		STREET ADDRESS, CITY, STATE, ZIP CODE 1719 BELLEVUE AVENUE RICHMOND, VA 23227		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES DY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION	
F 840	access care g. hemodialysis treat No further informatio 2. For Resident #83, a written dialysis agricenter. Resident #83 was ac 6/3/23 with diagnosis limited to: ESRD (en dialysis. A review of the comp 9/9/23 which reveale has ESRD and recei (M,W,F). INTERVEN weights. Auscultatio (pulse, bruit and thril flow per protocols." A review of the physi revealed, "Dialysis e and Friday at 11:45 / During the entrance 9/19/23, a request w contracts or agreeme On 9/20/23 at 12:37 staff member) #1, the do not have the dialy been working with th the old contract from do not have one for to corporation." When	d management imentation of appropriate imentation of appropriate iment days and times in was provided prior to exit. The facility failed to evidence element with a dialysis identited to the facility on a that included but were not identified to stage renal disease), and increhensive care plan dated in items of the Average in items of the A	F 84	10		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495283	B. WING		C 09/21/2023
	ROVIDER OR SUPPLIER	LITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 1719 BELLEVUE AVENUE RICHMOND, VA 23227	03/21/2020
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION
F 840	member) #1, the addirector of nursing a nurse consultant, w findings.	PM, ASM (administrative staff Iministrator, ASM #2, the and ASM #4, the regional ere made aware of the	F 84		
F 842 SS=E	Resident Records - CFR(s): 483.20(f)(5) §483.20(f)(5) Resid (i) A facility may not resident-identifiable (ii) The facility may resident-identifiable accordance with a cagrees not to use o except to the extent to do so. §483.70(i) Medical §483.70(i)(1) In accordessional standamust maintain medithat are- (i) Complete; (ii) Accurately docu (iii) Readily accessi (iv) Systematically of \$483.70(i)(2) The fall information contaregardless of the for records, except who (i) To the individual,	ent-identifiable information. It release information that is It to the public. It release information that is It to an agent only in It to an agent only in It to an agent only in It the facility itself is permitted It the facility itself is permitted It records. It is permitted It is p	F 84		11/3/23

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	PLE CONSTRUCTION IG		DATE SURVEY COMPLETED
		495283	B. WING _			C 09/21/2023
	ROVIDER OR SUPPLIER	LITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 1719 BELLEVUE AVENUE RICHMOND, VA 23227		03/21/2023	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR ((EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 842	(ii) Required by Law (iii) For treatment, poperations, as perm with 45 CFR 164.50 (iv) For public health neglect, or domestic activities, judicial ar law enforcement pupurposes, research medical examiners, a serious threat to health the purposes, research medical examiners, a serious threat to health the purposes of the record information aunauthorized use. §483.70(i)(3) The force of the period of tim (ii) Five years from there is no requirem (iii) For a minor, 3 y legal age under State §483.70(i)(5) The modification of the provided; (iv) The results of a and resident review determinations conductively (v) Physician's, nursiprofessional's progressional's progre	rayment, or health care nitted by and in compliance 106; h activities, reporting of abuse, coviolence, health oversight and administrative proceedings, proses, organ donation purposes, or to coroners, funeral directors, and to avert health or safety as permitted the with 45 CFR 164.512. Accility must safeguard medical against loss, destruction, or the date of discharge when hent in State law; or ears after a resident reaches the law. The dical record must containation to identify the resident; esident's assessments; sive plan of care and services any preadmission screening revaluations and ducted by the State; se's, and other licensed	F8	42		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII		CONSTRUCTION	COM	E SURVEY PLETED
		495283	B. WING _			1	C / 21/2023
NAME OF PR	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00	121/2020
				17	719 BELLEVUE AVENUE		
ROSEDAL	E HEALTH & REHABILI	TATION		R	RICHMOND, VA 23227		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 842	Continued From pag	e 137	F 8	842			
	facility document rev review, the facility sta accurate clinical reco the survey sample, F				This plan of correction is respectfully submitted, and it is an affirmation that corrections to the areas cited have; be made and the facility is in compliance participation requirements.	with	
	to accurately docume resident's pressure in wound evaluations a R108 presented with	R108), the facility staff failed ent the location of the njury on multiple weekly nd the resident's care plan. a pressure injury on the			 1. Resident #108□s medical record hat been updated to reflect resident □s pressure injury is on his sacral region. The update includes a clarification not and care plan revision. 2. An audit has been performed on all 	e	
	and care plan docum was on the right isch R108 was admitted t	ut the wound evaluations nented the pressure injury ial/ischium (2). o the facility on 5/27/23 with e four pressure injury (3) on			residents with pressure injuries to ensu accurate documentation of the location the pressure injury on their care plans wound evaluations. Any discrepancies have been corrected.	n of and	
	the sacral region. A weekly wound eval documented R108's on the right ischium. plan dated 6/4/23 do impairment to skin in ischium" Weekly w 6/9/23, 6/16/23, 6/23 documented the presthe right ischial. A pl 6/28/23 documented right buttock with nor				3. The Director of Nursing/Designee w reeducate Administrative Nurses, LPN and RNs on the importance of maintain accurate clinical records. This education will include, but not be limited to, ensurthe location of a resident spressure injury is documented accurately on wo evaluations and care plans. 4. The Director of Nursing/Designee w conduct an audit weekly for 4 weeks a monthly for 2 months to ensure the location of resident's pressure injuries accurately documented on their wound	s ning on ring und ill nd	
	with a dry adhesive of care. A physician's ridocumented R108 www.	lressing every shift for wound			evaluations and care plans. The Direct of Nursing/Designee will identify any issues, patterns or trends and report to the Quality Assurance and Performance Improvement Committee at least quarterly.	tor	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MUL IDENTIFICATION NUMBER: A. BUILD		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495283	B. WING		09/21/2023	
	ROVIDER OR SUPPLIER	ITATION	STREET ADDRESS, CITY, STATE, ZIP CODI 1719 BELLEVUE AVENUE RICHMOND, VA 23227		· · · · · · · · · · · · · · · · · · ·	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE COMPLETION	
F 842	wound on his buttood On 9/21/23 at 9:16 at conducted with LPN (the nurse who docute evaluations). LPN # injury was located of On 9/21/23 at 1:28 pt staff member) #1 (th (the director of nursity above concern. The facility policy title Prevention and Mand Documentation of the the pressure ulcer/ing the resident's medic may include: a. Locate References: (1) "The sacrum is at structure that is located vertebrae and that is This information was https://medlineplus.cg htm (2) The ischium is the hip bone. This information website: https://med (3) "Stage 4 Pressur and tissue loss. Full-thickness skin at	8. R108 stated he has had a k for over three years. a.m., an interview was (licensed practical nurse) #3 imented the weekly wound 3 stated R108's pressure in his buttock. b.m., ASM (administrative lie administrator) and ASM #2 ing) were made aware of the ed, "Pressure Injury agement" documented, "2. in e evaluations/assessment of injury will [sic] maintained in all record. Documentation	F 84	,	/3/23	
	ligament, cartilage of and/or eschar may be was obtained from the	r bone in the ulcer. Slough be visible." This information				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495283	B. WING				21/2023
	ROVIDER OR SUPPLIER E HEALTH & REHABILIT			1	TREET ADDRESS, CITY, STATE, ZIP CODE 719 BELLEVUE AVENUE RICHMOND, VA 23227	<u> </u>	21/2023
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 842 F 880 SS=D	Infection Prevention & CFR(s): 483.80(a)(1)(1)(1)(1)(1)(1)(1)(1)(1)(1)(1)(1)(1)	pressure_injury_stages.pdf & Control (2)(4)(e)(f) Introl blish and maintain an Ind control program It safe, sanitary and It sent and to help prevent the It semission of communicable Ins. Instruction and control Instruction and control Instruction prevention Instruction p		842	DELIGIENCI)		11/3/23
	reported; (iii) Standard and tran	nsmission-based precautions					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G	, ,	(X3) DATE SURVEY COMPLETED	
		495283	B. WING _			C 19/21/2023	
	ROVIDER OR SUPPLIER LE HEALTH & REHABILI	TATION		STREET ADDRESS, CITY, STATE, ZIP CO 1719 BELLEVUE AVENUE RICHMOND, VA 23227	•		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE	
F 880	(iv)When and how iso resident; including but (A) The type and dura depending upon the it involved, and (B) A requirement that least restrictive possicircumstances. (v) The circumstance must prohibit employed disease or infected struction of the contact with residents contact will transmit to (vi)The hand hygiene by staff involved in disease of the corrective actions take \$483.80(a)(4) A system of the corrective actions take \$483.80(e) Linens. Personnel must hand transport linens so as infection. §483.80(f) Annual reversidate the This REQUIREMENT by: Based on staff interved clinical record review review, it was determant follow infection controlled.	vent spread of infections; blation should be used for a at not limited to: ation of the isolation, infectious agent or organism at the isolation should be the ble for the resident under the sunder which the facility ees with a communicable kin lesions from direct is or their food, if direct he disease; and a procedures to be followed rect resident contact. The procedures to be followed rect resident contact.	F8	This plan of correction is resubmitted, and it is an affirm corrections to the areas cited made and the facility is in coparticipation requirements. 1. Resident #120 no longer of facility. Resident #49 □ s bi-pi	nation that d have; been empliance with resides at the		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495283	B. WING _				C 21/2023
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 03/	21/2023
	101.52.1.01.100.1.2.2.1				719 BELLEVUE AVENUE		
ROSEDAL	E HEALTH & REHABILI	TATION			RICHMOND, VA 23227		
					T		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 880	Continued From page	a 141	F	380			
	Continuou i rom page			300			
	1 Pesident #40's hi-r	pap mask was observed on			been stored properly when not in use.		
		bed partially covered with a			2. An audit has been performed on all		
		on 9/19/23 at 1:00 PM and			residents who use a bi-pap to ensure the	ne	
	9/20/21 at 11:05 AM.	011 3/ 13/23 at 1:00 1 W and			bi-pap masks are stored appropriately	10	
	0/20/21 dt 11:00 / tivi.				when not in use. An audit has been		
	Resident #49 was ad	mitted to the facility on			performed on all residents who have a		
		that included but were not			urinary catheter to ensure proper		
	limited to: diabetes, c	ongestive heart failure,			placement of the foley bag. Any		
	COPD (chronic obstru	uctive pulmonary disease)			discrepancies have been corrected.		
	and acute respiratory	failure.					
					The Director of Nursing/Designee with		
		rehensive care plan dated			reeducate CNAs, LPNs, and RNs on the		
		CUS: The resident has			importance of following infection control		
	COPD. INTERVENT	atus/difficulty breathing and			practices. This education will include, b		
	SETTINGS: Bi-pap a				not be limited to, the importance of stoll bi-pap masks properly and proper	ing	
	OLTTINGO. DI-pap a	t flight-1 102 30 70.			placement of foley bags.		
	A review of the physic	cian orders dated 6/13/23			placement of foley bags.		
		night- FIO2 30% every			4. The Director of Nursing/Designee wi	Ш	
		ift for sob (shortness of			conduct an audit weekly for 4 weeks a		
		covered when not in use,			monthly for 2 months to ensure that		
	every day shift."				bi-pap masks are stored properly and t	0	
					ensure proper placement of foley bags		
	On 9/20/23 at 11:10 A	-			The Director of Nursing/Designee will		
		(licensed practical nurse) #2.			identify any issues, patterns or trends a	and	
		ve Resident #49's bi-pap			report to the Quality Assurance and		
		, the resident must have			Performance Improvement Committee	at	
		the end of night shift and is nt. LPN #2 stated they			least quarterly.		
		tached to the bedside			5. The date of compliance is: 11/3/23		
		can be put in with a date.			3. The date of compliance is: 11/3/23		
		e for the resident to put the					
		d if the mask should be					
		N #2 stated, no, the mask					
		on her bed due to infection					
	control issues, it shou						
	,	•					
	On 9/21/23 at 1:20 Pl	M, ASM (administrative staff					

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		495283	B. WING				21/2023
	ROVIDER OR SUPPLIER	TATION	.	1	STREET ADDRESS, CITY, STATE, ZIP CODE 719 BELLEVUE AVENUE RICHMOND, VA 23227		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 880	director of nursing an nurse consultant was a nurse consultant was A review of the facility Equipment-Cleaning' "Resident-care equipitems and durable medicaned and disinfect recommendations for bloodborne pathoger. No further information 2. Resident #120's unwas observed on the and 2:45 PM. Resident #120 was a 9/12/23 with diagnosilimited to: diabetes, osteomyelitis, sepsis hypertrophy). A review of the basel revealed, "FOCUS: Catheter: history of BPH. INTE has 16 FR/10cc Posibelow the level of the bladd room door. Dignity be content." On 9/20/23 at 8:10 A conducted with RN (rasked what was the part of the pacing and the paci	ninistrator, ASM #2, the ad ASM #4, the regional a made aware of the findings. y's "Resident Care ' policy revealed, ment, including reusable edical equipment will be ted according to current CDC or disinfection and the OSHA has standard." In was provided prior to exit. In was provi	F	8880			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G		E SURVEY PLETED
		495283	B. WING _			C / 21/2023
	ROVIDER OR SUPPLIER	TATION		STREET ADDRESS, CITY, STATE, ZIP CODE 1719 BELLEVUE AVENUE RICHMOND, VA 23227		
(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 CORRECT (EACH CORRECTIVE ACTION SHOUT CROSS-REFERENCED TO THE APPRIDEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 880 F 881 SS=D	When asked if the Fo floor, RN #2 stated, n floor. When asked wi floor, RN #2 stated, it practice. On 9/21/23 at 1:20 PI member) #1, the admidirector of nursing an nurse consultant was No further information Antibiotic Stewardship CFR(s): 483.80(a)(3) §483.80(a) Infection program. The facility must esta and control program (a minimum, the follow §483.80(a)(3) An antithat includes antibiotic system to monitor and This REQUIREMENT by: Based on staff interview, it was determination a complete a program. The facility if documentation of antithe December 2022. The findings include:	ley bag should be on the ley bag should be on the o, it should never be on the hy it should not be on the is against infection control M, ASM (administrative staff inistrator, ASM #2, the d ASM #4, the regional made aware of the findings. In was provided prior to exit. To Program Drevention and control blish an infection prevention (IPCP) that must include, at ving elements: biotic stewardship program couse protocols and a dibiotic use. To is not met as evidenced few and facility document ined the facility staff failed to antibiotic stewardship failed to evidence biotic use monitoring for	F 8	This plan of correction is respectfus ubmitted, and it is an affirmation to corrections to the areas cited have made and the facility is in compliar participation requirements. 1. It is the policy of Rosedale Healt Rehabilitation to maintain a compleantibiotic stewardship program. Rothealth and Rehabilitation has determined to the supplementation of the supplement	hat ¿been nce with th and ete sedale rmined	11/3/23
		nth of December 2022.		that all residents have the potentia		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		495283	B. WING		C 09/21/2023	
NAME OF PR	ROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CODE	1 00:21:2020	\dashv
				1719 BELLEVUE AVENUE		
ROSEDAL	E HEALTH & REHABILIT	TATION		RICHMOND, VA 23227		
(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 E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	DATE	N
F 881	There was no evidence December 2022. A re 9/19/2023 at 4:32 p.m staff member) #1, the December documentate On 9/20/2023 at 10:2 the director of nursing have the documentate ASM #2 stated she at from the previous phase was unable to ac ASM #2 were made at The facility policy, "Ar documented in part," prescribed and admir guidance of the facility Program. Implementate The purpose of our Al Program is to monitor residents."	dship program was elve months were reviewed. See of any monitoring for quest was made on a., to ASM (administrative administrator, for the ation. 1 a.m. ASM #1 and ASM #2, g, stated the facility did not son for December 2022. Intempted to get the records armacy and since she didn't longer with that pharmacy, cleas the report. ASM #1 and aware of the above concern. Intibiotic Stewardship" Purpose: Antibiotics will be distered to resident under the later of the programment of the pr	F 88	affected by this alleged deficient practice. 2. Rosedale Health and Rehabilitation evidence of the facility santibiotic stewardship program from January 20 to current month. 3. The Director of Nursing/Infection Preventionist has educated all licensed clinical staff, including RNs and LPNs the antibiotic stewardship program. The education included, but was not limited the importance of antibiotic stewardship infection control, and the individual responsibilities of nurses in supporting and adhering to the antibiotic stewards program. 4. The Director of Nursing /Designee was perform an audit of all antibiotics used the facility weekly for 4 weeks and monthly for 2 months to ensure that antibiotics are administered, and antibe orders written, in accordance with the antibiotic stewardship program. Result audits will be shared with the QAPI committee. Any patterns or trends will reported to the Quality Assurance and Performance Improvement Committee.	has 23 don e don p in ship will in dotic s of be	
F 883 SS=D	Influenza and Pneum CFR(s): 483.80(d)(1)(§483.80(d) Influenza immunizations		F 88	least quarterly. 5. Date of Compliance: 11/3/23	11/3/23	
		za. The facility must develop				

	TEMENT OF DEFICIENCIES PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING A. BUILDING		' '	(X3) DATE SURVEY COMPLETED		
		495283	B. WING _			C 09/21/2023
NAME OF PROVIDER OR SUPPLIER ROSEDALE HEALTH & REHABILITATION		•	STREET ADDRESS, CITY, STATE, ZIP COD 1719 BELLEVUE AVENUE RICHMOND, VA 23227			
(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 E APPROPRIATE	(X5) COMPLETION DATE
F 883	each resident or the receives education repotential side effects (ii) Each resident is of immunization Octobe annually, unless the contraindicated or the immunized during thi (iii) The resident or the has the opportunity to (iv) The resident's medocumentation that in following: (A) That the resident was provided educat and potential side effimmunization; and (B) That the resident immunization or did rimmunization due to refusal. §483.80(d)(2) Pneummust develop policies that- (i) Before offering the immunization, each representative receiv benefits and potential immunization; (ii) Each resident is of immunization, unless medically contraindical already been immuniciii) The resident or the immunicial or the resident or the r	res to ensure that- influenza immunization, resident's representative garding the benefits and of the immunization; ffered an influenza in 1 through March 31 mmunization is medically resident has already been is time period; re resident's representative or refuse immunization; and dical record includes indicates, at a minimum, the or resident's representative ion regarding the benefits rects of influenza reither received the influenza reither received the influenza medical contraindications or resident's representative ion regarding the benefits rects of influenza rective the influenza r	F8	83		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		I DENTIFICATION NUMBER:		MULTIPLE CONSTRUCTION PUILDING			(X3) DATE SURVEY COMPLETED		
		495283	B. WING			1	C / 21/2023		
NAME OF PI	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	1 00/	21/2020		
				1	719 BELLEVUE AVENUE				
ROSEDAL	E HEALTH & REHABIL	ITATION			RICHMOND, VA 23227				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE		
F 883	Continued From pag	ge 146	F	883					
		edical record includes		-					
	` '	indicates, at a minimum, the							
	following:	indicates, at a minimum, the							
		t or resident's representative							
		tion regarding the benefits							
		ffects of pneumococcal							
	immunization; and	neets of pricumococcar							
	(B) That the residen								
	pneumococcal immu								
	the pneumococcal ir								
	contraindication or r								
	This REQUIREMEN	IT is not met as evidenced							
	by:								
	_	nterview, staff interview,			This plan of correction is respectfully				
	facility document rev	view and clinical record			submitted, and it is an affirmation that				
	review, it was deterr	nined the facility staff failed to			corrections to the areas cited have; be	en			
	provide education a	nd offer the pneumococcal			made and the facility is in compliance	with			
	vaccination for one	of five residents reviewed for			participation requirements.				
	immunizations; Resi	ident #108.							
					1. Resident #108 has been provided				
	The findings include	:			education and offered the pneumococ	cal			
					vaccination.				
		R108), the facility staff failed							
		and offer the pneumococcal			2. An audit has been performed on all				
	vaccination.				residents to ensure they have been				
					provided education and offered the				
		MDS (minimum data set)			pneumococcal vaccination. Any				
		nission assessment, with an			discrepancies have been corrected.				
		ce date of 6/8/2023, the							
		out of 15 on the BIMS (brief			3. The Director of Nursing/Designee w	III			
		status) score, indicating the			reeducate LPNs, and RNs on the				
	_	gnitively impaired for making			importance of providing education and				
	daily decisions. In S				offering the pneumococcal vaccination				
		ures and Programs it was			offering. This education will include, bu	it			
		pneumococcal vaccination			not be limited to, when to offer the				
		and that the resident had been			pneumococcal vaccination and where				
	offered and declined	the vaccination.			document the education and offering in	1			
		al managed data.			the clinical chart.		 		
	i ne electronic clinic	al record documented under							

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		I DENTIFICATION NUMBER:		2) MULTIPLE CONSTRUCTION BUILDING			(X3) DATE SURVEY COMPLETED	
		495283	B. WING _				1	21/2023
NAME OF P	ROVIDER OR SUPPLIER			STREE	T ADDRESS, CITY, STATE, ZIP CODE		1 037	2 1/2023
ROSEDAL	E HEALTH & REHABILI	TATION		1719 B	ELLEVUE AVENUE			
ROSEDAL	L HEALIN & KENADILI	IATION		RICHN	MOND, VA 23227			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE		(X5) COMPLETION DATE
F 883	Continued From page	e 147	F8	83				
	Immunization tab; it v "Pneumovax 23 - cor			co	The Director of Nursing/Designenduct an audit weekly for 4 weel	ks ar	nd	
	for the documentatio and the documented pneumococcal vaccin On 9/20/2023 the face "Pneumococcal Infor 9/19/2023 with the redocumented, "I herefore to administer a pneumococcal infor 9/20/2023 at 8:49 a.r. offered a pneumonia 9/19/2023, R108 state asked about it before An interview was corpractical nurse) #3 of When asked the prococcination status of stated, usually on ad vaccination data basishe transfers the inforecord. When explair consent refused, LPN resident if they want put it in the immunization provide any education the vaccines, LPN #3 ownership, they had	cality presented a form, med Consent" dated esident's signature. It was by give the facility permission mococcal vaccination." Inducted with R108 on m. When asked if he was vaccine before yesterday, and the couldn't recall being expesterday. Inducted with LPN (licensed in 9/20/2023 at 9:56 a.m. bees for screening for a new resident, LPN #3 mission she goes to the efor Virginia. She stated formation into the clinical in R108's record documented in R108's record documented in H3 stated they ask the the vaccines. Usually, we attend to the resident related to B explained prior to current a tab in the immunization tab		en ed va Nu pa Qu Im qu	onthly for 2 months on all new ac suring that residents are provide ucation and offered the pneumo occination. The Director of ursing/Designee will identify any tterns or trends and report to the uality Assurance and Performand provement Committee at least arterly. The date of compliance is: 11/3/	ed cocc issue e ce	al	
	don't have it any long	sent and education. They ger. LPN #3 stated she had vening and he agreed to take accination.						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED
		495283	B. WING _		C 09/21/2023
	ROVIDER OR SUPPLIER	TATION	•	STREET ADDRESS, CITY, STATE, ZIP CODE 1719 BELLEVUE AVENUE RICHMOND, VA 23227	1 00/2 1/2020
(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 APPRO DEFICIENCY)	D BE COMPLETION
F 909 SS=D	documented in part, " offered pneumococca preventing pneumonic infectionsSpecific P Prior to or upon admi: assessed for eligibility pneumococcal vaccin indicated, will be offer thirty (30) days of admedically contraindica already been vaccina ASM (administrative sadministrator, was ma finding on 9/20/2023 and No further information Resident Bed CFR(s): 483.90(d)(3) S483.90(d)(3) Conduct bed frames, mattress part of a regular main areas of possible entr and mattresses are u separately from the be ensure that the bed ra frame are compatible This REQUIREMENT by: Based on observatio interview, clinical reco document review, it w staff failed to evidence	neumococcal Vaccine," Policy: Residents will be all vaccines to aid in a/pneumococcal rocedures/Guidance: 1. ssion, resident will be y to receive the are series and when red the vaccine series within mission to the facility unless ated or the resident has ted." staff member) #1, the ade aware of the above at 10:30 a.m. In was provided prior to exit. ct Regular inspection of all es, and bed rails, if any, as tenance program to identify apment. When bed rails sed and purchased ed frame, the facility must ails, mattress, and bed	F 9		at been ce with

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED				
		495283	B. WING				C 21/2023
NAME OF P	ROVIDER OR SUPPLIER	100200	<u> </u>	S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 09/	21/2023
	101.52.1 0.1 00.1 2.2.1				719 BELLEVUE AVENUE		
ROSEDALE HEALTH & REHABILITATION				RICHMOND, VA 23227			
					T		I
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG	Х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 909	Continued From page	e 149	F 9	909			
	The findings include:				the use of positioning/assist bars has been completed.		
	For Resident #52, the	e facility staff failed to			·		
	perform bed rail inspe				2. An audit has been performed on all		
	positioning/assist bar	S.			residents□ bed rails. Any discrepancie have been corrected.	s	
	A review of the comp	rehensive care plan dated					
		ed, "FOCUS: The resident			3. The Administrator will reeducate		
	is at risk for falls relat				Maintenance Director on the important		
		e sure the resident's call			of inspecting bed rails as part of a regu		
		nd encourage the resident to			maintenance program to identify areas		
		as needed. The resident			possible entrapment. This education w		
	needs prompt respon assistance."	se to all requests for			include, but not be limited to, when bed bed rails or mattresses are purchased		
	assisiance.				rented separately, the facility must ens		
	Resident #52 was ob	served resting in bed on			that the bed rails, mattress and bed	uic	
		0/20/23 at 8:50 AM and			frames are compatible.		
		ith bilateral one quarter rails			'		
	raised on bed.	•			4. The Administrator will conduct an au	dit	
					weekly for 4 weeks and monthly for 2		
		/'s "Side Rail Risk and			months on the resident bed inspections	s to	
	Entrapment" form dat				ensure bed rails have been inspected.		
		Use both upper 1/4 rails for			The Director of Nursing/Designee will		
		pility. Reason for side rail			identify any issues, patterns or trends a	and	
	use: to assist with be	ed positioning."			report to the Quality Assurance and	-4	
	An intorvious was son	ducted on 9/19/23 at 1:20			Performance Improvement Committee	aı	
		2. When asked if he used			least quarterly.		
		2 stated, "Yes, I use the rails			5. The date of compliance is: 11/3/23		
	to turn in bed and to p				o. The date of compliance ic. Thorse		
	An interview was con	ducted on 9/19/23 at 2:54					
		staff member) #6, the					
	maintenance director	. When asked about bed					
		stated, "We have no bed					
		een here 4 weeks and am in					
		through every bed to inspect					
	and make sure they a						
	ordering parts that ne	ed to be replaced. Unable					

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION NG		(X3) DATE COMP	SURVEY LETED
		495283	B. WING _				21/2023
NAME OF PROVIDER OR SUPPLIER ROSEDALE HEALTH & REHABILITATION		•	STREET ADDRESS, CITY, STATE, ZIP CODI 1719 BELLEVUE AVENUE RICHMOND, VA 23227	E			
(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 COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE		(X5) COMPLETION DATE
F 909	Continued From page	÷ 150	F 9	009			
	previous director but calls." On 9/21/23 at 1:20 Pl	ne starting. I called the he has not returned my M, ASM (administrative staff					
	director of nursing an nurse consultant was	inistrator, ASM #2, the d ASM #4, the regional made aware of the findings.					
	deaths/injuries from the equipment (including rails, headboard, foot accessories), the faci safety inspections an approaches: Inspectiall beds and related eregular bed safety proproblems including por Review that gaps with the dimensions estabe The review shall conscaused by the resident bed position.). Ensur properly installed using instructions and other to ensure proper fit (eproper distance from footboard, etc.)."	realed, " To try to prevent the beds and related the frame, mattress, side board, and bed lity shall conduct regular bed divil promote the following from by maintenance staff of equipment as part of our orgam to identify risks and obtential entrapment risks. In the bed system are within lished by the FDA (Note: sider situations that could be not's weight, movement or the that bed side rails are not the manufacturer's repertinent safety guidance e.g., avoid bowing, ensure the headboard and					
F 919 SS=D	Resident Call System CFR(s): 483.90(g)(1)	(2)	F 9	019			11/3/23
	§483.90(g) Resident The facility must be a	Call System dequately equipped to allow					

			(X3) DATE SURVEY COMPLETED		
		495283	B. WING		09/21/2023
NAME OF PROVIDER OR SUPPLIER ROSEDALE HEALTH & REHABILITATION		ITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 1719 BELLEVUE AVENUE RICHMOND, VA 23227	03/21/2020
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE COMPLETION
F 919	communication systed directly to a staff me work area from- §483.90(g)(1) Each §483.90(g)(2) Toilet This REQUIREMEN by: Based on observation interview, clinical reconstruction of the bathroom for consurvey sample, Resistant with a session of the findings include. For Resident #76 (Rensure the call light bathroom. On the most recent I assessment rethe residents cognitic Section G document for walking in the rocextensive assistance. The resident was as incontinent. On 9/19/2023 at 12:3 made of R76's bathr sitting on the side of front of them. The worntained a call light attached. The call light attached. The call light attached.	staff assistance through a sem which relays the call mber or to a centralized staff resident's bedside; and and bathing facilities. T is not met as evidenced on, resident interview, staff cord review and facility was determined that the ensure an accessible call bell one of 40 residents in the dent #76. The facility staff failed to was within reach in the was within reach in the seference date) of 8/15/2023, on status was not assessed. The interview and staff requiring supervision in the seference date.	F9	This plan of correction is respectful submitted, and it is an affirmation the corrections to the areas cited have a made and the facility is in compliant participation requirements. 1. Resident #76 subthroom pull compliance been replaced and is now within reaction and it is now within reaction between the call bell pull cords are in place. All deficiencies have been corrected. 3. The Administrator will reeducate a Maintenance Director on the importation of ensuring an accessible call bell is place in the residents bathrooms. Education will include, but not be lime to, ensuring the pull cord is attached the call bell. 4. The Maintenance Director/Design conduct an audit weekly for 4 weeks monthly for 2 months to ensure residents bathrooms have an accessible call bell in place with the pull cord attached to the call bell. The Director Nursing/Designee will identify any is patterns or trends and report to the	at been be with at the ance s in This hited d to hee will s and bessible or of

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		495283	B. WING _			09/	21/2023
NAME OF PROVIDER OR SUPPLIER ROSEDALE HEALTH & REHABILITATION			17	TREET ADDRESS, CITY, STATE, ZIP CODE 719 BELLEVUE AVENUE ICHMOND, VA 23227	1 0311	172020	
(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 919	with R76. R76 stated of the wall over a week the cord to the nurses nurse on duty at the transition of the bathroom and walk would not be able to a would not be able to a stated that the nursing times that they would cord on the light but of the floor of the floor if needed. On 9/20/2023 at 2:13 conducted with CNA #8. CNA #8 stated that access to the call light problems with an unit. She stated that access to the call light problems with the call to have maintenance. On 9/20/2023 at 2:23 conducted with LPN (LPN #2 stated that all access to the call light She stated that it was call the staff if they need to find the staff if they need the staff if they need to find the staff if they need to find the staff if they need to find the staff if they need	an interview was conducted that the cord had come out ex ago and they had taken is station and given it to the ime and asked them to have. R76 stated that they used is scared that if they fell they call anyone because they reach the call light. R76 ig staff had told them several have someone come fix the no one had come. In sof R76's bathroom were to 8:55 a.m. and 9/20/2023 at that in the bathroom remained cessible to the resident from the p.m., an interview was (certified nursing assistant) at they were not aware of y resident call lights on the all residents should have it and if there were any I light they put in requisitions come to repair them. p.m., an interview was dicensed practical nurse) #2. I residents should have it when in the bathroom. It is a safety issue so they could	FS	919	Quality Assurance and Performance Improvement Committee at least quarterly. 5. The date of compliance is: 11/3/23		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDII		NSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495283	B. WING			l	C
NAME OF PROVIDER OR SUPPLIER ROSEDALE HEALTH & REHABILITATION		B. Wille	1719	EET ADDRESS, CITY, STATE, ZIP CODE BELLEVUE AVENUE HMOND, VA 23227	09/	21/2023	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFII TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 919	able to enter work ord stated that he checked day and added commodosed out completed his maintenance requilight and stated that it him. He observed the with no pull cord and cord in place for the reit if needed. The facility policy "And documented in part," functional call light sy reasonable efforts to the resident's request resident that a call syntis/her bathroom Reto the licensed nurse promptly" On 9/21/2023 at 1:20 staff member) #1, the director of nursing, ar nurse consultant were concern.	ders into for repairs. He d the system at least once a dents for repairs needed or repairs. OSM #6 checked dests for R76's bathroom call had not been reported to de call light in R76's bathroom destated that there should be a desident to be able to access swering the Call light" The facility will maintain a destem and will make all densure timely responses to destem is also located in desport all defective call lights and the maintenance p.m., ASM (administrative design and make all defective call lights defend as a second of the control	FS	919			