	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING		(X3) DATE COMP	SURVEY	
		495358	B. WING			C 15/2023	
NAME OF PF	ROVIDER OR SUPPLIER		STF	REET ADDRESS, CITY, STATE, ZIP COI			
AMELIA R	EHABILITATION AND HE	EALTHCARE CENTER		80 VIRGINIA STREET IELIA, VA 23002			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETIOI DATE	
E 000	Initial Comments		E 000				
F 000	survey was conducte 11/15/2023. The faci compliance with 42 C	lity was in substantial FR Part 483.73, g-Term Care Facilities. No ness complaints were e survey.	F 000				
	survey was conducted 11/15/2023. Correction compliance with 42 C Term Care requirement investigated during the unsubstantiated with VA00060010 was sub-	-					
F 550 SS=D	99 at the time of the s	cise of Rights	F 550			12/30/23	
	self-determination, an access to persons an	ght to a dignified existence, ad communication with and					
	with respect and dign resident in a manner	ry must treat each resident ity and care for each and in an environment that ce or enhancement of his or					

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.

	-	ID HUMAN SERVICES MEDICAID SERVICES				12/14/2023 APPROVED 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		495358	B. WING			5/2023
	ROVIDER OR SUPPLIER	EALTHCARE CENTER	ST 88 A			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 550	individuality. The faci promote the rights of §483.10(a)(2) The fac access to quality care severity of condition, must establish and m practices regarding tr provision of services residents regardless §483.10(b) Exercise The resident has the rights as a resident o or resident of the Uni §483.10(b)(1) The fac resident can exercise interference, coercion from the facility. §483.10(b)(2) The re free of interference, o reprisal from the facil rights and to be supp exercise of his or her subpart. This REQUIREMENT by: Based on observation document review, an facility staff failed to p experience for one of sample, Resident #10 The findings include:	ognizing each resident's lity must protect and the resident. cility must provide equal e regardless of diagnosis, or payment source. A facility maintain identical policies and ransfer, discharge, and the under the State plan for all of payment source. of Rights. right to exercise his or her f the facility and as a citizen ted States. cility must ensure that the e his or her rights without n, discrimination, or reprisal sident has the right to be coercion, discrimination, and ity in exercising his or her orted by the facility in the rights as required under this T is not met as evidenced on, staff interview, facility d clinical record review, the provide a dignified dining f 42 residents in the survey	F 550	The resident has been provided wit proper utensils and dishware, so the have a dignified dining experience. An audit was completed by the Dieta Manager on 12/4/2023 to ensure residents were served meals on stat dishware, no other residents were n to be affected.	ey ary ndard	

Facility ID: VA0002

		ID HUMAN SERVICES MEDICAID SERVICES					INTED: 12/14/2023 FORM APPROVED 1B NO. 0938-0391
STATEMENT O	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCT G		(X3) DATE SURVEY COMPLETED	
		495358	B. WING				C 11/15/2023
NAME OF PI	ROVIDER OR SUPPLIER	•		STREET ADDRE	ESS, CITY, STATE, ZIP CODE		
AMELIA R	EHABILITATION AND HI	EALTHCARE CENTER		8830 VIRGINIA			
				AMELIA, VA			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	```	PROVIDER'S PLAN OF COR EACH CORRECTIVE ACTION S OSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 550	F 550 Continued From page 2 provide lunch in a dignified manner on 11/13/23. R16 was served a meal on a Styrofoam plate and given plastic utensils.		F 5	Dietary N	Management will be ed	-	
	A review of R16's clir documentation that R on a Styrofoam plate	nical record failed to reveal 16 should be served meals or given plastic utensils (the	uld be served meals education will be completed		nce to ensure that resid d dignified dishware. Th on will be completed by	lents are ne 12/8/2023.	
	with dangerous beha	solation and did not present viors). o.m., R16 was observed	complete a dining observation that residents are provided dig dishware weekly for 4 weeks, r	to ensure nified			
	sitting up in bed and meal was on a Styrof	up in bed and eating lunch. The resident's2 months.vas on a Styrofoam plate and the residentthe resultsating with plastic utensils.QAPI mee		nonths. The Dietary Manager will bring e results of the audits to the monthly API meeting x 3 months or until mpliance is achieved			
	On 11/14/23 at 2:50 p.m., an interview was conducted with OSM (other staff member) #5 (the dietary director). OSM #5 stated that when she began employment 45 days ago, a lot of plates did not match, and she did not have enough plates. OSM #5 stated she requested four cases (each case containing 36 plates) of plates and had only received two cases. OSM #5 stated there was also a shortage of utensils and she had ordered multiple boxes of utensils because they get thrown in the trash or stockpiled in resident rooms. OSM #5 stated dining with a Styrofoam plate and plastic utensils is not dignified.						
	staff member) #1 (the (the director of nursin above concern. ASM	o.m., ASM (administrative administrator) and ASM #2 g) were made aware of the 1 #1 stated four cases of red but two cases had not					
	When assisting with o	ed, "Dignity" documented, "5. care, residents are ng their rights. For example,					

If continuation sheet Page 3 of 76

AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C		
		495358	B. WING		11/15/2023		
	ROVIDER OR SUPPLIER	EALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 8830 VIRGINIA STREET AMELIA, VA 23002			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE	(X5) COMPLETION DATE	
	residents are: e. prov experience" Notify of Changes (In CFR(s): 483.10(g)(14 §483.10(g)(14) Notifie (i) A facility must imm consult with the resid consistent with his or representative(s) whe (A) An accident involv results in injury and h physician intervention (B) A significant chan mental, or psychosoc deterioration in health status in either life-the clinical complications (C) A need to alter tree a need to discontinue treatment due to advec commence a new for (D) A decision to tran resident from the faci §483.15(c)(1)(ii). (ii) When making noti (14)(i) of this section, all pertinent informatic is available and provi physician. (iii) The facility must a resident and the reside when there is-	ided with a dignified dining jury/Decline/Room, etc.) ()(i)-(iv)(15) cation of Changes. rediately inform the resident; ent's physician; and notify, her authority, the resident en there is- ving the resident which as the potential for requiring n; ge in the resident's physical, ial status (that is, a n, mental, or psychosocial reatening conditions or); eatment significantly (that is, e an existing form of erse consequences, or to m of treatment); or sfer or discharge the lity as specified in fication under paragraph (g) the facility must ensure that on specified in §483.15(c)(2) ded upon request to the also promptly notify the dent representative, if any, or roommate assignment 10(e)(6); or	F 550		12	2/30/23	

Facility ID: VA0002

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		ID HUMAN SERVICES MEDICAID SERVICES				FORI	D: 12/14/2023 M APPROVED D. 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		495358	B. WING				/15/2023
NAME OF PI	ROVIDER OR SUPPLIER	•		S	TREET ADDRESS, CITY, STATE, ZIP CODE	•	
AMELIA R	EHABILITATION AND H	EALTHCARE CENTER			830 VIRGINIA STREET IMELIA, VA 23002		
(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 CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 580	Continued From page	e 4	Ѓ F	580			
		record and periodically mailing and email) and resident					
	that is a composite di §483.5) must disclose its physical configura locations that compri- part, and must specif room changes betwe under §483.15(c)(9). This REQUIREMENT by: Based on staff interv review, and clinical re failed to notify the ph	osite distinct part. A facility istinct part (as defined in e in its admission agreement tion, including the various se the composite distinct by the policies that apply to en its different locations T is not met as evidenced riew, facility document ecord review, the facility staff ysician of a potential need to e of 42 residents in the dent #20.			Resident #20 was assessed for any negative outcomes from the missed medications, and none were noted. T MD and RP were notified of the misse medications on 12/5/2023.		
	notify the physician w medication Gemtesa administration on mu 2023.	20), the facility staff failed to /hen the resident's (1) was not available for Itiple dates in September nical record revealed a			The Director of Nursing or designee w review the missed medication MAR re- for the last 3 days to ensure that if medications were missed that the MD were both notified. The audit was completed on 12/5/2023 The DON or designee will educate all licensed nurses on medication	⊧port ⊮RP	
	physician's order date mg (milligrams)- one morning for overactiv September 2023 MA record) revealed the Gemtesa. On 9/4/23 9/9/23, the MAR doce	ed 7/10/23 for Gemtesa 75 tablet by mouth in the e bladder. A review of R20's R (medication administration same physician's order for , 9/5/23, 9/6/23, 9/7/23 and umented the code, "9= Notes." A nurse's note			administration and medication administration and medication availab including notifying the MD of medicati not given. The education will be completed by 12/8/2023 The DON or designee will audit the missed medication MAR report week! 4 weeks, then monthly x2 to ensure th	ons y for	

Facility ID: VA0002

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TATEMENT (S FOR MEDICARE &	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DAT	O. 0938-039	
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		CON	IPLETED	
		495358	B. WING		11	C / 15/2023	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		10/2020	
AMELIA R	EHABILITATION AND HE	EALTHCARE CENTER		8830 VIRGINIA STREET AMELIA, VA 23002			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE	
F 580			F 580				
	pharmacy." A nurse's documented, "Waiting pharmacy." A nurse's documented, "Awaitin nurse's note dated 9/ to be delivered by pha dated 9/9/23 docume to deliver." Further re- failed to reveal the re- notified and made aw available for administ On 11/14/23 at 4:05 p conducted with LPN (LPN #5 stated nurses when a resident's me administration becaus	g on delivery from s note dated 9/6/23 ng pharmacy delivery." A 7/23 documented, "Waiting armacy." A nurse's note nted, "Waiting for pharmacy eview of R20's clinical record sident's physician was vare the medication was not ration. b.m., an interview was licensed practical nurse) #5. s should notify the physician dication is not available for se the doctor gave the order n for a reason, so the doctor		medications were not administer the MD/RP were notified. Resu audits will be taken to QAPI con monthly x3 for review and revise needed.	Its of nmittee		
	staff member) #1 (the	o.m., ASM (administrative administrator) and ASM #2 g) were made aware of the					
	documented, "1. The resident's Attending F physician on call whe	d, "Notification of Change" nurse will notify the Physician / practitioner or n there has been a(an): e. dent's medical treatment					
	This information was	to treat overactive bladder. obtained from the website: ov/druginfo/meds/a621015.h					

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STATEMENT (DF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´		DNSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		495358	B. WING				/15/2023
	ROVIDER OR SUPPLIER	EALTHCARE CENTER		8830	EET ADDRESS, CITY, STATE, ZIP CODE) VIRGINIA STREET ELIA, VA 23002	<u> </u>	
(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 CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 622 F 622 SS=D	Transfer and Discharg CFR(s): 483.15(c)(1)(§483.15(c) Transfer a §483.15(c)(1) Facility (i) The facility must peremain in the facility, discharge the resident (A) The transfer or discresident's welfare and cannot be met in the facility so the resident's ufficiently so the resident's sufficiently so the resident's services provided by (C) The safety of indirent endangered due to the status of the resident for the resident has a appropriate notice, to under Medicare or Medicard Nonpayment applies submit the necessary payment or after the to Medicare or Medicaid resident refuses to pare resident who become admission to a facility resident while the app § 431.230 of this char exercises his or her rise	ge Requirements (i)(ii)(2)(i)-(iii) and discharge- requirements- ermit each resident to and not transfer or at from the facility unless- scharge is necessary for the d the resident's needs facility; scharge is appropriate 's health has improved ident no longer needs the the facility; viduals in the facility is ne clinical or behavioral ; viduals in the facility would ered; failed, after reasonable and pay for (or to have paid edicaid) a stay at the facility. if the resident does not ' paperwork for third party third party, including d, denies the claim and the ay for his or her stay. For a es eligible for Medicaid after y, the facility may charge a le charges under Medicaid; s to operate. of transfer or discharge the beal is pending, pursuant to		622 622			12/30/23

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES					PRINTED: 12/14/2 FORM APPRO OMB NO. 0938-0		
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING		(X3) DATE SURVEY COMPLETED		
		495358	B. WING		C 11/15/2023		
	ROVIDER OR SUPPLIER	EALTHCARE CENTER	883	EET ADDRESS, CITY, STATE, ZIP CO 0 virginia street Elia, va 23002	DE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	DN SHOULD BE COMPLET IE APPROPRIATE DATE		
F 622	 431.220(a)(3) of this discharge or transfer or safety of the reside facility. The facility m that failure to transfer §483.15(c)(2) Docum When the facility transfer or safety of the resident under any of in paragraphs (c)(1)(i section, the facility m or discharge is docum medical record and a communicated to the institution or provider (i) Documentation in from the basis for the (i) of this section. (B) In the case of par section, the specific m be met, facility attemp needs, and the service facility to meet the need (ii) The documentation (2)(i) of this section m (A) The resident's ph discharge is necessar (A) or (B) of this section. (B) A physician when necessary under parathis section. (iii) Information provider must include a minim (A) Contact informatic responsible for the case of parathis section. 	chapter, unless the failure to would endanger the health ent or other individuals in the hust document the danger r or discharge would pose. The circumstances specified)(A) through (F) of this ust ensure that the transfer mented in the resident's ppropriate information is receiving health care the resident's medical record transfer per paragraph (c)(1) agraph (c)(1)(i)(A) of this resident need(s) that cannot pts to meet the resident ce available at the receiving red(s). In required by paragraph (c) hust be made by- ysician when transfer or ry under paragraph (c) (1) ion; and transfer or discharge is agraph (c)(1)(i)(C) or (D) of ded to the receiving provider ium of the following: on of the practitioner	F 622				

Facility ID: VA0002

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TATEMENT (DF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´	PLE CONSTRUCTION	(X3) DAT	NO. 0938-039 TE SURVEY MPLETED
		495358	B. WING		1	C 1/15/2023
	ROVIDER OR SUPPLIER	EALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 8830 VIRGINIA STREET AMELIA, VA 23002	•	
(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)	N SHOULD BE COMPL E APPROPRIATE DA	
F 622	 (C) Advance Directive (D) All special instruction ongoing care, as app (E) Comprehensive of (F) All other necessal copy of the resident's consistent with §483. any other documentaria a safe and effective the This REQUIREMENT by: Based on staff interver review, and clinical redetermined the facility required clinical documentarial for a facility-if 42 residents in the suffective that the findings include: The findings include: For Resident #82 (to evidence what documented in part, "room by assigned CN assistant) of this resident room, he wais ide, on the L (left) side arm under him. Resis is is floor beside him. With noted with swelling to Lacerations to L. Side 	e information tions or precautions for ropriate. are plan goals; ary information, including a discharge summary, 21(c)(2) as applicable, and tion, as applicable, to ensure ransition of care. is not met as evidenced rew, facility document ecord review, it was y staff failed to evidence the ments were sent to the nitiated transfer for three of arvey sample, Residents R82), the facility staff failed suments were sent to the dent on 8/10/2023. 10/2024 at 8:10 p.m. I was called to resident IA (certified nursing dent. When I arrived in the s noted laying on this left de of his bed, noted his left dent was noted with his left	F 62	Unable to retroactively correct for residents #82, #32, and #5. The Medical Records or designer audit Acute transfers for the last ensure that the discharge transfer documents have been sent as react This audit was completed on 12/ The Director of Nursing or designer educate all licensed nurses on co a discharge or transfer with the r clinical documentation with signar proof. The education will be com 12/8/2023. The Medical Records or designer audit the discharge or transfer assessments to ensure evidence required documents being sent v resident weekly x four and then r x2. The findings of the audits will provided to the monthly QAPI me months.	e will 7 days to er equired. 01/2023. nee will ompleting equired ature as pleted by e will e of vith the nonthly be	

Facility ID: VA0002

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		ID HUMAN SERVICES MEDICAID SERVICES				l	NTED: 12/14/2023 FORM APPROVED B NO. 0938-0391	
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·		STRUCTION	(X3) DATE SURVEY COMPLETED		
		495358	B. WING			C 11/15/2023		
NAME OF P	ROVIDER OR SUPPLIER			STREET	ADDRESS, CITY, STATE, ZIP CODE			
	EHABILITATION AND HE	ALTHCARE CENTER		8830 VI	RGINIA STREET			
,				AMELI	A, VA 23002			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 622	shoulder/arm pain, La mouthOn call conta to send (R82) to hosp for further evaluation town) EMS (emergen contacted and transp Hospital), R.P. (respon (name of RP) (Name aware and gave verb) A copy of evidence of to the hospital for the requested on 11/14/2 no documents were re An interview was com practical nurse) #5 or When asked what do hospital when a resid stated they send the laboratory test results notes, if the resident if resuscitation), send the notice and medication where it is documents sent to the hospital, L be documentation in the A copy of the policy re- related to a hospital to 11/15/2023 at 8:40 a. "Transfer and Discha the required document at the time of a facility ASM (administrative st the director of nursing president of clinical o	aceration to L. side of incted and gave verbal order pital E.R (emergency room) and treatment. (Name of icy medical services) orted (R82) to (Name of possible party) made aware of nurse practitioner) made al order." If what documents were sent transfer of 8/10/2023 was 023 at 11:37 a.m. however eceived. ducted with LPN (licensed in 11/14/2023 at 4:16 p.m. cuments are sent to the ent is sent out, LPN #5 face sheet, any pertinent s, doctor's notes, nurse's is a DNR (do not hat form, care plan, bed hold in list. LPN #5 was asked ed that those documents are .PN #5 stated there should the nurse's notes. egarding documentation ransfer was requested on m. The policy presented, rge Notice," did not address ints to be sent with a resident	F6	522				

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM): 12/14/2023 MAPPROVED). 0938-0391
STATEMENT (DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` '			(X3) DATE	
		495358	B. WING				C 15/2023
NAME OF PI	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
AMELIA R	EHABILITATION AND HE	EALTHCARE CENTER			830 VIRGINIA STREET MELIA, VA 23002		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	ĸ	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 622	2 Continued From page 10		F6	622			
	No further information	a was provided prior to exit.					
	2. For Resident #32, the facility staff failed to evidence what documents were sent to the hospital with the resident on 10/30/2023.						
	showed significant an but given patient histo	ts in part, "Patient's labs emia, no signs of bleeding ory and her feeling unwell cy room) to rule out bleed.					
	documented, "NP awa nurse's note dated, 10	ed, 10/30/2023 at 10:00 a.m. are of sending out." The D/30/2023 at 11:19 a.m., send to ED (emergency ation."					
	There was no docume the ED with the reside	entation of what was sent to ent.					
		what documents were sent transfer of 10/30/2023 was 023 at 11:37 a.m.					
	10/30/2023 failed to e were sent with the res Transfer Document C was blank. The form o	tal Transfer Form dated evidence what documents sident. The Acute Care hecklist dated 10/30/2023 didn't have a check off for are plan goals to be sent					
	practical nurse) #5 on When asked what doo	ducted with LPN (licensed 11/14/2023 at 4:16 p.m. cuments are sent to the ent is sent out, LPN #5					

Facility ID: VA0002

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		ID HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´		E CONSTRUCTION	(X3) DATE	
		495358	B. WING				C 15/2023
NAME OF P	ROVIDER OR SUPPLIER	•	•	S	STREET ADDRESS, CITY, STATE, ZIP CODE		
AMELIA F	EHABILITATION AND HE	EALTHCARE CENTER			8830 VIRGINIA STREET AMELIA, VA 23002		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 622	stated they send the f laboratory test results notes, if the resident if resuscitation), send the notice and medication where it is documented sent to the hospital, L be documentation in the ASM (administrative set the director of nursing president of clinical op of the above concern No further information 3. For Resident #5, the evidence what docum hospital with the reside The nurse's note dated documented, "Notified a ground level fall that to go to the bathroom that she is complainin her neck. No other in she had neck pain to to be evaluated. Prim the fall and sending h called an ambulance her to the nearest hose The nurses' note dated documented, Ambula patient and transport Information packet giv A copy of evidence of	face sheet, any pertinent a, doctor's notes, nurse's s a DNR (do not nat form, care plan, bed hold n list. LPN #5 was asked ed that those documents are PN #5 stated there should the nurse's notes. staff member) #1, ASM #2, g and ASM #3, the vice perations, were made aware on 11/14/2023 at 5:04 p.m. n was provided prior to exit. the facility staff failed to nents were sent to the	F	622			

Facility ID: VA0002

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TATEMENT (DF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DAT	O. 0938-039 E SURVEY IPLETED
		495358	B. WING		C 11/15/2023	
	ROVIDER OR SUPPLIER	EALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 3830 VIRGINIA STREET AMELIA, VA 23002		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETIO DATE
F 622 F 623 SS=D	requested on 11/14/2 no further documents An interview was compractical nurse) #5 or When asked what do hospital when a resid stated they send the laboratory test results notes, if the resident resuscitation), send the notice and medication where it is documents sent to the hospital, L be documentation in ASM (administrative) the director of nursing president of clinical of of the above concern No further information Notice Requirements CFR(s): 483.15(c)(3) §483.15(c)(3) Notice Before a facility trans resident, the facility in (i) Notify the resident representative(s) of the the reasons for the m language and manne facility must send a c representative of the Long-Term Care Oml (ii) Record the reason	2023 at 11:37 a.m. however a were provided. ducted with LPN (licensed in 11/14/2023 at 4:16 p.m. cuments are sent to the lent is sent out, LPN #5 face sheet, any pertinent a, doctor's notes, nurse's is a DNR (do not hat form, care plan, bed hold in list. LPN #5 was asked ed that those documents are .PN #5 stated there should the nurse's notes. staff member) #1, ASM #2, g and ASM #3, the vice perations, were made aware on 11/14/2023 at 5:04 p.m. in was provided prior to exit. Before Transfer/Discharge -(6)(8) before transfer. fers or discharges a hust- and the resident's he transfer or discharge and tove in writing and in a r they understand. The opy of the notice to a Office of the State pudsman. hs for the transfer or lent's medical record in	F 622			12/30/23

Event ID: J0FD11

Facility ID: VA0002

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		495358	B. WING				 15/2023
NAME OF P	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
AMELIA R	EHABILITATION AND HE	EALTHCARE CENTER			8830 VIRGINIA STREET AMELIA, VA 23002		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 623	and (iii) Include in the noti paragraph (c)(5) of th §483.15(c)(4) Timing (i) Except as specified (c)(8) of this section, 1 discharge required ur made by the facility a resident is transferred (ii) Notice must be ma before transfer or disc (A) The safety of indiv be endangered under this section; (B) The health of indiv be endangered, under this section; (C) The resident's her allow a more immedia under paragraph (c)(7 (D) An immediate tran required by the reside under paragraph (c)(7 (E) A resident has not days. §483.15(c)(5) Conten notice specified in par must include the follo (i) The reason for tra (ii) The location to wh transferred or dischar (iv) A statement of the including the name, a and telephone number	ce the items described in is section. of the notice. d in paragraphs (c)(4)(ii) and the notice of transfer or oder this section must be t least 30 days before the d or discharged. ade as soon as practicable charge when- viduals in the facility would paragraph (c)(1)(i)(C) of viduals in the facility would r paragraph (c)(1)(i)(D) of alth improves sufficiently to ate transfer or discharge, 1)(i)(B) of this section; nsfer or discharge is ent's urgent medical needs, 1)(i)(A) of this section; or t resided in the facility for 30 ts of the notice. The written ragraph (c)(3) of this section wing: nsfer or discharge; of transfer or discharge; nich the resident is ged; e resident's appeal rights, ddress (mailing and email),	F	623	3		

Facility ID: VA0002

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CENTER	S FOR MEDICARE &	ID HUMAN SERVICES MEDICAID SERVICES			FORM APPROVE OMB NO. 0938-039
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495358	B. WING		C 11/15/2023
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COE	DE
AMELIA R	EHABILITATION AND HE	EALTHCARE CENTER		8830 VIRGINIA STREET AMELIA, VA 23002	
(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 COMPLETION E APPROPRIATE DATE
F 623	hearing request; (v) The name, address telephone number of Long-Term Care Omk (vi) For nursing facility and developmental di disabilities, the mailin telephone number of the protection and ad developmental disabi C of the Developmen and Bill of Rights Act codified at 42 U.S.C. (vii) For nursing facility disorder or related dise email address and tel agency responsible for advocacy of individua established under the for Mentally III Individual §483.15(c)(6) Change If the information in the effecting the transfer must update the recip as practicable once the becomes available. §483.15(c)(8) Notice In the case of facility of the administrator of the written notification pri to the State Survey A State Long-Term Care the facility, and the recip	orm and assistance in and submitting the appeal as (mailing and email) and the Office of the State oudsman; y residents with intellectual isabilities or related g and email address and the agency responsible for vocacy of individuals with lities established under Part tal Disabilities Assistance of 2000 (Pub. L. 106-402, 15001 et seq.); and ty residents with a mental sabilities, the mailing and lephone number of the or the protection and als with a mental disorder e Protection and Advocacy uals Act.	F 62	3	

If continuation sheet Page 15 of 76

		ID HUMAN SERVICES MEDICAID SERVICES				F	NTED: 12/14/202 FORM APPROVEI B NO. 0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION		DATE SURVEY COMPLETED C
		495358	B. WING	3. WING		11/15/2023	
NAME OF P	ROVIDER OR SUPPLIER		•	ST	REET ADDRESS, CITY, STATE, ZIP CODE	•	
AMELIA R	EHABILITATION AND HE	EALTHCARE CENTER			130 VIRGINIA STREET MELIA, VA 23002		
(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 CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 623	Continued From page	9 15	F	623			
	by: Based on staff intervi review, and clinical re determined the facility State Long-Term Cara initiated transfer for of survey sample, Resid The findings include: For Resident #82 (R8 notify the ombudsman transfer on 8/10/2023 The nurse's notes 8/1 documented in part, " his left side of his face assessed, Resident w L. eye/L side of face, temple/hair line area,	 is not met as evidenced iew, facility document icord review, it was i staff failed to notify the e Ombudsman of a facility ne of 42 residents in the ent #82. 2), the facility staff failed to in of a facility-initiated 0/2024 at 8:10 p.m. Resident was noted with e to the floorWhen vas noted with swelling to his (2) Lacerations to L. Side L. eye red and swollen, C/O 			The ombudsman was notified of facility-initiated transfer for reside on 11/15/23. The Social Worker will complete by 12/01/2023 of all discharges f 30 days to ensure the ombudsman notified in writing to include the re- discharge. The Administrator will in-service Worker on transfer or discharge requirements to ensure that all appropriate residents are include 12/08/2023. The Administrator or designee w admission to discharge/transfer re- weekly for 4 weeks and then more	ent # 82 an audit for the last an was eason for the Social ed by ill run an report nthly for 2	
	to L. side of mouthC verbal order to send ((emergency room) for treatment. (Name of medical services) con (R82) to (Name of Ho party) made aware (n practitioner) made awar A copy of the notice to transfer of 8/10/2023 11/14/2023 at 11:37 a A copy of the notice s	further evaluation and town) EMS (emergency tacted and transported spital), R.P. (responsible ame of RP) (Name of nurse vare and gave verbal order."			months to ensure all transfers an discharges have been document the ombudsman notification is co The Administrator or designee w the results of the audits to the mo QAPI meeting x 3 months or unti compliance is achieved	ed and omplete. ill bring onthly	

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	-	ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12/14/20 FORM APPROV OMB NO. 0938-03
	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C
		495358	B. WING		11/15/2023
	ROVIDER OR SUPPLIER	EALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 8830 VIRGINIA STREET AMELIA, VA 23002	
(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 C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	DN SHOULD BE COMPLETIC THE APPROPRIATE DATE
F 623	member) #1, the direct 11/14/2023 at 3:56 p. documents sent to the in August 2023 were OSM #1 didn't know of she stated she just di OSM #1 returned on stated, R82 had a be stated the resident we transfer in PCC (poin as he was holding the when she ran the rep show up because the asked if a resident do accurately reporting to to the ombudsman, C not, there had to be a system. The facility policy, "Tr Notice" documented in notice is sent to the C -Term Care Ombudsr transfer or discharge and representative."	ot on the list. ducted with OSM (other staff ctor of social services, on m. The notification e ombudsman for transfers reviewed with OSM #1. why it didn't populate (R82),	F 623	3	
F 641	president of clinical o of the above concern	perations, were made aware on 11/14/2023 at 5:04 p.m. n was provided prior to exit.	F 64	1	12/30/23
	CFR(s): 483.20(g)				

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	-	ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12/14/20 FORM APPROVE OMB NO. 0938-039
	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C
		495358	B. WING _		11/15/2023
NAME OF PF	ROVIDER OR SUPPLIER	l		STREET ADDRESS, CITY, STATE, ZIP	•
AMELIA R	EHABILITATION AND HI	EALTHCARE CENTER		8830 VIRGINIA STREET	
				AMELIA, VA 23002	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE COMPLETION THE APPROPRIATE DATE
F 641	Continued From page	e 17	F6	641	
	resident's status.	of Assessments. It accurately reflect the is not met as evidenced			
	Based on staff interv review it was determi failed to ensure an ac	iew and clinical record ned that the facility staff ccurate MDS (minimum data one of 42 residents in the lent #98.		The MDS Coordinator co assessment for Resident 11/15/2023 to reflect that transferred to another faci	#98 on the resident ility.
	accurately code the d	98), the facility staff failed to lischarge MDS assessment		potential to be affected by practice. The MDS Coorc designee will audit resider of resident who discharge	this deficient dinator or nt assessments d within the last
	10/25/2023, with the	sment reference date) of correct discharge location.		30 days to ensure their dis reflected accurately. The completed by 12/8/2023	-
	with an ARD of 10/25 a planned discharge	DS, a discharge assessment /2023, coded R98 as having on 10/25/2023 to a short with a return to the facility		The Regional Director of 0 Reimbursement or design education to the MDS dep RAI manual section A2100 the medical record includi	nee will provide partment on the 0 that reviews
	(social services) and spoke with Pt (patient covered day) of 10/24 (discharge) date of 10	2:14 p.m.) Note Text : SS DT (director of therapy) t) and Son about LCD (last 4/2023 with a D/C D/25/2023. Pt and Son		plan and discharge orders documentation of discharg to select the two-digit cod corresponds to the reside status. The education will by 12/8/2023	s for ge location and e that nts discharge
	her home SS will set preference. SS has s home health agency) - "10/25/2023 11:00 (e would pick up Pt to take up home health PT has no ent referral to (Name of ." 11:00 a.m.) Note Text : Pt nome and has departed the		The MDS Coordinator or of audit discharge assessme resident that discharges of weekly x four and then mo ensure an accurate dischar been selected for the resid	ents for any or transfers onthly x2 to arge status has

Facility ID: VA0002

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	S FOR MEDICARE &					O. 0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			· · ·	E SURVEY IPLETED
		405259	R WING		С	
		495358	B. WING		1'	1/15/2023
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
AMELIA F	EHABILITATION AND H	EALTHCARE CENTER		8830 VIRGINIA STREET AMELIA, VA 23002		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE
F 641	Continued From page	a 18	F 641			
	F 641 Continued From page 18 On 11/15/2023 at 8:47 a.m., an interview was conducted with RN (registered nurse) #2, MDS coordinator. RN #2 stated that they followed the RAI (resident assessment instrument) manual when completing the MDS resident assessments. She stated that when completing the discharge assessments for residents she reviewed the medical record documentation, used the information provided in the morning meetings, 24 hour report and communication from the nursing staff. RN #2 reviewed the discharge MDS for R98 with the ARD of 10/25/2023 and the progress notes and stated that the MDS stated the resident was discharged to the hospital and it looked like the progress notes documented the resident being discharged home. She stated that she would further review her notes and follow up. On 11/15/2023 at 9:10 a.m., RN #2 stated that they had reviewed R98's notes and MDS and felt that it was a data entry error. She stated that she had corrected the MDS to reflect the correct			audits to the monthly QAPI meeti months.	ng x 3	
	the corrected MDS at According to the RAI October 2018, section steps for assessment record including the co orders for documenta and to select the two to the resident's disch On 11/15/2023 at 9:3 staff member) #1, the director of nursing an	Manual, Version 1.16, dated n A2100 documented in the to review the medical lischarge plan and discharge tion of discharge location digit code that corresponds harge status. 7 a.m., ASM (administrative e administrator, ASM #2, the				

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	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í	IPLE CONSTRUC			ATE SURVEY
	CONNECTION	IDENTIFICATION NOMBER.	A. BUILDING			C	
		495358	B. WING _			11/15/2023	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDF	RESS, CITY, STATE, ZIP COD)E	
AMELIA R	EHABILITATION AND HI	EALTHCARE CENTER		8830 VIRGINI AMELIA, VA			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CC EACH CORRECTIVE ACTION ROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE APPROPRIATE	(X5) COMPLETION DATE
F 641	Continued From page	e 19	F 6	41			
	No further information	n was provided prior to exit.					
F 656 [SS=E (; ; ; ; ; ;		Comprehensive Care Plan (3)	F 6	56			12/30/23
	§483.21(b) Comprehe §483.21(b)(1) The fac implement a compreh care plan for each res						
	§483.10(c)(3), that in objectives and timefra	th at §483.10(c)(2) and cludes measurable ames to meet a resident's I mental and psychosocial					
	needs that are identif	ied in the comprehensive nprehensive care plan must					
	or maintain the reside	are to be furnished to attain ent's highest practicable psychosocial well-being as					
	(ii) Any services that	24, §483.25 or §483.40; and would otherwise be required .25 or §483.40 but are not					
		esident's exercise of rights Jing the right to refuse 3.10(c)(6).					
		ervices or specialized s the nursing facility will PASARR					
		a facility disagrees with the RR, it must indicate its ent's medical record.					
	(iv)In consultation wit resident's representa (A) The resident's go						
	desired outcomes.	eference and potential for					
		ilities must document					

Facility ID: VA0002

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		ND HUMAN SERVICES MEDICAID SERVICES				FOF	ED: 12/14/20 RM APPROVE IO. 0938-03
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILDI		(X3) DATE SURVEY COMPLETED		
		495358	B. WING			C 11/15/2023	
NAME OF PI	ROVIDER OR SUPPLIER		•	ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
AMELIA R	EHABILITATION AND H	EALTHCARE CENTER			330 VIRGINIA STREET MELIA, VA 23002		
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION	N	(X5)
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	COMPLETIO
F 656	Continued From page	e 20	F	656			
	10	es and/or other appropriate					
	entities, for this purpo						
		in the comprehensive care					
		in accordance with the					
:	requirements set fort	h in paragraph (c) of this					
	section.						
		ervices provided or arranged					
		lined by the comprehensive					
	care plan, must-	we also we have a later and a second s					
		petent and trauma-informed.					
		T is not met as evidenced					
	by: Based on staff interv	view, clinical record review			Care plans for residents #12, 78, 90,	17	
		t review, it was determined			73, 20, 5 and 62 will be reviewed and		
		ailed to develop and/or			revised on 12/08/2023.		
	-	rehensive care plan for eight					
	of 42 residents in the	survey sample; Residents			All residents with weight orders are a	t risk	
	#12, #78, #90, #17, #	#73, #20, #5, and #62.			for this deficient practice. The MDS		
					Coordinator or Designee completed a		
	The findings include:				care plan audit on 12/08/2023 care pl		
					were comprehensive and reflect resid	lents	
		, the facility staff failed to			current status		
	-	nsive care plan to obtain			The Director of Nursing or Designed	will	
	weekiy weights as or	dered by the physician.			The Director of Nursing or Designee educate the Material Data Set nurses		
	The facility policy "C	are Plans, Comprehensive			licensed staff regarding the requireme		
		as reviewed. This policy			comprehensive care plans by 12/8/23		
		prehensive, person-centered					
		es measurable objectives			The Material Data Set Coordinator or		
		et the resident's physical,			Designee will audit 10 comprehensive		
	psychosocial and fun	nctional needs is developed			care plans weekly x 4 weeks, then		
	-	each resident 1. The			monthly x 2 months to ensure care pl		
		n (IDT), in conjunction with			are comprehensive and reflect reside		
	the resident and his/				current status. ¿ Results of these au		
	-	lops and implements a			will be presented to the facility Quality	ý	
		on-centered care plan for			Assurance and Performance		
	each resident"				Improvement (QAPI) Committee mon	thly	
	A review of the second				for three months for review and, if		
	A review of the comp	prenensive care plan			warranted, further action.		

Facility ID: VA0002

	-	ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12/14/20 FORM APPROVI OMB NO. 0938-03
TATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING		(X3) DATE SURVEY COMPLETED
		495358	B. WING		C 11/15/2023
NAME OF P	ROVIDER OR SUPPLIER		STR	EET ADDRESS, CITY, STATE, ZIP CO	
AMELIA R		EALTHCARE CENTER) VIRGINIA STREET	
				ELIA, VA 23002	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	DN SHOULD BE COMPLETIO IE APPROPRIATE DATE
F 656	Continued From page	e 21	F 656		
	15	/20/23 for "The resident has	1 030		
		for alteration in renal			
	function" This care				
		20/23 for "Obtain weights per			
		ale and preferably same			
		same amount of clothing			
		hts. Report significant gain or			
	loss to MD (Medical I	Doctor)."			
	A review of the clinica	al record revealed a			
		ed 5/10/23 for "Obtain weight			
	Further review of the	clinical record revealed that			
	there were no weight	s obtained during the			
		ow dates run a Sunday			
	through Saturday tim	,			
	Week of May 14 thro	• •			
	Week of May 21 thro Week of May 28 thro	• •			
	Week of June 4 throu	-			
	Week of June 18 thro	U			
	Week of July 2 through				
	Week of July 9 throug	gh July 15, 2023.			
	Week of July 16 throu				
	Week of July 23 throu				
	Week of July 30 throu				
		ough August 12, 2023. hrough September 2, 2023.			
		10 through September 16,			
	2023.				
		17 through September 23,			
	2023.				
	Week of September 2 2023.	24 through September 30,			
		nrough October 7, 2023.			
		nrough October 14, 2023.			
		through October 21, 2023.			
	Week of October 22	through October 28, 2023.			

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	-	ID HUMAN SERVICES				FORM	M APPROVED
		MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	IPLE	E CONSTRUCTION	(X3) DATE	D. 0938-0391 SURVEY
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	NG _			PLETED
		495358	B. WING				C 15/2023
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	15/2025
	EHABILITATION AND HE			8	3830 VIRGINIA STREET		
				A	AMELIA, VA 23002		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	ĸ	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ЗE	(X5) COMPLETION DATE
F 656		≥ 22 hrough November 4, 2023.	F6	656			
	There was no eviden weighed the above w	ce the resident refused to be eeks.					
	Nurse). She stated the obtain weights weekly expected that they are resident refuses. She documented, then it we that if it was care plan care plan was not foll purpose of the care p supposed to do for the individualized needs. On 11/14/23 at 3:30 F Staff Member) the Ad Director of Nursing, a President of Clinical (⁴⁷ (Licensed Practical nat if there is an order to y or monthly, then it is e obtained unless the stated that if it is not vas not done. She stated nned and not done, then the owed. She stated that the lan is everything you are e resident, their ^{ASM} #1 (Administrative ministrator, ASM #2 the nd ASM #3, the Vice Operations were made No further information was 					
	follow the comprehent weekly weights as ord The facility policy, "Ca Person-Centered" wa documented, "A comp care plan that include and timetables to men psychosocial and fun and implemented for	the facility staff failed to sive care plan to obtain dered by the physician. are Plans, Comprehensive as reviewed. This policy prehensive, person-centered as measurable objectives et the resident's physical, ctional needs is developed each resident 1. The (IDT), in conjunction with her family or legal					

Facility ID: VA0002

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM): 12/14/2023 MAPPROVED). 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		495358	B. WING				C 15/2023
NAME OF PI	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
AMELIA R	EHABILITATION AND HE	ALTHCARE CENTER			8830 VIRGINIA STREET AMELIA, VA 23002		
(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 656	representative, developmentative, developmentative, developmentative, developmentative, personance and resident" A review of the comparevealed one dated 1 has alteration or poter function" This care intervention dated 11/per orders. Use same time of day wearing s when obtaining weigh loss to MD (Medical E A review of the clinical physician's order date weekly weight every of the there were no weights any other day during the day during the day during the day during the frame): Week of July 2 throug Week of September 3 2023. Week of September 3 2023. Week of September 4 2023. Week of October 1 th Week of October 8 th There was no evidend weighed the above we of 0 11/15/23 at 9:11 A conducted with LPN #	ops and implements a on-centered care plan for rehensive care plan 1/21/22 for "The resident ntial for alteration in renal plan included an 21/22 for "Obtain weights scale and preferably same ame amount of clothing ts. Report significant gain or Octor)." If record revealed a ed 6/19/23 for "Obtain evening shift every Monday." clinical record revealed that s obtained on the Monday or the following weeks (below mough Saturday time gh July 8, 2023. 5 through September 9, 7 through September 23, rough October 7, 2023. rough October 14, 2023. ce the resident refused to be eeks. M, an interview was f7 (Licensed Practical	F	656			
F 656	representative, developmentative, developmentative, developmentative, developmentative, personance and resident" A review of the comparevealed one dated 1 has alteration or poter function" This care intervention dated 11/per orders. Use same time of day wearing s when obtaining weigh loss to MD (Medical E A review of the clinical physician's order date weekly weight every of the there were no weights any other day during the day during the day during the day during the frame): Week of July 2 throug Week of September 3 2023. Week of September 3 2023. Week of September 4 2023. Week of October 1 th Week of October 8 th There was no evidend weighed the above we of 0 11/15/23 at 9:11 A conducted with LPN #	ops and implements a on-centered care plan for rehensive care plan 1/21/22 for "The resident ntial for alteration in renal plan included an 21/22 for "Obtain weights scale and preferably same ame amount of clothing ts. Report significant gain or Octor)." If record revealed a ed 6/19/23 for "Obtain evening shift every Monday." clinical record revealed that s obtained on the Monday or the following weeks (below mough Saturday time gh July 8, 2023. 5 through September 9, 7 through September 9, 7 through September 30, rough October 7, 2023. rough October 14, 2023. ce the resident refused to be eeks. 	F	656			

Facility ID: VA0002

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						APPROVED		
CENTERS FOR MEDICARE &	PROVIDER/SUPPLIER/CLIA	(X2) MULTI	PLE CONSTRUCTION		(X3) DATE	0. 0938-0391 SURVEY		
AND PLAN OF CORRECTION ID	DENTIFICATION NUMBER:	A. BUILDIN	G		COMPLETED			
	495358	B. WING				C 15/2023		
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CIT	Y, STATE, ZIP CODE				
AMELIA REHABILITATION AND HEALTH	ICARE CENTER		8830 VIRGINIA STREET AMELIA, VA 23002					
PREFIX (EACH DEFICIENCY MUST				ER'S PLAN OF CORRECTION RRECTIVE ACTION SHOULD BE ERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE		
 F 656 Continued From page 24 obtain weights weekly or m expected that they are obtain resident refuses. She state documented, then it was not that if it was care planned a care plan was not followed. purpose of the care plan is supposed to do for the reside individualized needs. On 11/14/23 at 3:30 PM, AS Staff Member) the Administ Director of Nursing, and AS President of Clinical Operat aware of the findings. No fit provided by the end of the set of comprehensive of weekly weights as ordered. The facility policy, "Care Pla Person-Centered" was revide documented, "A compreher care plan that includes meat and timetables to meet the psychosocial and functiona and implemented for each reinterdisciplinary team (IDT) the resident and his/her fan representative, develops ar comprehensive, person-cert each resident" A review of the comprehension or potential for alt function" This care plan is care plan is supported and the function	ained unless the ed that if it is not of done. She stated and not done, then the . She stated that the everything you are dent, their SM #1 (Administrative trator, ASM #2 the SM #3, the Vice tions were made further information was survey. acility staff failed to care plan to obtain by the physician. ans, Comprehensive iewed. This policy nsive, person-centered asurable objectives resident's physical, al needs is developed resident 1. The), in conjunction with mily or legal nd implements a ntered care plan for sive care plan 2 for "The resident has teration in renal	F 6	56					

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391	
STATEMENT (DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495358	B. WING				C 15/2023	
NAME OF PI	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE			
AMELIA R	EHABILITATION AND HE	EALTHCARE CENTER			830 VIRGINIA STREET MELIA, VA 23002			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ЗE	(X5) COMPLETION DATE	
F 656	intervention dated 12/ orders. Use same sca time of day wearing s when obtaining weigh loss to MD (Medical D A review of the clinica 6/7/23 for "Obtain wea every Thursday for m Further review of the there were no weights or any other day durin (below dates run a Su frame): Week of July 23 throu Week of October 22 t Week of October 22 t Week of October 29 t There was no evidend weighed the above we On 11/15/23 at 9:11 A conducted with LPN # Nurse). She stated th obtain weights weekly expected that they are resident refuses. She documented, then it w that if it was care plan care plan was not foll purpose of the care p supposed to do for the individualized needs. On 11/14/23 at 3:30 F Staff Member) the Ad Director of Nursing, a	 /5/22 for "Obtain weights per ale and preferably same amount of clothing its. Report significant gain or Doctor)." al record revealed an order ekly weight every night shift onitoring." clinical record revealed that sobtained on the Thursday ing the following weeks unday through Saturday time ugh July 29, 2023. hrough October 28, 2023. hrough November 4, 2023. ce the resident refused to be eeks. AM, an interview was 47 (Licensed Practical nat if there is an order to y or monthly, then it is e obtained unless the e stated that if it is not was not done. She stated in the lan is everything you are e resident, their PM, ASM #1 (Administrative ministrator, ASM #2 the 	F	656				

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		ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 12/14/2023 M APPROVED O. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· <i>`</i>		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495358	B. WING				C / 15/2023
NAME OF PI	ROVIDER OR SUPPLIER			Ş	STREET ADDRESS, CITY, STATE, ZIP CODE		
AMELIA R	EHABILITATION AND HI	EALTHCARE CENTER			8830 VIRGINIA STREET		
	-				AMELIA, VA 23002		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 656		No further information was	F	656			
	follow the comprehen	the facility staff failed to sive care plan to obtain dered by the physician.					
	The facility policy, "Care Plans, Comprehensive Person-Centered" was reviewed. This policy documented, "A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident 1. The interdisciplinary team (IDT), in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive, person-centered care plan for each resident"						
	alteration or potential function" This care intervention dated 1/2 orders. Use same sca time of day wearing s	/20/22 for "The resident has for alteration in renal plan included an 20/22 for "Obtain weights per ale and preferably same ame amount of clothing nts. Report significant gain or					
	A review of the clinica physician's order date day shift every Wedn	ed 6/1/23 for "Weight every					
	there were no weight	her day during the following					

Facility ID: VA0002

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	-	ID HUMAN SERVICES MEDICAID SERVICES			FOF	RM APPROVED
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	(X3) DAT	TE SURVEY MPLETED
		495358	B. WING		1	C 1/15/2023
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
AMELIA R	EHABILITATION AND HE	EALTHCARE CENTER		8830 VIRGINIA STREET AMELIA, VA 23002		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 656	Saturday time frame) Week of July 23 throu	: igh July 29, 2023. ce the resident refused to be	F 6	56		
	Nurse). She stated the obtain weights weekly expected that they are resident refuses. She documented, then it we that if it was care plan care plan was not foll	#7 (Licensed Practical nat if there is an order to y or monthly, then it is e obtained unless the e stated that if it is not vas not done. She stated nned and not done, then the owed. She stated that the lan is everything you are				
	Staff Member) the Ad Director of Nursing, a President of Clinical (Dperations were made No further information was				
	follow the comprehen	the facility staff failed to sive care plan to obtain rdered by the physician.				
	Person-Centered" wa documented, "A comp care plan that include and timetables to me psychosocial and fun and implemented for	are Plans, Comprehensive is reviewed. This policy prehensive, person-centered is measurable objectives et the resident's physical, ctional needs is developed each resident 1. The (IDT), in conjunction with				

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391	
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C		
		495358	B. WING				/15/2023	
NAME OF P	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE	<u>.</u>		
AMELIA R	EHABILITATION AND HE	EALTHCARE CENTER			8830 VIRGINIA STREET AMELIA, VA 23002			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)				(X5) COMPLETION DATE	
F 656	the resident and his/h representative, develo comprehensive, perso each resident" A review of the compre- revealed one dated 6 alteration or potential function" This care intervention dated 6/4 orders. Use same sca time of day wearing s when obtaining weigh loss to MD (Medical E A review of the clinical physician's order date monthly." Further review of the reveal any weights of June 2023. There was no evident weight for June 2023. On 11/15/23 at 9:11 A conducted with LPN # Nurse). She stated th obtain weights weekly expected that they are resident refuses. She documented, then it w that if it was care plan care plan was not foll	er family or legal ops and implements a on-centered care plan for rehensive care plan (4/22 for "The resident has for alteration in renal plan included an /22 for "Obtain weights per ale and preferably same ame amount of clothing its. Report significant gain or Octor)." If record revealed a ed 5/10/23 for "Obtain weight clinical record failed to otained for the month of the resident refused the M, an interview was f7 (Licensed Practical hat if there is an order to y or monthly, then it is e obtained unless the e stated that if it is not was not done. She stated and and not done, then the lan is everything you are	F	656				

If continuation sheet Page 29 of 76

	MENT OF HEALTH AN S FOR MEDICARE & I	D HUMAN SERVICES					FORM): 12/14/2023 APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		495358	B. WING			_		C 15/2023
NAME OF PI	ROVIDER OR SUPPLIER		I	S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
AMELIA R	EHABILITATION AND HE	ALTHCARE CENTER		-	830 VIRGINIA STREET MELIA, VA 23002			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	x	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 656	On 11/14/23 at 3:30 F Staff Member) the Add Director of Nursing, a President of Clinical C aware of the findings. provided by the end o 6. For Resident #20 (I to implement the resident plan for medication action overactive bladder. A review of R20's clining physician's order date 75 mg (milligrams)- or morning for overactive R20's comprehensive documented, "The resise potential for alteration to) BPH (benign prost Kidney disease, Prost Overactive bladder. I medication and treat A review of R20's Sep (medication administr same physician's order 9/5/23, 9/6/23, 9/7/23 documented the code Notes." A nurse's not "Medication pending p dated 9/5/23 document from pharmacy." A nu documented, "Awaitin nurse's note dated 9/7 to be delivered by pha	M, ASM #1 (Administrative ministrator, ASM #2 the nd ASM #3, the Vice Operations were made No further information was f the survey. R20), the facility staff failed dent's comprehensive care dministration to treat ical record revealed a ed 7/10/23 for Gemtesa (1) he tablet by mouth in the bladder. care plan dated 7/24/23 sident has alteration or in renal function r/t (related atic hyperplasia), Diuretics, tate enlargement, nterventions: Administer ments as ordered"	F	656				

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DEPARTMENT OF HEALTH AN CENTERS FOR MEDICARE & M					FORM	APPROVED 0. 0938-0391
STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	IPLE CONSTRUCTION		(X3) DATE	SURVEY
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDII	NG			LETED
	495358	B. WING _				C 15/2023
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, C	CITY, STATE, ZIP CODE	1 17	10/2020
AMELIA REHABILITATION AND HE	ALTHCARE CENTER					
			AMELIA, VA 2300	2		
PREFIX (EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH C	/IDER'S PLAN OF CORRECTION CORRECTIVE ACTION SHOULD B EFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
LPN #5 stated, "I known us to check. Orders a updated, and everythin to know how to take c everything that person nurses usually try to o seven days before the that if a medication is administration, the numedication is in the fa supply and if it is not, physician, possibly put until it arrives from the pharmacy know they not On 11/14/23 at 4:57 p staff member) #1 (the (the director of nursing above concern. Reference: (1) Gemtesa is used to This information was on https://medlineplus.go tml 7. For Resident #5, th implement the compre- obtaining weights per The comprehensive c documented in part, "I compromised cardiova- risk for compromise r/	 an., an interview was licensed practical nurse) #5. w the care plan is there for are put in, the care plan is ing is there for us to check are of that person and a needs." LPN #5 stated the order medications six or ever un out. LPN #5 stated not available for reses should see if the acility backup medication the nurses should notify the at a hold on the medication e pharmacy and let the need the medication. a.m., ASM (administrative administrator) and ASM #2 g) were made aware of the bo treat overactive bladder. obtained from the website: bv/druginfo/meds/a621015.h be facility staff failed to ehensive care plan for the physician orders. are plan dated, 4/3/2023, Focus: The resident has ascular conditions or is at tr (related to) CHF ure), Diabetes, Hypertension ." The "Interventions" 	F	556			

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE COMP	SURVEY PLETED
		495358	B. WING _				C 15/2023
	ROVIDER OR SUPPLIER	ALTHCARE CENTER		8	TREET ADDRESS, CITY, STATE, ZIP CODE 830 VIRGINIA STREET MELIA, VA 23002		
(X4) ID PREFIX TAG	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH				PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 656	routine/prn (as neede The physician order of documented, "Weight Wed (Wednesday)." Review of the clinical documentation of the Wednesdays: 7/5/2023 8/30/2023 9/13/2023 10/25/2023 11/1/2023. On 11/14/2023, ASM member) #2, the direct were weights that were orders. An interview was com- practical nurse) #5, or When asked the purp #4 stated, the staff ca going on and what the asked if the care plan as ordered and the we ordered, is that follow stated, no. ASM #1, the administ the vice president of of made aware of the ab at 5:04 p.m. No further information 8. For Resident #62 (fit	d)/orders." lated, 6/19/2023, every evening shift, every record failed to evidence weights on the following	F	556			

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391	
STATEMENT (OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPL	E CONSTRUCTION	(X3) DATE	SURVEY	
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG _			LETED	
		495358	B. WING				C 15/2023	
NAME OF P	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	15/2025	
AMELIA R	EHABILITATION AND HE	EALTHCARE CENTER	8830 VIRGINIA STREET					
					AMELIA, VA 23002			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL PF REGULATORY OR LSC IDENTIFYING INFORMATION)				PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 656	Continued From page	32	F	656	5			
	administer oxygen pe	r the physician orders.						
	documented, "Focus: respiratory status or is difficulty r/t (related to obstructive pulmonary supplemental oxygen documented in part, " OXYGEN SETTINGS Observation was made approximately 1:30 p. in her bed with her ox (NC). The oxygen was minute). A second ob 11/14/2023 9:10 a.m. the resident and the second of the physician order of	s at risk for breathing b): COPD (chronic y disease), dependence on ." The "Interventions" OXYGEN THERAPY: :: O2 as ordered." de of R62 on 11/13/2023 at m. The resident was sitting tygen on via a nasal cannula as set at 2.5 LPM (liters per servation was made on , the oxygen was in use by setting was at 2.5 LPM.						
	made of R62 with LPI #5. R62 had her oxyg read the setting of the was set at 2.5 LPM. V prescribed rate was for resident is supposed was asked how often be checked by the nu once a shift. When as plan, LPN #4 stated, f what is going on and #5 was asked if the ca administer oxygen pe	br R62, LPN #5 stated, the to be on 3 LPM. LPN #5 should the oxygen setting rse, LPN #5 stated at least sked the purpose of the care the staff can look at it to see what the patient needs. LPN are plan documents to r the physician order and it's rate, is that following the						

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	-	ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12/14/20 FORM APPROVE OMB NO. 0938-039
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C
		495358	B. WING _		11/15/2023
NAME OF PF	ROVIDER OR SUPPLIER	I		STREET ADDRESS, CITY, STATE, ZIP COL	
AMELIA R	EHABILITATION AND HE	EALTHCARE CENTER		8830 VIRGINIA STREET AMELIA, VA 23002	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE COMPLETIO E APPROPRIATE DATE
F 656	Continued From page	e 33	F6	56	
F 692 SS=E	and ASM #3, the vice operations, were mad concern on 11/14/202 No further information Nutrition/Hydration St	2, the director of nursing, president of clinical le aware of the above 23 at 3:31 p.m. n was provided prior to ext. ratus Maintenance	F 6	92	12/30/23
	(Includes naso-gastric both percutaneous er percutaneous endosc enteral fluids). Basec	ssment, the facility must			
	of nutritional status, s desirable body weigh balance, unless the re	ins acceptable parameters uch as usual body weight or t range and electrolyte esident's clinical condition s is not possible or resident otherwise;			
	§483.25(g)(2) Is offer maintain proper hydra	ed sufficient fluid intake to ation and health;			
	there is a nutritional p provider orders a the	ed a therapeutic diet when problem and the health care rapeutic diet. is not met as evidenced			
	Based on staff interv and facility document	iew, clinical record review review, it was determined ailed to monitor residents 's orders for six of 42		1. The facility is unable to recorrect missing weights for re #78, #78, #90, #17, #73, # ar	esidents #12,

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		ID HUMAN SERVICES MEDICAID SERVICES				FOF	ED: 12/14/2023 RM APPROVED IO. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495358	B. WING			1	C 1/15/2023
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
				8	830 VIRGINIA STREET		
	EHABILITATION AND HI	EALINCARE CENTER		Α	MELIA, VA 23002		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 692	Continued From page	e 34	F (692			
		ey sample; Residents #12,			 The Director of Nursing or Design completed an audit on 12/06/2023 to ensure weight orders are appropriate 		
	The findings include:				reflected in the resident orders		
	1. For Resident #12, obtain weekly weights physician.	the facility staff failed to s as ordered by the			 The Director of Nursing or Design will educate nursing staff on obtaining weights as ordered by 12/08/23. Required weights are being 		
	A review of the clinica physician's order date weekly."	al record revealed a ed 5/10/23 for "Obtain weight			communicated to nursing staff on a routine basis and entered into PCC.4. The Director of Nursing or Design	20	
	there were no weight following weeks (belo through Saturday tim Week of May 14 throu Week of May 21 throu Week of May 28 throu Week of June 4 throu Week of June 18 throu Week of July 2 throug	w dates run a Sunday e frame): ugh May 20, 2023. ugh May 27, 2023. ugh June 3, 2023. ugh June 10, 2023. ough June 24, 2023. gh July 8, 2023.			will audit that weights are obtained as ordered weekly x 4 weeks, then moni 2 months. ¿ Results of these audits v presented to the facility Quality Assur and Performance Improvement (QAP Committee monthly for three months review and, if warranted, further action	hly x ⁄ill be ance I) for	
	Week of August 27 th Week of September 7 2023. Week of September 7 2023.	ugh July 22, 2023. Jugh July 29, 2023. Jugh August 5, 2023. Jugh August 12, 2023. Jugh September 2, 2023. 10 through September 16, 17 through September 23,					
	2023. Week of October 1 th Week of October 8 th Week of October 15 t	24 through September 30, rrough October 7, 2023. rrough October 14, 2023. through October 21, 2023. through October 28, 2023.					

Facility ID: VA0002

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	MENT OF HEALTH AN S FOR MEDICARE & I					FORM	D: 12/14/2023 MAPPROVED D. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		E CONSTRUCTION	(X3) DATE	
		495358	B. WING				C 15/2023
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
AMELIA REHABILITATION AND HEALTHCARE CENTER			-	8830 VIRGINIA STREET AMELIA, VA 23002			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 692	Continued From page Week of October 29 th There was no evidence weighed the above we On 11/15/23 at 9:11 A conducted with LPN # Nurse). She stated th obtain weights weekly expected that they are resident refuses. She documented, then it w A review of the compr revealed one dated 1/ alteration or potential function" This care intervention dated 1/2 orders. Use same sca time of day wearing si when obtaining weigh loss to MD (Medical D The facility policy, "W Intervention" was revi documented, "1. The resident weights on an weekly for two weeks	a 35 hrough November 4, 2023. The the resident refused to be eeks. M, an interview was 7 (Licensed Practical that if there is an order to or monthly, then it is a obtained unless the a stated that if it is not vas not done. The resident has for alteration in renal plan included an 0/23 for "Obtain weights per the and preferably same ame amount of clothing ts. Report significant gain or 0/0ctor)." eight Assessment and ewed. This policy nursing staff will measure dmission, the next day, and thereafter. If no weight		692	DEFICIENCY)		
	measured monthly the not address obtaining orders, that may have the facility protocol of On 11/14/23 at 3:30 F	PM, ASM #1 (Administrative ministrator, ASM #2 the nd ASM #3, the Vice					

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	-					FOR	M APPROVED
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA				(X3) DATE	D. 0938-0391 SURVEY PLETED
			A. BUILDI	ING _			C
		495358	B. WING				/15/2023
NAME OF P	A. BUILDINGA. BUILDING						
AMELIA R	REHABILITATION AND HE	EALTHCARE CENTER					
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREF		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 692			F	692			
	obtain weekly weights	5					
	physician's order date	ed 6/19/23 for "Obtain					
	there were no weight any other day during dates run a Sunday th frame): Week of July 2 throug Week of September 3 2023.	s obtained on the Monday or the following weeks (below nrough Saturday time gh July 8, 2023. 3 through September 9,					
	2023. Week of September 2 2023.	24 through September 30,					
	There was no eviden weighed the above w	ce the resident refused to be eeks.					
	conducted with LPN # Nurse). She stated th obtain weights weekly expected that they ar resident refuses. She	#7 (Licensed Practical nat if there is an order to y or monthly, then it is e obtained unless the e stated that if it is not					
	A review of the comp revealed one dated 1	rehensive care plan 1/21/22 for "The resident					

Facility ID: VA0002

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		ID HUMAN SERVICES MEDICAID SERVICES				FO	ED: 12/14/2023 RM APPROVED IO. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DA	TE SURVEY MPLETED
		495358	B. WING			1	1/15/2023
	ROVIDER OR SUPPLIER	EALTHCARE CENTER		8	TREET ADDRESS, CITY, STATE, ZIP CODE 830 VIRGINIA STREET MELIA, VA 23002		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 692	function" This care intervention dated 11, per orders. Use same time of day wearing s when obtaining weigh loss to MD (Medical II The facility policy, "W Intervention" was revi documented, "1. The resident weights on a weekly for two weeks concerns are noted a measured monthly th not address obtaining orders, that may have the facility protocol of On 11/14/23 at 3:30 F Staff Member) the Ad Director of Nursing, a President of Clinical O aware of the findings. provided by the end of 3. For Resident #90, obtain weekly weights physician. A review of the clinica 6/7/23 for "Obtain we every Thursday for m Further review of the there were no weights or any other day during	ntial for alteration in renal plan included an /21/22 for "Obtain weights e scale and preferably same ame amount of clothing nts. Report significant gain or Doctor)." Weight Assessment and iewed. This policy nursing staff will measure dmission, the next day, and thereafter. If no weight t this point, weights will be ereafter" The policy did g weights per physician's e a different frequency than a monthly weight. PM, ASM #1 (Administrative ministrator, ASM #2 the and ASM #3, the Vice Dperations were made . No further information was of the survey. the facility staff failed to s as ordered by the al record revealed an order ekly weight every night shift	F	692			

Facility ID: VA0002

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		ID HUMAN SERVICES MEDICAID SERVICES				FORI	M APPROVED D. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMF	E SURVEY PLETED
		495358	B. WING				C / 15/2023
NAME OF P	ROVIDER OR SUPPLIER		•		STREET ADDRESS, CITY, STATE, ZIP CODE	- ·	
AMELIA R	EHABILITATION AND HE	EALTHCARE CENTER			830 VIRGINIA STREET AMELIA, VA 23002		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 692	frame): Week of July 23 throu Week of October 22 t Week of October 29 t There was no evidence weighed the above w On 11/15/23 at 9:11 A conducted with LPN # Nurse). She stated th obtain weights weekly expected that they an resident refuses. She documented, then it w A review of the compu- revealed one dated 1 alteration or potential function" This care intervention dated 12, orders. Use same sca time of day wearing s when obtaining weigh loss to MD (Medical D The facility policy, "W Intervention" was revi documented, "1. The resident weights on a weekly for two weeks concerns are noted a measured monthly the not address obtaining orders, that may have the facility protocol of On 11/14/23 at 3:30 F	Igh July 29, 2023. hrough October 28, 2023. hrough November 4, 2023. ce the resident refused to be eeks. M, an interview was 7 (Licensed Practical hat if there is an order to y or monthly, then it is e obtained unless the e stated that if it is not vas not done. rehensive care plan 2/5/22 for "The resident has for alteration in renal plan included an /5/22 for "Obtain weights per ale and preferably same ame amount of clothing its. Report significant gain or Doctor)." reight Assessment and ewed. This policy nursing staff will measure dmission, the next day, and thereafter. If no weight t this point, weights will be ereafter" The policy did weights per physician's e a different frequency than	F	692			

Facility ID: VA0002

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	
AND I LAN OF	OUNTEDHON	IDENTIFICATION NOMBER.	A. BUILDI	NG _			C
		495358	B. WING			11/	15/2023
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE 8830 VIRGINIA STREET		
AMELIA R	EHABILITATION AND HE	EALTHCARE CENTER			AMELIA, VA 23002		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE
F 692	Director of Nursing, a President of Clinical (aware of the findings. provided by the end o	nd ASM #3, the Vice Operations were made No further information was of the survey. the facility staff failed to	F	692			
	physician. A review of the clinica physician's order date day shift every Wedne	al record revealed a ed 6/1/23 for "Weight every esday." clinical record revealed that					
	Wednesday or any ot weeks (below dates r Saturday time frame) Week of July 23 throu	her day during the following un a Sunday through : ıgh July 29, 2023.					
	weighed the above w On 11/15/23 at 9:11 A conducted with LPN # Nurse). She stated th obtain weights weekly expected that they are resident refuses. She documented, then it w	M, an interview was 7 (Licensed Practical hat if there is an order to y or monthly, then it is e obtained unless the e stated that if it is not vas not done.					
	alteration or potential function" This care intervention dated 1/2 orders. Use same sca	/20/22 for "The resident has for alteration in renal					

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	-	D HUMAN SERVICES				FOR	M APPROVED
STATEMENT (OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	TIPL	LE CONSTRUCTION	(X3) DAT	O. 0938-0391 E SURVEY
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG		COM	PLETED
		495358	B. WING			11	C / 15/2023
NAME OF P	ROVIDER OR SUPPLIER			:	STREET ADDRESS, CITY, STATE, ZIP CODE		
AMELIA R	EHABILITATION AND HE	EALTHCARE CENTER			8830 VIRGINIA STREET AMELIA, VA 23002		
(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 SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 692	when obtaining weigh loss to MD (Medical E The facility policy, "W Intervention" was revi documented, "1. The resident weights on a weekly for two weeks concerns are noted a measured monthly the not address obtaining orders, that may have the facility protocol of On 11/14/23 at 3:30 F Staff Member) the Ad Director of Nursing, a President of Clinical C	tts. Report significant gain or Doctor)." eight Assessment and ewed. This policy nursing staff will measure dmission, the next day, and thereafter. If no weight t this point, weights will be ereafter" The policy did weights per physician's e a different frequency than a monthly weight. PM, ASM #1 (Administrative ministrator, ASM #2 the nd ASM #3, the Vice Dperations were made No further information was	F	692			
	 5. For Resident #73, fobtain monthly weight physician. A review of the clinical physician's order date monthly." Further review of the reveal any weights of June 2023. There was no evidend weight for June 2023. On 11/15/23 at 9:11 A 	the facility staff failed to ts as ordered by the al record revealed a ed 5/10/23 for "Obtain weight clinical record failed to otained for the month of ce the resident refused the					

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		ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12/14/20 FORM APPROVE OMB NO. 0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED C
		495358	B. WING		11/15/2023
NAME OF P	ROVIDER OR SUPPLIER	1	STR	REET ADDRESS, CITY, STATE, ZIP CO	-
AMELIA R	EHABILITATION AND HE	EALTHCARE CENTER		0 VIRGINIA STREET IELIA, VA 23002	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE COMPLETION DE APPROPRIATE DATE
F 692	Nurse). She stated the obtain weights weekly expected that they are resident refuses. She documented, then it we A review of the compo- revealed one dated 6 alteration or potential function" This care intervention dated 6/4 orders. Use same sca time of day wearing s when obtaining weigh loss to MD (Medical D The facility policy, "We Intervention" was revi documented, "1. The resident weights on a weekly for two weeks concerns are noted a measured monthly the not address obtaining orders, that may have the facility protocol of On 11/14/23 at 3:30 F Staff Member) the Ad Director of Nursing, a President of Clinical C aware of the findings. provided by the end of 6. For Resident #5, the obtain physician order of	hat if there is an order to y or monthly, then it is e obtained unless the e stated that if it is not vas not done. rehensive care plan /4/22 for "The resident has for alteration in renal plan included an 4/22 for "Obtain weights per ale and preferably same ame amount of clothing nts. Report significant gain or Doctor)." //eight Assessment and iewed. This policy nursing staff will measure dmission, the next day, and thereafter. If no weight t this point, weights will be ereafter" The policy did g weights per physician's e a different frequency than a monthly weight. PM, ASM #1 (Administrative ministrator, ASM #2 the and ASM #3, the Vice Dperations were made . No further information was of the survey. he facility staff failed to red weekly weights.	F 692		

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DEPARTMENT OF HEAL CENTERS FOR MEDICA						FORM	APPROVED 0. 0938-0391
STATEMENT OF DEFICIENCIES		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE	E CONSTRUCTION	(X3) DATE	SURVEY
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDI	NG _			LETED
		495358	B. WING				
NAME OF PROVIDER OR SUPPLI	ER				STREET ADDRESS, CITY, STATE, ZIP CODE		
AMELIA REHABILITATION A	ND HE	EALTHCARE CENTER			8830 VIRGINIA STREET AMELIA, VA 23002		
PREFIX (EACH DEF	ICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 692 Continued Fror	n page	÷ 42	F	692	2		
Review of the or documentation Wednesdays: 7/5/2023 8/30/2023 9/13/2023 10/25/2023 11/1/2023. On 11/14/2023. On 11/14/2023. On 11/14/2023. Member) #2, th some of the we and stated, yes obtained per th An interview wa practical nurse. When asked if weekly weights take, LPN #5 st obtained per th The compreher documented in compromised or risk for compro (congestive hea (high blood pre documented in routine/prn (as ASM #1, the ao the vice preside made aware of at 5:04 p.m.	ASM e direct ights t , there e orde as con #5 or there i , what atted, f e physic part, " ardiov mise r, ardiov mise r, art failu ssure) part, " neede	record failed to evidence weights on the following (administrative staff ctor of nursing, presented hat were previously missing e were weights that were not rs. ducted with LPN (licensed 11/14/2023 at 4:16 p.m. s a physician order for actions should the nurse the weights should be sician order. are plan dated, 4/3/2023, Focus: The resident has ascular conditions or is at (t (related to) CHF ure), Diabetes, Hypertension ." The "Interventions" Monitor weightper					

Facility ID: VA0002

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		ND HUMAN SERVICES				FOR	D: 12/14/2023 M APPROVED D. 0938-0391	
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,			(X3) DATE SURVEY COMPLETED		
		495358	B. WING				C / 15/2023	
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1		
AMELIA R	EHABILITATION AND HI	EALTHCARE CENTER			830 VIRGINIA STREET MELIA, VA 23002			
(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 E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ЗE	(X5) COMPLETION DATE	
F 695	Continued From page	e 43	E F	695				
F 695 SS=D		stomy Care and Suctioning		695			12/30/23	
	The facility must ensure needs respiratory car care and tracheal succare, consistent with practice, the compreher and 483.65 of this sure plan, the resider and 483.65 of this sure this REQUIREMENT by: Based on observation interview, facility doct record review, the face adequate respiratory of 42 residents in the #77, #71, and #62. The findings include:	nd tracheal suctioning. ure that a resident who re, including tracheostomy ctioning, is provided such professional standards of nensive person-centered nts' goals and preferences, bpart. T is not met as evidenced on, resident interview, staff ument review, and clinical cility staff failed to provide care and services for three survey sample, Residents			 A covering for incentive spirometer resident #77 was placed on 11/14/23. The nebulizer mask for resident #71 w stored appropriately on 11/14/23. The oxygen setting was corrected for resid #62 on 11/14/23. The Director of Nursing or Designe completed an audit of all respiratory equipment on 12/06/2023 to ensure all items were covered and stored appropriately, and that all oxygen delive systems were set as ordered. 	vas e lent ee		
	physician's order date spirometer.	nical record revealed a ed 10/24/23 for an incentive IDS (minimum data set), an			 The Director of Nursing or Designed will educate nursing staff on proper storage of respiratory equipment, and ensuring oxygen delivery systems are 			
	reference date) of 10 15 out of 15 on the B	nt with an ARD (assessment /30/23, the resident scored IMS (brief interview for iting the resident was			to the appropriate flow rate as ordered the physician by 12/8/23. 4.The Director of Nursing or Designee			
		naking daily decisions.			audit 10 residents per week x 4 weeks then monthly x 2 months to ensure			
	On 11/13/23 at 1:04 p	o.m., R77 was observed			respiratory equipment is properly store	ed,		

Facility ID: VA0002

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		ID HUMAN SERVICES MEDICAID SERVICES				FORI	D: 12/14/2023 M APPROVED D. 0938-0391
STATEMENT O	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` <i>`</i>		E CONSTRUCTION	(X3) DATE COMF	E SURVEY PLETED
		495358	B. WING				C / 15/2023
NAME OF PF	ROVIDER OR SUPPLIER	•	•	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
	EHABILITATION AND HE			8	830 VIRGINIA STREET		
				A	MELIA, VA 23002		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 695	with the mouthpiece e on the resident's over facility staff had not o incentive spirometer. the incentive spirometer. the incentive spirometer. the incentive spirometer. the incentive spirometer on the overbed table. On 11/14/23 at 4:05 p conducted with LPN (LPN #5 stated incenti stored in a bag becau On 11/14/23 at 4:57 p staff member) #1 (the (the director of nursin above concern. The specific policy regards Reference: (1) The spirometer is keep your lungs healt spirometer teaches yo breaths. This informa https://medlineplus.go 00451.htm 2. For Resident #71 (to store the resident's sanitary manner. A review of R71's clin physician's order date sulfate (1) nebulizatio milligrams/3 milliliters nebulizer every six ho shortness of breath.	wered incentive spirometer exposed to air was observed bed table. R77 stated the ffered a cover for the On 11/14/23 at 8:22 a.m., ter remained uncovered and o.m., an interview was licensed practical nurse) #5. ve spirometers should be use germs can get on them. o.m., ASM (administrative a dministrator) and ASM #2 g) were made aware of the facility staff did not provide a ing incentive spirometers. a device used to help you thy. Using the incentive but how to take slow deep tion was obtained from: ov/ency/patientinstructions/0 R71), the facility staff failed enebulizer mask in a ical record revealed a ed 5/10/23 for albuterol n solution (1) 2.5 0.083%- one vial via burs for wheezing and	F	695	and that oxygen delivery systems are to the appropriate rate. ¿ The results these audits will be presented to the facility Quality Assurance and Performance Improvement (QAPI) Committee monthly for three months f review and, if warranted, further action	of	
	On 11/13/23 at 1:25 p	o.m. and 3:56 p.m., R71 was					

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		ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12/14/2023 FORM APPROVED OMB NO. 0938-0391
STATEMENT O	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495358	B. WING		C 11/15/2023
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	•
AMELIA R	EHABILITATION AND HI	EALTHCARE CENTER		8830 VIRGINIA STREET	
				AMELIA, VA 23002	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE COMPLETION D THE APPROPRIATE DATE
F 695	Continued From page	e 45	F 69	5	
	observed lying in bed	. An uncovered nebulizer on the resident's nightstand.			
	conducted with LPN (o.m., an interview was (licensed practical nurse) #5. zer masks should be stored ms can get on them.			
	staff member) #1 (the	o.m., ASM (administrative administrator) and ASM #2 g) were made aware of the			
	documented, "Store t	d, "Departmental)- Prevention of Infection" he circuit in plastic bag, I resident's name, between			
	shortness of breath. obtained from the we https://medlineplus.ge tml 3. For Resident #62 (bsite: ov/druginfo/meds/a682145.h R62), the facility staff failed at the physician prescribed			
	approximately 1:30 p in her bed with her ox (NC). The oxygen wa observation was mad	de of R62 on 11/13/2023 at .m. The resident was sitting xygen on via a nasal cannula as set at 2.5 LPM. A second le on 11/14/2023 9:10 a.m., e by the resident and the M.			
	The physician order of documented, "O2 (ox	lated, 5/10/2023, ygen) at 3LPM via NC			

Facility ID: VA0002

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM): 12/14/2023 // APPROVED). 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		E CONSTRUCTION		LETED
		495358	B. WING				C 15/2023
NAME OF PF	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
AMELIA R	EHABILITATION AND HE	EALTHCARE CENTER			8830 VIRGINIA STREET AMELIA, VA 23002		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 695	made of R62 with LPI #5. R62 had her oxyg read the setting of the was set at 2.5 LPM. V prescribed rate was for resident is supposed was asked how often be checked by the nu once a shift. The comprehensive of documented, "Focus: respiratory status or is difficulty r/t (related to obstructive pulmonary supplemental oxygen documented in part, " OXYGEN SETTINGS The facility policy, "Ox documented in part, " delivery device so tha resident and the prop administered14. Mo	41 p.m. an observation was N (licensed practical nurse) en in use. When asked to e oxygen, LPN #5 stated it When asked what the or R62, LPN #5 stated, the to be on 3 LPM. LPN #5 should the oxygen setting rse, LPN #5 stated at least are plan dated, 4/9/2021, Resident has altered as at risk for breathing): COPD (chronic y disease), dependence on ." The "Interventions" OXYGEN THERAPY: : O2 as ordered." xygen Administration" 7. Adjust the oxygen ti ti is comfortable for the er flow of oxygen is being unitor oxygen per MD order."	F	695			
F 698 SS=E	Dialysis	n was provided prior to ext.	F	698	3		12/30/23

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	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION		TE SURVEY MPLETED
		495358	B. WING			1	C 1/15/2023
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
				8	830 VIRGINIA STREET		
AMELIA R	EHABILITATION AND HI	EALTHCARE CENTER		A	MELIA, VA 23002		
(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 I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ЗE	(X5) COMPLETION DATE
F 698	§483.25(I) Dialysis. The facility must ensu require dialysis receiv	e 47 ure that residents who /e such services, consistent ndards of practice, the	F	698			
	comprehensive perso the residents' goals a This REQUIREMENT by: Based on staff interv review, and clinical re determined the facility communication with t one residents receivin Resident #82. The findings include:	on-centered care plan, and nd preferences. is not met as evidenced iew, facility document ecord review, it was y staff failed to evidence he dialysis center for one of			The facility is unable to retroactively correct the missing dialysis communication for resident #82. Any resident receiving dialysis is at ris this deficient practice. On 12/01/23, communication forms between the dialysis center and the facility were audited since 11/13/2023 to ensure communication between the dialysis	k for	
	each visit. The physician orders documented, "Hemoo center) M, W, F (Mon	ation with the dialysis center dated, 8/18/2023, dialysis at (name of dialysis day, Wednesday, Friday) I up 0900 (9:00 a.m.)."			center and the facility were complete. The Director of Nursing or Designee we educate nursing staff on ensuring dialy communication forms are initiated and sent to dialysis, and that the form is complete when resident returns from dialysis. Education will be completed	ysis I	
	staff did not have the forms were missing of from either party (nur center) as follows: 9/4/2023 - no commu 9/6/2023 - no commu dialysis center on form 9/8/2023 - no commu dialysis center on form 9/11/2023 - no commu dialysis center on form	nication documented from n. nication documented from n. unication documented from			12/8/23. The Director of Nursing or Designee w audit dialysis communication forms to ensure forms are present and complet weekly x 4 weeks, then monthly x 2 months. ¿ Results of these audits will presented to the facility Quality Assura and Performance Improvement (QAPI Committee monthly for three months f review and, if warranted, further action	ted be ance) or	

Facility ID: VA0002

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	-	ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12/14/2023 FORM APPROVED OMB NO. 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CC A. BUILDING		(X3) DATE SURVEY COMPLETED
		495358	B. WING		C 11/15/2023
NAME OF P	ROVIDER OR SUPPLIER	1	STRI	EET ADDRESS, CITY, STATE, ZIP COL	
AMELIA F	REHABILITATION AND HE	EALTHCARE CENTER) VIRGINIA STREET ELIA, VA 23002	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	IN SHOULD BE COMPLETION E APPROPRIATE DATE
F 698	communication forms 10/13/2023 - no comm from dialysis center o 10/16/2023 - no comm from dialysis center o 10/20/2023 - no comm from dialysis center o 10/23/2023 - no comm from dialysis center o 10/25/2023 - no comm from dialysis center o 10/25/2023 - no comm from dialysis center o 10/27/2023 - no comm from dialysis center o 10/27/2023 - no comm from dialysis center o 10/30/2023 - no comm from dialysis center o 10/30/2023 - no comm from dialysis center o 11/1/2023 - there was 11/6/2023 - no comm dialysis center on form 11/10/2023 - there was 11/6/2023 - there was 1	i. munication documented n form. munication documented n form. as no communication form. unication documented from m. as no communication form. care plan dated, 8/18/2023, Focus: The resident has for alteration in renal o (hemodialysis)." The	F 698		

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CENTER	S FOR MEDICARE &	MEDICAID SERVICES				<u>10. 0938-039</u>
	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DATE SURVEY COMPLETED	
		495358	B. WING		1	C 1/15/2023
NAME OF PF	OVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP C		
AMELIA R	EHABILITATION AND H	EALTHCARE CENTER		830 VIRGINIA STREET		
			A	MELIA, VA 23002		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 698	Continued From pag	e 49	F 698			
		y do, LPN #5 stated they get	1 000			
		nd review the communication				
	form. LPN #5 stated					
	communication form center.	is not filled in by the dialysis				
	An interview was conducted with RN (registered					
		2023 at 1:34 p.m. When				
		f the communication form				
		t to dialysis, RN #3 stated it				
	•	nter know the stability of the arge from the facility and the				
	-	et us know how the resident				
	did at dialysis.					
	The facility policy, "Dialysis Communication"					
		"Nursing facility and dialysis				
		ective communication and to resident care. 1. Any				
	changes in condition	-				
	-	e dialysis center by facility				
		n condition that occurs during				
	-	er will be communicated by				
	-	nication form. 2. Any n/treatment orders or lab				
		vill be communicated to				
	dialysis center by fac	cility staff by communication				
		Any changes made my				
	values will be made	center or changes in lab				
	communication form					
	ASM (administrative	staff member) #1, ASM #2,				
	the director of nursin	g and ASM #3, the vice				
	-	operations, were made aware				
	oi the above concerr	n on 11/14/2023 at 5:04 p.m.				
	No further informatio					

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		ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 12/14/2023 M APPROVED D. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í	(X2) MULTIPLE CONSTRUCTION A. BUILDING			E SURVEY PLETED
		495358	B. WING				C / 15/2023
	NAME OF PROVIDER OR SUPPLIER AMELIA REHABILITATION AND HEALTHCARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 8830 VIRGINIA STREET AMELIA, VA 23002	•	
(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 CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 698 F 755 SS=E	(1) Hemodialysis filte body of harmful waste This information was website: https://medli Pharmacy Srvcs/Proc	rs your blood to rid your es, extra salt, and water. obtained from the following neplus.gov/dialysis.html. cedures/Pharmacist/Records		698 758			12/30/23
	drugs and biologicals them under an agree §483.70(g). The facil personnel to administ	ide routine and emergency to its residents, or obtain ment described in ity may permit unlicensed					
	pharmaceutical servic that assure the accur dispensing, and admi	es. A facility must provide ces (including procedures ate acquiring, receiving, inistering of all drugs and ne needs of each resident.					
	,	onsultation. The facility n the services of a licensed					
	§483.45(b)(1) Provide aspects of the provisi the facility.	es consultation on all on of pharmacy services in					
		shes a system of records of n of all controlled drugs in able an accurate					
		nines that drug records are in count of all controlled drugs riodically reconciled.					

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CENTER	S FOR MEDICARE &	ID HUMAN SERVICES MEDICAID SERVICES				FORM OMB NO	D: 12/14/2023 MAPPROVED D: 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					SURVEY PLETED
		495358	B. WING				15/2023
	ROVIDER OR SUPPLIER	EALTHCARE CENTER	•	8	STREET ADDRESS, CITY, STATE, ZIP CODE 1830 VIRGINIA STREET AMELIA, VA 23002		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(X5) COMPLETION DATE
F 755	This REQUIREMENT by: Based on staff interv and clinical record rev to provide pharmacy residents in the surve The findings include: For Resident #20 (R2 ensure the medicatio for administration on 2023. A review of R20's clim physician's order date mg (milligrams)- one morning for overactiv September 2023 MAI record) revealed the s Gemtesa. On 9/4/23 9/9/23, the MAR docu Other/ See Progress dated 9/4/23 docume pharmacy." A nurse's documented, "Waiting pharmacy." A nurse's documented, "Awaitin nurse's note dated 9/ to be delivered by ph dated 9/9/23 docume to deliver." A review of the facility list revealed the medi available in the suppl On 11/14/23 at 4:05 p	 is not met as evidenced iew, facility document review view, the facility staff failed services for one of 42 ey sample, Resident #20. 20), the facility staff failed to n Gemtesa (1) was available multiple dates in September actional record revealed a ed 7/10/23 for Gemtesa 75 tablet by mouth in the e bladder. A review of R20's R (medication administration same physician's order for , 9/5/23, 9/6/23, 9/7/23 and umented the code, "9= Notes." A nurse's note inted, "Medication pending s note dated 9/5/23 g on delivery from s note dated 9/6/23 ng pharmacy delivery." A 7/23 documented, "Waiting armacy." A nurse's note inted, "Waiting for pharmacy y backup medication supply ication Gemtesa was not 	F	755	The medication for resident #20 was received from pharmacy on 09/10/202 The resident had no negative outcome from the missed doses of medication. All residents are at risk for this deficier practice. The Director of Nursing or designee completed an audit on 12/06/2023 to ensure that all residents have the ordered medications availabl The Director of Nursing or Designee w educate licensed staff on the medication availability process. The process will the readily available at the nursing stations reference. 4. The Director of Nursing or Designeed will audit the missed medication report weekly x 4 weeks, then monthly x 2 months for any missed medications to ensure the process has been followed Results of these audits will be present to the facility Quality Assurance and Performance Improvement (QAPI) Committee monthly for three months for review and, if warranted, further action	es nt e. vill on be s for t t t t t t t t t t t t t t t t t t t	

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	-	ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12/14/2023 FORM APPROVED OMB NO. 0938-0391
	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING		(X3) DATE SURVEY COMPLETED C
		495358	B. WING		11/15/2023
	Rovider or supplier	EALTHCARE CENTER	8830	EET ADDRESS, CITY, STATE, ZIP CO I VIRGINIA STREET ELIA, VA 23002	
(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 ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TH DEFICIENC	ON SHOULD BE COMPLETION HE APPROPRIATE DATE
F 755 F 756 SS=F	medications six or se out. LPN #5 stated the available for administ see if the medication medication supply an should notify the physic the medication until it and let the pharmacy medication. On 11/14/23 at 4:57 p staff member) #1 (the (the director of nursin above concern. The facility policy title Treatment Orders" do biologicals that are re- reordered from the iss than three (3) days pri- administered to ensur- available." Reference: (1) Gemtesa is used to This information was https://medlineplus.go tml Drug Regimen Review CFR(s): 483.45(c)(1)0	rses usually try to order ven days before they run nat if a medication is not ration, the nurses should is in the facility backup d if it is not, the nurses sician, possibly put a hold on arrives from the pharmacy know they need the 0.m., ASM (administrative e administrator) and ASM #2 g) were made aware of the d, "Medication and boumented, "11. Drugs and equired to be refilled must be suing pharmacy not less rior to the last dosage being re that refills are readily to treat overactive bladder. obtained from the website: bv/druginfo/meds/a621015.h w, Report Irregular, Act On (2)(4)(5) imen Review.	F 755		12/30/23
	must be reviewed at l licensed pharmacist.	ug regimen of each resident east once a month by a view must include a review			

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		ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12/14/2023 FORM APPROVED OMB NO. 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C
	495358		B. WING		11/15/2023
NAME OF PI	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP CODE	
AMELIA R	REHABILITATION AND HI	EALTHCARE CENTER	-	830 VIRGINIA STREET MELIA, VA 23002	
(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 APPI DEFICIENCY)	OULD BE COMPLETION
F 756	Continued From page of the resident's med		F 756		
	irregularities to the at facility's medical direct and these reports mut (i) Irregularities inclu drug that meets the c (d) of this section for (ii) Any irregularities in during this review mut separate, written report attending physician at director and director of minimum, the resider and the irregularity th (iii) The attending phy resident's medical real irregularity has been action has been take be no change in the r physician should doc the resident's medical §483.45(c)(5) The fac maintain policies and drug regimen review limited to, time frame the process and step when he or she ident requires urgent action This REQUIREMENT by: Based on staff interv review, it was determ develop a policy for n reviews with times fra- in the process, including in the process, including the state of the process of the state in the process, including the state of the state in the process, including the state of the state in the process, including the state of the state of the state in the process, including the state of the state	de, but are not limited to, any riteria set forth in paragraph an unnecessary drug. noted by the pharmacist ist be documented on a bort that is sent to the nd the facility's medical of nursing and lists, at a nt's name, the relevant drug, e pharmacist identified. ysician must document in the cord that the identified reviewed and what, if any, in to address it. If there is to medication, the attending ument his or her rationale in		 The Drug Regimen Review porevised on 11/15/2023 to reflect the necessary time frames The Director of Nursing complete audit of the pharmacy recommendation 	ne eted an

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495358	B. WING		С
	ROVIDER OR SUPPLIER	495356		STREET ADDRESS, CITY, STATE, ZIP CODE	11/15/2023
NAME OF PI	ROVIDER OR SUPPLIER			3830 VIRGINIA STREET	
AMELIA R	EHABILITATION AND HE	EALTHCARE CENTER		AMELIA, VA 23002	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE COMPLETI
F 756	Continued From page	e 54	F 756		
	should respond to the consulting pharmacis	e recommendations from the t for five of five residents essary medication reviews,		for the month of November to e the physician responded withir required timeframe on 12/01/20) the 023.
	The findings include: Resident #71, #17, #2	22, #32, and #5's clinical		3. The Director of Nursing or I will educate the Nursing Admir team on the revised Drug Regi Review policy by 12/8/23	istrative
	part, "11. If the Physic	v of the facility policy, Reviews" documented in cian does not provide a		4. The Director of Nursing or D will audit the pharmacy recomm monthly x 3 months to ensure	nendations that
	Pharmacist identifies taken, he/she contact	sponse, the Consultant that no action has been is the Medical Director of (if e physician of record) the		recommendations are complet the designated time frames. ¿ these audits will be presented facility Quality Assurance and Performance Improvement (QA	Results of to the
	The policy failed to in regarding the timefrar	clude any documentation ne in which the physician Consultant Pharmacist's		Committee monthly for three m review and, if warranted, furthe	onths for
	5:05 p.m. She presen Regimen Reviews po				
	Administrative staff m administrator, ASM #	2, the director of nursing and sident of clinical operations ne above findings on			

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		ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 12/14/2023 M APPROVED D. 0938-0391
STATEMENT O	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` <i>`</i>		CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		495358	B. WING				C /15/2023
NAME OF PF	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STATE, ZIP CODE	•	
AMELIA R	EHABILITATION AND HE	EALTHCARE CENTER			830 VIRGINIA STREET IMELIA, VA 23002		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 758	Continued From page	e 55	F	758			
F 758 SS=D		rchotropic Meds/PRN Use (e)(1)-(5)	F	758			12/30/23
	affects brain activities processes and behav but are not limited to, categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehe resident, the facility m §483.45(e)(1) Reside psychotropic drugs an unless the medication specific condition as o in the clinical record; §483.45(e)(2) Reside	hotropic drug is any drug that associated with mental rior. These drugs include, drugs in the following ensive assessment of a nust ensure that ents who have not used re not given these drugs in is necessary to treat a diagnosed and documented					
	drugs receive gradua behavioral interventio	I dose reductions, and					
	unless that medicatio	ursuant to a PRN order n is necessary to treat a ondition that is documented					
	are limited to 14 days	rders for psychotropic drugs 5. Except as provided in attending physician or					

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NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE AMELIA REHABILITATION AND HEALTHCARE CENTER 8830 VIRGINIA STREET (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION		OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS. CITY, STREE, ZIP CODE AMELIA REHABILITATION AND HEALTHCARE CENTER ISTREET ADDRESS. CITY, STREET, ZIP CODE MULIA REHABILITATION AND HEALTHCARE CENTER ISTREET ADDRESS. CITY, STREET, ZIP CODE MILIA REHABILITATION AND HEALTHCARE CENTER ISTREET ADDRESS. CITY, STREET, ZIP CODE MILIA REHABILITATION AND HEALTHCARE CENTER ISTREET ADDRESS. CITY, STREET, ZIP CODE MILIA REHABILITATION AND HEALTHCARE CENTER ISTREET ADDRESS. CITY, STREET, ZIP CODE MILIA REHABILITATION AND HEALTHCARE CENTER ISTREET ADDRESS. CITY, STREET, ZIP CODE MILIA REHABILITATION AND HEALTHCARE CENTER ISTREET ADDRESS. CITY, STREET, ZIP CODE MILIA REHABILITATION AND HEALTHCARE CENTER ISTREET ADDRESS. CITY, STREET, ZIP CODE MILIA REHABILITATION AND HEALTHCARE CENTER ISTREET ADDRESS. CITY, STREET, ZIP CODE MILIA REHABILITATION AND HEALTHCARE CENTER ISTREET ADDRESS. CITY, STREET, ZIP CODE MILIA REHABILITATION AND HEALTHCARE CENTER ISTREET ADDRESS. CITY, STREET, ZIP CODE F758 ISTREET ADDRESS, CITY, STREET, ZIP CODE F758			495358	B. WING			11	С 1/15/2023
AMELIA REHABILITATION AND HEALTHCARE CENTER AMELIA, VA 23002 (74) ID PREFX TAG SUMMARY STATEMENT OF DEFICIENCES (EACH DEFICIENCY MUST ETE PRICEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PD PROVIDES (EACH DEFICIENCY MUST ETE PRICEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PT PROVIDE (EACH DEFICIENCY) F 758 Continued From page 56 prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. F 758 §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Resident #71 no longer resides at the facility. Based on staff interview, facility staff failed to ensure a resident was free from unnecessary psychotropic medications for one of 42 residents in the survey sample, Resident #71. The findings include: Resident #71 no longer resides at the facility. F7 1 was admitted to the facility staff failed to attempt GDRs (gradual dose reductions) for the resident's use of Seroquel (1) and Cymbalta (2). All icensed staff will be educated to ensure residents who receive psychotropic medications receive medication appropriately by 12/08/2023. R71 was admitted to the facility on 9/21/22. A review of R71's clinical record revealed the following hysician's orders: 9/21/22: Seroquel 25 mg - two tablets every morning and at bedtime for depression. 11/21/22: Sero	NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	•	
AMELIA. VA 23002 VMID. PERK TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH OURSEND MAN OF CORRECTION (EACH OURSEND MAN OF CORECTION (EACH OURSEND MAN					8	830 VIRGINIA STREET		
PREFIX TAG (EACH OFFICENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC DENTIFYING INFORMATION) PREFIX TAG CEACH CORRECTVE ACTION SHOULD BE CROSHAETEENCECED TO HEAPPROPRIATE DEFICENCY) F 758 Continued From page 56 prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. F 758 S483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriatemess of that medication. This REQUIREMENT is not met as evidenced by; Resident #71 no longer resides at the facility. Based on staff interview, facility document review, and clinical record review, the facility staff failed to ensure a resident was free from unnecessary psychotropic medications for one of 42 residents in the survey sample, Resident #71. The findings include: All resident #71 no longer resides at the facility. F7 1 was admitted to the facility on 9/21/22. A review of R71's clinical record revealed the following physicians orders: 9/21/22- Seroquel 25 mg (milligrams)- two tablets every morning and at bedtime for dementia with behavioral disturbance. All licensed staff will be educated to ensure residents who receive psychotropic medications receive medication appropriately by 12/08/2023. The Director of Nursing or designee will review weekly for two weeks and then morning and the tablets at bedtime for halucinations. The Director of Nursing or designee will review weekly for two exes and then mornithy for three monthy for three months for<	AMELIA REHABILITATION AND HEALTHCARE CENTER		EALTHCARE CENTER		A	MELIA, VA 23002		
prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order.§483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, and clinical record review, the facility staff failed to ensure a resident was free from unnecessary psychotropic medications for one of 42 resident #71 (R71), the facility staff failed to attempt GDRs (gradual dose reductions) for the resident was of R71 was admitted to the facility on 9/21/22. A review of R71's clinical record revealed the following physician's orders: 9/21/22- Seroquel 25 mg (milligrams)- two tablets every morning and at bedtime for depression. 11/21/22- Seroquel 25 mg two tablets every morning and at bedtime for depression. 11/21/22- Seroquel 25 mg two tablets every morning and at bedtime for depression. 11/21/22- Seroquel 25 mg two tablets every morning and at bedtime for depression. 11/21/22- Seroquel 25 mg two tablets in the morning and at bedtime for depression. 11/21/22- Seroquel 25 mg two tablets every morning and at bedtime for depression. 11/21/22- Seroquel 25 mg two tablets in the morning and three tablets at bedtime for hallucinations.Resident #71Resident #71The Director of Nursing or designee will review weekly for two weekls and then morning and three tablets at bedtime for hallucinations.All residents the ceive psychotropic medications have and the presented to the facility Quality Assurance and Performance	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFI		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA		(X5) COMPLETIO DATE
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following physician's orders:The Director of Nursing or designee will review weekly for two weeks and then monting and at bedtime for depression.11/21/22- Seroquel 25 mg- two tablets every morning and at bedtime for dementia with behavioral disturbance.The Director of Nursing or designee will review weekly for two weeks and then monthly for two months that residents have had a drug regimen review.¿ Results of these audits will be presented to the facility Quality Assurance and Performance Improvement (QAPI) Committee monthly for three months for			-				3.	
9/21/22- Seroquel 25 mg (milligrams)- two tablets every morning and at bedtime for depression. 11/21/22- Seroquel 25 mg- two tablets every morning and at bedtime for dementia with behavioral disturbance. 5/10/23- Seroquel 25 mg- two tablets in the morning and three tablets at bedtime for hallucinations.The Director of Nursing or designee will review weekly for two weeks and then monthly for two months that residents have had a drug regimen review. Results of these audits will be presented to the facility Quality Assurance and Performance Improvement (QAPI) Committee monthly for three months for							- 1	
every morning and at bedtime for depression.review weekly for two weeks and then11/21/22- Seroquel 25 mg- two tablets everymonthly for two months that residentsmorning and at bedtime for dementia withhave had a drug regimen review.¿behavioral disturbance.Results of these audits will be presented5/10/23- Seroquel 25 mg- two tablets in theto the facility Quality Assurance andmorning and three tablets at bedtime forPerformance Improvement (QAPI)hallucinations.Committee monthly for three months for						The Director of Nursing or designee wi	11	
11/21/22- Seroquel 25 mg- two tablets every morning and at bedtime for dementia with behavioral disturbance.monthly for two months that residents have had a drug regimen review. Results of these audits will be presented to the facility Quality Assurance and Performance Improvement (QAPI) Committee monthly for three months for								
morning and at bedtime for dementia with behavioral disturbance.have had a drug regimen review.; Results of these audits will be presented to the facility Quality Assurance and Performance Improvement (QAPI) Committee monthly for three months for			-			-		
5/10/23- Seroquel 25 mg- two tablets in the morning and three tablets at bedtime for hallucinations.to the facility Quality Assurance and Performance Improvement (QAPI) Committee monthly for three months for								
morning and three tablets at bedtime for hallucinations.Performance Improvement (QAPI) Committee monthly for three months for		behavioral disturbanc	ce.			Results of these audits will be presented	ed	
hallucinations. Committee monthly for three months for			-					
		-	blets at bedtime for					
review and, if warranted, further action.		hallucinations.						
9/21/22- Cymbalta 30 mg- one capsule in the						review and, if warranted, further action		

Facility ID: VA0002

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		ID HUMAN SERVICES MEDICAID SERVICES					RINTED: 12/14/202 FORM APPROVE MB NO. 0938-039
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION		(3) DATE SURVEY COMPLETED
		495358	B. WING				C 11/15/2023
NAME OF PF	ROVIDER OR SUPPLIER			STF	REET ADDRESS, CITY, STATE, ZIP COL	DE	
				883	0 VIRGINIA STREET		
AMELIA REHABILITATION AND HEALTHCARE CENTER			AM	IELIA, VA 23002			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE APPROPRIATE	(X5) COMPLETION DATE
F 758	morning for major dep 12/14/22- Cymbalta 6 mg in the evening for 2/6/23- Cymbalta 60 mg in the evening for A consultant pharmac physician dated 5/16/ guidelines state antip an attempt at a gradu twice per year for the quarters with at least then annually thereaf taking SEROQUEL 55 and SEROQUEL 75 N since 11/21/22 withou a dose reduction at th MG BID (twice a day) the lowest possible do response below." Th a check mark beside, relevant current stand psychiatric disorder." A consultant pharmac physician dated 9/29/ guidelines state antip an attempt at a gradu twice per year for the quarters with at least then annually thereaf behavior, stabilize mo This resident has bee (Cymbalta) 60 MG BI	0 mg- one capsule every pression disorder. 30 mg in the morning and 30 major depressive disorder. mg in the morning and 60 major depressive disorder. the major depressive disorder. the morning and 60 major depressive disorder. The month between attempts, ter. This resident has been 0 MG QAM (every morning) MG QHS (every bedtime) at a GDR. Could we attempt the to SEROQUEL 50 to verify this resident is on the SEROQUEL 50 to verify this resident is on the second match is a conserved "Use in accordance with dards of practice for the fact of practice for the fact of the second for the 23 documented, "Federal sychotic drugs should have al dose reduction (GDR) first year in 2 different 1 month between attempts, ter, when used to manage bod or treat psych disorder. In taking DULOXETINE D since 12/14/22 without a mpt a dose reduction at this	F	758			
	possible dose? If not	n's response was a check					

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		ID HUMAN SERVICES MEDICAID SERVICES				FOF	ED: 12/14/2023 RM APPROVED IO. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION	(X3) DA	TE SURVEY MPLETED
		495358	B. WING			1	C 1/15/2023
NAME OF P	ROVIDER OR SUPPLIER	•	I	ST	TREET ADDRESS, CITY, STATE, ZIP CODE	•	
AMELIA R	EHABILITATION AND H	EALTHCARE CENTER			330 VIRGINIA STREET MELIA, VA 23002		
(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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 758	mark beside, "Continue therapy; dose reduction (blank space)." Further review of R71 reveal a GDR was attrast use of Seroquel and a reveal a documented was contraindicated of The nurse practitioner pharmacy recomment employed at the facilition of 11/14/23 at 4:53 p conducted with ASM member) #2 (the dire stated a GDR for antia antidepressants shoutly year for the first year one month in betwee ASM #2 stated that if practitioners decide to they need to docume being attempted. On 11/15/23 at 9:38 a administrator) and AS the above concern. The facility policy title Use" documented, "A be prescribed at the I the shortest period of gradual dose reduction of the state of the sta	ue this antidepressant on contraindicated due to: I's clinical record failed to tempted for the resident's Cymbalta, and failed to clinical rational why a GDR for the resident. The resident resident. The resident resident resident. The resident r	F	758			

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		ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12/14/202 FORM APPROVED OMB NO. 0938-039
	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		. ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495358	B. WING		C 11/15/2023
NAME OF PI	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP CODE	1
AMELIA R	EHABILITATION AND HE	EALTHCARE CENTER		3830 VIRGINIA STREET AMELIA, VA 23002	
(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 CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION
F 758	tml (2) Cymbalta is used information was obtai	e 59 ov/druginfo/meds/a698019.h to treat depression. This ned from the website: ov/druginfo/meds/a604030.h	F 758		
F 812 SS=E	tml Food Procurement,St CFR(s): 483.60(i)(1)(1) §483.60(i) Food safet The facility must -		F 812		12/30/23
	state or local authoriti (i) This may include for from local producers, and local laws or regu (ii) This provision doe facilities from using p gardens, subject to co safe growing and food (iii) This provision doe from consuming food §483.60(i)(2) - Store,	ed satisfactory by federal, ies. bod items obtained directly subject to applicable State ulations. es not prohibit or prevent roduce grown in facility pompliance with applicable			
	standards for food se This REQUIREMENT by: Based on observatio document review, it w	rvice safety. is not met as evidenced n, staff interview, and facility /as determined that the tore food in a sanitary		The identified sanitation concerns we corrected by the Dietary Manager on 11/14/2023 All residents have the potential to be affected by this deficient practice. The	

Facility ID: VA0002

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	S FOR MEDICARE & I					O. 0938-039
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			· · · ·	E SURVEY IPLETED
		495358	B. WING		1	C 1/15/2023
NAME OF P	ROVIDER OR SUPPLIER		- 1	STREET ADDRESS, CITY, STATE, ZIP CODE	1 1	1/10/2020
				8830 VIRGINIA STREET		
AMELIA R	EHABILITATION AND HE	EALTHCARE CENTER		AMELIA, VA 23002		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
F 812	Continued From page	e 60	F 812			
	On 11/13/23 at 11:30 inspected with OSM # Director of Dietary Se were noted: 1. A box of individual crackers was on the f The box was open. 2. A baseball cap was thickened apple juice. 3. A large storage bin powder was left open also left open and exp at the bin utilizing it. kitchen sink. 4. The stand mixer, w for use, and was cove meat slicer. The meat for this day's lunch meat for this day's lunch meat thad been used to sh roast beef (identified a noted inside the mixin On 11/14/23 at 2:47 F conducted with OSM animal crackers shou stated that she addree on the thickened appl member, and that it sho of food products. She items should not be in Regarding the storage stated that staff took to should not have been roast beef that was in	AM, the kitchen was #5 (Other Staff Member) the ervices. The following items packages of animal floor in dry storage area. a on top of a box of on wheels of thickener with the bag of thickener bosed. There was no staff This bin was near the which was clean and ready ered, was stored next to at slicer was recently used eal that was being prepared. lice roast beef. A piece of as such by OSM #5) was ng bowl of the stand mixer. PM, an interview was #5 who stated that the Id not be on the floor. She ssed the ball cap that was le juice with the staff hould not be stored on top e further stated that personal n the kitchen area. e bin of thickener, she the lid off to wash it but it n left open. Regarding the iside the mixing bowl of the ready for use, she stated		 storage area and food prep are audited by the Administrator to no sanitation concerns persist. will be completed by 12/8/2023 The Dietary Manager will be exite the Administrator on proper food safe handling of food, and alway maintaining clean food storage accordance with the regulation. Services Manager will educate team on proper food storage, shandling of food, and always m clean food storage areas in act with the regulation. The educate completed by 12/8/2023. The Food Service Manager or will audit the kitchen to ensure stored in a safe and sanitary m that the floor is clear of any pay food weekly x four and then mo The Food Service Manager or will bring results of these audits monthly x 3 months or until cor achieved. 	ensure that The audits ducated by d storage, ays areas in The Food the dietary afe naintaining cordance tion will be designee food is anner, and ckaged onthly x 2. designee s to QAPI	

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	-	ID HUMAN SERVICES MEDICAID SERVICES			FORM APPR OMB NO. 0938		
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495358	B. WING		C 11/15/202	11/15/2023	
	ROVIDER OR SUPPLIER	EALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CC 8830 VIRGINIA STREET AMELIA, VA 23002	DE		
(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 COMPL HE APPROPRIATE DA	(5) LETIO ATE	
F 812 F 842 SS=E	The facility policy, "Fo was reviewed. This p shall be received and complies with safe fo Food Services, or oth maintain clean food s times6. Food in de shall be kept off the ff sprinkler heads, sewa and vents" The po other identified conce On 11/14/23 at 3:30 F Staff Member) the Ad Director of Nursing, a President of Clinical O aware of the findings. provided by the end of Resident Records - Io CFR(s): 483.20(f)(5), §483.20(f)(5) Resider (i) A facility may not re resident-identifiable to accordance with a co agrees not to use or of except to the extent t to do so. §483.70(i) Medical re §483.70(i) 1 In accord	bod Receiving and Storage" bolicy documented, "Foods a stored in a manner that od handling practices1. her designated staff, will storage areas at all signated dry storage areas oor (at least 18 inches) and age/waste disposal pipes dicy did not address the erns above. PM, ASM #1 (Administrative ministrator, ASM #2 the and ASM #3, the Vice Operations were made . No further information was of the survey. dentifiable Information 483.70(i)(1)-(5) ht-identifiable information. elease information that is to the public. elease information that is o an agent only in ntract under which the agent disclose the information he facility itself is permitted cords. rdance with accepted as and practices, the facility al records on each resident	F 84		12/30/	/23	

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		495358	B. WING				C 15/2023
NAME OF P	ROVIDER OR SUPPLIER						
AMELIA R	EHABILITATION AND HE	EALTHCARE CENTER		8830 VIRGINIA STREET AMELIA, VA 23002			
(X4) ID PREFIX TAG			ID PREFI TAG				(X5) COMPLETION DATE
F 842	 (iii) Readily accessible (iv) Systematically org §483.70(i)(2) The facial information contair regardless of the form records, except when (i) To the individual, or representative where (ii) Required by Law; (iii) For treatment, pay operations, as permitt with 45 CFR 164.506 (iv) For public health an eglect, or domestic wat activities, judicial and law enforcement purp purposes, research purp medical examiners, fur a serious threat to heat by and in compliance §483.70(i)(3) The facial record information agunauthorized use. §483.70(i)(4) Medical for- (i) The period of time (ii) For a minor, 3 year legal age under State §483.70(i)(5) The mere (ii) A record of the rest 	e; and ganized lity must keep confidential ned in the resident's records, n or storage method of the release is- r their resident permitted by applicable law; yment, or health care ted by and in compliance ; activities, reporting of abuse, violence, health oversight administrative proceedings, tooses, organ donation urposes, or to coroners, uneral directors, and to avert alth or safety as permitted with 45 CFR 164.512. lity must safeguard medical ainst loss, destruction, or records must be retained required by State law; or e date of discharge when nt in State law; or ars after a resident reaches law.	F	842			

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 12/14/2023 M APPROVED O. 0938-0391
	DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION	(X3) DATI COM	E SURVEY PLETED C
		495358	B. WING				/15/2023
NAME OF PRO	OVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
AMELIA RE	HABILITATION AND HE	EALTHCARE CENTER			830 VIRGINIA STREET MELIA, VA 23002		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORR PREFIX (EACH CORRECTIVE ACTION SI TAG CROSS-REFERENCED TO THE AF DEFICIENCY)		BE	(X5) COMPLETION DATE
	and resident review e determinations condu (v) Physician's, nurse professional's progres (vi) Laboratory, radiol services reports as re This REQUIREMENT by: Based on staff intervi and facility document the facility staff failed accurate documentati the survey sample, Re #45. The findings include: 1. For Resident #301, evidence complete ar for incontinence care, A review of the ADL (a document for Septem revealed September '' documentation missin 9/21, 9/22, and 9/29/2 documentation missin 10/2, 10/2, 10/3, 10/4 A review of the ADL d 2023 revealed Septer documentation missin shifts 9/21, 9/22 and 9 evening shifts 9/29 ar twelve night shifts 9/29	y preadmission screening valuations and octed by the State; 's, and other licensed as notes; and ogy and other diagnostic equired under §483.50. ' is not met as evidenced iew, clinical record review review, it was determined to provide complete and ion for two of 42 residents in esident #301 and Resident , the facility staff failed to nd accurate documentation , bathing, and weights. activities of daily living) ther 2023 and October 2023 'Bathing" ng for three of twelve shifts: 23; October "Bathing" ng from five of nine shifts: , and 10/5/23.	F	842	 The facility is unable to retroactively correct ADL documentation for resider #301 and resident #45. The Director of Nursing or Designe completed an audit of ADL documenta for showers and weights on 12/01/23 the last 7 days The Director of Nursing or Designe will educate nursing staff on the requirement of completing ADL documentation by the end of each scheduled shift by 12/8/23 The Director of Nursing or Designe will audit ADL documentation for completion weekly x 4 weeks, then monthly x 2 months. Results of these audits will be presented to the facility Quality Assurance and Performance Improvement (QAPI) Committee mont for three months for review and, if warranted, further action. 	e ition for e	

If continuation sheet Page 64 of 76

		ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12/14/2023 FORM APPROVED OMB NO. 0938-0391
STATEMENT (OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495358	B. WING		C 11/15/2023
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C	
	EHABILITATION AND HI	AI THCARE CENTER		8830 VIRGINIA STREET	
/				AMELIA, VA 23002	
(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 (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE COMPLETION THE APPROPRIATE DATE
F 842	 Continued From page 64 revealed October "incontinence" documentation missing from five of nine-day shifts 10/1, 10/2, 10/3, 10/4 and 10/5/23, two of eight evening shifts 10/1 and 10/3/23, and two of eight night shifts 10/1 and 10/3/23. 		F 84	2	
	on the September TA record) showed no m were documented as with no evidence of th the TAR or the vital si	of the weights in the vital sign sheet and eptember TAR (treatment administration howed no missing weights. Weights umented as done on the October TAR, vidence of the weight obtained either on or the vital sign sheet. Unable to locate aper weight documentation.			
	PM with CNA (certifie When asked the proc incontinence care and CNA #1 stated, we ro perform incontinence residents twice a wee get sweaty/dirty then frequently. This is do When asked what it r or showers/baths are stated, it means it wa was not done. When and accurate medica	d bathing for the residents, und every two hours and care. We bathe/shower ek. If they are incontinent or they are bathed more boumented on the CNA form. neans if incontinence care not documented, CNA #1 s not documented, not that it asked if this is a complete record if there is missing #1 stated, no, it is not a			
	AM with LPN (license unit manager. When documentation for Re incontinence care, LF agency aides at the ti	imented in PCC (point click			

Facility ID: VA0002

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	-	ID HUMAN SERVICES MEDICAID SERVICES					INTED: 12/14/2023 FORM APPROVED IB NO. 0938-0391	
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495358	B. WING				C 11/15/2023	
	ROVIDER OR SUPPLIER	EALTHCARE CENTER		883	REET ADDRESS, CITY, STATE, ZIP COD 10 VIRGINIA STREET IELIA, VA 23002	E		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIZ TAG	×	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 842	residents and saw that the aides did not doci An interview was com PM with LPN #4, whe #301, and if her signal line on the October 2 "Yes, those are my im put the weight in ther for obtaining weights, write the weights on a nurses are to transcrib medical record is com stated, no, there is no When asked if there is forms, LPN #4 stated An interview was com AM with CNA #3. Wh obtaining resident we this paper form, the m residents that need w residents that need w this form and the nurs PCC. On 11/14/23 at appro (administrative staff m administrator, ASM # ASM #3, the vice pre was made aware of the A review of the facility Documentation" polic provided to the reside plan goals, or any char medical, physical, fur	at care was being provided, ument it in PCC. ducted on 11/14/23 at 1:30 en asked about Resident ature was on 10/4/23 weight 023 TAR, LPN #4 stated, itials. I do not why I did not e." When asked the process , LPN #4 stated, the CNAs a sheet of paper and the be it into the medical record. e it. When asked if the nplete and accurate, LPN #4 o evidence of the weight. are copies of the paper , no. ducted on 11/14/23 at 8:15 hen asked the process for sights, CNA #3 stated, see surse highlights in pink the veights and in yellow the ital signs. We document on ses enter the information in xximately 4:00 PM, ASM nember) #1, the 2, the director of nursing and sident of clinical operations he findings.	F	342				

Facility ID: VA0002

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	-	ID HUMAN SERVICES MEDICAID SERVICES				F	TED: 12/14/2023 DRM APPROVED NO. 0938-0391	
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		DNSTRUCTION		ATE SURVEY OMPLETED	
		495358	B. WING			11/15/2023		
	ROVIDER OR SUPPLIER	EALTHCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 8830 VIRGINIA STREET AMELIA, VA 23002					
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIZ TAG	×	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 842	medical record. The r facilitate communicat interdisciplinary team condition and respon- in the medical record opinionated or specul accurate." No further information 2. For Resident #45 to maintain accurate a documentation for ba August 2023 and Oct The ADL (activities of for R45 dated 8/1/202 part, "ADL- Bathing (I Review of the ADL do evidence a shower/ba 8/11/2023 and 8/22/2 documentation on the be blank. The ADL documentat 10/1/2023-10/31/2023 Bathing (Prefers: Sho the ADL documentations shower/bath docume 10/31/2023. The are 10/17/2023 and 10/3 blank. On 11/14/2023 at 10: conducted with CNA #3. CNA #3 stated th bathing were complet that showers were give and were about every	medical record should ion between the regarding the resident's se to care. Documentation will be objective (not lative), complete, and n was provided prior to exit. (R45), the facility staff failed ADL (activities of daily living) thing/showers provided in ober 2023. f daily living) documentation 23-8/31/2023 documented in Prefers: Shower/Whirlpool)." bocumentation failed to ath documented on 023. The areas for ese dates were observed to	F	342				

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CENTERS FOR MEDICARE & ME	HUMAN SERVICES EDICAID SERVICES				ED: 12/14/2023 RM APPROVED IO. 0938-0391
	(1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION		E SURVEY IPLETED
	495358	B. WING _		1'	C 1/15/2023
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C	CODE	
AMELIA REHABILITATION AND HEAI			8830 VIRGINIA STREET		
AMELIA REPADILITATION AND HEAT	LINCARE CENTER		AMELIA, VA 23002		
PREFIX (EACH DEFICIENCY M	EMENT OF DEFICIENCIES /UST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
later that day and then r and charge nurse if they that they had shower ca residents who preferred hair. She stated that the employed by the facility and they completed the stated that all care was and there should not be documentation. She sta blanks in the document failed to document and t care was not provided. On 11/14/2023 at 1:44 p conducted with LPN (lice LPN #2 stated that R45 often refused to get out staff to brush their hair a She stated that she had week and they attempte but they mostly refused. On 11/14/2023 at 2:00 p conducted with CNA #4 worked Monday through and used a schedule for were scheduled for show stated that R45 mostly r would accept bed baths and showers were docu in the ADL documentation	that when residents ffered them a second time notified the unit manager y still refused. She stated aps that they used for I bed baths to wash their ere was a shower aide Monday through Friday scheduled showers. She documented every shift any blanks in the ADL ated that if there were ation the staff probably they could not say that the o.m., an interview was tensed practical nurse) #2. Trefused care often and of bed, refused to allow and refused showers. I showers were twice a ed to get R45 to take them o.m., an interview was . CNA #4 stated that they h Friday as a shower aide r know which residents wers each day. She refused to shower but s. She stated that baths umented in the computer on by the assigned CNA the bath/shower on a paper nt list.	F 8	42		

Facility ID: VA0002

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	-	ID HUMAN SERVICES MEDICAID SERVICES	-			FC	red: 12/14/202 PRM APPROVE NO. 0938-039
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED C 11/15/2023	
		495358					
	ROVIDER OR SUPPLIER	EALTHCARE CENTER		8830	STREET ADDRESS, CITY, STATE, ZIP CODE 8830 VIRGINIA STREET AMELIA, VA 23002		
(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 CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
F 842 F 880 SS=D	had reviewed the pap ADL documentation f find evidence a show 8/22/2023, 10/17/202 that they had a lot of during that time and t completed. She state was not complete and not documenting the the care. On 11/15/2023 at 9:3 staff member) #1, the director of nursing an president of clinical o of the findings. No further information Infection Prevention & CFR(s): 483.80(a)(1) §483.80 Infection Con The facility must esta infection prevention a designed to provide a comfortable environm development and tran diseases and infection §483.80(a) Infection p program. The facility must esta and control program a a minimum, the follow §483.80(a)(1) A syste reporting, investigatin	ber shower/bath sheets and or R45 and was unable to er/bath on 8/11/2023, 3 or 10/31/2023. She stated agency staff in the building the documentation was not ed that the medical record d there was no excuse for care provided or refusal of 7 a.m., ASM (administrative e administrator, ASM #2, the d ASM #3, the vice perations were made aware h was provided prior to exit. & Control (2)(4)(e)(f) htrol blish and maintain an and control program a safe, sanitary and hent and to help prevent the hsmission of communicable ns. prevention and control blish an infection prevention (IPCP) that must include, at		842			12/30/23

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		ND HUMAN SERVICES				RM APPROVE 10. 0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING			E SURVEY
		495358	B. WING		1'	C 1/15/2023
NAME OF PR	ROVIDER OR SUPPLIER	•	STR	EET ADDRESS, CITY, STATE, ZIP CODI	E	
	EHABILITATION AND HI		883	0 VIRGINIA STREET		
			AM	ELIA, VA 23002		
(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 COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 880	Continued From page	2 69	F 880			
		ors, and other individuals	1 000			
	providing services un					
		ipon the facility assessment				
		to §483.70(e) and following				
	accepted national sta	indards;				
	6400.00/-\/0\ \\/ .:#					
		n standards, policies, and ogram, which must include,				
	but are not limited to:	•				
		llance designed to identify				
	possible communicat	ole diseases or				
	infections before they	-				
	persons in the facility					
	· · /	m possible incidents of se or infections should be				
	reported;					
	•	nsmission-based precautions				
		ent spread of infections;				
		plation should be used for a				
	resident; including bu					
	(A) The type and dura	ation of the isolation, infectious agent or organism				
	involved, and	mectious agent of organism				
		at the isolation should be the				
		ble for the resident under the				
		s under which the facility				
	must prohibit employ	ees with a communicable				
		kin lesions from direct				
		s or their food, if direct				
	contact will transmit t					
	by staff involved in di	procedures to be followed rect resident contact.				
	§483.80(a)(4) A svste	em for recording incidents				
	identified under the fa	-				
	corrective actions tak	-				

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CENTER	S FOR MEDICARE &	ID HUMAN SERVICES MEDICAID SERVICES				FORM OMB NO	D: 12/14/2023 MAPPROVED D. 0938-0391	
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			(X3) DATE SURVEY COMPLETED C		
		495358	B. WING					
NAME OF PI	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE	1		
AMELIA R	EHABILITATION AND H	EALTHCARE CENTER			30 VIRGINIA STREET MELIA, VA 23002			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(X5) COMPLETION DATE	
F 880	 §483.80(e) Linens. Personnel must hand transport linens so as infection. §483.80(f) Annual rey The facility will condul IPCP and update the This REQUIREMENT by: Based on observation record review and face determined that the faction control proce administration for two survey sample, Resident The findings include: 1. For Resident #60 to prepare medication during medication ad 11/14/2023 at 8:3 made of LPN (license preparing medication observed to prepare a medication cup prior room for administration - Norvasc 2.5mg (mill - Buspar 15mg 1 tablet - Risperidone 0.5mg LPN #8 was observe 	Ile, store, process, and s to prevent the spread of view. Int an annual review of its ir program, as necessary. T is not met as evidenced on, staff interview, clinical cility document review, it was acility staff failed to follow edures during medication of four residents in the dents #60 and #88. (R60), the facility staff failed ns in a sanitary manner ministration observation was ed practical nurse) #8 s for R60. LPN #8 was the following medications in or to taking them into R60's on : ligram) 1 tablet. et. et. 1 tablet. d to use her ungloved	F	880	 1.LPN #8 was educated on 11/14/23 regarding preparing resident medicatio in a sanitary manner. Resident #60 ar #88 was assessed by the Director of Nursing on 11/14/23 and no negatives outcomes were identified. The Director of Nursing or Designe completed a medication pass observation with scheduled nurses on 12/06/23 to observe medication preparation The Director of Nursing or Designe will educate licensed staff on preparing medications in a sanitary manner by 12/8/23 The Director of Nursing or Designe will complete 5 medication pass observations weekly x 4 weeks, then monthly x 2 months to ensure medicatiare prepared in a sanitary manner. Results of these audits will be present to the facility Quality Assurance and Performance Improvement (QAPI) Committee monthly for three months for review and, if warranted, further action 	nd e tion e g cions ed or		
		Buspar 15mg, Celexa nd Risperidone 0.5mg tablets			5. 12/30/2023			

Event ID: J0FD11

Facility ID: VA0002

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	-	D HUMAN SERVICES				FORM	MAPPROVED
	S FOR MEDICARE & I	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	FIPLE	E CONSTRUCTION	OMB NO. 0938-0391 (X3) DATE SURVEY	
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:				COMF	PLETED
		495358	B. WING				C 15/2023
NAME OF PI	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	1 17	10/2020
AMELIA R	EHABILITATION AND HE	EALTHCARE CENTER					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE
F 880	from their packaging a medication cup. On 11/14/2023 at 8:52 conducted with LPN # handling of tablets, LF should have put the p medication cup from th handling them with th that it was a habit the handle them to keep th A review of the facility Medications" revised part, "Staff follows e control procedures (e technique, gloves, iso the administration of the applicable" According to Fundam edition, Lippincott, Wi "Administering Oral M Wash hands. Rational microorganisms from medicationsPrepare Medications from a bi containing the correct medication cup. Do r On 11/14/2023 at 3:32 staff member) #1, the director of nursing an	and place them into the 5 a.m., an interview was 48. When asked about PN #8 stated that they ills directly into the the packaging rather than eir bare hands. She stated y had and they should not them clean. P policy, "Administering April 2019, documented in established facility infection .g., handwashing, antiseptic lation precautions, etc.) for medications; as entals of Nursing, 5th lliams & Wilkins, page 568, ledications: Procedure - 1. le - Reduces transfer of hands to selected medicationsc. ngo card: Snap the bubble : medication directly over the not touch the medication." 2 p.m., ASM (administrative administrator, ASM #2, the	F	880			
		n was provided prior to exit.					
	2. For Resident #88	(R88), the facility staff failed					

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	(2) MULTIPLE CONSTRUCTION . BUILDING			(X3) DATE SURVEY COMPLETED C	
		495358	B. WING _			11/15/2023		
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO				
AMELIA R	EHABILITATION AND HE	EALTHCARE CENTER			830 VIRGINIA STREET IMELIA, VA 23002			
(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)		(X5) COMPLETION DATE	
F 880	during medication adr 11/14/2023. On 11/14/2023 at 8:43 made of LPN (license preparing medications observed to prepare t a medication cup prio room for administratic - Levetiracetam 1000 - Novolog 15U (units) - Bumetanide 1mg 1/2 - Escitalopram 10mg - Stool softener 100m LPN #8 was observed fingers to remove the Escitalopram 10mg at tablets from their pack the medication cup. On 11/14/2023 at 8:52 conducted with LPN # handling of tablets, LF should have put the p medication cup from t handling them with th that it was a habit the handle them to keep the On 11/14/2023 at 3:32 staff member) #1, the director of nursing an president of clinical op of the findings.	as in a sanitary manner ministration observation on 3 a.m., an observation was be practical nurse) #8 s for R88. LPN #8 was the following medications in r to taking them into R88's on: mg (milligram) 1 tablet. via insulin syringe. 2 tablet. 1 tablet. 1 tablet. 1 tablet. 1 tablet. 2 tablet. 3 to use her ungloved Bumetanide 1mg 1/2 tablet, nd Stool softener 100mg kaging and place them into 5 a.m., an interview was t8. When asked about PN #8 stated that they ills directly into the the packaging rather than eir bare hands. She stated y had and they should not them clean. 2 p.m., ASM (administrative administrator, ASM #2, the	F	\$80				

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		ID HUMAN SERVICES MEDICAID SERVICES				FORI	D: 12/14/2023 M APPROVED D. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495358			(X2) MUL A. BUILD		(X3) DATE SURVEY COMPLETED		
		B. WING	B. WING			C 11/15/2023	
NAME OF PF	ROVIDER OR SUPPLIER		- 1	S	IREET ADDRESS, CITY, STATE, ZIP CODE	1 10	10/2020
AMELIA R	EHABILITATION AND HI	EALTHCARE CENTER			330 VIRGINIA STREET MELIA, VA 23002		
(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 APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 909 F 909 SS=D	Resident Bed CFR(s): 483.90(d)(3) §483.90(d)(3) Conduct Regular inspection of all bed frames, mattresses, and bed rails, if any, as part of a regular maintenance program to identify areas of possible entrapment. When bed rails and mattresses are used and purchased separately from the bed frame, the facility must ensure that the bed rails, mattress, and bed frame are compatible. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility document review, the facility staff failed to conduct regular bed inspections for two of 42			909 909	Resident #32 no longer resides in the facility. Resident #16 had a bed inspection completed on 11/15/23. Th facility developed and implemented a		12/30/23
	 residents in the survey sample, Residents #16 and #32. The findings include: For Resident #16 (R16), the facility staff failed to conduct a regular bed inspection. A copy of the bed inspections was requesting during the entrance conference on 11/13/2023 at 11:20 a.m. On 11/13/23 at 1:20 p.m. and 11/14/23 at 8:28 a.m., R16 was observed in bed. On 11/15/23 at 9:17 a.m., an interview was conducted with OSM (other staff member) #6, the director of maintenance. OSM #6 stated the maintenance department has not completed bed inspections since before the pandemic. 				regular maintenance program to inspe- bed frames, mattresses, and or bedrail to identify areas of possible entrapmer including separately purchased special mattresses and bed frames. All residents have the potential to be affected by this deficient practice. The Plant Operations Manager or designed will complete an inspection of all current bed frames, mattresses, and or bed ra to identify areas of possible entrapmer The audit will be completed by 12/8/23 The maintenance director will be educated by the Administrator regardin completion of routine bed safety inspections to ensure that there are no safety or entrapment issues. The education will be completed by 12/8/23	ls ht, lty nt ils ht.	
		a.m., ASM (administrative administrator) and ASM #2			The Administrator or designee will aud	it	

Facility ID: VA0002

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		ID HUMAN SERVICES				FOR	D: 12/14/2023 M APPROVED	
CENTERS FOR MEDICARE & STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			MULTIPLE CONSTRUCTION JILDING		OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED C 11/15/2023	
		495358						
NAME OF P	ROVIDER OR SUPPLIER		•		TREET ADDRESS, CITY, STATE, ZIP CODE			
AMELIA REHABILITATION AND HEALTHCARE CENTER					830 VIRGINIA STREET MELIA, VA 23002			
(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 CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 909	above concern. The facility policy title documented, "To try t from the beds and rel the frame, mattress, s footboard, and bed ac promote the following by maintenance staff equipment as part of program to identify ris potential entrapment 2. For Resident #32, conduct regular bed i Observation was mad 11/13/2023 at approx in bed with bilateral s A copy of the bed inst during the entrance c 11:20 a.m. A second 11/14/2023 at 3:31 p. on 11/14/2023 at 3:31 p. on 11/15/2023 at 9:11 conducted with OSM director of maintenan maintenance departm inspections since befor Administrative staff m administrator, ASM #	ed, "Bed Safety" to prevent deaths/injuries lated equipment (including side rails, headboard, ccessories), the facility shall g approaches: a. Inspection of all beds and related our regular bed safety sks and problems including risks" the facility staff failed to nspections. de of Resident #32 (R32) on imately 1:20 p.m. R32 was ide rails in place. pections was requesting conference on 11/13/2023 at request was made on m. A third request was made 4 p.m. and again on m. 7 a.m., an interview was (other staff member) #6, the ce. OSM #6 stated the nent has not completed bed ore the pandemic. nember (ASM) #1, the 2, the director of nursing and sident of clinical operations he above findings on	F	909	TELS monthly x 3 months to ensure routine bed inspection documentation been uploaded. The Administrator or designee will bring results of audits to monthly QAPI meeting x 3 months. 12/30/2023			

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CENTERS FOR MEDICARE & MEDICAID SERVICES			OMB NO. 0938-0391			
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED			
495358	B. WING		C 11/15/2023			
NAME OF PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE				
AMELIA REHABILITATION AND HEALTHCARE CENTER		8830 VIRGINIA STREET AMELIA, VA 23002				
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)				
F 909 Continued From page 75 No further information was provided prior to exit.	F 9					

Event ID: J0FD11

Facility ID: VA0002

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