	-	ID HUMAN SERVICES			FOR	M APPROVED
						<u>D. 0938-0391</u>
-	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	COM	E SURVEY PLETED
		495193	B. WING			C / 04/2023
NAME OF PF	ROVIDER OR SUPPLIER		:	STREET ADDRESS, CITY, STATE, ZIP CODE		
	HEALTH & REHABILITA		:	561 NORTH AIRPORT DRIVE		
HENRICO		HON CENTER		HIGHLAND SPRINGS, VA 23075		
(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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
E 000	Initial Comments		E 000			
F 000	survey was conducte 10/4/2023. The facilit compliance with 42 C	FR Part 483.73 ng Term Care Facilities. No ness complaints were e survey	F 000			
	survey was conducted An extended survey we through 10/4/23. Sigurequired for complian Federal Long Term C Safety Code survey/me Immediate Jeopardy of Freedom from Abuse at a Scope and Sever constituted Substand accepting and verifyin Immediate Jeopardy of determining that the I removed, the deficient and Severity level of I	was identified in the area of , Neglect, and Exploitation rity Level 4, pattern which ard Quality of Care. After ng the plan for removal of from the Administrator, and mmediate Jeopardy was acy was assigned a Scope evel two, pattern.				
	survey with findings a VA00059688=Substa VA00059493=Substa VA00059313=Substa VA00059202=Substa The census in this 12 115 at the time of the	ntiated with Deficiency ntiated with Deficiency ntiated with Deficiency ntiated with Deficiency 0 certified bed facility was survey. The survey sample				
	DIRECTOR'S OR PROVIDER/S cally Signed	SUPPLIER REPRESENTATIVE'S SIGNATUR	ΚΕ	TITLE		(X6) DATE 11/10/2023

Electronically Signed

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

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		DNSTRUCTION	(X3) DATE SURVEY COMPLETED	
					с		
		495193	B. WING			10	/04/2023
NAME OF PI	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP				
HENRICO HEALTH & REHABILITATION CENTER					NORTH AIRPORT DRIVE HLAND SPRINGS, VA 23075		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 000	Continued From page	e 1	F	000			
	consisted of 48 reside	ent reviews.					
F 553 SS=D	Right to Participate in CFR(s): 483.10(c)(2)		F	553			11/19/23
	development and imp person-centered plan limited to: (i) The right to particip including the right to be included in the plan request meetings and revisions to the perso (ii) The right to particip expected goals and c amount, frequency, a other factors related to plan of care. (iii) The right to be inf changes to the plan of (iv) The right to receive included in the plan of (v) The right to see the right to sign after sign of care.	on-centered plan of care. ipate in establishing the butcomes of care, the type, and duration of care, and any to the effectiveness of the formed, in advance, of of care. we the services and/or items of care. he care plan, including the hificant changes to the plan					
	of the right to particip and shall support the planning process musi- (i) Facilitate the inclus- resident representativ (ii) Include an assess strengths and needs. (iii) Incorporate the re-	sion of the resident and/or ve. sment of the resident's esident's personal and n developing goals of care.					

Facility ID: VA0100

If continuation sheet Page 2 of 156

		MEDICAID SERVICES				IB NO. 0938-03	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495193	B. WING			C 10/04/2023	
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CIT	Y, STATE, ZIP CODE	10/04/2020	
				561 NORTH AIRPORT	DRIVE		
IENRICO HEALTH & REHABILITATION CENTER				HIGHLAND SPRING	S, VA 23075		
(X4) ID PREFIX TAG	IX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECT B REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCE		DER'S PLAN OF CORRECTION RRECTIVE ACTION SHOULD BE ERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETIO DATE			
F 553	Continued From page	a 9		53			
		terview, staff interview,			participate in Planning		
	clinical record review	, and facility documentation aff failed to ensure the		Care			
		ticipate in care planning for 1		1. Resident #	# 48 still resides in the		
	•	8, in a survey sample of 48		facility. A care	plan meeting scheduled		
	residents.			and resident #4	48 and her RP (responsible		
				party) were inv			
	The findings included	l:			sidents in the facility have		
					be affected. An audit by		
	For Resident #48, the	-			or designee on all residents		
		ity for her to participate in her			quarterly or short-term conducted. Care plan		
	own care planning.				s were completed and		
	On 09/26/2023 at an	proximately 9:30 a.m., an			nts. To those residents with		
		ted with Resident #48, and			rties listed, the facility⊡s		
		participated in the planning			team ensured all letters		
		ility, to which Resident #48			by mail. All letters uploaded		
		been asked or invited to		in PCC system	and retained in a separate		
	attend any meetings	about my care here, I would		file.			
	like to be involved."				nistrator or designee will		
					cility social workers on		
		proximately 11:30 a.m., a			ents and responsible party		
		18's clinical record was			ving care plan notification		
	performed and revea				g of date and time of care		
	an Assessment Refe	IDS), a quarterly review with			tters for approaching care s are kept and uploaded		
		esident #48 with a Brief			s are kept and uploaded ystem for adequate		
	•	tatus (BIMS) score of 12 out		documentation	, i		
		erate cognitive impairment.			histrator or designee will		
		cumented as her own			ly audits x 4 weeks then		
	Responsible Party.			monthly x 2 mc	onths to ensure care plan		
					ers are sent out in a timely		
		record also revealed a			ceived by all residents;		
	-	plan for Resident #48;		-	nts and/or RP the		
		no documentation indicating			participate in their care		
		is invited to participate with			f the review will be		
		There was an admission		· ·	e QAPI committee for ommendation. Once the		
		23 that read, "Family notified e plan] meeting, she [family			ermines the problem no		

Facility ID: VA0100

If continuation sheet Page 3 of 156

OLITICI	S FOR MEDICARE &	MEDICAID SERVICES				O. 0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495193	B. WING		10	C)/04/2023
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
				561 NORTH AIRPORT DRIVE		
HENRICO	HEALTH & REHABILITA	TION CENTER	1	HIGHLAND SPRINGS, VA 23075		
(X4) ID PREFIX TAG	REFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE
F 553	Continued From page	- 3	F 553			
	member] said that sh attend"			longer exist, the review will be c on a random basis. 5. Date of compliance: 11/19/		
	interview was conduct Administrator and Re- which included a revir record. The RCN veri- that Resident #48 hav- in her care planning so 04/13/2023. The Fac- "[Name redacted, Re- been invited to attend plan of care, I expect documented in her cl	eted with the Facility egional Clinical Nurse (RCN) ew of Resident #48's clinical ified there was no evidence d been invited to participate since her admission on ility Administrator stated, sident #48] should have d any meetings about her				
	& Care Planning," eff subheading "Procedu Coordinator or design inviting the patient and conference utilizing the Planning Invitation fo "Notes will be kept for discussed at the conference attending the electronic progress n conference and statin	he MFA Resident Care rm" and item 9 read, r each patient's care plan ference. A designated staff e conference will include an ote summarizing the				
	On 10/02/2023, the F made aware of the fir information was provi Self-Determination	-	F 561			11/19/23

Facility ID: VA0100

If continuation sheet Page 4 of 156

		ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495193	B. WING				C 04/2023
NAME OF PI	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE		
				ŧ	561 NORTH AIRPORT DRIVE		
HENRICO	HEALTH & REHABILITA	HON CENTER		I	HIGHLAND SPRINGS, VA 23075		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 561	Continued From page	2 4	F	561			
	promote and facilitate through support of res not limited to the right (1) through (11) of this §483.10(f)(1) The res activities, schedules (waking times), health care services consiste assessments, and pla applicable provisions §483.10(f)(2) The res choices about aspects facility that are signific §483.10(f)(3) The res with members of the of community activities to facility. §483.10(f)(8) The res participate in other ac religious, and commu interfere with the right facility. This REQUIREMENT by:	right to and the facility must a resident self-determination sident choice, including but ts specified in paragraphs (f) s section. ident has a right to choose including sleeping and care and providers of health ent with his or her interests, an of care and other of this part. ident has a right to make s of his or her life in the cant to the resident. ident has a right to interact community and participate in both inside and outside the ident has a right to stivities, including social, inity activities that do not ts of other residents in the is not met as evidenced					
	facility documentation ensure the resident's	clinical record review, and the facility staff failed to right to choose healthcare ent, Resident #22, in a			 F561 Self-determination 1. Resident #22 still resides in the facility. Resident #22 spain managen 	nent	
	survey sample of 48 r	residents.			appointment was scheduled and inform of date and times of the appointment w	ned rith	
	The findings included	:			transportation was arranged. Resident 22 right to choose was honored with hi		

Event ID: EB1X11

Facility ID: VA0100

			0.00			OMB NO	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION	(X3) DATE COMF	SURVEY
					С		
		495193	B. WING		10/	04/2023	
NAME OF P	ROVIDER OR SUPPLIER			STF	REET ADDRESS, CITY, STATE, ZIP CODE		
HENRICO	ENRICO HEALTH & REHABILITATION CENTER				1 NORTH AIRPORT DRIVE GHLAND SPRINGS, VA 23075		
(X4) ID	(4) ID SUMMARY STATEMENT OF DEFICIENCIES				PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETIO DATE
F 561	Continued From page	e 5	F 56	51			
		e facility staff failed to			physician choice.		
	schedule an appointr			 Current residents in the facility hav 	/e		
	Management Clinic"			the potential to be affected. An audit wa			
	and ordered by the p				conducted by the DON or designee to		
					ensure all upcoming appointments were	е	
	On 09/25/2023 at ap	proximately 3:00 p.m.,			scheduled and transportation has been		
		ted to speak to this surveyor.			arranged. No other residents have		
	-	eviously been interviewed			requested to change health care provid	ler.	
		acility and wanted to add one			3. The SDC or designee will educate		
		lent stated he had inquired			license nursing staff, unit secretary and		
	with the Medical Dire	ctor about pain medicine			discharge planners on the importance of	of	
	(Oxycodone) that he			ensuring physician orders for appointm	ent		
	discontinued, and wa			or follow up appointment are scheduled			
		#22 stated the Medical			timely with documentation. The physicia		
		ould be better if he would			Resident and/or RP will be notified with	l	
		ent clinic and wrote a			documentation if delay in obtaining		
	-	anagement clinic in the			appointment. Resident rights will be		
	chart. Resident #22 s				honored to scheduled own appointmen	its,	
		e still has not been told about			assist with arranging transportation as		
		view of the clinical record			needed. Residents have the right to		
		tten in the progress notes by			choose healthcare provider and reques		
	the physician on 07/2	28/2023.			change physician will be accommodate		
	A rovious of the aligi	al record revealed the			with choice of other participating provid	lers	
	following progress no				at the facility. 4. The Unit Manger or designee will		
					complete weekly audits x 4 weeks then		
	 "9/15/2023 2·57 pm -	COMMUNICATION- Note			monthly x 2 months to verify resident		
		dent and the MD explained			right to choose healthcare providers ha		
		work had been faxed over to			been honored and verify all resident		
		clinic on 9/11/23 and that I			appointments or follow up appointment	S	
		Irn call. I called on 9/15/23 to			per physician orders are scheduled or		
		t clinic and spoke with them			resident scheduled own appointment ha	ave	
		re that the paperwork had			transportation arranged, if delay in		
		at it is still under review, and			obtaining appointment the physician,		
	they will call patient of				resident and/or RP have documented		
	completed."				notification. Results of the review will be	е	
					presented to the QAPI committee for		
		proximately 10:30 a.m., an			review and recommendation. Once the		
	interview was conduc	cted with Employee R, who	1		committee determines the problem no		1

Facility ID: VA0100

If continuation sheet Page 6 of 156

	OF DEFICIENCIES	MEDICAID SERVICES	(X2) MULTIP	LE CONSTRUCTION		NO. 0938-039
	CORRECTION	IDENTIFICATION NUMBER:	· · ·			OMPLETED
					С	
		495193	B. WING			10/04/2023
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DE	
HENRICO	HEALTH & REHABILITA			561 NORTH AIRPORT DRIVE		
				HIGHLAND SPRINGS, VA 23075		
(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	N SHOULD BE E APPROPRIATE	(X5) COMPLETIOI DATE
F 561	Continued From page	e 6	F 56	1		
		ents for residents. She stated	1 00	longer exist and sustained th	ne review will	
	it was documented in			be conducted on a random b		
	appointment was req	uested on 09/11/2023. She				
		e that the appointment was		5. Date of compliance: 11/	19/2023	
		wever, she had been out of				
		the original referral. Also,				
		he request until 09/11/2023 ain management clinic at that				
	point.	in management cirric at that				
	On 10/04/2023 during	g the end of day meeting, the				
		ade aware of the concerns.				
	No further information			_		
F 565 SS=D	Resident/Family Grou CFR(s): 483.10(f)(5)(• •	F 56	5		11/19/23
		ident has a right to organize				
		ident groups in the facility. rovide a resident or family				
		vith private space; and take				
	• • •	th the approval of the group,				
		d family members aware of				
	upcoming meetings in					
		ther guests may attend				
		nily group meetings only at				
	the respective group	s invitation. provide a designated staff				
		red by the resident or family				
		and who is responsible for				
		and responding to written				
	requests that result fr					
		consider the views of a				
		up and act promptly upon				
		ecommendations of such sues of resident care and life				
	in the facility.					
		be able to demonstrate their				
	response and rationa					

Facility ID: VA0100

If continuation sheet Page 7 of 156

		ND HUMAN SERVICES				FOR	D: 11/29/202 MAPPROVE <u>0. 0938-039</u>
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED C 10/04/2023	
		495193					
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
				5	61 NORTH AIRPORT DRIVE		
HENKICO	HENRICO HEALTH & REHABILITATION CENTER			н	IIGHLAND SPRINGS, VA 23075		
(X4) ID PREFIX TAG	REFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			ix	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 565	Continued From page	e 7	F	565			
		e construed to mean that the					
		ent as recommended every					
	§483.10(f)(6) The res participate in family g						
	family member(s) or representative(s) me families or resident re residents in the facilit This REQUIREMENT	et in the facility with the epresentative(s) of other					
		on, interview, clinical record ocumentation, the facility			F565 Resident/Family Group and Response		
	-	mptly upon the grievances					
	arising from Resident	t Council.			1. The Administrator reviewed the		
	The findings included	1:			grievances from the resident council meeting. A resident council meeting v held on 11/15/23 to discuss prior and		
	Resident council con	tinues to have complaints of			current levels of professionalism,		
		no improvement month			environmental services, dietary services	ces,	
		lity has not effectively			and care concerns.		
	addressed the conce				2. Current residents in the facility ha	ave	
		ood, timeliness of medication			the potential to be affected.		
		/ incontinence care, poor eanliness of the building.			3. The Administrator, or designee we educate the discharge planners, staff		
	Stan attitudes, and th				development coordinator , Director of		
	A review of the Resid	lent Council minutes			Activities, Dietary Manager, Director of		
	revealed the following				Environment and the Rehab Director		
		-			nursing managers on the grievance		
	March 2023 - Reside	ents complained that staff			process with documentation appropria	ate	
		nedication not given in a			follow-up for verification that concerns	S	
	-	s not providing care to			from resident council are addressed		
		routinely during the day and			regarding staff professionalism, care		
	night.				concerns, environmental, pest contro		
	April 2022 04-#	rude stoff are loved at might			dietary issues with resolution , at resid	aent	
	April 2023 - Staff are	rude, staff are loud at night,			council meetings the prior		

Facility ID: VA0100

If continuation sheet Page 8 of 156

AB NO. 0938-039) DATE SURVEY COMPLETED C
10/04/2023
(X5) COMPLETION DATE
, ,

If continuation sheet Page 9 of 156

	-	ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 11/29/20 FORM APPROVE OMB NO. 0938-03
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
		495193	B. WING		C 10/04/2023
	NAME OF PROVIDER OR SUPPLIER HENRICO HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP C 561 NORTH AIRPORT DRIVE HIGHLAND SPRINGS, VA 23075	ODE
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE COMPLETION THE APPROPRIATE DATE
F 565	Continued From page Administrator:	9	F 56	65	
	resident with a BIMS	acted] is an 84 year old [Brief Interview of Mental ng no cognitive impairment]. lity on 3/3/23"			
	[name redacted] curs	acted] alleged that CNA ed at him saying "Kiss my his call bell, left the room ng the same verbal			
	redacted] substantiat				
F 580 SS=D	Administrator was ma No further information	jury/Decline/Room, etc.)	F 58	80	11/19/23
	consult with the resid consistent with his or representative(s) whe (A) An accident invol- results in injury and h physician intervention (B) A significant chan mental, or psychosoc	ediately 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,			

Facility ID: VA0100

If continuation sheet Page 10 of 156

	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 11/29/2023 MAPPROVED D. 0938-0391	
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• • •		CONSTRUCTION	(X3) DATE SURVEY COMPLETED C 10/04/2023		
		495193	B. WING					
NAME OF P	ROVIDER OR SUPPLIER		•	ST	REET ADDRESS, CITY, STATE, ZIP CODE			
HENRICO	HEALTH & REHABILITA	TION CENTER			I NORTH AIRPORT DRIVE			
	HENRICO HEAEIN & REHABIENATION CENTER			HIC	GHLAND SPRINGS, VA 23075			
(X4) ID PREFIX TAG	IX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			IX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE	
F 580	a need to discontinue treatment due to adve commence a new form (D) A decision to trans resident from the facil §483.15(c)(1)(ii). (ii) When making noti (14)(i) of this section, all pertinent information is available and provide physician. (iii) The facility must at resident and the reside when there is- (A) A change in room as specified in §483.1 (B) A change in reside State law or regulation (e)(10) of this section (iv) The facility must r update the address (r phone number of the representative(s). §483.10(g)(15) Admission to a compo- that is a composite di §483.5) must disclose its physical configurat locations that compris part, and must specify room changes betwee under §483.15(c)(9).); 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 IO(e)(6); or ent rights under Federal or ns as specified in paragraph record and periodically mailing and email) and	F	580				
	by: Based on clinical rec	ord review, staff interview, ation review, the facility staff			F580 Notify of Changes			

Facility ID: VA0100

If continuation sheet Page 11 of 156

							<u>10. 0938-039</u>
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING			· · ·	TE SURVEY MPLETED
							С
		495193	B. WING			10/04/2023	
NAME OF P	ROVIDER OR SUPPLIER	1	STREET ADDRESS, CITY, STATE, ZIP CODE				
				561 NORT	H AIRPORT DRIVE		
HENRICO	IENRICO HEALTH & REHABILITATION CENTER			HIGHLAN	ND SPRINGS, VA 23075		
(X4) ID PREFIX TAG	(EACH DEFICIENC	SUMMARY STATEMENT OF DEFICIENCIES ID EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX EGULATORY OR LSC IDENTIFYING INFORMATION) TAG			PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 580	Continued From page	e 11	F 58	0			
		ponsible party of a change			Resident #362 no longer resides	s in	
	-	ident, Resident #362, in a			acility.		
	sample size of 48 Re	sidents.			Current residents in the facility h		
	T I C II · I I I				otential to be affected. The DON	l or	
	The findings included	1:		-	nee will conduct an audit on all		
	For Resident #362 f	acility staff failed to notify the			nt residents with changes in itions since 10/4/2023 to verify I	R P	
	responsible party/fam				been notified. `	,	
	condition on 07/20/20			3.	The SDC or designee will educa	te all	
					sed nurses on the process for		
		proximately 3:00 p.m.,			ges in condition with documente		
		cal record was reviewed in ular attention given to			ician, resident as able and/or RI ed timely from occurrence of the		
	• •	ursing assessments, and			ge in condition.	;	
	progress notes. A pro	-			Unit Manager will conduct week	y	
		.m. documented, "Resident's			s x 4 weeks then monthly x 2 m	-	
		cted] upset upon arrival to			rify residents with change of		
	•	informed her residents			itions have RP notification. All		
		elevated approx. noon time notified of elevation and			ngs will be reported to the QA mittee and the action plan will be	-	
		d, family was not notified of			ed as needed. Results of the rev		
		daughter request that			e presented to the QAPI commi		
		ed to hospital for evaluation,			view and recommendation. Onc		
		st, resident was taken to the			nittee determines the problem n		
	ER via EMS."				er exist and sustained the review	/ will	
	On 10/02/2022 at 4.1	5 p.m., the Clinical Nurse		pe cc	onducted on a random basis.		
		is interviewed and stated, "It		5. [Date of compliance: 11/19/2023		
		d facility policy that both the					
	doctor and family are	notified if a resident					
	experiences a change	e in their condition, always."					
	Review of the facility	policy titled, "Significant					
		" with an effective date of					
	11/01/2019, "Procedu						
		ill also be notified of a					
	-	and item 9, "Notification of					
		all be documented in the ling time and name of					

If continuation sheet Page 12 of 156

	OF DEFICIENCIES	MEDICAID SERVICES	(X2) MULTIPLE C	CONSTRUCTION	OMB NO. 0938-03 (X3) DATE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:			COMPLETED
					С
		495193	B. WING		10/04/2023
NAME OF P	ROVIDER OR SUPPLIER	•	STE	REET ADDRESS, CITY, STATE, ZIP CODE	
HENRICO	HEALTH & REHABILITA	TION CENTER			
				GHLAND SPRINGS, VA 23075	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE COMPLETIO
F 580	Continued From page person informed."	e 12	F 580		
F 582 SS=D	Facility Administrator the findings. No furth Medicaid/Medicare C	e end of day meeting, the and CNC were updated on er information was provided. coverage/Liability Notice 7)(18)(i)-(v)	F 582		11/19/23
	writing, at the time of facility and when the Medicaid of- (A) The items and se nursing facility service for which the resident (B) Those other items facility offers and for charged, and the amo services; and (ii) Inform each Medic changes are made to	acility must caid-eligible resident, in admission to the nursing resident becomes eligible for rvices that are included in es under the State plan and t may not be charged; s and services that the which the resident may be ount of charges for those caid-eligible resident when the items and services g)(17)(i)(A) and (B) of this			
	resident before, or at periodically during the available in the facility services, including ar covered under Medic facility's per diem rate (i) Where changes in and services covered Medicaid State plan,	acility must inform each the time of admission, and e resident's stay, of services y and of charges for those hy charges for services not eare/ Medicaid or by the e. coverage are made to items I by Medicare and/or by the the facility must provide the change as soon as is			

Facility ID: VA0100

If continuation sheet Page 13 of 156

	MENT OF HEALTH AN S FOR MEDICARE & I	D HUMAN SERVICES			FOF	ED: 11/29/2023 RM APPROVED O. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •	IPLE CONSTRUCTION	(X3) DAT	E SURVEY
		495193	B. WING _		1	C D/04/2023
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COL		
				561 NORTH AIRPORT DRIVE		
HENRICO	HEALTH & REHABILITA	TION CENTER		HIGHLAND SPRINGS, VA 23075		
(X4) ID PREFIX TAG			ID PREFI TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	(X5) COMPLETION DATE	
F 582	items and services that facility must inform the 60 days prior to imple (iii) If a resident dies of transferred and does facility must refund to representative, or esta deposit or charges all per diem rate, for the resided or reserved of facility, regardless of a discharge notice requi (iv) The facility must r resident representative the resident within 30 date of discharge from (v) The terms of an action behalf of an individual facility must not confli- these regulations. This REQUIREMENT by: Based on staff intervi- and facility documenta- failed to issue approp- services were ending #87) in a survey samp were all reviewed for The findings included For Resident #87, the an Advance Beneficia- skilled services were On 09/25/2023, the fa- asked to provide a list discharged from Medi	at the facility offers, the e resident in writing at least mentation of the change. or is hospitalized or is not return to the facility, the the resident, resident ate, as applicable, any eady paid, less the facility's days the resident actually r retained a bed in the any minimum stay or irements. efund to the resident or e any and all refunds due days from the resident's in the facility. dmission contract by or on seeking admission to the ct with the requirements of is not met as evidenced ew, clinical record review, ation review, the facility staff riate notices when skilled for 1 resident (Resident ble of 3 residents, which such notices.	F	582 582 F582 Medicaid/Medicare Coverage/Liability Notice 1. Resident #87 still resider facility. The BOM informed t Advance Beneficial Notice (A 2. All residents with a qualistay and Medicare Part A ber available, have the potential by this deficient practice. An Regional MDS was conducted any current residents required skilled services in the facility. 3. The Administrator will eco Social Service /Director of Di Planner and Assistant Dischardon on the process for ensuring a	he RP of the kBN). fying hospital hefit days to be affected audit by the ed to identify if d an ABN for lucate the scharge arge Planner	

Facility ID: VA0100

If continuation sheet Page 14 of 156

	OF DEFICIENCIES	MEDICAID SERVICES	(X2) MULTIP	PLE CONSTRUCTION	(X3) DATE SURVEY	<u>3-039</u> Y
	CORRECTION	IDENTIFICATION NUMBER:	· /	G	COMPLETED	-
					С	
		495193	B. WING		10/04/202	23
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIF	P CODE	
HENRICO	HEALTH & REHABILITA	TION CENTER		561 NORTH AIRPORT DRIVE HIGHLAND SPRINGS, VA 230	75	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE COMPL D THE APPROPRIATE DA	K5) LETIOI ATE
F 582	Continued From page	e 14	F 58	32		
	Resident #87. The no	otices issued to these		ABNs are given to skilled	residents with	
	residents were review			services ending timely. T		
	following:			Office team has also rece	eived education	
				on ensuring all ABNs are	received,	
		e facility staff failed to		signed, and uploaded.		
	•	sing Facility Advance		4. The Administrator or	•	
		NF ABN) notice prior to ending. Only a Notice of		conduct audits weekly x of monthly x 2 months for a		
		age (NOMNC) was issued.		receiving skilled services		
	Resident #87 was un	÷ , ,		scheduled to end, to ens		
	Medicare Part A as th	ne primary payer from		received by residents or		
	06/11/2023 - 07/02/2	023. Upon skilled care		of the review will be pres	ented to the	
		remained a resident of the		QAPI committee for revie		
	-	build have been issued a SNF		recommendation. Once t		
	ABN in addition to the	e NOMNC.		determines the problem i and sustained the review	-	
	On 09/26/2023 at ap	proximately 4:30 p.m., an		conducted on a random l		
		ted with Employee O, the		5. Date of compliance:		
		Vhen asked to explain the				
		and when they are issued,				
		hey are issued before				
		t them know when insurance				
		when copays will start." explained that when a				
		erm care, both the NOMNC				
	and ABN are issued.					
	Emplovee O reviewe	d the notice for Resident #87				
		n Advance Beneficiary				
	Notice should have b	een issued but was not.				
	The facility policy title	ed, "Advanced Beneficiary				
		eviewed. The policy read,				
		ficiary Notice will be used to				
		licare Part A or Medicare Part				
		onsible party of the clinical e patient no longer meets the				
		skilled services 2. The				
	Social Worker and Di					

Facility ID: VA0100

If continuation sheet Page 15 of 156

TATEMENT C	F DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DA	10. 0938-039 TE SURVEY MPLETED
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING			C
		495193	B. WING		1	0/04/2023
NAME OF PR	ROVIDER OR SUPPLIER	•	S	TREET ADDRESS, CITY, STATE, ZIP CODE	•	
HENRICO	HEALTH & REHABILITA	TION CENTER		61 NORTH AIRPORT DRIVE		
			H	IGHLAND SPRINGS, VA 23075		
(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 APF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 582	Continued From page	e 15	F 582			
		notice to the beneficiary or	1 002			
		n person or by telephone of				
		verage status based on				
	clinical team recomm	nade at least 2 days in				
		rage status for Part A				
	recipients"					
	In the CMS documer	it, "Form Instructions Skilled				
	Nursing Facility Adva	nced Beneficiary Notice of				
		ABN)," the instruction sheet				
		3N provides information to at s/he can decide whether or				
	not to get the care the	at may not be paid for by				
		e financial responsibility.				
		SNFABN when applicable for yment System services				
	(Medicare Part A)"	Accessed online at:				
	https://www.cms.gov -Information/BNI/FFS	/Medicare/Medicare-General S-SNF-ABN-				
	On 09/26/2023 during	g the end of day meeting, the				
	facility's Director of N were made aware of	lursing and Corporate staff the above findings.				
	No further information	-				
F 584 SS=E	Safe/Clean/Comforta CFR(s): 483.10(i)(1)-	ble/Homelike Environment (7)	F 584			11/19/23
	§483.10(i) Safe Envi	ronment.				
	The resident has a right					
	comfortable and hom but not limited to rece	elike environment, including				
	supports for daily livin	-				
	The facility must prov	vide-				
		clean, comfortable, and				
	homelike environmer		1			1

Facility ID: VA0100

If continuation sheet Page 16 of 156

		ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	
		495193	B. WING				04/2023
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
HENRICO	HEALTH & REHABILITA	TION CENTER			61 NORTH AIRPORT DRIVE IIGHLAND SPRINGS, VA 23075		
(X4) ID PREFIX TAG	IX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE			(X5) COMPLETION DATE			
F 584	possible. (i) This includes ensure receive care and serve physical layout of the independence and do (ii) The facility shall end the protection of the reservices necessary to and comfortable inter §483.10(i)(2) Houseke services necessary to and comfortable inter §483.10(i)(3) Clean be in good condition; §483.10(i)(4) Private resident room, as specent §483.10(i)(5) Adequate levels in all areas; §483.10(i)(6) Comfort levels. Facilities initiant 1990 must maintain and 81°F; and §483.10(i)(7) For the sound levels. This REQUIREMENT by: Based on observatio interview, clinical record documentation review maintain a safe, clear	al belongings to the extent ring that the resident can rices safely and that the facility maximizes resident bes not pose a safety risk. xercise reasonable care for esident's property from loss eeping and maintenance o maintain a sanitary, orderly, ior; ed and bath linens that are closet space in each ecified in §483.90 (e)(2)(iv); te and comfortable lighting table and safe temperature fly certified after October 1, temperature range of 71 to maintenance of comfortable is not met as evidenced n, resident interview, staff ord review, and facility v, the facility staff failed to n, comfortable, and homelike ents residing on 2 of 2 units,	F	584	F584 Safe/Clean/Comfortable/Homelii Environment 1. Residents #363 no longer resides the facility. Resident #19 still resides in the facility and pest control treated the room. The pest control team was notifi	in 1	

Facility ID: VA0100

				E CONSTRUCTION		0938-039
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DATE S COMPLI	
					с	
		495193	B. WING			4/2023
NAME OF P	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP CODE	1 10/0	
				561 NORTH AIRPORT DRIVE		
HENRICO	HEALTH & REHABILITA			HIGHLAND SPRINGS, VA 23075		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE
F 584	Continued From pag	e 17	F 584	4		
	The findings included			and exterminated all areas iden	tified. The	
	Ŭ			pest control team did a follow-u	p visit	
		sidents the staff failed to		regarding the bed bugs and roo		
		er rooms on 2 of 2 units and		identified, there were no other o		
	roaches.	s, such as bedbugs and		bed bugs. Shower rooms on bo were detailed clean, all identifie		
	Toaches.			will be replaced.		
	On 09/26/2023 at 2:0	00 p.m. during the Resident		2. Current residents in the fac	ility have	
		6 residents (all the residents		the potential to be affected. An		
		stated the shower rooms		the maintenance director was c	-	
	-	s to shower in those rooms?"		to identify other floor tiles that re		
		she would rather sponge		repair, and none noted. Any oth	-	
	other 5 participants a	the shower rooms and the		sightings were treated by the per- vendor. The director of environr		
		agreed.		services observed shower room		
	Observations were m	nade of the shower rooms on		units to verify cleaning and was		
	-	7/2023 and 09/29/2023, the		maintained.		
	shower rooms were	not clean, and the shower		3. The Regional Director of M		
	•	d black stains. The shower		educated the Maintenance Dire		
		ins and the floor needed		process of pest control, review of		
	repair in the North sh	nower room.		control book, bed bug managen		
	0n 09/26/2023 at an	proximately 3:30 p.m., an		maintenance repairs, with follow ensure all areas of concerns are	-	
		cted with CNA D who was		The Director of Environmental S		
		hat the black and orange		educated all housekeepers on t		
		ower stalls. CNA D stated		cleaning process and schedulin		
	-	black stains might be dirt.		shower rooms. The SDC will ed	ucate the	
		en the shower stalls were		facility staff on ensuring all and		
		that "Housekeeping cleans		control services are logged in th		
		ut we use the wipes and		Control book and work orders s		
	resident."	er chairs between each		for maintenance repairs. Any co with the cleanliness of shower re		
				resident rooms need to be repo		
	From 09/25/2023 thr	ough 10/04/2023, fruit flies		Director of Environmental Servi		
	as well as house flies	s were sighted throughout		Furniture in resident rooms inclu	ude a	
		ts' rooms on both units, and		chair.		
	in the dining room.			4. The Maintenance Director		
	On 00/20/2022 at an	provimately 1.15		designee will conduct audits we		
	00 09/29/2023 at ap	proximately 1:15 p.m.,		weeks then monthly x 2 months	to review	

Facility ID: VA0100

		MEDICAID SERVICES				OMB NC T	
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		495193	B. WING			(C 04/2023
NAME OF P	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE	1 10/	04/2023
					61 NORTH AIRPORT DRIVE		
HENRICO	HEALTH & REHABILITA	TION CENTER			IGHLAND SPRINGS, VA 23075		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETIO DATE
F 584	Continued From page	1 8	F 5	84			
1 001	- 15	Resident #19's room with	10	-04	pest control book to verify pest sighting	10	
	-	e cabinet door and drawer			were treated and if follow up required v		
	· ·	aches ran out (approximately			completed and observe shower room fl		
		re all over the sides and top			tiles to ensure both shower rooms are		
	of the bedside cabine	et.			operable with no other broken floor tile		
					and review work orders for repairs and		
		control log revealed that on			completion. The Director of Environme		
		nbers 32, 37, and 54 were			Services or designee will conduct week		
		however, no follow-up o ensure any eggs that have			x4, then monthly x2 months to verify bo shower rooms are cleaned and as	oin	
		for, which is standard			needed, and a chair is available in roor	m	
	practice for bedbug tr				for each resident. Results of the review		
	, v				will be presented to the QAPI committe	e	
		esident in Room #8 was			for review and recommendation. Once	the	
		g, and stated he had bed			committee determines the problem no		
	bugs. The facility did 09/29/2023.	treat that room on			longer exist and sustained the review v be conducted on a random basis	vill	
		g the end of day meeting the ade aware of the findings.			5. Date of compliance: 11/19/2023		
	No further information	n was provided.					
	2. For Resident #363 provide a chair in her	, the facility staff failed to room at her request.					
	On 09/26/2023 at apr	proximately 9:30 a.m.,					
		bserved sitting on her bed in					
		w was conducted and					
		l, "I have asked constantly					
		n my room since I got here a					
		because my husband has he comes to visit me. He					
		ery day and has to sit in my					
		sking for much, just a chair.					
		o use my wheelchair to be					
	comfortable while he	visits, it makes no sense at					
		wheelchair was observed at					
	the foot of her bed, a	nd there was no chair in her					

If continuation sheet Page 19 of 156

		D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	
		495193	B. WING				04/2023
NAME OF PF	ROVIDER OR SUPPLIER		-	ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
HENRICO	HEALTH & REHABILITA	TION CENTER			31 NORTH AIRPORT DRIVE IGHLAND SPRINGS, VA 23075		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG PREFIX TAG PREFIX TAG PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) COMPLETION DATE	
F 584	group interview was of Administrator and the (CNC), both of whom for a chair to be place part of the regular roo	e 19 proximately 10:30 a.m., a conducted with the Facility Clinical Nurse Consultant stated that it was expected d in a resident's room as m set up or at minimum, a ed upon the resident's	F	584			
F 600 SS=G	Exploitation	Neglect m Abuse, Neglect, and	F	600			11/19/23
	neglect, misappropria and exploitation as de includes but is not lim corporal punishment,	involuntary seclusion and cal restraint not required to					
	physical abuse, corpor involuntary seclusion; This REQUIREMENT by: Based on resident int clinical record review, review, the facility fail	e verbal, mental, sexual, or oral punishment, or			F600 Free from Abuse and Neglect 1. Resident #53 and resident #85 no longer reside in the facility. The identifie	ed	
		ber and failed to protect the			agency CNA assigned to both residents since allegations on 8/10/2023 has not	S	

Event ID: EB1X11

Facility ID: VA0100

If continuation sheet Page 20 of 156

	S FOR MEDICARE &	MEDICAID SERVICES			OME	<u>8 NO. 0938-03</u>
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	· · ·	DATE SURVEY
		495193	B. WING			C 10/04/2023
	ROVIDER OR SUPPLIER	400100		STREET ADDRESS, CITY, STATE, ZIP C		10/04/2023
				561 NORTH AIRPORT DRIVE		
HENRICO	HEALTH & REHABILITA	TION CENTER		HIGHLAND SPRINGS, VA 23075	;	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE	(X5) COMPLETIO DATE
F 600	Continued From page	a 20	F 60	20		
1 000			FOU			
		2 residents (Resident #53		worked at the facility, FRIs submitted for both resident		
	,	sample of 48 residents, chosocial harm for Resident		with investigation on 9/27/2		
	#53.			2. Current residents in th		
	,,			the potential to be affected		
	The findings included	1:		were interviewed, with no o		
	ge			form of abuse. The facility		
	1. For Resident #53.	the facility staff failed to		skin assessments on all re	•	
		rom enduring physical and		could not be interviewed.,	no areas form	
		resulted in psychosocial		of abuse were identified.		
h	harm for the resident	· •		3. The SDC will provide	education to all	
				facility staff on resident right	nt to be free	
	On 09/26/2023, durin	g a clinical record review of		from any type of abuse, the	e abuse	
	Resident #53's clinica	al chart the following was		policies, and procedures re	egarding	
	noted:			protecting resident and/or		
		a Brief Interview for Mental		reporting to Administrator of	or DON, and	
		of 14, which indicated the		submitting Facility Reporte		
	resident was cognitiv	,		includes appropriate state		
		ated 08/10/2023 at 5:06 p.m.,		investigation process, prote		
		to Saint Mary's for evaluation		residents from any type of	-	
		l assault, MD [medical		staff identified in an allegat		
	doctor] made aware.			will be suspended pending		
	understanding the rea			immediately upon knowled		
		note dated 08/10/2023 at		the resident or other reside		
		ient made a statement in		potential abuse and/or emo		
		that took place this morning,		4. The SDC or designee		
	-	en from patient to myself		audits weekly x 4 weeks th	•	
		at the south unit nursing aced to nonemergency		months on new hires to ve Neglect training completed		
	services so patient co			orientation period. The Adr		
	statement and press			designee will audit weekly		
				monthly x 2 months to revi		
	On 09/27/2023 a rev	view was conducted of the		concerns to identify any typ	-	
		that had been performed.		of abuse/neglect to ensure	•	
		statement that was taken		residents were protected, t		
	from Resident #53 th			member was immediately		
		ent #53's name redacted]		pending upon knowledge a		
	-	nile he was asleep, he was		submitted, and the investig		
		cloth being placed on his		followed and completed. R		

Facility ID: VA0100

If continuation sheet Page 21 of 156

	F DEFICIENCIES	MEDICAID SERVICES	(X2) MI II TI		CONSTRUCTION		O. 0938-039 E SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	. ,			· · ·	PLETED
							С
		495193	B. WING			10	0/04/2023
NAME OF PF	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
				56	61 NORTH AIRPORT DRIVE		
HENRICO	HEALTH & REHABILITA	TION CENTER		HI	IGHLAND SPRINGS, VA 23075		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 600	Continued From page	o 21	F 60	00			
1 000			FO	00	review will be presented to the OARI		
		a voice say, can you see me? eturn, I am not blind. Patient			review will be presented to the QAPI committee for review and		
	-	fied nursing assistant/CNA			recommendation. Once the committee		
		sheets and undid his brief			determines the problem no longer exis		
		s penis back and forth.			and sustained the review will be		
		IA then stated he was going			conducted on a random basis.		
		irs. Patient stated he began			5. Date of compliance: 11/19/2023		
		hich caused the CNA to					
		ck the patient up and throw ent then restated all of the					
	above details to the s						
		26 a.m., an interview was					
	conducted with the facility Director of Nursing (DON), with the Administrator and survey team						
	. ,	as asked about the incident					
	•	53 and CNA C. The DON					
	reported, "On 8/10 w	hen I came in, the speech					
		and talked with me 8:30					
	-	service concern and said					
		3 and he reported that a					
		n inappropriately. I went and dent #53] and he said when					
	_	as discomfort. Then at noon					
	-	put a washcloth over his					
		ing his penis back and forth.					
		ame or describe the person,					
		A working that day, she					
	_	s name redacted]. I asked					
		he wanted to be sent out, he stated that she had CNA C					
	•	er arrival at the facility early					
	•	performance issues, prior to					
	her knowledge of the Resident #53.	-					
		10 p.m., an interview was					
	conducted with Empl Language Pathologis						

Facility ID: VA0100

If continuation sheet Page 22 of 156

			()(0)			10.0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	· · /	TE SURVEY MPLETED
			A. BUILDING	i		С
		495193	B. WING		1	0/04/2023
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		0/04/2023
				561 NORTH AIRPORT DRIVE		
HENRICO	HEALTH & REHABILITA	TION CENTER		HIGHLAND SPRINGS, VA 23075		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
E 000	0 11 15					
F 600	Continued From page		F 60	0		
		rrived to work at 7:50 a.m.,				
		own the hall, Resident #53 reported, "the aide [CNA C]				
		on his face and he had				
		old the nurse." The SLP				
	-	out 9:30 a.m., she saw				
		lining room being fed by the				
		dly abused Resident #53				
	earlier that morning.	The SLP said, "I saw his				
	[Resident #53] mouth	n was stuffed full of food, and				
		oo much and he [CNA C] was				
		nore in his mouth. I had the				
		d said that's why too much				
		diet texture, he [CNA C] said				
	-	I had to take over feeding P reported that she reported				
	this incident to nursin					
		r. Later that day she saw				
		lity/in passing in the hall.				
		the time. The SLP said she				
		o the Director of Nursing				
		tatement regarding the				
		ident #53 and CNA C.				
	Surveyors D and F at					
		ne day, but the resident was				
	not available for inter	view.				
	On 00/28/2023 at 3:0	0 p.m., Surveyors D and F				
		in his room. Resident #53				
		Inting of events that were in				
	-	referenced earlier. There				
	was no change in his					
	became very tearful a	and stated he was so afraid				
		me flat in the chair on my				
		to silence me and say I				
		sident #53 said, "[Employee				
		ook a picture." The resident				
		his incident he was afraid to				
		round, and had to be				

If continuation sheet Page 23 of 156

	-	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
		495193	B. WING				C 04/2023
NAME OF P	ROVIDER OR SUPPLIER			:	STREET ADDRESS, CITY, STATE, ZIP CODE		
HENRICO	HEALTH & REHABILITA	TION CENTER			561 NORTH AIRPORT DRIVE HIGHLAND SPRINGS, VA 23075		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD E TAG CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)			(X5) COMPLETION DATE
F 600	prescribed Trazadone asked how all of this r said, "Like I wanted to can't move, I was afra was trying to silence r choked. I watched all An additional review of revealed that Resider Trazodone 50 mg tab for sleep aid on 08/23 On the afternoon of 0 conducted with the so the afternoon of 08/10 Director of Nursing to "complaints and work payroll records reveal out and leave the pre- 1:17 p.m. A review was conduct policy titled, "Abuse/Neglect/Misag ative Reference Guid- read, "1. Physical abu intentionally or throug in, or is likely to result pain, or psychological Indications of psychol noticeable level of fea- emotional distress in Abuse: a. sexual hara touching."	e so he could sleep. When made him feel, Resident #53 o leave here, I was scared, I aid I was going to choke, he me so he could say I the time." This was harm. of the clinical record at #53 was ordered let to be given at bedtime b/2023. 9/29/2023, an interview was scheduler, who stated that on 0/2023, she was told by the send CNA C home, due to performance." Review of led that CNA C did not clock mises on 08/10/2023 until ted of the facility's abuse opropriation/Crime/Administr e." Excerpts from this policy use: b. physical contact h recklessness that results : in, death, physical injury, I harm to the patient. ogical harm include a ar, anxiety, agitation, or	F	600			

Facility ID: VA0100

If continuation sheet Page 24 of 156

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		495193	B. WING				C 104/2023
NAME OF P	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE	·	
HENRICO	HEALTH & REHABILITA	TION CENTER			561 NORTH AIRPORT DRIVE HIGHLAND SPRINGS, VA 23075		
(X4) ID PREFIX TAG	(EACH DEFICIENC	SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)					(X5) COMPLETION DATE
F 600	abuse, neglect, misag any crime against a p Rehabilitation Center have the legal right to mental, and physical 2. Any employee and Center, who willfully a criminal activity again will be immediately su action." On 09/27/2023 and 0 Administrator and cor aware of the above fir corporate staff notifier would be re-opening events involving Resi No further information 2. For Resident #85, ensure the resident's abuse. On 09/26/2023, an int Resident #103, who so 08/10/2023 Resident male CNA. She allow an audio recording of Resident #85. Accord CNA E could be hear that man shave you d stated that she did no which you can hear th mighty bald down the me and I was waxed.	propriation of property, or atient of the Health and . 1. Patients of the center be free from verbal, sexual, abuse, corporal punishment. /or covered agent of the abuses or participates in any st any patient of the center ubjected to corrective 9/28/2023, the facility porate staff were made ndings. On 09/27/2023, the d the survey team they the investigation into the dent #53 and CNA C. In was provided. the facility staff failed to right to be free from sexual terview was conducted with stated she knew that on #85 had been molested by a ed the surveyors to listen to CNA E questioning ling to the audio recording, d saying, "Why did you let lown there." Resident #85 the CNA reply "You are re. You got less hair than	F	600			

Facility ID: VA0100

If continuation sheet Page 25 of 156

		ID HUMAN SERVICES			PRINTED: 11/29/2023 FORM APPROVED OMB NO. 0938-0391		
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	COM	E SURVEY PLETED C	
		495193	B. WING			/04/2023	
	ROVIDER OR SUPPLIER	TION CENTER	561	REET ADDRESS, CITY, STATE, ZIP CODE			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	GHLAND SPRINGS, VA 23075 PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 600 F 607 SS=K	knowledge of the inci nurse on duty and the On 09/27/2023 an int the DON who stated and stated. "Coming was not inclined to be what she was suppose abuse, she stated she When asked what sh repeated "Investigate advised that facilities complete the investig was also advised to r the State Operations reporting. The incident was not until 09/27/2023 (2 da The incident was rep- Licensure and Certifie Services, the Departr and the Police by the Services. On 10/04/2023 during Administrator was ma No further information Develop/Implement A CFR(s): 483.12(b) The facilit	E who admitted that she had dent and that she made the e DON aware of the incident. erview was conducted with she did not view it as abuse from [Resident #103] she elieve her." When asked sed to do with allegations of e should investigate them. e should do first, she e them." The DON was are to report first and dation is second. The DON eview the facility's policy and Manual (SOM) on abuse reported nor investigated ays after the survey began). orted to the Office of cation, Adult Protective ment of Health Professions, Regional Director of Clinical g the end of day meeting, the ade aware of the concerns. h was provided. Abuse/Neglect Policies -(5)(ii)(iii) ty must develop and licies and procedures that: it and prevent abuse,	F 600			11/19/23	

Facility ID: VA0100

If continuation sheet Page 26 of 156

	-	ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 11/29/2023 FORM APPROVED OMB NO. 0938-0391				
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED				
		495193	B. WING		C 10/04/2023				
NAME OF P	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP CODE	10/04/2020				
HENRICO	HEALTH & REHABILITA	TION CENTER	561 NORTH AIRPORT DRIVE HIGHLAND SPRINGS, VA 23075						
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION				
F 607	Continued From page misappropriation of re		F 607						
	§483.12(b)(2) Establi to investigate any suc	sh policies and procedures ch allegations, and							
	§483.12(b)(3) Include paragraph §483.95,	e training as required at							
	§483.12(b)(4) Establi QAPI program require	sh coordination with the ed under §483.75.							
	§483.12(b)(5) Ensure reporting of crimes occurring in federally-funded long-term care facilities in accordance with section 1150B of the Act. The policies and procedures must include but are not limited to the following elements.								
		ting a conspicuous notice of lefined at section 1150B(d)							
	retaliation, as defined (2) of the Act.	hibiting and preventing I at section 1150B(d)(1) and is not met as evidenced							
	Based on resident in clinical record review review, the facility sta	terview, staff interview, , and facility documentation Iff failed to implement their		F607 Develop/Implement Abuse/Neg Policies					
	abuse policy affecting resulting in harm for F Immediate Jeopardy			 Resident #53 and resident #85 nd longer reside in the facility. The identif agency CNA assigned to both residen since allegations on 8/10/2023 has no 	īed ts				
	09/27/2023 at 5:25 p. Administrator and Dir aware. Following veri immediacy, the facility	m., at which time the facility ector of Nursing were made fication of the removal of y abated IJ on 10/04/2023 at		worked at the facility, FRIs were submitted for both residents #53 and a with investigation on 9/27/2023. Employee #4, #10, #13, #24 has not	#85				
	10:45 a.m. The scope to a level 3, pattern.	e and severity was lowered		returned to the facility and were terme from the facility.	d				

Facility ID: VA0100

		ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 11/29/2023 MAPPROVED D. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495193	B. WING				C /04/2023
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
				50	61 NORTH AIRPORT DRIVE		
HENRICO	HEALTH & REHABILITA	TION CENTER		н	IIGHLAND SPRINGS, VA 23075		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 607	Continued From page	e 27	F	607			
					2. Current residents in the facility ha		
	The findings included	:			the potential to be affected. An audit of	ofall	
	1 The facility staff fai	led to implement their obugo			criminal background checks was		
	•	led to implement their abuse acility staff to work when			completed by the HR Director and Regional HR support on all current st	aff	
		ound status was unknown.			had background checks Any staff	an	
	5				providing direct patient care that did r	ot	
	On 09/27/2023, a rev	iew was conducted of a			have a criminal background check on	file	
		files which revealed the			was immediately removed from the		
	following:				schedule. Resident interviews were		
	a Staff #1 was bired	03/17/2022 and terminated			conducted to identify any allegations abuse and residents that could not be		
		1/2022. Staff #4's employee			interviewed had skin assessments	;	
	record had no eviden				performed with no findings. Resident	#	
		d been obtained. Therefore,			103 reported allegation of abuse by a		
	-	/01/2022, facility staff were			employee, the abuse policy followed,		
		criminal background status,			employee suspended pending		
		provided direct resident			investigation, resident protected, FRI		
	care during this time.				submitted with appropriate state ager	icies	
	b. Staff #10 was hired	1 on 10/31/2022 ond			and investigation with supporting documentation completed.		
		ent on 01/10/2023. There			3. The Regional HR Director and		
		vided to indicate that Staff #3			Regional Director of Clinical Operatio	ns	
		round check performed.			held a mandatory training with the		
		1/2022 - 01/10/2023, facility			Administrator, HR Director and		
	staff were unaware of				Department Managers on the hiring		
	-	nd was permitted to provide			process, screening new and prior hire	s	
	direct care to residen	IS.			employees with review of prior		
	c. Staff #13 was hired	07/5/2022 and terminated			employment and must have a Virginia State Police criminal background che		
		3/2022. Staff #13's employee			returned, reviewed for barrier crimes		
		ce of a criminal background			to employee work with direct resident		
	check on file. Therefore	ore, from 07/05/2022 -			care. SDC or designee educated all		
		aff were unaware of Staff			facility staff on the abuse policies and		
	#13's criminal backgr				procedures regarding protecting resid	ent	
	permitted to provide of	direct care to residents.			and/or residents, reporting to		
	d Staff #24 was hired	d 03/08/2023. Staff #24's			Administrator or DON, and submitting		
		check was requested on			Facility Reported Incident (FRI) includ appropriate state agencies, and	162	
		oncon was requested on					

Facility ID: VA0100

If continuation sheet Page 28 of 156

		MEDICAID SERVICES				<u>/B NO. 0938-03</u>
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3	3) DATE SURVEY COMPLETED
		495193	B. WING			C 10/04/2023
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY		10/04/2023
				561 NORTH AIRPORT		
HENRICO	HEALTH & REHABILITA	TION CENTER		HIGHLAND SPRINGS		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH COF	ER'S PLAN OF CORRECTION RECTIVE ACTION SHOULD BE RENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETIO DATE
F 607	Continued From page	- <u>2</u> 9		7		
F 007	Continued From page		F 60			
		d to read, "Transaction is		v .	ocess, protecting the	
		d the final report was not on 03/08/2023 until the time of			any type of abuse. Any an allegation of abuse	
		aff were unaware of Staff			ed pending investigation	
	#24's criminal backgr				on knowledge to protect	
	-	tted to continue to work			other residents from	
		e employee was guilty of a		potential abuse.		
	barrier crime.			· · ·	al harm. Investigation	
					ented and retain copies in	
	On 09/27/2023 at app	proximately 1:00 p.m., an			sident interviews, staff	
	interview was conduc	cted with the Human		statements and	any other documents that	
		HRD) who stated, "We get			s of investigation.	
		checks on every applicant.			strator or designee will	
		Police, we wait 30 days,			weekly x 4 then monthly x	
	-	th another employee while			new hires or rehires to	
	we wait for it."				riminal background	
				checks are rece	-	
		t Staff #4, #10, #13, and #24			cess and employee	
	30 days of their respe	al background report within			Iministrator or designee / x 4 weeks then monthly >	,
	50 days of their respe	ective fille dates.			iew any service concerns	
	A review of the facility	's policy entitled			/pe of allegations of	
	"Abuse/Neglect/Misa				o ensure resident or	
	Prevention/Screening				protected, the alleged staff	f
		"Procedure," item 1 read,			mediately suspended	
		and reference checks are			nowledge a FRI report is	
	performed on all emp				the investigation process	
					mpleted ,the investigation	
		the survey, the facility staff			ented and retain copies in	
		eam with a facility policy			sident interviews, staff	
		/Virginia," with an effective			any other documents that	
		which was reviewed. This			s of investigation. Results	
		npany will comply with all			Il be presented to the	
		ations and guidelines as		QAPI committee		
		yees who are employed in			n. Once the committee	
		of Virginia. 1. A complete			problem no longer exist	
		nel file, as outlined in Policy			ne review will be	
		nce with 12VAC5-371-140-E		conducted on a		
	or the Administrative	Code of Virginia, will be		5. Date of con	npliance: 11/19/2023	

Facility ID: VA0100

If continuation sheet Page 29 of 156

	-	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	(X3) DATE SURVEY COMPLETED C	
		495193	B. WING				04/2023	
NAME OF PI	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	<u>, </u>		
HENRICO	HEALTH & REHABILITA	TION CENTER			561 NORTH AIRPORT DRIVE HIGHLAND SPRINGS, VA 23075			
(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 607	created for each new the basic demographineeded for employmen history check of the C Exchange conducted Non-Criminal Justice accordance with 32.1 Virginia" 2. For Resident #53,	employee which contains ic and indicative data ent, as well as: a. A criminal central Criminal Records via Virginia State Police	F	607				
	to protect the Resider perpetrator, which pe abuse the resident ac	staff failed to take measures nt #53 from their alleged rmitted the staff member to						
	Resident #53's clinica noted: a. Resident #53 had a Status (BIMS) score of resident was cognitive b. A progress note da stated, "Patient sent t r/t [related to] alleged doctor] made aware. understanding the rea c. Another progress m 5:15 p.m. read, "Patier regard to an assault t a statement was give dictated at 2:11 PM a	a Brief Interview for Mental of 14, which indicated the ely intact. ted 08/10/2023 at 5:06 p.m. o Saint Mary's for evaluation assault, MD [medical Patient verbalized ason for transfer." ote dated 08/10/2023 at ent made a statement in hat took place this morning, n from patient to myself t the south unit nursing aced to nonemergency puld give an official						

If continuation sheet Page 30 of 156

		MEDICAID SERVICES				OMB NO. 0938-03	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	PLE CONSTRUCTION	· · · ·	E SURVEY IPLETED	
IND PLAN OF	CORRECTION	IDENTIFICATION NUMBER.	A. BUILDING	3			
						С	
		495193	B. WING		1	0/04/2023	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DE		
				561 NORTH AIRPORT DRIVE			
HENRICO	HEALTH & REHABILITA	ATION CENTER		HIGHLAND SPRINGS, VA 23075			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CA (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 607	Continued From page	o 30	E 60	7			
			F 60)7			
		view was conducted of the					
	facility's documentation regarding the events						
	•	53. There was a written					
		Resident #53 that read,					
	-	ent #53's name redacted]					
		nile he was asleep, he was					
		cloth being placed on his					
		a voice say, can you see me?					
		return, I am not blind. Patient					
	-	fied nursing assistant/CNA					
		sheets and undid his brief					
		s penis back and forth.					
		IA then stated he was going					
		airs. Patient stated he began					
		hich caused the CNA to					
		ick the patient up and throw					
		ent then restated all of the					
	above details to the s	speech therapist."					
		:26 a.m., an interview was					
		acility Director of Nursing					
	(DON), with the Adm	inistrator and survey team					
	•	as asked about the incident					
		53 and CNA C. The DON					
		hen I came in the speech					
		e and talked with me 8:30					
		service concern and said					
		53 and he reported that a					
		n inappropriately. I went and					
	-	dent #53] and he said when					
	-	as discomfort. Then at noon					
		put a washcloth over his					
		ing his penis back and forth.					
	-	name or describe the person,					
		IA working that day, she					
	-	s name redacted]. I asked					
		he wanted to be sent out, he					
	said yes." The DON	stated she had CNA C sent					
	home prior to her arri						

Facility ID: VA0100

If continuation sheet Page 31 of 156

CENTER	S FOR MEDICARE &	MEDICAID SERVICES				O. 0938-039
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			E SURVEY IPLETED
		495193	B. WING		1	C D/04/2023
NAME OF P	ROVIDER OR SUPPLIER	I		STREET ADDRESS, CITY, STATE, ZIP CODE		
HENRICO	HEALTH & REHABILITA	TION CENTER	561 NORTH AIRPORT DRIVE HIGHLAND SPRINGS, VA 23075			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETIOI DATE
F 607	knowledge of the alle #53. However, it was had not been remove over 5 hours following On 09/27/2023 at 12: conducted with Empl Language Pathologis on 08/10/2023, she a and as she walked do got her attention and had put a washcloth touched his penis. I to stated at about 9:30 a saw Resident #53 be allegedly abused the morning. The SLP sa mouth was stuffed fu way too much and he to put more in his mo out and said that's will wrong diet texture, he they sent. I had to tal Resident." The SLP r this incident to nursin immediate supervisor CNA C still in the faci She was not sure of to reported the events to wrote a statement res	rmance issues, prior to her egation involving Resident later determined that CNA C ed from the premises until g the initial incident. (10 p.m., an interview was oyee M, the Speech it (SLP). The SLP reported irrived to work at 7:50 a.m., own the hall, Resident #53 reported, "the aide [CNA C] on his face and he had old the nurse." The SLP a.m. in the dining room, she sing fed by the CNA who had resident earlier that id, "I saw his [Resident #53] II of food, and I saw that was e [CNA C] was getting ready uth. I had the Resident spit it ny too much and it was the e [CNA C] said that's what ke over feeding the reported that she reported ig leadership and her r. Later that day, she saw lity/in passing in the hall. the time. The SLP said she o the Director of Nursing and garding the events involving	F 60			
	D and F attempted to the resident was not	IA C. On 9/27/23, Surveyors interview Resident #53, but available for interview. 0 p.m., Surveyors D and F				
	visited Resident #53	in his room. Resident #53 Inting of events that were in				

Facility ID: VA0100

If continuation sheet Page 32 of 156

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE COMP	SURVEY PLETED
		495193	B. WING				C 04/2023
NAME OF P	ROVIDER OR SUPPLIER		1		STREET ADDRESS, CITY, STATE, ZIP CODE	1	
HENRICO	HEALTH & REHABILITA	TION CENTER			561 NORTH AIRPORT DRIVE HIGHLAND SPRINGS, VA 23075		
(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 607	and that CNA C "laid back and was trying t choked on food." Res M's name redacted] to stated that following t sleep, kept looking an prescribed Trazadone asked how all of this is said, "Like I wanted to can't move, I was afra was trying to silence is choked. I watched all An additional review of revealed that Resider Trazodone 50 mg tab for sleep aid on 08/23 On the afternoon of 0 conducted with the so afternoon of 08/10/20 Director of Nursing to "complaints and work payroll records reveal out and leave the pre 1:17 p.m. A review was conduct policy titled, "Abuse/Neglect/Misag ative Reference Guid read, "1. Physical abu intentionally or throug in, or is likely to result pain, or psychologica Indications of psychol	report. The resident and stated he was so afraid me flat in the chair on my o silence me and say I ident #53 said, "[Employee bok a picture." The resident his incident he was afraid to ound, and had to be a so he could sleep. When made him feel, Resident #53 o leave here, I was scared, I aid I was going to choke, he me so he could say I the time." This was harm. of the clinical record ht #53 was ordered let to be given at bedtime 2/2023. 9/29/2023, an interview was scheduler, who stated on the 23, she was told by the send CNA C home, due to performance." Review of led that CNA C did not clock mises on 08/10/2023 until ted of the facility's abuse opropriation/Crime/Administr e". Excerpts from this policy use: b. physical contact th recklessness that results t in, death, physical injury, I harm to the patient.	F	607	7		

Facility ID: VA0100

If continuation sheet Page 33 of 156

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		495193	B. WING				C 104/2023
NAME OF PI	ROVIDER OR SUPPLIER	L		S	STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
HENRICO	HEALTH & REHABILITA	TION CENTER			561 NORTH AIRPORT DRIVE HIGHLAND SPRINGS, VA 23075		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 607	touching." The policy titled, "Abuse/Neglect/Misap Protection," was revie "There is a zero tolera abuse, neglect, misap any crime against a p Rehabilitation Center have the legal right to mental, and physical 2. Any employee and Center, who willfully a any criminal activity a center will be immedia action." 3. For Resident #53, report and investigate On 09/27/2023, a rev facility's documentation actions taken regarding incidents with CNA C statement taken from also a written stateme Speech Language Pa was evidence the stat Licensure and Certific Protective Services (A the incident on 08/10) was no evidence that allegations was conduct	the patient. 3. Sexual assment, inappropriate opropriation/Crime/ Patient ewed. This policy read, ance for mistreatment, opropriation of property, or vatient of the Health and . 1. Patients of the center o be free from verbal, sexual, abuse, corporal punishment. /or covered agent of the abuses or participates in against any patient of the ately subjected to corrective the facility staff failed to e allegations of abuse. iew was conducted of the on of the allegation and ng Resident #53 and the . There was a written Resident #53. There was ent from Employee M, the athologist (SLP). Lastly there te survey agency/Office of cation (OLC) and Adult APS) were faxed a report of /2023 at 7:10 p.m. There an investigation into the ucted. to the OLC and APS lacked in regarding Resident #53's	F	607			
	was no evidence that allegations was condu The report submitted significant information	an investigation into the ucted. to the OLC and APS lacked					

Facility ID: VA0100

If continuation sheet Page 34 of 156

TATEMENT (S FOR MEDICARE &	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	PLE CONSTRUCTION	OMB NO. 0938-03 (X3) DATE SURVEY
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	G	COMPLETED
		495193	B. WING		C 10/04/2023
NAME OF PI	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP C	
HENRICO	HEALTH & REHABILITA	TION CENTER		561 NORTH AIRPORT DRIVE HIGHLAND SPRINGS, VA 23075	
(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 COMPLETIC THE APPROPRIATE DATE
F 607	Continued From page	e 34	F 60	07	
	awakened by a wash	cloth being put across his			
		going to shave the resident's			
	pubic hair, and the de feeding were all omiti	etails of the aggressive ted from the report.			
	_				
		26 a.m., an interview was			
		cility's Director of Nursing nistrator and survey team			
		as asked about the incident			
	-	3 and CNA C. The DON			
		hen I came in the speech			
		and talked with me 8:30 service concern and said			
		3 and he reported that a			
		n inappropriately. I went and			
		dent #53] and he said when as discomfort. Then at noon			
		put a washcloth over his			
		ing his penis back and forth.			
	-	ame or describe the person,			
		A working that day," which A C's name redacted]. "I			
		#53] if he wanted to be sent			
	-	DON stated that she had			
	-	or to her arrival at the facility			
		e to performance issues, e of the allegation involving			
	Resident #53.				
	During the above inte	erview, the DON was asked			
	to explain what steps	were taken to investigate			
		he had any additional			
		ding an investigation. The interviewed other residents			
	-	spital records of Resident			
	#53. Because there v	vas no forensic evidence,			
	she unsubstantiated	the allegation. The DON was			
	asked to provide evid	-			

Facility ID: VA0100

If continuation sheet Page 35 of 156

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		495193	B. WING				C 04/2023
NAME OF PI	ROVIDER OR SUPPLIER		•	ŝ	STREET ADDRESS, CITY, STATE, ZIP CODE	·	
HENRICO	HEALTH & REHABILITA	TION CENTER			561 NORTH AIRPORT DRIVE HIGHLAND SPRINGS, VA 23075		
(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 607	CNA C, were interview none of the staff were had no evidence of an conducted.	ncluding but not limited to wed, the DON indicated interviewed. The facility ny investigation being	F	607	7		
	policy titled, "Abuse/Neglect/Misap Requirements/Investi policy read, "2. The A of Nursing will immed internal investigation occurrence. The invest include, but not be lim interviewing alleged v	nited to, collecting evidence, rictims and witnesses, and priate individuals, agents, or					
	were made aware. On 10/02/2023 at 3:3 an accepted IJ remov submitted a revised p "1. 9/27/23: Resident of abuse on 8/10/202 regarding resident #8 2. 9/27/23: FRI submit	m., at which time the and Director of Nursing 0 p.m., the facility submitted ral plan and on 10/04/2023, lan which read as follows: #103 reported an allegation 3 and FRI submitted					
	#85. Physician, response notified, and case ass	nsible party, and police signed to detective Alphin. , [Name redacted], removed					

Facility ID: VA0100

If continuation sheet Page 36 of 156

	-	ND HUMAN SERVICES MEDICAID SERVICES			FOR	ED: 11/29/202 MAPPROVE O. 0938-039	
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495193	B. WING		10	C)/04/2023	
NAME OF P	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP CODE			
HENRICO	HEALTH & REHABILITA		5	61 NORTH AIRPORT DRIVE			
			H	IIGHLAND SPRINGS, VA 23075			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 607	Continued From page	e 36	F 607				
1 007		0/2023 and no longer	F 007				
	permitted in the center	0					
	1	redacted] license (CNA)					
	reported to the board						
		personnel educated on the					
		ify, protect, report, and					
	• •	is of abuse prior to working. res educated on abuse					
	policy prior to working						
	7. 9/27/2023: Region						
	-	all personnel files to verify					
		(VSP) background checks.					
	8. 10/2/2023: Employ	ees with pending VSP					
	-	earances removed from the					
	schedule.						
		al Human Resources					
	educated Administrat	s and VSP background					
	checks clearance.	and vor background					
		acility educated all personnel					
		ng, investigation, screening					
	employees, and adhe						
	reporting procedure.						
		acility interviewed residents					
		was any other allegation of					
	abuse.	backs completed an					
	12. 9/27/2023: skin c residents who could i	-					
	determine any signs						
	13. 9/27/2023: The fa						
		of all FRIs and service					
		ed from January 2023 up to					
	-	e no other case of abuse					
	existed.						
		acility identified an allegation					
	#103.	receptionist, and resident					
	15. Receptionist susp	pended pending an					
	investigation. A FRI						

Facility ID: VA0100

If continuation sheet Page 37 of 156

CENTERS FOR MEDICARE & MEDICAID SERVI	CES				RM APPROVED O. 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPP AND PLAN OF CORRECTION IDENTIFICATION I	LIER/CLIA (X2)		PLE CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
4951	93 B. W	/ING		1	C 0/04/2023
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	•	
HENRICO HEALTH & REHABILITATION CENTER			561 NORTH AIRPORT DRIVE HIGHLAND SPRINGS, VA 23075		
(X4) ID SUMMARY STATEMENT OF DEFICIEN PREFIX (EACH DEFICIENCY MUST BE PRECEDED TAG REGULATORY OR LSC IDENTIFYING INFOR	BY FULL P	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
 F 607 Continued From page 37 Licensure and Certification on 9/26/202 16. The implementation deadline of this immediacy removal plan is October 2, 2 3:20 PM." On 10/02/2023, the facility's administrat submitted to the survey team credible e the IJ immediacy removal plan. Included documents was documentation of "Dire Supervision," which indicated that empl without a criminal background check cle would be permitted to work under the di supervision of a staff member with a cri background clearance. The survey team the facility's administration that this was permissible, and that each employee ha a criminal background check clearance beyond 30 days of employment. On 10/03/2023, the survey team attempt to verify the facility staff had implemente approved IJ immediacy removal plan. S interviews were conducted with facility s various departments to ensure they wer of what abuse is, how to respond and p residents in the event of abuse, and tha were mandated reporters. The survey team obtained a resident ce listing and cross checked to ensure that who could be interviewed had been inter and residents who could not be intervie head-to-toe assessment. There was on identified that had not been interviewed assessed for signs of abuse. 	2023, by ion vidence of d in the ct oyees earance irect minal n notified n nt ad to have to work oted again ed their staff staff from re aware rotect t they ensus t residents erviewed, wed had a e resident or e audits y,	F 60			

Facility ID: VA0100

If continuation sheet Page 38 of 156

		ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 11/29/2023 MAPPROVED D: 0938-0391
STATEMENT O	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		495193	B. WING				C 04/2023
NAME OF PI	ROVIDER OR SUPPLIER			s	TREET ADDRESS, CITY, STATE, ZIP CODE		
HENRICO	HEALTH & REHABILITA	TION CENTER			61 NORTH AIRPORT DRIVE		
				ŀ	IIGHLAND SPRINGS, VA 23075		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 607	check from the Virgin they were free from a On 10/03/23 at 4:40 p Administrator and cor aware that the survey verify abatement. On 10/04/2023, the su facility for them to atte staff provided the sur- assessment for the re- not been assessed for abuse. Additionally, the employee record aud contracted staff were audit indicated that Si was noted as having check. It had previous as 10/03/2023, Staff a background check on status regarding barri record remained unkn staff members were re- schedule for the day a evidence provided to screened for criminal On 10/04/2023 at app	y had a criminal background ia State Police that indicated ny barrier crimes. o.m., the facility porate staff were made r team had been unable to urvey team returned to the empt to abate IJ. The facility vey team with a head-to-toe esident that had previously or signs and symptoms of ne team reviewed the it and noted that the now listed. However, the taff #24, who was a cook, had a criminal background sly been noted as recently #24 did not have a criminal nown. In addition, 2 agency noted on the current working and there was not any indicate they had been records.	F	607	DEFICIENCY)		
	Administrator returned correctly reflected that criminal record on file employees without a	40 a.m., the facility's d with a revised audit which at Staff #24 did not have a e. The audit verified that criminal background check om the schedule and were					

Facility ID: VA0100

If continuation sheet Page 39 of 156

		D HUMAN SERVICES MEDICAID SERVICES				FORM): 11/29/2023 APPROVED . 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	PLE CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		495193	B. WING		-	(10/	C 04/2023
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STA	ATE, ZIP CODE		
HENRICO	HEALTH & REHABILITA			561 NORTH AIRPORT DRIV	E		
_	-			HIGHLAND SPRINGS, VA	A 23075		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BE CED TO THE APPROPRIAT EFICIENCY)		(X5) COMPLETION DATE
F 607	Continued From page not currently working. also provided a crimin from barrier crimes fo The survey team cont 10/04/2023 at 10:45 at 4. For Resident #85, to implement the abuse allegation of sexual at On or about 08/10/20 shaved the pubic hair cognitively impaired at The allegation was re cares for her and the On 09/26/2023, an int Resident #103, who s Resident #85 had bee She allowed the surver recording of CNA E que According to the audit heard saying, "Why di you down there." Res Interview of Mental St and stated she did no which you can hear the	 39 The facility's administration hal background that was free r the 2 agency staff working. The 2 agency staff working. The 2 agency staff working. The 3 agency staff solution of the 2 agency staff failed to policy by reporting an ouse. 23, an allegation that a CNA of Resident #85, who is nd unable to be interviewed. ported by the CNA who roommate of Resident #85. Perview was conducted with tated she knew that en molested by a male CNA. Beyors to listen to an audio uestioning Resident #85. Direcording, CNA E could be id you let that man shave 	F 60	D			
	me and I was waxed. ¹ p.m., an interview was who admitted that she incident and that she former DON aware of did not report it as abu On 09/26/2023, an int the DON, who was as	' On 09/27/2023 at 1:00 s conducted with CNA E e had knowledge of the made the nurse and the the incident; however, she					

Facility ID: VA0100

If continuation sheet Page 40 of 156

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL ⁻ A. BUILDI		E CONSTRUCTION	(X3) DATE COMP	
		495193	B. WING				04/2023
NAME OF P	ROVIDER OR SUPPLIER			:	STREET ADDRESS, CITY, STATE, ZIP CODE		
HENRICO	HEALTH & REHABILITA	TION CENTER			561 NORTH AIRPORT DRIVE HIGHLAND SPRINGS, VA 23075		
(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 607 F 609 SS=D	she did not find it was heard about it from R not consider it abuse. from (Resident #103 f believe it." When ask abuse policy, and rep parties, she stated sh so she did not report A review of the Abuse "All alleged violations exploitation or mistrea unknown source and property, are reported than 2 hours after the events that cause the result in serious bodil hours if the events that not involve abuse and bodily injury." On 10/04/2023 during Administrator was ma No further information Reporting of Alleged Y CFR(s): 483.12(b)(5) §483.12(c) In respons neglect, exploitation, must: §483.12(c)(1) Ensure involving abuse, negli- mistreatment, includir source and misappro- are reported immedia	a abuse. She stated she esident #103, and she did . The DON stated, "Coming name redacted) I don't ed again if she followed the ported to the appropriate the did not think it was abuse it. Policy read: involving abuse, neglect, atment, including injuries of misappropriation of resident d immediately, but not later e allegation is made, if the e allegation involve abuse or y injury, or not later than 24 at cause the allegation do d do not result in serious g the end of day meeting, the ade aware of the findings. h was provided. Violations (i)(A)(B)(c)(1)(4) se to allegations of abuse, or mistreatment, the facility that all alleged violations		607			11/19/23

Facility ID: VA0100

If continuation sheet Page 41 of 156

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 11/29/2023 APPROVED). 0938-0391	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION	(X3) DATE SURVEY COMPLETED C		
		495193	B. WING					
NAME OF P	ROVIDER OR SUPPLIER		•	ST	REET ADDRESS, CITY, STATE, ZIP CODE	•		
HENRICO	HEALTH & REHABILITA	TION CENTER			31 NORTH AIRPORT DRIVE IGHLAND SPRINGS, VA 23075			
(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)		(X5) COMPLETION DATE	
F 609	serious bodily injury, the events that cause abuse and do not res the administrator of th officials (including to adult protective servic for jurisdiction in long accordance with Stat procedures. §483.12(c)(4) Report investigations to the a designated represent accordance with Stat Survey Agency, withi incident, and if the all appropriate corrective This REQUIREMENT by: Based on resident in clinical record review review, the facility fail abuse by a staff merr (Residents #53 and # residents. The findings included 1. For Resident #53, complete a timely and allegation of physical to the state survey ag services, and law enf On 09/26/2023, durin Resident #53's clinica noted:	tion involve abuse or result in or not later than 24 hours if a the allegation do not involve ult in serious bodily injury, to he facility and to other the State Survey Agency and ces where state law provides -term care facilities) in e law through established the results of all administrator or his or her rative and to other officials in e law, including to the State in 5 working days of the leged violation is verified e action must be taken. 5 is not met as evidenced terview, staff interview, , and facility documentation led to report allegations of other involving 2 residents 485) in a survey sample of 48 the facility staff failed to d accurate report of an and sexual abuse by CNA C gency, adult protective	F	609	 F609 Reporting of Alleged Violations 1. Resident #53 and resident #85 no longer reside in the facility. The identified agency CNA assigned to both residents since allegations on 8/10/2023 has not worked at the facility. FRIs were submitted for both residents #53 and #85 with investigation on 9/27/2023 with appropriate state agend with accurate description of allegation investigation include retained copies of documents to support findings of allegation. Current residents in the facility has the potential to be affected. An audit of service concerns and facility incident reports from 10/4/2023 were reviewed the Regional Director of Clinical Service 	o y, s and f ve f all by		

Facility ID: VA0100

If continuation sheet Page 42 of 156

	F DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA			ISTRUCTION		D. 0938-03 SURVEY	
	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING				PLETED	
							С	
		495193	B. WING			10	/04/2023	
NAME OF PF	ROVIDER OR SUPPLIER				T ADDRESS, CITY, STATE, ZIP CODE			
HENRICO	HEALTH & REHABILITA	TION CENTER		561 NG				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ЗE	(X5) COMPLETIC DATE	
					, 			
F 609	Continued From page	e 42	F 60	9				
	read, "Patient sent to	saint Mary's for evaluation		(R	DSC) and the Vice President of			
		assault, MD [medical		Ö	perations (VPO) to identify any			
	doctor] made aware.				legations of abuse/neglect with none	;		
	understanding the rea	ason for transfer."		nc	oted. Residents were interviewed, wi	th		
				nc	o concerns of any type of abuse. The	e		
	b. Another progress r	note dated 08/10/2023 at		fa	cility also performed skin assessme	nts		
	5:15 p.m., stated, "Pa	itient made a statement in		or	all residents that could not be			
	regard to an assault t	hat took place this morning,		in	terviewed, no areas identified.			
	a statement was give	n from patient to myself		R	esident # 103 reported allegation of			
	dictated at 2:11 PM a	t the south unit nursing		ab	ouse by an employee, the abuse pol	icy		
	station. Phone call pla	aced to nonemergency		fo	llowed, employee suspended pendir	ng		
	services so patient co	ould give an official		in	vestigation, resident protected, FRI			
	statement and press	charges."			Ibmitted with appropriate state agen Id investigation conducted with	cies		
		iew was conducted of the			pporting documentation completed.			
	facility's documentation	on of the allegation and			The RDCS provided education to			
		was a written statement that			dministrator and the DON on the abu	lse		
	was taken from Resid				blicy and procedures with timely			
		f [Resident #53's name			porting of FRI submitted with			
		ed that while he was asleep,			propriate state agencies, accurate			
	•	a washcloth being placed			escription of allegation, thorough			
		ieard a voice say, can you			vestigation with retained documents	to		
		says in return, I am not			pport findings. SDC or designee			
		he CNA [certified nursing			lucated all facility staff on the abuse			
	-	n pulled off his sheets and			plicies and procedures regarding			
		gan flicking his penis back			otecting resident and/or residents,			
		tes the CNA then stated he			porting to Administrator or DON, and			
		is pubic hairs. Patient			Ibmitting Facility Reported Incident (
		ell out for help, which caused			thin 2 hours of allegation of abuse if			
		top, then pick the patient up			her type of abuse and no serious bo	-		
		chair. Patient then restated			arm can report within 24 hours includ	ies		
	all of the above detail	s to the speech therapist."			propriate state agencies, and			
	Thorowson oviders - 4	the state our as			vestigation process, importance and			
	There was evidence t				nderstanding of protecting the reside	ms		
		nsure and Certification			om any type of abuse. Any staff	ha		
	. ,	ective Services (APS) were			entified in an allegation of abuse will	be		
	-	ncident on 08/10/2023 at			spended pending investigation	ot		
	7:10 p.m., almost 12	nours alter lacility		l im	mediately upon knowledge to prote	ان	1	

Facility ID: VA0100

If continuation sheet Page 43 of 156

	S FOR MEDICARE &					NO. 0938-03	
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·			ATE SURVEY	
					С		
		495193	B. WING			10/04/2023	
NAME OF P	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CO	DE		
	HEALTH & REHABILITA			561 NORTH AIRPORT DRIVE			
				HIGHLAND SPRINGS, VA 23075			
(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	(X5) COMPLETIO DATE	
F 609	Continued From page	- 13	F 60	0			
1 000	-		F 00	potential abuse and/or emot	ional harm		
	abuse allegation. Ad submitted grossly mis			4. The RDCS or VPO will a			
		he report read, "It was		4 weeks then monthly x 2 m	•		
		nerapist and floor nurse by		FRIs (facility incident reports	•		
		e redacted], BIMS [brief		abuse policy was followed, r			
	interview for mental s	tatus score] 14, that the aide		protected if staff involved su	spended		
		touched him inappropriately,		pending investigation immed			
		states not today or yesterday		allegation of abuse reported			
		t worked this morning. Aide		hours, if other abuse and no			
immediately sent home upon know investigation." During Surveyor F's of this incident, payroll records reve	-			bodily harm within 24 hours			
			appropriate state agencies, i compete with copies of docu				
	did not leave the facil			retained to support findings.			
	allegations until 1:17			review will be presented to the			
		F		committee for review and			
	On 09/27/2023 at 11:	26 a.m., an interview was		recommendation. Once the	committee		
	conducted with the fa	cility's Director of Nursing		determines the problem no l	onger exist		
		nistrator and survey team		and sustained the review wil	l be		
		as asked about the incident		conducted on a random bas	is.		
		3 and CNA C. The DON					
	· ·	hen I came in the speech		5. Date of compliance: 11/	19/2023		
		and talked with me 8:30					
	-	service concern. She said 3 and he reported that a					
		n inappropriately. I went and					
		dent #53] and he said when					
	-	as discomfort. Then at noon					
	-	put a washcloth over his					
		ing his penis back and forth.					
	-	ame or describe the person,					
		A working that day, she					
		s name redacted] I asked					
		he wanted to be sent out, he					
	-	stated she had CNA C sent val at the facility early that					
		rmance issues, prior to her					
		gation involving Resident					
	#53.	galon myoning resident					

If continuation sheet Page 44 of 156

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING C 495193 B. WING 10/04/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 561 NORTH AIRPORT DRIVE HENRICO HEALTH & REHABILITATION CENTER STREET ADDRESS, VA 23075 HIGHLAND SPRINGS, VA 23075 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5)			ID HUMAN SERVICES MEDICAID SERVICES				FORM	: 11/29/2023 APPROVED . 0938-0391
10/04/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE HENRICO HEALTH & REHABILITATION CENTER STREET ADDRESS, CITY, STATE, ZIP CODE MAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE HENRICO HEALTH & REHABILITATION CENTER STREET ADDRESS, CITY, STATE, ZIP CODE MAME OF PROVIDER'S PLAN OF CORRECTION COMPLET (X4) ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE (CACH CORRECTIVE ACTION SHOULD BE (CACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY) COMPLET: F 609 Continued From page 44 F 609 F 609 F 609 F 609 F 609 During the above interview, the DON was asked about the reporting of the incident. The DON was able to verbalize that reports regarding allegations of abuse are to be reported within 2 hours. When questioned about the timing of the report involving Resident #53, she did not respond as to why it was delayed. F 609 The DON was asked about the lack of details regarding Resident #53's allegations involving CNA C, in the report submitted. The details of being awakened by a washcloth being put across his face, saying he was going to shave the resident's pubic hair and the details of the ID	STATEMENT O	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	. ,			(X3) DATE S COMPL	SURVEY .ETED
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE HENRICO HEALTH & REHABILITATION CENTER 561 NORTH AIRPORT DRIVE IMAGE OF PROVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG Continued From page 44 PROVIDER SPLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE DEFICIENCY) CONFLETU (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 609 Continued From page 44 F 609 F 609 OUTING the above interview, the DON was able to verbalize that reports regarding CRO AC, in			495193	B. WING				
HENRICO HEALTH & REHABILITATION CENTER HIGHLAND SPRINGS, VA 23075 (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG PROVIDER'S PLAN OF CORRECTIVE ACTION SHOLD BE (EACH OCRECTIVE ACTION SHOLD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COMPLETM DATE F 609 Continued From page 44 F 609 During the above interview, the DON was asked about the reporting of the incident. The DON was able to verbalize that reports regarding allegations of abuse are to be reported within 2 hours. When questioned about the timing of the report involving Resident #53, she did not respond as to why it was delayed. F 609 The DON was asked about the lack of details regarding Resident #53's allegations involving CNA C, in the report submitted. The details of being awakened by a washcloth being put across his face, saying he was going to shave the resident's pubic hair and the details of the F	NAME OF PI	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE,	, ZIP CODE		
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COMPLETM DATE F 609 Continued From page 44 F 609 F 609 F 609 During the above interview, the DON was asked about the reporting of the incident. The DON was able to verbalize that reports regarding allegations of abuse are to be reported within 2 hours. When questioned about the timing of the report involving Resident #53, she did not respond as to why it was delayed. F 609 The DON was asked about the lack of details regarding Resident #53's allegations involving CNA C, in the report submitted. The details of being awakened by a washcloth being put across his face, saying he was going to shave the resident's pubic hair and the details of the Image: Content Conten	HENRICO	HEALTH & REHABILITA	TION CENTER			3075		
During the above interview, the DON was asked about the reporting of the incident. The DON was able to verbalize that reports regarding allegations of abuse are to be reported within 2 hours. When questioned about the timing of the report involving Resident #53, she did not respond as to why it was delayed. The DON was asked about the lack of details regarding Resident #53's allegations involving CNA C, in the report submitted. The details of being awakened by a washcloth being put across his face, saying he was going to shave the resident's pubic hair and the details of the	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIV CROSS-REFERENCE	E ACTION SHOULD BE D TO THE APPROPRIA		COMPLETION
 report. Again, the DON did not give an answer as to why those details were omitted. When asked if the allegations against CNA C were reported to the Board of Nursing, which is the agency that certified CNA C to practice as a nursing assistant, the DON said yes, but was unable to provide any credible evidence it was reported. On 09/27/2023 at 12:10 p.m., an interview was conducted with Employee M, the speech language pathologist (SLP). The SLP confirmed Resident #53's report of abuse was reported to her on 08/10/2023, when she arrived to work at 7:50 a.m. She also stated she immediately reported the allegation to her departmental supervisor, the nursing unit manager, and then to the Director of Nursing. On 09/27/2023, Surveyors D and F attempted to interview. On 09/28/2023 at 3:00 p.m., Surveyors D and F 	F 609	During the above inter about the reporting of able to verbalize that allegations of abuse a hours. When question report involving Resider respond as to why it w The DON was asked regarding Resident #2 CNA C, in the report s being awakened by a his face, saying he wa resident's pubic hair a aggressive feeding wa report. Again, the DO to why those details w When asked if the alle were reported to the B the agency that certifin nursing assistant, the unable to provide any reported. On 09/27/2023 at 12: conducted with Emple language pathologist Resident #53's report her on 08/10/2023, w 7:50 a.m. She also st reported the allegation supervisor, the nursin the Director of Nursin Surveyors D and F at Resident #53, but the for interview.	rview, the DON was asked the incident. The DON was reports regarding are to be reported within 2 hed about the timing of the lent #53, she did not vas delayed. about the lack of details 53's allegations involving submitted. The details of washcloth being put across as going to shave the and the details of the ere all omitted from the N did not give an answer as vere omitted. egations against CNA C Board of Nursing, which is ed CNA C to practice as a DON said yes, but was to credible evidence it was 10 p.m., an interview was byce M, the speech (SLP). The SLP confirmed of abuse was reported to hen she arrived to work at ated she immediately n to her departmental g unit manager, and then to g. On 09/27/2023, tempted to interview resident was not available	F 609				

Facility ID: VA0100

If continuation sheet Page 45 of 156

	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE	E SURVEY PLETED
		495193	B. WING				C / 04/2023
NAME OF P	ROVIDER OR SUPPLIER		•		STREET ADDRESS, CITY, STATE, ZIP CODE		
					561 NORTH AIRPORT DRIVE		
HENRICO	HEALTH & REHABILITA	TION CENTER			HIGHLAND SPRINGS, VA 23075		
(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 CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 609	gave the same account the written statement was no change in his became very tearful, st that CNA C "laid me f and was trying to sile food." Resident #53 s redacted] took a pictur following this incident looking around, and h Trazadone so he count all of this made him fe I wanted to leave here move, I was afraid I w trying to silence me s watched all the time." A review was conduct policy titled, "Abuse/Neglect/Misag Requirements/Investin policy read, "1. Immer any alleged violations exploitation, or mistre unknown source and property, the Administ to the State Agency, the after the allegation is caused the allegation serious bodily injury. I Services Agency, the appropriate local law (police, sheriff's office as deemed appropria abuse, mistreatment, of personal property of suspicion of a crime.	n his room. Resident #53 nting of events that were in referenced earlier. There report. Resident #53 said he was so afraid, and lat in the chair on my back nce me and say I choked on raid, "[Employee M's name tre." The resident stated he was afraid to sleep, kept had to be prescribed ld sleep. When asked how eel, Resident #53 said, "Like e, I was scared, I can't vas going to choke, he was o he could say I choked. I ted of the facility's abuse opropriation/Crime/Reporting gations." Excerpts from this diately upon notification of s involving abuse, neglect, atment, including injuries of misappropriation of resident trator will immediately report out not later than 2 hours made, if the events that involves abuse or results in b. Notify the Adult Protective local Ombudsman, and the enforcement authorities e, and/or medical examiner te) for any incident of patient neglect, or misappropriation	F	609	9		

Facility ID: VA0100

If continuation sheet Page 46 of 156

		ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>í</i>		E CONSTRUCTION	(X3) DATE	
			A. BUILDI	NG .			C
		495193	B. WING				04/2023
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
HENRICO	HEALTH & REHABILITA	TION CENTER			561 NORTH AIRPORT DRIVE HIGHLAND SPRINGS, VA 23075		
(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 609	 Physicians, or others DHP." On 09/27/2023 and 0 Administrator and cor aware of the above fin On 09/27/2023, the cost of the above fine On 09/27/2023, the cost of the allegation into the #53 and CNA C and how the allegation into the #53 and CNA C and how the allegation store the agencies/authorities. No further information 2. For Resident #85, ensure allegations of 24 hours for allegations of 24 hours for allegations are cognitively impaired at the allegation was recognitively impaired at the allegation was record for the allegation was record for	 hurse aides, RNs, LPNs, licensed or certified by 9/28/2023, the facility's porate staff were made ndings. orporate staff notified the uld be re-opening the events involving Resident nad made an accurate report ne required h was provided. the facility staff failed to abuse are reported within ns that do not result in 23, an allegation that a CNA of Resident #85 who is and unable to be interviewed. ported by the CNA who roommate of the resident. terview was conducted with 	F	609			
	Resident #85 has a B Status (BIMS) score o	man shave you down there." rief Interview of Mental of 99 and stated that she did her, to which you can hear					

Facility ID: VA0100

If continuation sheet Page 47 of 156

	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		E CONSTRUCTION	(X3) DATE	
		495193	B. WING				C 04/2023
NAME OF P	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE	<u>. </u>	
				5	561 NORTH AIRPORT DRIVE		
HENRICO	HEALTH & REHABILITA	HON CENTER		H	HIGHLAND SPRINGS, VA 23075		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI. DEFICIENCY)		(X5) COMPLETION DATE
F 609	the CNA reply "You ai You got less hair than 09/27/2023 at 1:00 p. conducted with CNA I knowledge of the inci- nurse aware of the inci- nurse aware of the inci- nurse aware of the inci- nurse aware of the inci- was also made aware it as abuse at that tim On 09/26/2023, an int the DON who was as allegation of sexual ai she did not find it was heard about it from R- not consider it abuse. from (Resident #103 of believe it." When aske Abuse Policy and rep appropriate parties, si was abuse, so she did A review of the Abuse "All alleged violations exploitation or mistrea unknown source and property, are reported than 2 hours after the events that cause the result in serious bodil hours if the events that not involve abuse and bodily injury." The incident was not until 09/27/2023 2 day The incident was repo-	re mighty bald down there. I me and I was waxed." On m., an interview was E who admitted that she had dent and that she made the cident and the former DON a, however she did not report e. terview was conducted with ked if she reported the buse and she stated that a abuse. She stated she esident #103, and she did The DON stated, "Coming name redacted) I don't ed again if she followed the orted the incident to the he stated she did not think it d not report it. Policy read: involving abuse, neglect, atment, including injuries of misappropriation of resident d immediately, but not later allegation is made, if the allegation involve abuse or y injury, or not later than 24 at cause the allegation do d do not result in serious reported nor investigated ys after the survey began. orted to the Office of cation, Adult Protective Health Professions, and the	F	609			

Facility ID: VA0100

If continuation sheet Page 48 of 156

		D HUMAN SERVICES MEDICAID SERVICES			FORI	M APPROVED D. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	(X3) DATE COMF	E SURVEY PLETED
		495193	B. WING			04/2023
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	•	
HENRICO	HEALTH & REHABILITA	TION CENTER		561 NORTH AIRPORT DRIVE HIGHLAND SPRINGS, VA 23075		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 609			F 60	09		
F 610 SS=D	CFR(s): 483.12(c)(2)- §483.12(c) In respons	orrect Alleged Violation	F 6 ⁷	10		11/19/23
	violations are thoroug §483.12(c)(3) Preven	t further potential abuse, or mistreatment while the				
	designated represent accordance with State Survey Agency, within incident, and if the all appropriate corrective	the results of all administrator or his or her ative and to other officials in e law, including to the State n 5 working days of the eged violation is verified a action must be taken.				
	Based on resident in clinical record review, review, the facility fail of allegations of abus	(Residents #53 and #85) in 3 residents.		 F610 Investigate/Prevent/Correct / Violation 1. Resident #53 and resident #85 longer reside at the facility. The identified agency CNA assigned both residents since allegations on 8/10/2023 has not worked at the facility ongoing police investigation and resident r	ō no ed to cility,	

Event ID: EB1X11

Facility ID: VA0100

If continuation sheet Page 49 of 156

	OF DEFICIENCIES	MEDICAID SERVICES	(X2) MULTIF		CONSTRUCTION	OMB NC	SURVEY	
	CORRECTION	IDENTIFICATION NUMBER:				· /	PLETED	
							С	
		495193	B. WING				04/2023	
NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE			
				56	1 NORTH AIRPORT DRIVE			
HENRICO	HEALTH & REHABILITA	ATION CENTER		HI	GHLAND SPRINGS, VA 23075			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETIC DATE	
F 610	Continued From page	e 49	F 61	10				
		who reported an allegation			to the Board of Nursing, FRIs were			
		al abuse by CNA C, the			submitted for both residents #53 and #	85		
		conduct an investigation and			with investigation on 9/27/2023.			
		event further abuse while an			2. Current residents in the facility hav	/e		
	investigation was cor	nducted.			the potential to be affected. Residents			
					were interviewed, with no concerns of a	•		
	On 08/10/2023, Resi	•			type of abuse. The facility also perform	ed		
	allegation of abuse to	o facility staff.			skin assessments on all residents that			
	On 00/26/2022 durin	a c clinical record review of			could not be interviewed., no areas for	m		
		ng a clinical record review of al chart the following was			of abuse were identified. Resident # 103 reported allegation of			
	noted:	a chart the following was			abuse by an employee, the abuse police	N/		
		ated 08/10/2023 at 5:06 p.m.,			followed, employee suspended pending	-		
		saint Mary's for evaluation			investigation, resident protected, FRI	9		
		l assault, MD [medical			submitted with appropriate state agenc	ies		
	doctor] made aware.	Patient verbalized			and investigation with supporting			
	understanding the rea	ason for transfer."			documentation completed.			
					3. The Regional Director of Clinical			
		note dated 08/10/2023 at			Services (RDCS) educated the			
		atient made a statement in			Administrator, DON and all Departmen	t		
	-	that took place this morning,			Managers on the abuse policy, FRI			
		n from patient to myself It the south unit nursing			submitted with accurate description of allegation and thorough investigation w	ith		
		aced to nonemergency			documentation to support findings. SD(
	services so patient co	0,1			or designee educated all facility staff or			
	statement and press	-			the abuse policies and procedures	•		
		5			regarding protecting resident and/or			
	On 09/27/2023, a rev	view was conducted of the			residents, reporting to Administrator or			
		on of the allegation and			DON, and submitting Facility Reported			
		was a written statement that			Incident (FRI) within 2 hours of allegati	on		
	was taken from Resid				of abuse if other type of abuse and no			
		of [Resident #53's name			serious bodily harm report within 24 ho			
		ed that while he was asleep,			includes appropriate state agencies, ar	IQ		
		r a washcloth being placed neard a voice say, can you			investigation process, importance and understanding of protecting the resider	nte		
		n says in return, I am not			from any type of abuse. Any staff	113		
		he CNA [certified nursing			identified in an allegation of abuse will	be		
		n pulled off his sheets and			suspended pending investigation	~~		
		egan flicking his penis back			immediately upon knowledge to protect	L		

Facility ID: VA0100

If continuation sheet Page 50 of 156

		MEDICAID SERVICES	(X2) MULTI	IPLE	CONSTRUCTION		D. 0938-039 SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	· /			· /	PLETED
							С
		495193	B. WING			10	/04/2023
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
HENRICO	HEALTH & REHABILITA	TION CENTER					
				н	IGHLAND SPRINGS, VA 23075		1
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 610	Continued From page	e 50	F 6	10			
		tes the CNA then stated he			the resident or other residents from		
		is pubic hairs. Patient			potential abuse and/or emotional harm.		
		ell out for help, which caused			The Administrator, Staff Development		
		stop, then pick the patient up			Coordinator and all Department Heads		
	and throw him in the	chair. Patient then restated			educated all staff on the policy and		
	all of the above detai	ls to the speech therapist."			procedure for abuse policy and mandat		
					reporting and the investigation process		
	There was also a write				with supporting documentation. All staff		
		eech Language Pathologist			understand they are mandated reporter		
	(SLP). Lastly, there w			and must report witnessed or allegation	1 OT		
	survey agency, Office Certification (OLC), a			abuse with accurate description and knowledge of allegation for staff			
	(APS) were faxed a r			statement.			
		.m. There was no evidence			4. The RDCS or designee will audit		
	an investigation into t				weekly x 4 weeks then monthly x2 mon	ths	
	conducted.	5			on any FRI submitted to verify accurate		
					description of allegation, resident		
	During Surveyor F's i	nvestigation of this incident,			protected, employee time of suspension	n,	
		led CNA C did not leave the			and thorough investigation with		
		the allegations until 1:17			documentation to support findings.		
	p.m., despite the initi			Results of the review will be presented	to		
	approximately 7:50 a			the QAPI committee for review and			
	incident of physical a			recommendation. Once the committee			
		ovide care for Resident #53			determines the problem no longer exist and sustained the review will be		
		s seen aggressively feeding oint the SLP had to intervene			conducted on a random basis		
	for the resident's safe				5. Date of compliance: 11/19/2023		
	On 09/27/2023 at 11:	26 a.m., an interview was					
		acility's Director of Nursing					
		inistrator and survey team					
	present. The DON wa	as asked about the incident					
	-	53 and CNA C. The DON					
	-	hen I came in the speech					
		and talked with me 8:30 AM					
		ce concern and said she saw					
		reported that a CNA had					
		oriately. I went and talked 53] and he said when he did					

Facility ID: VA0100

If continuation sheet Page 51 of 156

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT O	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPL	E CONSTRUCTION	(X3) DATE	SURVEY
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	NG _			LETED
		495193	B. WING				C 04/2023
NAME OF PI	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE	1 10/	•
HENRICO	HEALTH & REHABILITA	TION CENTER			561 NORTH AIRPORT DRIVE		
	HIGHLAND SPRINGS, VA 23075						
(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 610	foley care it was disco the CNA had put a way he was flicking his per not give a name or de one male CNA workin identified as [CNA C's him [Resident #53] if said yes." The DON s home prior to her arrive morning due to perfor knowledge of the allest #53. During the above inter to explain what steps the allegation and if s documentation regard DON stated she had if and reviewed the hos #53, and because the evidence, she unsubs DON was asked to pr residents' interviews as she had nothing to pro- When asked if staff, in CNA C, were interview The facility had no ev- being conducted. On 09/27/2023 at 12: conducted with Emplo language pathologist Resident #53's report 08/10/2023, when she a.m. She also stated as the allegation to her d	omfort. Then at noon he said ashcloth over his face and nis back and forth. He could escribe the person, we had ag that day," which she is name redacted]. "I asked he wanted to be sent out, he stated she had CNA C sent val at the facility early that mance issues, prior to her gation involving Resident rview, the DON was asked were taken to investigate he had any additional ding the investigation. The interviewed other residents pital records of Resident re was no forensic stantiated the allegation. The ovide evidence of the she conducted, and she said ovide. ncluding but not limited to wed, the DON indicated no. idence of any investigation 10 p.m., an interview was byee M, the speech (SLP). The SLP confirmed of abuse reported to her on e arrived to work at 7:50 she immediately reported lepartmental supervisor, the	F	610			
	nursing unit manager	, and then to the Director of 23, Surveyors D and F					

Facility ID: VA0100

If continuation sheet Page 52 of 156

		ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		495193	B. WING				C 04/2023
NAME OF P	ROVIDER OR SUPPLIER	I			STREET ADDRESS, CITY, STATE, ZIP CODE		
HENRICO	HEALTH & REHABILITA	TION CENTER			561 NORTH AIRPORT DRIVE HIGHLAND SPRINGS, VA 23075		
(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 610	attempted to interview resident was not avai On 09/28/2023 at 3:0 visited Resident #53 i gave the same accou the written statement was no change in his became very tearful, s that CNA C "laid me f and was trying to sile food." Resident #53 s redacted] took a pictu that following this inci kept looking around, a Trazadone so he cou all of this made him fe I wanted to leave here move, I was afraid I w trying to silence me s watched all the time." A review was conduct policy titled, "Abuse/Neglect/Misa Requirements/Investi policy read, "2. The A of Nursing will immed internal investigation occurrence. The inve- include, but not be lim interviewing alleged v involving other approp authorities to assist in determinations."	v Resident #53, but the lable for interview. 0 p.m., Surveyors D and F in his room. Resident #53 inting of events that were in referenced earlier. There report. Resident #53 said he was so afraid, and lat in the chair on my back nce me and say I choked on said, "[Employee M's name tre." The resident also stated dent, he was afraid to sleep, and had to be prescribed ld sleep. When asked how sel, Resident #53 said, "Like e, I was scared, I can't vas going to choke, he was o he could say I choked. I ted of the facility's abuse opropriation/Crime/Reporting gations." Excerpts from this dministrator and/or Director liately initiate a thorough of the alleged/suspected stigation protocol will nited to, collecting evidence, rictims and witnesses, and priate individuals, agents, or in the process and	F	610			

Facility ID: VA0100

If continuation sheet Page 53 of 156

	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM	D: 11/29/2023 APPROVED D: 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		495193	B. WING					C 04/2023
NAME OF PF	ROVIDER OR SUPPLIER	L		S	TREET ADDRESS, CITY, STATE, Z	IP CODE		
				5	61 NORTH AIRPORT DRIVE			
HENRICO	HEALTH & REHABILITA	HON CENTER		н	IIGHLAND SPRINGS, VA 23)75		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN (EACH CORRECTIVE) CROSS-REFERENCED DEFICI	ACTION SHOULD B		(X5) COMPLETION DATE
F 610	the investigation into a Resident #53 and CN No further information 2. For Resident #85, at thoroughly investigate abuse at the time it of On or about 08/10/20, shaved the pubic hair cognitively impaired a The allegation was re cares for her and the On 09/26/2023, an int Resident #103 who st Resident #103 who st Resident #85 had bee She allowed the surve recording of CNA E qu According to the audie "Why did you let that there?" Resident #85 Mental Status (BIMS) she did not let anyone hear the CNA reply, " there. You got less ha waxed." On 09/27/202 was conducted with O knowledge of the incide nurse and the former however, she did not time.	am they would be re-opening the events involving IA C. In was provided. the facility staff failed to e an allegation of sexual courred. 23, an allegation that a CNA of Resident #85 who is and unable to be interviewed. oported by the CNA who roommate of the resident. terview was conducted with tated she knew that en molested by a male CNA. eyors to listen to an audio uestioning Resident #85. o recording, CNA E stated, man shave you down has a Brief Interview of o score of 99, and stated that e shave her to which you can You are mighty bald down air than me and I was 23 at 1:00 p.m., an interview CNA E who admitted she had dent and that she made the DON aware of the incident; report it as abuse at that	F	610				
	On 09/26/2023, an int	terview was conducted with ked if she reported the						

Facility ID: VA0100

If continuation sheet Page 54 of 156

		D HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION		SURVEY PLETED
		495193	B. WING				04/2023
NAME OF PF	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
HENRICO	HEALTH & REHABILITA	TION CENTER			61 NORTH AIRPORT DRIVE IIGHLAND SPRINGS, VA 23075		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 610	allegation of sexual al she did not find it was heard about it from Re not consider it abuse. from (Resident #103 of believe it." When aske abuse policy and repor- parties, she stated sh so she did not report if A review of the Abuse "All alleged violations exploitation or mistrea unknown source and property, are reported than 2 hours after the events that cause the result in serious bodil hours if the events that not involve abuse and bodily injury." The incident was not until 09/27/2023, 2 da The incident was repor- Licensure and Certific Services, the Departm and the Police by the Services on 09/27/202	buse and she stated that a abuse. She stated she esident #103, and she did The DON stated, "Coming name redacted) I don't ed again if she followed the orted it to the appropriate e did not think it was abuse, it. Policy read: involving abuse, neglect, atment, including injuries of misappropriation of resident a lingation is made, if the allegation involve abuse or y injury, or not later than 24 at cause the allegation do d do not result in serious reported nor investigated hys after the survey began. orted to the Office of eation, Adult Protective nent of Health Professions, Regional Director of Clinical	F	610			
	Administrator was ma	de aware of the findings.					
F 637 SS=D	No further information Comprehensive Asse CFR(s): 483.20(b)(2)(ssment After Signifcant Chg	F	637			11/19/23
	§483.20(b)(2)(ii) With	in 14 days after the facility					

Facility ID: VA0100

If continuation sheet Page 55 of 156

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391	
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		495193	B. WING				C 104/2023	
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE			
				5	61 NORTH AIRPORT DRIVE			
HENRICO	HEALTH & REHABILITA	HON CENTER		F	HIGHLAND SPRINGS, VA 23075			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	х	·	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		
F 637	determines, or should there has been a sign resident's physical or purpose of this sectio means a major declin resident's status that itself without further in implementing standar interventions, that has one area of the reside requires interdisciplin care plan, or both.) This REQUIREMENT by: Based on staff interv review, the facility sta comprehensive asses change in a timely ma (Resident #19) in a su residents. For Resident #19, the perform a significant of assessment after 2 an ulcer formation after the significant weight loss hospitalization within the 2 declines. The findings included For Resident #19, the intervene during the se resident with known of insulin dependent Dia wounds. Resident #19 was add	I have determined, that ificant change in the mental condition. (For n, a "significant change" e or improvement in the will not normally resolvent tervention by staff or by d disease-related clinical is an impact on more than ent's health status, and ary review or revision of the is not met as evidenced iew and clinical record ff failed to complete a assment after significant anner for one resident urvey sample of 48 e facility staff failed to change in status reas of decline in pressure hospitalization, and a prior to and after 14 days of knowing about : e facility staff did not ignificant weight loss of a lysphagia following a stroke,	F	637	 F637 Comprehensive Assessment Aft Significant Chg 1. Resident #19 still resides in the facility. Resident #19 had a nutritional assessment by registered dietitian with diet texture change with supplements physician orders and hydration risk updated on care plan 11/9/2023. 2. Current residents in the facility har the potential to be affected. An audit o current residents by the registered dietitian (RD) or designee conducted to identify any other resident with significa weight loss. An audit of by DON or designee on current residents with physician orders for hydration replacement is reflected on resident is care plan and an audit to identify resid that require to be fed or assistance, cur have care plan reviewed and updated indicate level of assistance needed. An findings the RD will complete a nutritio assessment with supplemental orders applicable by physician and hydration 	ve f o ant s ents ing to ny nal if		

Facility ID: VA0100

If continuation sheet Page 56 of 156

	OF DEFICIENCIES	MEDICAID SERVICES	(X2) MI II TI	PLE CONSTRUCTION	(X3) DATE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	, <i>i</i>	G	COMPLETED
					С
		495193	B. WING		10/04/2023
IAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIF	CODE
	HEALTH & REHABILITA			561 NORTH AIRPORT DRIVE	
				HIGHLAND SPRINGS, VA 2307	75
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A) CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE COMPLETI D THE APPROPRIATE DATE
F 637	Continued From page	e 56	F 63	37	
		/19/2023 with diagnoses		replacement is care plan	ned.
		pathy, urinary tract infection,		3. The SDC or designe	
		COVID-19. Resident #19 had		licensed nurses, MDS sta	
		uding, stroke, diabetes, and		Activities and Activity, RD	
	-	I bleeding with resulting		therapist and nursing ma	č
		gic anemia and weakness		unit mangers, supervisor	
	from the 12/26/2022	admission.		for identification of signification	-
	Desident #101e meet	waa a ad awaa waa ah i N Aimiyaa waa		meets criteria to submit a	
		recent quarterly Minimum essment was dated with an		assessment for significan conditions. RD will compl	
		e date of 06/21/2023, and		assessment with identifie	
		s moderately cognitively		risk for weight loss or with	
		tensive assistance with		weight loss with supplem	-
		ounds nor skin problems, at		applicable per physician	
	risk for malnutrition, v	weight 148.0 lbs (pounds),		plan updated. MDS or nu	
		sues. The assessment was		management will initiate,	revise/update
		nt had 2 ongoing long		care plan for hydration re	-
		s from an original admission		CNAs, licensed nurses, c	
	known for years.			therapist will provide feed	
	14 : 4 - 1 - 4	- 4		for identified residents the	
		at no significant change to		fed, cueing or need assis	
		t was completed from nission from the hospital on		nurse of resident does no documentation. Activities	
		he time of survey ending		food intake of food and h	
		after readmission). Resident		identified residents at risk	-
	, ,	nificant weight loss before		loss.	
	-	a new pressure sore on		4. Director of MDS or d	esignee will audit
		buttock found on the day of		weekly x 4 weeks then m	-
		geable due to slough in the		determine if resident mee	
		sues would require further		a significant change in co	
	nutritional support for			assessment completed if	
	significant weight los			DON or designee will aud	-
		ant change assessment within 14 days of a known		weeks then monthly x 2 r resident with significant w	
		areas such as unplanned		RD nutrition assessment	-
		w unstageable pressure		supplements as applicab	
	wound.			order and care plan upda	
				observation audits on 10	
		Registered Dietician (RD)		require assistance with e	

Facility ID: VA0100

If continuation sheet Page 57 of 156

				CONSTRUCTION	(VO) DATE	
OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION	· /	E SURVEY PLETED
		A. DOILDIN	<u> </u>			С
	495193	B. WING			10/04/2023	
ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP CO			
			561 NORTH AIRPORT DRIVE			
HEALTH & REHABILITA	TION CENTER		Н	IIGHLAND SPRINGS, VA 23075		
(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	K	· ·		(X5) COMPLETIO DATE
Continued From page	e 57	F 6	637			
				being fed and audit residents receiving hydration have care plan initiated or		
•				updated. Results of the review will be		
				presented to the QAPI committee for		
	•			_		
					vill	
with minerals to aid in	n wound healing (2) Add			be conducted on a random basis.		
-	•			5. Date of compliance: 11/19/2023		
•	,					
•						
-	,					
-	. ,					
weights, meal intake	and provide follow up per					
protocol. weight 148.3	3 lbs (pounds)."					
On 09/07/2023 and 0	9/14/2023, dietary notes					
indicated significant v	veight loss was identified;					
	erventions nor orders were					
added.						
The facility inspection	n/survey began 09/25/2023					
and ended on 10/04/2	2023. Resident #19's weight					
document was review following:	ved and revealed the					
	SUMMARY ST (EACH DEFICIENC REGULATORY OR I Continued From page evaluated Resident # "Nutrition Assessmen diet level 4 pureed te consistency. Po (ora meals, supplement no medications named Prescription/intervent with minerals to aid in ensure compact 4 out variable oral intake, in healing, malnutrition Monitor/Evaluation (M intake and provide fo On 06/20/2023, the la was completed in the "Nutrition Assessmen 6-21-23Diagnoses. thin liquids consistent of most meals, supple milliliters by mouth wi medications named interventions Monitor weights, meal intake protocol. weight 148.3 On 09/07/2023 and 0 indicated significant w however, no new inter added. The facility inspectior and ended on 10/04/2 document was review following: 1. 07/03/2023 - 145.0	ACVIDER OR SUPPLIER HEALTH & REHABILITATION CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 57 evaluated Resident #19, and documented "Nutrition Assessment (A) Diagnosesregular diet level 4 pureed texture, regular liquids consistency. Po (oral) intake 25-75% of most meals, supplement none,pressure wound, medications namedNutrition Prescription/interventions (1) add multivitamin with minerals to aid in wound healing (2) Add ensure compact 4 ounces by mouth due to variable oral intake, increased needs for wound healing, malnutrition prevention, advanced age Monitor/Evaluation (M/E): Monitor weights, meal intake and provide follow up per protocol." On 06/20/2023, the last RD evaluation document was completed in the clinical record and stated, "Nutrition Assessment (A) quarterly ARD 6-21-23Diagnosesregular diet regular texture, thin liquids consistency. Po (oral) intake 50-100% of most meals, supplement med plus 2.0 at 120 milliliters by mouth with (hs) bedtime labs, medications namedcontinue current interventions Monitor/Evaluation (M/E): Monitor weights, meal intake and provide follow up per protocol. weight 148.3 lbs (pounds)." On 09/07/2023 and 09/14/2023, dietary notes indicated significant weight loss was identified; however, no new interventions nor orders were added. The facility inspection/survey began 09/25/2023 and ended on 10/04/2023. Resident #19's weight document was reviewed and revealed the	495193 B. WING_ ROVIDER OR SUPPLIER HEALTH & REHABILITATION CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREEPINT TAG Continued From page 57 F 6 evaluated Resident #19, and documented "Nutrition Assessment (A) Diagnosesregular diet level 4 pureed texture, regular liquids consistency. Po (oral) intake 25-75% of most meals, supplement none,pressure wound, medications namedNutrition Prescription/interventions (1) add multivitamin with minerals to aid in wound healing (2) Add ensure compact 4 ounces by mouth due to variable oral intake, increased needs for wound healing, malnutrition prevention, advanced age Monitor/Evaluation (M/E): Monitor weights, meal intake and provide follow up per protocol." On 06/20/2023, the last RD evaluation document was completed in the clinical record and stated, "Nutrition Assessment (A) quarterly ARD 6-21-23Diagnosesregular diet regular texture, thin liquids consistency. Po (oral) intake 50-100% of most meals, supplement med plus 2.0 at 120 milliliters by mouth with (hs) bedtime labs, medications namedcontinue current interventions Monitor/Evaluation (M/E): Monitor weights, meal intake and provide follow up per protocol. weight 148.3 lbs (pounds)." On 09/07/2023 and 09/14/2023, dietary notes indicated significant weight loss was identified; however, no new interventions nor orders were added. The facility inspection/survey began 09/25/2023 and ended on 10/04/2023. Resident #19's weight document was reviewed and revealed the f	495193 B. WING	Be WING	10 STREET ADDRESS, CITY, STATE, 2IP CODE STREET ADDRESS, CITY, STATE, 2IP CODE SEMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC DEMINIFYING INFORMATION) ID PROVIDERS FULL OF CORRECTION (EACH CORRECTIVE ATOM SHOLD BE (CROSS-HEPERENCED TO THE APPROPRIATE DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC DEMINIFYING INFORMATION) F 637 Continued From page 57 evaluated Resident #19, and documented "Nutrition Assessment (A) Diagnosesregular diet level 4 pureed texture, regular injuids consistency. Po (oral) intake 25-75% of most mediations namedNutrition Prescription/interventions (1) add multivitamin with minerals to aid in wound healing (2) Add ensure compact 4 ounces by mouth due to variable oral intake, increased needs for wound healing, mainutrition prevention, advanced age Monitor/Evaluation (M/E): Monitor weights, meal intake and provide follow up per protocol." F 637 On 06/20/2023, the last RD evaluation document was completed in the clinical record and stated, "Nutrition Assessment (A) quarterly ARD 6-21-23Diagnosesregular ideit regular texture, thin liquids consistency. Po (oral) intake 50-100% of most meals, supplement med plus 2.0 at 120 millitiers by mouth with (hs): Monitor weights, meal intake and provide follow up per protocol. weight 148.3 lbs (pounds)." Date of compliance: 11/19/2023 and 09/14/2023, Resident #19% weight document was reviewed and revealed the following: Interventions nor orders were added. Interventions nor orders were added. Interventions nor orders were added. Interventions for Devind weight <t< td=""></t<>

If continuation sheet Page 58 of 156

		ID HUMAN SERVICES MEDICAID SERVICES				FC	TED: 11/29/2023 RM APPROVED NO. 0938-0391	
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495193	B. WING				C 10/04/2023	
NAME OF PF	ROVIDER OR SUPPLIER			ŝ	STREET ADDRESS, CITY, STATE, ZIP CODE	•		
HENRICO	HEALTH & REHABILITA				561 NORTH AIRPORT DRIVE			
					HIGHLAND SPRINGS, VA 23075			
(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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
F 637	 (10 %) weight loss in 4. 09/11/2023 - 129.0 weight loss 9 weeks) the hospital on 09/16/ 09/19/2023. 5. 09/19/2023 - 135.0 during hospitalization 6. 09/25/2023 - 126.0 loss begins again) 7. 09/27/2023 - 119.4 weight loss in less that loss continues. Physician and RD order revealed that from 01 ordered and discontine regular diet was discontinued on 06/07 supplement was started discontinued on 06/07 supplement weight loss on 09/07 order. Weekly weight: 09/06/2023, indicating significant weight loss hospitalization on 09/07 	pounds (now a 14 pound 2 months) pounds (now a 16 pound Resident #19 went out to 2023, and returned on (a 6 pound weight gain) pounds (a 9 pound weight pounds (now almost 20% an 4 months) and weight ders were reviewed, and /03/2023, multivitamin was nued on 06/30/2023, the pontinued on 06/30/2023, and supplement was 1/2023. The Med Plus 2.0 ed on 06/01/2023, and D/2023. a for supplements after the uance until 09/19/2023, after ss had occurred and been The multivitamin, and Med ed on 09/19/2023; however, plement was discontinued /28/2023 by a physician's s were obtained beginning g knowledge of the	F	637	7			
		nistration record (MAR) Med plus 2.0 was given						

Facility ID: VA0100

If continuation sheet Page 59 of 156

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		495193	B. WING				C 04/2023
NAME OF P	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
HENRICO	HEALTH & REHABILITA	TION CENTER			561 NORTH AIRPORT DRIVE HIGHLAND SPRINGS, VA 23075		
(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 637	daily after 09/28/2023 discontinued, and on changed to mechanic staff indicated meant Resident #19 did not 06/30/2023 through 0 significant weight loss evaluate nor intervent loss. Resident #19's nutrition initiated on 01/02/202 09/18/2023 by the RE nor any other care plat the time of survey on 09/27/2023 (9 days at documents were obta care plan was "in dev nurses when asked to electronic clinical reco Resident #19 did not plan even though the dehydration in the fac resuscitation instilled occasions. Resident # medications which as from the body. Activities of Daily Livin reviewed and reveale be assisted and recei The resident consume meals from 0% to 759 Family interviews to in daughter, and grandd	 a, even after being 09/28/2023, the diet was ally altered which dietary chopped. receive supplements from 9/19/2023 during a s, and the RD did not e during a significant weight on care plan, completed and 3, was canceled on 0. No new nutrition care plan an had been completed at 09/25/2023, nor through fter readmission) when sined. The new readmission elopment" according to staff o review the care plan in the ord. have a dehydration care resident had experienced sility and received Clysis fluid subcutaneously on several #19 did not receive diuretic sists with removing fluid ng records (ADLs) were d Resident #19 needed to ved extensive assistance. ed varying amounts of %. 	F	637			

Facility ID: VA0100

If continuation sheet Page 60 of 156

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 11/29/2023 APPROVED D: 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		495193	B. WING		_		C 04/2023
NAME OF P	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, ST	TATE, ZIP CODE		
HENRICO	HEALTH & REHABILITA	TION CENTER		61 NORTH AIRPORT DRI ^I IIGHLAND SPRINGS, V			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 637	accept things in her h sandwiches. However them. The family was resident's care and w daily. The family state baseline care plan no care plan meeting sin readmitted on 09/19/2 concerned about the Staff interviews revea be fed, and that she w Observations conduct p.m., revealed Reside dining room on the nu- sitting at a table with 3 trays in front of them, assisted by one staff the residents at the ta- observed to have 1/2 inch chopped cubes of potatoes and gravy. T and Certified Nursing was sitting with the re- be feeding Resident # Observations were co- teaspoonful of potator mouth of Resident #1 took half into her mou p.m., all trays were lo to the kitchen. Reside to have 1/2 spoonful of consumed and the oth	d to be fed and will, at times, ands to eat, such as r, she must be cued to eat very involved with the ere in the facility almost ad they had not received a r had they been invited to a ce Resident #19 was 2023, and they were resident's weight loss. led that Resident #19 had to vould stop eating if not fed. ted on 09/29/2023 at 12:00 ent #19 in the communal arsing unit. The resident was 3 other residents with meal and they were being member to set-up, and feed able. Resident #19's tray was inch cubed turkey meat, 1/2 of cabbage, mashed The resident was not eating Assistant (CNA) D, who sidents, stated she would #19. ontinued and only one es was placed up to the 9, of which, the resident th and swallowed. At 1:00 aded onto the cart to return ent #19's tray was observed	F 637				

Facility ID: VA0100

If continuation sheet Page 61 of 156

	OMB NO. 0938-0391 TIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED COMPLETED
A. BUILD	NG C
495193 B. WING	
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HENRICO HEALTH & REHABILITATION CENTER	561 NORTH AIRPORT DRIVE HIGHLAND SPRINGS, VA 23075
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREF TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG	
At 1:15 p.m., CNA D was interviewed and asked why she had not fed Resident #19. CNA D stated, "She (Resident#19) was very sleepy, so I told the nurse (LPN D) and didn't offer her any more food." LPN (Licensed Practical Nurse) D was interviewed and stated, "the speech therapist was changing the resident's diet" and the resident "would receive another tray, but the resident has thrush so she probably won't eat anyway." The surveyor told LPN D that CNA D stated she was sleepy and that is why she was not eating. LPN D stated "she didn't tell me that." Resident #19 was observed for the rest of the shift, and never received another tray. It is notable to mention that the resident's finger stick blood sugar (FSBS) testing that morning indicated 78, which was low for the resident. On 09/29/2023 at the end of day debriefing, the Administrator and Regional Director of Operations were notified of the findings for Resident #19. On 10/04/2023 at approximately 2:00 p.m., the Administrator, Corporate Nurse Consultant, and Regional Director of Operations were again notified of the findings, and they stated they had nothing further to provide.	637 637 11/19/23

Facility ID: VA0100

If continuation sheet Page 62 of 156

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	
		495193	B. WING				
NAME OF P	ROVIDER OR SUPPLIER		-	S	TREET ADDRESS, CITY, STATE, ZIP CODE	•	
HENRICO	HEALTH & REHABILITA	TION CENTER			61 NORTH AIRPORT DRIVE HIGHLAND SPRINGS, VA 23075		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 655	that meet professiona The baseline care pla (i) Be developed withi admission. (ii) Include the minimu necessary to properly including, but not limit (A) Initial goals based (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recomm §483.21(a)(2) The fac comprehensive care p care plan if the compr (i) Is developed within admission. (ii) Meets the requirer (b) of this section (exc this section). §483.21(a)(3) The fa resident and their rep of the baseline care p limited to: (i) The initial goals of (ii) A summary of the dietary instructions. (iii) Any services and administered by the fa on behalf of the facilit (iv) Any updated infor of the comprehensive This REQUIREMENT by: Based on observation	al standards of quality care. In must- in 48 hours of a resident's I m healthcare information r care for a resident ted to- I on admission orders. endation, if applicable. cility may develop a olan in place of the baseline rehensive care plan- n 48 hours of the resident's ments set forth in paragraph cepting paragraph (b)(2)(i) of cility must provide the resentative with a summary lan that includes but is not i the resident. resident's medications and treatments to be acility and personnel acting	F	655	F655 Baseline Care Plan		

Facility ID: VA0100

If continuation sheet Page 63 of 156

						NO. 0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	· · · ·	OATE SURVEY OMPLETED
			7.1 20122111			С
		495193	B. WING			10/04/2023
NAME OF P	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZI	P CODE	
				561 NORTH AIRPORT DRIVE		
HENRICO	HEALTH & REHABILITA	ATION CENTER		HIGHLAND SPRINGS, VA 230	75	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	CTION SHOULD BE	(X5) COMPLETION DATE
F 655	Continued From page	e 63	F 65	55		
	10	cility staff failed to complete	1.00	1. Resident #19 still re	sides in the	
		are plan for one resident		facility. The timeframe h		
	(Resident #19) in a s	•		correct for baseline care		
	residents.			the care plan reflects the		
				plan of care was reviewe	ed with RP and	
		e facility staff failed to		copy given. Resident #19	9 is cognitively	
		onalize a 48-hour base line		impaired.		
		nission and discontinuance		2. Current residents in	•	
		er care plan, which was		the potential to be affected		
	canceled.			current residents admitte to verify resident if cogni		
	The findings included	4-		and RP received a copy		
		4.		plan. Any findings were of		
	For Resident #19, the	e facility staff did not		copy reviewed / given.		
		significant weight loss of a		3. The SDC or designe	ee will educate all	
	resident with known of	dysphagia following a stroke,		discharge planners and l	licensed nurses	
	insulin dependent Dia	abetes Mellitus, and 3		on the process of comple		
	wounds.			care plans within 48 hou		
				current plan of care need		
		lmitted to the facility on		reviewed and given to re		
		st recently readmitted after		cognitively appropriate a	nd to RP with	
		/19/2023 with diagnoses pathy, urinary tract infection,		documentation, 4. The discharge planr	per director or	
		COVID-19. The resident had		designee will audit week		
		luding, stroke, diabetes, and		monthly x 2 to verify a co		
		I bleeding with resulting		baseline care plan was g		
		gic anemia and weakness		resident if cognitively ap		
	from the 12/26/2022	admission.		the RP with documentati		
				hours. Any findings will b		
		recent quarterly Minimum		Results of the review will	•	
		essment was dated with an		the QAPI committee for i		
		e date of 06/21/023, and s moderately cognitively		recommendation. Once t determines the problem		
		tensive assistance with		and sustained, the review		
		ounds nor skin problems, at		conducted on a random		
		weight 148.0 lbs (pounds),				
		sues. The assessment was		5. Date of compliance:	11/19/2023	
	-	#19 had 2 ongoing long				
	standing foot wounds	s from an original admission				

Facility ID: VA0100

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	`, ´		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		495193	B. WING				C 04/2023
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
				5	61 NORTH AIRPORT DRIVE		
HENRICO	HEALTH & REHABILITA	TION CENTER		F	HGHLAND SPRINGS, VA 23075		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 655	MDS assessment was #19's readmission fro 09/19/2023 through th 10/04/2023 (15 days #19 had a known sign hospitalization, and a resident's right buttoc readmission at unstag wound bed. These iss nutritional support for significant weight loss regulations, a significat should be conducted decline in 2 or more a weight loss and a new wound. On 01/02/2023, the R evaluated Resident # "Nutrition Assessmen diet level 4 pureed tex consistency. Po (oral) meals, supplement no medications named Prescription/intervent with minerals to aid in ensure compact 4 our variable oral intake, in healing, malnutrition p Monitor/Evaluation (M intake and provide fol On 06/20/2023, the la was completed in the	at no significant change s completed from Resident m the hospital on he time of survey ending on after readmission). Resident hificant weight loss before new pressure sore on the k was found on the day of geable due to slough in the sues would require further wound healing and s. According to the ant change assessment within 14 days of a known areas such as unplanned v unstageable pressure registered Dietician (RD) 19 and documented t (A) Diagnosesregular kture, regular liquids) intake 25-75% of most one,pressure wound, Nutrition ions (1) add multivitamin a wound healing (2) Add nees by mouth due to hereased needs for wound orevention, advanced age M/E): Monitor weights, meal low up per protocol."	F	655			
		t (A) quarterly ARD 6-21-23 ar diet regular texture, thin					

Facility ID: VA0100

If continuation sheet Page 65 of 156

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		495193	B. WING				C /04/2023
NAME OF PI	ROVIDER OR SUPPLIER		•	Ś	STREET ADDRESS, CITY, STATE, ZIP CODE	•	
HENRICO	HEALTH & REHABILITA	TION CENTER			561 NORTH AIRPORT DRIVE HIGHLAND SPRINGS, VA 23075		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE
F 655	most meals, supplem milliliters by mouth wi medications named interventions Monitor/ weights, meal intake a protocol. Weight 148. On 09/27/2023 and 00 indicated significant w however, no new inte added. The facility inspection and ended 10/04/202 document was review following: 1. 07/03/2023 - 145.0 2. 08/07/2023 - 145.0 2. 08/07/2023 - 140.2 loss in one month beg 3. 09/06/2023 - 131.6 (10 %) weight loss in 4. 09/11/2023 - 129.0 weight loss 9 weeks) the hospital on 09/16/ 09/19/2023. 5. 09/19/2023 - 135.0 during hospitalization 6. 09/25/2023 - 126.0 loss begins again) 7. 09/27/2023 - 119.4 weight loss in less tha loss continues.	Po (oral) intake 50-100% of ent med plus 2.0 at 120 th (hs) bedtime labs, ., continue current 'Evaluation (M/E): Monitor and provide follow up per 3 lbs (pounds)." 9/14/2023, dietary notes veight loss was identified; rventions nor orders were //survey began 09/25/2023 3. Resident #19's weight ved and revealed the pounds pounds (5 pound weight gins) pounds (now a 14 pound 2 months) pounds (now a 16 pound Resident #19 went out to '2023 and returned on (a 6 pound weight gain) pounds (a 9 pound weight pounds (now almost 20% an 4 months) and weight	F	655			
	ordered and discontin	/03/2023, multivitamin was nued on 06/30/2023, the ontinued on 06/30/2023, and					

Facility ID: VA0100

If continuation sheet Page 66 of 156

		ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		495193	B. WING				C 04/2023
NAME OF PF	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	<u>.</u>	
HENRICO	HEALTH & REHABILITA	TION CENTER			561 NORTH AIRPORT DRIVE HIGHLAND SPRINGS, VA 23075		
(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 655	supplement was start discontinued on 06/30 There were no orders 06/30/2023 discontinue a significant weight lo ongoing for months. T Plus 2.0 were restarted the Med Plus 2.0 sup nine days later on 09/ order. Weekly weights 09/06/2023, indicating significant weight loss hospitalization on 09/ however, no intervent weight loss. The medication admin documented that the daily after 09/28/2023 discontinued, and on changed to mechanic staff indicated meant Resident #19 did not 06/30/2023 through 0 significant weight loss evaluate nor intervent loss. Resident #19's nutritio initiated on 01/02/202 09/18/2023 by the RD nor any other care plat the time of survey on 09/27/2023 (9 days at	supplement was 1/2023. The Med Plus 2.0 ed on 06/01/2023 and 0/2023. a for supplements after the uance until 09/19/2023 after ass had occurred and been The multivitamin and Med ed on 09/19/2023; however, plement was discontinued (28/2023 by a physician's s were obtained beginning g knowledge of the s (10 days) before 16/2023 for Resident #19; tions were added for the histration record (MAR) Med plus 2.0 was given 8, even after being 09/28/2023, the diet was eally altered which dietary chopped. receive supplements from 19/19/2023 during a s, and the RD did not e during a significant weight on care plan, completed and 23, was canceled on 0. No new nutrition care plan an had been completed at 09/25/2023 nor through fter readmission) when	F	655			
	09/27/2023 (9 days a	-					

Facility ID: VA0100

If continuation sheet Page 67 of 156

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		495193	B. WING				C 04/2023
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
HENRICO	HEALTH & REHABILITA	TION CENTER			61 NORTH AIRPORT DRIVE HIGHLAND SPRINGS, VA 23075		
(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 655	nurses when asked to electronic clinical reco Resident #19 did not plan even though the dehydration in the fac resuscitation instilled occasions. Resident # medications which ref Activities of Daily Livin reviewed and reveale to be assisted and rec The resident consume meals from 0% to 75% Family interviews to in daughter and grandda an Licensed Practical the resident had to be things in her hands to however, she must be family was very involv and were there in the family stated they had care plan nor had the meeting since Reside 09/19/2023, and they resident's weight loss Staff interviews revea be fed, and that she v Observations conducc p.m., revealed Reside dining room on the nu	elopment" according to staff o review the care plan in the ord. have a dehydration care resident had experienced sility and received Clysis fluid subcutaneously on several #19 did not receive diuretic move fluid from the body. ng records (ADLs) were d that Resident #19 needed ceived extensive assistance. ed varying amounts of %. nclude the resident's aughter, who stated she was Nurse (LPN), revealed that e fed and will at times accept o eat, such as sandwiches; e cued to eat them. The ved with the resident's care facility almost daily. The d not received a baseline y been invited to a care plan out #19 was readmitted on were concerned about the led that Resident #19 had to vould stop eating if not fed. ted on 09/29/2023 at 12:00 ent #19 in the communal ursing unit. The resident was 3 other residents with meal	F	655			

Facility ID: VA0100

If continuation sheet Page 68 of 156

	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	D: 11/29/2023 APPROVED D: 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		495193	B. WING				C 04/2023
NAME OF PI	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STATE, ZIP CODE	•	
HENRICO	HEALTH & REHABILITA	TION CENTER			61 NORTH AIRPORT DRIVE HIGHLAND SPRINGS, VA 23075		
					,		(1/5)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 655	Continued From page	• 68	F	655			
		member to set up, and feed					
		ble. Resident #19's tray was					
	inch chopped cubes of	inch cubed turkey meat, 1/2 of cabbage, mashed					
	potatoes and gravy. F	Resident #19 was not eating					
		ursing Assistant) D, who sidents, stated she would					
	be feeding Resident #						
	Observations were co	es was placed up to the					
		9, of which, the resident					
		th and swallowed. At 1:00					
		aded onto the cart to return nt #19's tray was observed					
	to have 1/2 spoonful of	-					
		ner half of the spoonful was					
	still on the spoon, indified to Resident #19.	cating no other food was					
	At 1:15 p.m., CNA D v	was interviewed and asked					
	why she had not fed F	Resident #19. CNA D stated,					
	. ,	as very sleepy so I told the					
	LPN (Licensed Practic	dn't offer her any more food. cal Nurse) D was					
	interviewed and state	d, "the speech therapist was					
		's diet" and Resident #19					
		er tray, but the resident has y won't eat anyway." The					
		hat CNA D stated she was					
		y she was not eating. LPN D					
		me that." The resident was of the shift, and never					
		. It is notable to mention that					
	Resident #19's finger	stick blood sugar (FSBS)					
	testing that morning ir for the resident.	ndicated 78, which was low					
	On 09/29/2023 at the	end of day debriefing, the					

Facility ID: VA0100

If continuation sheet Page 69 of 156

TATEMENT (OF DEFICIENCIES F CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING	ONSTRUCTION	(X3) DATE COMF	LETED
		495193	B. WING			C 1 04/2023
	ROVIDER OR SUPPLIER	TION CENTER		EET ADDRESS, CITY, STATE, ZIP CODI NORTH AIRPORT DRIVE	E	
_			I	HLAND SPRINGS, VA 23075		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE
F 655	Administrator and Re Operations were notif #19.		F 655			
F 657 SS=D	Administrator, Region Corporate Director of aware of findings, and nothing further to pro- Care Plan Timing and	nal RN consultant, and Operations were made d they stated they had vide. I Revision	F 657			11/19/23
	 be- (i) Developed within 7 the comprehensive as (ii) Prepared by an initial includes but is not lime (A) The attending phy (B) A registered nurse resident. (C) A nurse aide with resident. (D) A member of food (E) To the extent practice the resident and the resident and the resident and the resident report for the resident report practicable for the resident's care plan. (F) Other appropriate disciplines as determ or as requested by th (iii)Reviewed and rev 	orehensive care plan must Y days after completion of ssessment. terdisciplinary team, that ited to visician. With responsibility for the responsibility for the I and nutrition services staff. cticable, the participation of esident's representative(s). be included in a resident's participation of the resident resentative is determined a development of the staff or professionals in ined by the resident's needs e resident. ised by the interdisciplinary ssment, including both the				

Event ID: EB1X11

Facility ID: VA0100

If continuation sheet Page 70 of 156

	-	ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 11/29/2023 FORM APPROVED OMB NO. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C
		495193	B. WING		10/04/2023
NAME OF P	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP CODE	10/04/2020
HENRICO	HEALTH & REHABILITA	TION CENTER	-	61 NORTH AIRPORT DRIVE HIGHLAND SPRINGS, VA 23075	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION
F 657	by: Based on observatio review, and facility do staff failed to review a residents (Residents sample of 48 resident The findings included 1. For Resident #21 t review and revise the	is not met as evidenced n, interview, clinical record ocumentation, the facility and revise care plans for 2 #21 and #53), in a survey ts.	F 657	 F657 Care Plan Time and Revision 1. Resident #21 resides in the facilit Resident #21 care plan was updated to reflect current plan of care needs. Resident #53 no longer resides in the facility. 2. Current residents in the facility hat the potential to be affected. An audit conducted by MDS staff or designee of current residents care plans admitte from 10/4/2023 and resident who had 	ive was on d a
	Resident #21 was ob her room looking out feet. She stated she h now is in a wheelchai the fall occurred or if facility. A review of the clinica Resident #21 had fall 04/03/2023 and was 04/05/2023 with a dia Upon return to the fac updated to include a PT/OT, limitations, no since returning from t The care plan regard FOCUS: The resident the potential for furthe fluctuations with decli	sent to the hospital on ignosis of fractured right hip. cility, the care plan was not foley, surgical incision, or any new fall interventions he hospital on 04/10/2023. ing falls read as follows: t has had an actual fall with er falls IDT expects		 change in condition or fall since 10/4/2 to verify care plans initiated, revised/updated to reflect current resider care needs with intervention for falls. A findings were corrected. 3. The DON or designee will educate MDS staff and the unit managers on the process for care plans initiated, revised and updated for change in condition, nadmit and readmits reflect the resident current plan of care needs and resider who fall required care plan reviewed a updated with interventions to prevent further falls and/or injuries. The SDC or designee will educate the current licensed nurses on the process resident s care plans to reflect current plan of care needs for new admits, readmits, and change in condition and resident who fall required care plan current licensed nurses on the process resident s care plans to reflect current plan of care needs for new admits, readmits, and change in condition and resident who fall required care plan current further falls and/or injuries. The MDS staff will audit weekly x weeks and monthly x 2 months to verificate to prevent further falls and to verificate the fall and the process for new admits, readmits, and change in condition and resident who fall required care plan for the plan falls and/or injuries. 	dent Any e the he id, new tos nt ind s for nt i und 4

Facility ID: VA0100

If continuation sheet Page 71 of 156

STATEMENT (DF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		CONSTRUCTION	(X3) DATE	D. 0938-039 SURVEY PLETED
		495193	B. WING _				C / 04/2023
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 10	0
				56	61 NORTH AIRPORT DRIVE		
HENRICO	HEALTH & REHABILITA	TION CENTER		н	IGHLAND SPRINGS, VA 23075		
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 657	Continued From page	o 71	Fe	657			
1 007				557	agra plan reflect ourrent resident plan	of	
	on: 03/01/2021.				care plan reflect current resident plar care needs for new admits, readmits,		
	GOAL: The resident	will resume usual activities			change in condition and if resident ha		
	without further incide	nt through the review date.			fall care plan verified updated with		
	Date Initiated: 03/01/				intervention. Results of the review wi	l be	
		on: 04/24/2023 Target Date:			presented to the QAPI committee for		
	07/15/2023.				review and recommendation. Once the		
		Vaciat with repeationing in			committee determines the problem ne		
		Assist with repositioning in 5/02/2021 Created on:			longer exists and is sustained, the re will be conducted on a random basis.		
	05/02/2021.						
		call for assistance Date			5. Date of compliance: 11/19/2023		
		Created on: 04/03/2023.					
	Floor mats Date Initia	ated: 03/01/2021 Created on:					
	03/01/2021 Revision						
		t promote exercise and					
		ere possible. Date Initiated:					
	04/03/2023 Created of Readucate resident t	on: 04/03/2023. o wear no skid socks or					
	shoes when ambulat						
	04/04/2023 Created	-					
	Re-direct resident an						
	activities when noted	wandering aimlessly. Date					
	Initiated: 07/28/2021	Created on: 08/16/2021.					
	On 09/27/2023 an in	terview was conducted with					
		ed when care plans should					
		stated they should be					
	updated as the care i	-					
		l who updates the care					
	plans, she stated that	-					
	coordinator or the DC	ON updates the care plans.					
	On 10/04/2023 during	g the end of day meeting, the					
		ade aware of the concerns					
	and no further inform	ation was provided.					
	2 For Resident #52	the facility staff failed to					
	2.1 01 Nesident #33,	แกะ เลงแม่ง รเล่ม เล่มชน เบ					

If continuation sheet Page 72 of 156

	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		495193	B. WING				C 04/2023
NAME OF PI	ROVIDER OR SUPPLIER			s	STREET ADDRESS, CITY, STATE, ZIP CODE		
HENRICO	HEALTH & REHABILITA	TION CENTER			561 NORTH AIRPORT DRIVE HIGHLAND SPRINGS, VA 23075		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI. DEFICIENCY)		(X5) COMPLETION DATE
F 657	hydration. On 09/26/2023 during was noted that Reside Clysis due to "AKI" (A "Sodium Chloride Sol intravenously X 24 ho 1.5L, use Clysis 60ml 9/22/2023 6:00 PM." "9/23/2023 12:06 AM Note Text: Clysis place thigh d/t residents' siz Inserted subcutaneou transparent dressing 0.9% Sodium Chlorid 60ml; resident tolerate resting peacefully with issues noted. Resider for AKI. Staff to contin "9/23/2023 8:50 PM H Resident fine, tolerati well. Ate 90% of dinne of pain and no s/s of of to monitor throughout A review of the clinica plan had not been up plan on admission. Th	to include Clysis orders for g clinical record review, it ent #53 was started on acute Kidney Injury). ution 0.9 % Use 100 ml/hr. burs for AKI for 2 Days FOR /hr. if iv line not obtained Orders - Administration red to right posterior/lateral re/amount of fatty tissue. Isly, covered with noted clean, dry, and intact. e infusing via doppler flow at ed well. As of 0011; resident in Clysis intact without any int to receive a total of 1.5L mue to monitor." Health Status Note Text: ing Clysis (sodium chloride) er with ensure. No complaint distress noted. Will continue	F	657			
	08/10/2023 Created o	/t Infection Date Initiated:					

Facility ID: VA0100

If continuation sheet Page 73 of 156

	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMF	
		495193	B. WING				04/2023
NAME OF PF	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
HENRICO	HEALTH & REHABILITA	TION CENTER			61 NORTH AIRPORT DRIVE HIGHLAND SPRINGS, VA 23075		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 657	drink fluids of choice. fluids Date Initiated: 0 Created on: 08/10/20 Ensure that all bevera diet/fluid restrictions a requirements. Date In Lab work as ordered Created on: 08/10/20 Monitor/document/rep dehydration: decrease concentrated urine, st cracked lips, furrowed confusion, dizziness of increased pulse, head dizziness, fever, thirst dry/sunken eyes. Date Created on: 08/10/20 On 09/27/2023, an int LPN B who stated that the DON are the ones When asked if a chan should warrant an up stated that it should.	tain moist mucous n turgor. 2023 Created on: ncourage the resident to See md order for extra 8/10/2023. 23. ages offered comply with and consistency itiated: 08/10/2023. Date Initiated: 08/10/2023 23. bort PRN any s/sx of ed or no urine output, trong odor, tenting skin, a tongue, new onset on sitting/standing, dache, fatigue/weakness, c, recent/sudden weight loss, e Initiated: 08/10/2023	F	657			
		de aware of the findings.					
F 658 SS=D		et Professional Standards	F	658			11/19/23
	§483.21(b)(3) Compre	ehensive Care Plans					

Facility ID: VA0100

If continuation sheet Page 74 of 156

CENTER	S FOR MEDICARE &	MEDICAID SERVICES					APPROVE 0. 0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	`, ´		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495193	B. WING				C 04/2023
NAME OF PF	ROVIDER OR SUPPLIER	·	•	ST	IREET ADDRESS, CITY, STATE, ZIP CODE		
	HEALTH & REHABILITA			56	1 NORTH AIRPORT DRIVE		
HENRICO		ATION CENTER		н	IGHLAND SPRINGS, VA 23075		
(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 E CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 658	Continued From page	e 74	F	658			
		d or arranged by the facility,		000			
	•	mprehensive care plan,					
	must-	,					
	(i) Meet professional						
	This REQUIREMENT	Γ is not met as evidenced					
	by:						
		on, staff interview, clinical			F658 Services Provided Meet		
		icility documentation review, to provide care and services			Professional Standards		
		rofessional standards for 1			1. Resident #362 no longer resides	in	
	-	362, in a survey sample of 48			the facility.		
	residents.	,,,,			2. Current residents in the facility ha	ve	
					the potential to be affected. An audit b		
	The findings included	1:			the DON or designee on the current		
					resident⊡s admitted since 10/4/2023 t		
	For Resident #362, fa				verify residents medication transcrib		
	administer medication physician on 07/17/20				with scheduled medication date and the		
		023 and 07/16/2023.			available, and administered per physic order. Any findings will be corrected.	Jan	
	On 09/28/2023, Resi	dent #362's clinical record			3. The SDC or designee will educate	e all	
		vealed physician orders and			licensed nurses on the processes for		
		ation times as follows:			transcribing medication orders with		
					scheduled medication date and time,		
		e tablet delayed release,			obtaining medication from pharmacy a		
	81mg, give 1 tablet b	-			process for unavailable medications a		
	•	3/23, documented as given			medications administered per physicia	in	
	on 7/19/23				order. 4. The Unit Manager or designee wi		
	*Ferrous Sulfate table	et 325 (65 Fe)mg, give 1			audit weekly x 4 weeks then monthly >		
		time a dayordered on			months to ensure new admits medicat		
	7/18/23, documented	•			were transcribed, scheduled with accu		
					date and time, available and administe	ered	
		ng, give 1 tablet by mouth			per physician orders and unavailable		
	•	red on 7/18/23, documented			medication process was followed. Any		
	as given on 7/19/23				findings will be corrected. Results of the	ne	
	*Cabapantin Oral Ca	psule 300mg, give 1 capsule			review will be presented to the QAPI committee for review and		
	-	ordered on 7/17/23,			recommendation. Once the committee		
			1			,	

Facility ID: VA0100

If continuation sheet Page 75 of 156

		ND HUMAN SERVICES MEDICAID SERVICES				FOR	D: 11/29/2023 M APPROVEE D. 0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION	COM	E SURVEY PLETED
		495193	B. WING _				C / 04/2023
NAME OF PR	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
				56	1 NORTH AIRPORT DRIVE		
HENRICO	HEALTH & REHABILITA	TION CENTER		н	IGHLAND SPRINGS, VA 23075		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	K	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ЗE	(X5) COMPLETION DATE
F 658	Continued From page	e 75	F6	58			
	1.0				and sustained, the review will be		
	*Multiple Vitamin Tab	let, give 1 tablet by mouth			conducted on a random basis.		
	one time a dayordered on 7/18/23, documented as given on 7/19/23				5. Date of compliance: 11/19/2023		
	Hour 90mg, give 120	Tablet Extended Release 24 mg by mouth one time a /23, documented as given					
		et 6.25mg, give 6.25mg by ayordered on 7/17/23, n on 7/18/23					
	*Eliquis Oral Tablet 2 two times a dayorde documented as given						
	interview was conduct Consultant (CNC) which stated that medication as ordered by the phy Resident #362 was a 07/17/2023 and state his [Resident #362's] into the system on the	proximately 2:00 p.m., an eted with the Clinical Nurse to confirmed the findings and ns are expected to be given ysician. She verified ctually admitted on ed, "It appears that most of med orders weren't entered e day of his admission as en, it is my expectation that					
	admitting nurse will e which includes all me question about medic contact the doctor for it in a note, this nurse admissions process." unavailable to intervie facility's professional was "Lippincott." A fa	arrival to our facility, the nter all admitting orders edications, if there is a cations then the nurse should clarification and document e failed to follow our The admitting nurse was ew. The CNC stated the nursing standards reference cility policy on medication equested and received.					

Facility ID: VA0100

If continuation sheet Page 76 of 156

		ID HUMAN SERVICES MEDICAID SERVICES			FORM	APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		495193	B. WING			C 04/2023
NAME OF P	ROVIDER OR SUPPLIER		•	STREET ADDRESS, CITY, STATE, ZIP CODE	•	
HENRICO	HEALTH & REHABILITA	TION CENTER		561 NORTH AIRPORT DRIVE		
	1			HIGHLAND SPRINGS, VA 23075		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 658	Continued From page	976	F 65	58		
F 677 SS=D	Guidelines for Medica 08-2020, heading "Po- administered as prese good nursing principle According to Lippinco Seventh Edition, 2016 Drug Administration," of medication adminis not limited to: "Verify administered at the pr risk of medication error On 10/02/2023 at the facility Administrator v No further information ADL Care Provided for CFR(s): 483.24(a)(2) §483.24(a)(2) A resid out activities of daily I services to maintain g personal and oral hyg This REQUIREMENT by: Based on observatio interview, clinical reco documentation review provide Activities of D to residents residing of The findings included 1. For Resident #19, y facility staff for eating	tt "Nursing Procedures," 6, section entitled, "Oral steps in the implementation stration included but were the medication is being roper timeto reduce the ors." end of day meeting, the vas updated on the findings. was provided. or Dependent Residents ent who is unable to carry iving receives the necessary good nutrition, grooming, and iene; is not met as evidenced n, resident interview, staff ord review, and facility <i>y</i> , the facility staff failed to aily Living (ADL) assistance on 1 of 2 nursing units.	F 67	 F677 ADL Care for Dependent Reside 1. Resident #19 still resides in the facility. The timeframe has passed to correct. Resident #19 is being assisted with feeding with documentation. 2. Current residents in the facility hav the potential to be affected. An audit by the DON or designee to identify dependent residents that require need be fed, assisted or cued and have care 	/e / to	11/19/23

Event ID: EB1X11

Facility ID: VA0100

If continuation sheet Page 77 of 156

TATEMENT (OF DEFICIENCIES	MEDICAID SERVICES	(X2) MULTI	PLE CONSTRUCTION		IB NO. 0938-03
	CORRECTION	IDENTIFICATION NUMBER:				COMPLETED
						С
		495193	B. WING			10/04/2023
NAME OF P	ROVIDER OR SUPPLIER	-		STREET ADDRESS, CITY,	, STATE, ZIP CODE	
				561 NORTH AIRPORT D	RIVE	
HENRICO	HEALTH & REHABILITA	ATION CENTER		HIGHLAND SPRINGS	s, VA 23075	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH COR	R'S PLAN OF CORRECTION RECTIVE ACTION SHOULD BE RENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETIO DATE
F 677	Continued From page	e 77	F 6	77		
	resident was fed a m				nd updated to indicate	
				level of assistant	-	
	Observations conduc	ted on 09/29/2023 at 12:00		3. The SDC w	ill educate the CNAs,	
	-	ent #19 in the communal			or speech therapist on	
		ursing unit. The resident was			dentifying dependent	
		3 other residents with meal			quire feeding assistance,	
	trays in front of them,				ted or cued, the resident	
		member to set up, and feed able. Resident #19's tray was			tely fed, do not rush and sident to clear food from	
		inch cubed turkey meat, 1/2			ving more food. Report to	
	inch chopped cubes				t does not eat with	
		The resident was not eating			ADL and incontinent care	
		lursing Assistant) D who was		provide timely, a	nswering of call bells	
	sitting with the reside	ents stated she would be		timely to meet re	esident⊡s needs. Care	
	feeding Resident #19	Э.		1 .	ill identify level of	
					apy referral for declines	
		ontinued and only one		-	self or changes in	
		es was placed up to the			y or not eating, report to	
		19, of which, the resident uth and swallowed. At 1:00			care and document.	
		baded onto the cart to return		-	itively appropriate and RP f baseline care plans and	
		ent #19's tray was observed			end care plan meetings	
	to have 1/2 spoonful	-			e planner or designee.	
		ther half of the spoonful was			ignee will conduct	
		licating no other food was			its weekly x 4 weeks then	
	fed to the resident.			monthly x 2 mon	ths on 10 residents that	
				require assistant	ce with eating, incontinent	
		was interviewed and asked			sponse time to verify are	
	-	the resident. CNA D stated		•	tinent care provided, and	
	,	was very sleepy so I told the			swered timely. Results of	
	, ,	idn't offer her any more food.		committee for re	e presented to the QAPI	
	LPN (Licensed Practi	ed that "the speech therapist			1. Once the committee	
		sident's diet" and that the			problem no longer exist	
		ve another tray, but the		and sustained th		
		o she probably won't eat		conducted on a		
		or told LPN D that CNA D				
	stated she was sleep	y and that is why she was		5. Date of com	pliance: 11/19/2023	
	not eating I PN D sta	ated "she didn't tell me that."				

Facility ID: VA0100

	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` <i>`</i>		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		495193	B. WING				C 04/2023
NAME OF P	ROVIDER OR SUPPLIER		•	5	STREET ADDRESS, CITY, STATE, ZIP CODE	<u>.</u>	
HENRICO	HEALTH & REHABILITA	TION CENTER			561 NORTH AIRPORT DRIVE HIGHLAND SPRINGS, VA 23075		
(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)	3E	(X5) COMPLETION DATE
F 677	shift, and never received notable to mention the blood sugar (FSBS) to indicated 78, which we Activities of Daily Livin reviewed and revealed to be assisted and revealed that the resident had accept things in her has andwiches; however them. The family was resident's care and we almost every day. The received a baseline co invited to a care plan was readmitted on 09 concerned about the Staff interviews reveal be fed, and that she we 2. Resident Council effective over the lack of incon- resolution. On 09/26/2023 at 1:0 held with 6 residents of Resident Council. Du Surveyor, residents wo over the lack of call b	served for the rest of the ved another tray. It is at the resident's finger stick esting that morning as low for the resident. In (ADL) records were d that Resident #19 needed ceived extensive assistance. ed varying amounts of %. Include the resident's laughter, who stated she ctical Nurse (LPN), revealed to be fed and will at times ands to eat, such as r, she must be cued to eat s very involved with the ere there in the facility e family stated they had not are plan nor had they been meeting since the resident /19/2023, and they were resident's weight loss. led that Resident #19 had to yould stop eating if not fed.	F	677			

Facility ID: VA0100

If continuation sheet Page 79 of 156

STATEMENT OF I	DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				D. 0938-0391
NAME OF PRO	AD PLAN OF CORRECTION IDENTIFICATION NUMBER. 495193			PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
NAME OF PRO		495193	B. WING		10	C / 04/2023
	VIDER OR SUPPLIER		•	STREET ADDRESS, CITY, STATE, ZIP CODE		
HENRICO HE	EALTH & REHABILITAT	TION CENTER		561 NORTH AIRPORT DRIVE		
				HIGHLAND SPRINGS, VA 23075		
(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 CORREC' (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 677 C	Continued From page	79	F 67	77		
A P C A P C ir R o a C f a SS=E C SS=E C S S S S S S S S S S S S S S S S S S	ambulate and have de oom area" on the Sor being changed. Six of attendance at the Res stated, that the room i activities; however, th here and they cannot he room always smel because they do not of bark in there. A review of the Reside complaining about cal mproper incontinent of Review of the grievan ongoing concerns about assistance with ADLs. On 10/03/2023 during acility Administrator w above findings. No further information Free of Accident Haza CFR(s): 483.25(d)(1)((483.25(d)(2)Each res (483.25(d)(2)Each res	sident Council meeting is supposed to be used for e staff park residents in a do activities. They stated lls of urine and feces change the residents they ent Council minutes for the ed that residents are ll bell answer times and care repeatedly. ces revealed the same, but incontinence care and an end of day meeting, the was made aware of the was provided. ards/Supervision/Devices 2)	F 68	19		11/19/23

Facility ID: VA0100

If continuation sheet Page 80 of 156

		MEDICAID SERVICES	(X2) MU		CONSTRUCTION		E SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	. ,			1 Y /	IPLETED
							С
		495193	B. WING			1 10)/04/2023
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
				56	61 NORTH AIRPORT DRIVE		
HENRICO	HEALTH & REHABILITA	TION CENTER		н	IGHLAND SPRINGS, VA 23075		
(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)		(X5) COMPLETION DATE
F 689	Continued From page	a 80		689			
1 000		is not met as evidenced		009			
	by:	IS NOT THET AS EVIDENCED					
	Based on observatio	n, interview, facilitv			F689 Free of Accident		
		clinical record review, the			Hazards/Supervision/Devices		
	facility staff failed to e	ensure the resident					
		free of accident hazards for			1. Resident #42 and resident #18 sti	II	
	1 of 2 units.				reside in the facility. Resident #68 no		
	The findings included				longer resides in the facility. Pest cont exterminated all areas identified and	rol	
	The infulfigs included				shower rooms were cleaned on both		
	For the residents usir	ng the showers on the South			units. The shower room floor tiles will l	ре	
		failed to ensure the shower			repaired.		
	room tiles were in goo	od repair.			2. Current residents in the facility ha	ve	
					the potential to be affected. An audit b	-	
		0 p.m. during the Resident			the maintenance director conducted to		
		as brought up that the			identify if any other shower rooms floo	r	
		lirty, and Resident #42 er room has bugs and is			tiles need repair to prevent accidents, hazards or injury and a caution sign		
		and #18 added that in the			placed on any identified areas. The		
		les are loose and coming up			housekeeping conducted an audit to		
		ked how long this was going			ensure both shower rooms were on a		
	on 6 of 6 residents in	attendance agreed that it			cleaning schedule and as needed.		
		hs (more than 2). When			3. The Administrator or designee		
		re of the issue, Resident			educated the maintenance director an		
	-	oup agreed "The staff have			the environmental services director on		
	in that room."	giving showers to residents			process for identifying maintenance re to prevent accident, hazards and injury		
					placing caution signs, process for repa		
	On 09/26/2023 at 4:0	00 p.m., this surveyor			work orders, pest control book and		
		intenance Director to the			process, cleanliness of facility, shower		
		erve the condition of the			rooms and informing the Administrator		
		entering the shower room,			outsource vendors are needed to corre	ect	
		k and white tiles that were			items.		
		I were missing. An interview			The SDC or designee will educate the		
		he maintenance director t presents a safety issue.			facility staff on cleanliness of the facilit environmental services cleaning	у,	
		ector stated that it does			schedules and as needed, shower roo	ms	
		afety issue as tiles may be			cleaned and disinfected by environme		
		could possibly cut their feet			services, between resident showers by		

Facility ID: VA0100

If continuation sheet Page 81 of 156

TATEMENT (OF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
					С		
		495193	B. WING		10/04/2023		
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
HENRICO	HEALTH & REHABILITA	TION CENTER		561 NORTH AIRPORT DRIVE HIGHLAND SPRINGS, VA 23075			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETI		
F 689 F 692 SS=E	was not aware of the On the afternoon of 0 conducted with CNA of the broken tiles and the nurse. She stated broken tiles "a month On 10/04/2023 during	enance director stated he tiles being broken. 9/26/2023, an interview was D who stated she was aware d had complained about it to t that they had reported the or so ago." g the end of day meeting, the ade aware of the concern. h was provided.	F 68	 CNAs to prevent transmission of infa and communicable transmission, are the process to prevent accidents and hazard that posed a risk for injury sut the broken shower floor tiles, submosf work orders for maintenance rep and/or removal of broken shower flot tiles and place caution sign in area of prevent accidents and injury and profor pest sightings writing in pest combook with follow up by maintenance pest control company. The maintenance director or dewill audit weekly x 4 then monthly x months to verify work orders are recomboned as required and the administrator notified for delay in report or outsource vendor required for report audit weekly x 4 weeks then monthly months the shower rooms are clearn both units and observe 10 residents room to verify clean and disinfected scheduled. Results of the review will presented to the QAPI committee for review and recommendation. Once committee determines the problem for get and sustained the review be conducted on a random basis Date of compliance: 11/19/2020 	nd on d uch as ission pairs por to occess ttrol e and esignee 2 ceived trol low up pairs pair. will / x 2 ned on s as II be or the no w will		
		nutrition and hydration. c and gastrostomy tubes,					

Facility ID: VA0100

If continuation sheet Page 82 of 156

	-	ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 11/29/ FORM APPRC OMB NO. 0938-0	OVED
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ° ′	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		495193	B. WING		10/04/2023	
NAME OF P	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE		
HENRICO	HEALTH & REHABILITA	TION CENTER		561 NORTH AIRPORT DRIVE HIGHLAND SPRINGS, VA 23075		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLE	TION
F 692	percutaneous endoso enteral fluids). Based comprehensive asses ensure that a residen §483.25(g)(1) Mainta of nutritional status, s desirable body weigh balance, unless the re- demonstrates that thi preferences indicate §483.25(g)(2) Is offer maintain proper hydra §483.25(g)(3) Is offer there is a nutritional p provider orders a the This REQUIREMENT by: Based on observatio review, and facility do staff failed to ensure acceptable paramete residents (Residents survey sample of 48 f The findings included 1. For Resident #22, ensure the resident d weight loss. On 09/25/2023 at app Resident #22 was int food is horrible, and t	hooscopic gastrostomy and copic jejunostomy, and d on a resident's ssment, the facility must t- ins acceptable parameters such as usual body weight or t range and electrolyte esident's clinical condition s is not possible or resident otherwise; red sufficient fluid intake to ation and health; red a therapeutic diet when problem and the health care rapeutic diet. T is not met as evidenced in, interview, clinical record poumentation, the facility residents maintain rs of nutritional status for 3 #22, #53 and #19) in a residents. I. the facility staff failed to id not sustain a significant proximately 2:00 p.m., erviewed and stated, "The hey never give what is They don't care if I eat or	F 69	F692 Nutrition/Hydration Status Maintenance 1. Resident #22 still resides in th Timeframe has passed to correc Resident #22 weights are indicating gains with continue supplements. RD assessed weig 11/9/2023. Resident #19 had a nutritional assessment by registered dietitian with diet texture change supplements per physician order hydration risk updated on care plan 11/9/2023. Resident #53 no longer resides i facility. 2. Current residents in the facility	t. ed yhts on facility. with rs and n the	

Facility ID: VA0100

If continuation sheet Page 83 of 156

	-	ND HUMAN SERVICES MEDICAID SERVICES				FORM): 11/29/20 1 APPROVE 0. 0938-03
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		495193	B. WING _				, 04/2023
NAME OF PI	ROVIDER OR SUPPLIER	•		ST	REET ADDRESS, CITY, STATE, ZIP CODE		
HENRICO	HEALTH & REHABILITA	TION CENTER					
a					GHLAND SPRINGS, VA 23075		0(5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETIOI DATE
F 692	Continued From page	e 83	F 6	92			
					potential to be affected. An audit of		
	A review of the clinica	al record revealed that on			current residents by		
		ity on 05/03/2023, Resident			the registered dietitian (RD) or designe		
(v t	#22 weighed 175 lbs.				conducted to identify any other residen	t	
		t # 22 weighed 154 lbs.,			with significant		
	-	nt loss (21 lbs.) in 3 months'			weight loss has supplements	au	
	time.				/interventions as applicable. Findings w be corrected.	VIII	
	A review of the care r	plan revealed the following:			3. The Dietary Manager or designee wi	ill	
	,				educate all dietary staff on processes for		
	"FOCUS:				meal tray		
		weight fluctuations related			preparation with accurate diet, per mer	าน	
		ion, BMI, pressure ulcers,			with resident likes and no dislikes. Men	nu	
		L1 Lumbar Spinal Cord,			substitutions		
		ry and Idiopathic Neuropathy, Colostomy, Psychoactive			and logged in menu substitution book a registered dietitian review substitutions		
		nemia, malnutrition. date			menu book on		
	initiated: 5/3/23 Revis				visits. Staff inform dietary if meal tray n	ot	
	revision Resident #22				accurate and another meal tray prepare		
		-			The SDC or designee will educate the		
	GOAL:				licensed nurses, MDS staff, director of		
		e optimal nutrition and			activities and		
		review period Date Initiated:			activity staff, RD, speech therapist on t		
	05/03/2023 Revision	9120123.			process for accurate diet, per menu an residents likes	u	
	INTERVENTIONS:				and dislikes with verification of meal tra	v	
	Diet as ordered Date	Initiated: 09/26/2023			accuracy prior to delivery of meal tray t		
	Created on: 09/26/20				resident.		
	-	te Initiated: 05/09/2023			Dietary will be informed if not accurate		
	Created on: 05/09/20				and another meal tray prepared.		
		e Initiated: 09/26/2023			Identification of		
	Created on: 09/26/20				significant change meets criteria to for	,	
	Created on: 05/03/20	d Date Initiated: 05/03/2023			MDS significant change. RD will review weights,	/	
		e Date Initiated: 05/03/2023			complete nutritional assessment with		
	Created on: 05/03/20				identified residents at risk for weight los	ss	
		rences with the resident as			or with significant		
		1: 06/07/2023 Created on:			weight loss with supplements as		
	06/07/23.				applicable per physician order. CNAs,		

Event ID: EB1X11

Facility ID: VA0100

If continuation sheet Page 84 of 156

		ND HUMAN SERVICES MEDICAID SERVICES				FOR	D: 11/29/20 MAPPROVE D. 0938-039
TATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` <i>`</i>		CONSTRUCTION	СОМ	E SURVEY PLETED
		495193	B. WING _				C / 04/2023
NAME OF PR	ROVIDER OR SUPPLIER	·	•	ST	REET ADDRESS, CITY, STATE, ZIP CODE		
				56	1 NORTH AIRPORT DRIVE		
HENRICO	HEALTH & REHABILITA	ATION CENTER		н	GHLAND SPRINGS, VA 23075		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	K	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETIO DATE
F 692	Continued From page	e 84	F6	i92			
	Supplements as orde			52	licensed nurses, or speech		
	09/28/2023 Created				licensed nurses, or speech therapist will provide feeding assistanc	e	
		Date Initiated: 05/09/2023.			for identified residents that required to		
					fed, cueing or		
	A review of the clinica	al record revealed the			need assistance. If resident wear		
	following excerpts fro	om the Registered Dietician			dentures are placed when eating. Repo	ort	
	Admission note dated				to nurse of resident does		
		BW (ideal body weight)			not eat with documentation. Pest sighti	ng	
	•	2023=175.0# (Hosp wt.			place in pest control book.		
	175#) BMI: 25.1	l fan wainht fluistustians n/t			4. Dietary manager will conduct		
		Il for weight fluctuations r/t , Incomplete Lesion of L1			observation audit weekly x 4 weeks the monthly x 2 months of	;	
	-	Paraplegia, Hereditary and			dietary staff preparing 10 meal trays fo	r	
	•	y, Sepsis, Necrotizing			accuracy of diet, menu items prepared		
		Psychoactive Substance			with likes and no		
	Abuse, Anemia in CK				dislikes on meal tray. Any findings will	be	
	Nutrition Prescription	n / Interventions (I): Add MVI			immediately corrected. The unit manage	ger	
		n wound healing Monitor /			will audit 10		
		nitor weights, meal intake			10 meal trays being served to verify		
	and provide follow up	per protocol."			accuracy of diet, menu items, likes and	l no	
	The following execret	t is from the Registered			dislikes on meal		
		t is from the Registered note dated 06/06/2023:			tray. Any findings will be corrected. DC or designee will audit weekly x 4 weeks		
		legular texture, Thin Liquids			then monthly	-	
	u	ke: 76-100% of most meals			x 2 months to verify resident with		
	Supplement: none				significant weight loss have RD nutritio	n	
		o Sacrum per 5/30/2023			assessment with		
		ol Labs: none Pertinent			supplements as applicable per physicia	an	
	Meds: Morphine Sulfa				order and care plan updated, conduct		
	Ondansetron HCl, Ga	-			observation audits		
		HCI Height: 70 inches, IBW			on 10 residents that require assistance		
	(Ideal Body Weight) =	=166.0# weight: osp wt. 175#) BMI: 25.1			with eating to verify are being fed. Res of the review	uns	
	Continue current inte				will be presented to the QAPI committee	e	
		nitor weights, meal intake			for review and recommendation. Once		
	and provide follow up	-			committee		
					determines the problem no longer exis	t	
	The following Registe	ered Dietician note was			and sustained the review will be		
	entered during the su	irvey:			conducted on a random		

Facility ID: VA0100

If continuation sheet Page 85 of 156

	-	D HUMAN SERVICES				FORM	APPROVED
	S FOR MEDICARE & I	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE	CONSTRUCTION	(X3) DATE	0. 0938-0391 SURVEY
	CORRECTION	IDENTIFICATION NUMBER:					LETED
		405400	B. WING				C
	ROVIDER OR SUPPLIER	495193	B. WING		TREET ADDRESS, CITY, STATE, ZIP CODE	10/	04/2023
	NOWDER ON SOLUEIR				61 NORTH AIRPORT DRIVE		
HENRICO	HEALTH & REHABILITA	TION CENTER			IIGHLAND SPRINGS, VA 23075		
(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 692	15	2023 6:33 AM -Nutrition/Dietary Note: Note basis. Spoke with resident 9/27/2023, requested basis. ement change from Med Plus to Mighty 5. Date of compliance: 11/19/2023 q day at 2pm. Residents goal weight is 5. Date of compliance: 11/19/2023 #. Weights now appear stable at goal, mit refused monthly weight. Continues ming current diet well. Monitor /Evaluation Monitor weights, meal intake and provide					
					Dasis.	IGS, VA 23075 /IDER'S PLAN OF CORRECTION :ORRECTIVE ACTION SHOULD BE EFERENCED TO THE APPROPRIATE DEFICIENCY)	
	supplement change fr Shake q day at 2pm. ~160.#. Weights now	om Med Plus to Mighty Residents goal weight is appear stable at goal,			5. Date of compliance:11/19/2023		
	consuming current die	et well. Monitor /Evaluation s, meal intake and provide					
		proximately 3:00 p.m., an					
	interview was conduc was asked if he was t	ted with Resident #22. He rying to lose weight, and he I now they are giving him					
		e end of day meeting, the de aware of the concerns.					
	No further information	n was provided.					
		the facility staff failed to id not sustain a significant					
	08/01/2023 weighing	mitted to the facility on 130 lbs. On 09/25/2023, d 119 lbs. this is a weight n little over a month.					
	A review of the care p	lan read as follows:					
	malnutrition related to mechanically altered Opioid Dependence,	lepatitis Date Initiated:					

Facility ID: VA0100

If continuation sheet Page 86 of 156

DEPART CENTER	FORM	D: 11/29/2023 MAPPROVED D. 0938-0391					
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		E CONSTRUCTION	(X3) DATE	
		495193	B. WING			C 10/04/2023	
NAME OF PI	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
				5	561 NORTH AIRPORT DRIVE		
HENRICO	HEALTH & REHABILITA	TION CENTER		F	HIGHLAND SPRINGS, VA 23075		
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			
F 692	Continued From page	86	F	692			
	and hydration status t	vill have optimal nutrition thru review period Date Created on: 08/07/2023.					
	and observe for any of Date Initiated: 08/10/2 08/10/2023. Diet/fluids as ordered Created on: 08/10/202 Encourage to eat Dat Created on: 08/07/202 RD consult as needed Record meal % intake Created on: 08/07/202 Review dietary prefer needed Date Initiated	Date Initiated: 08/10/2023 23. e Initiated: 08/07/2023 23. d Date Initiated: 08/07/2023. e Date Initiated: 08/07/2023					
	08/10/2023. Supplements as orde 08/07/2023 Created of Weights as ordered D Created on: 08/07/202	on: 08/07/2023. 0ate Initiated: 08/07/2023					
	A review of the clinica Resident #53 had onl Registered Dietician of 08/07/2023. Excerpts	on one occasion,					
	Nutrition Assessment Description: 57-year-o Medical Dx: Encepha Asymptomatic HIV, C Rhabdomyolysis, Opi Infarction, Dysphagia Diet: Regular diet, Dy Altered texture, Necta	old male, admitted 8/1/2023 lopathy, HTN, ardiac Arrhythmia, oid Dependence, Cerebral					

Facility ID: VA0100

If continuation sheet Page 87 of 156

	-					FORM	APPROVED	
		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	TIPLE	ECONSTRUCTION	(X3) DATE). 0938-0391 SURVEY	
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:					LETED	
		495193	B. WING				C 04/2023	
NAME OF PI	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	1 10/	•	
HENRICO	HEALTH & REHABILITA	TION CENTER						
				ŀ				
(X4) ID PREFIX TAG	AN OF CORRECTION IDENTIFICATION NUMBER: 495193 OF PROVIDER OR SUPPLIER RICO HEALTH & REHABILITATION CENTER ID FIX G Continued From page 87 Ensure Nutrition Shake BID." Height: 67 inches, IBW [Ideal Body Weight] =148.0# Weight: 8/1/2023=130.0# BMI: 20.4 Estimated nutritional needs: 59 kg = 1700-1900 kcal (28-32 kcal/kg), 59-70 gms protein (1.0-1.2 gms/kg), 1700-1900 mL fluid (1 mL/kcal) Nutrition risk potential for weight fluctuations or malnutrition r/t recent hospitalization, mechanically altered diet, Encephalopathy, Asymptomatic HIV, Opioid Dependence, Cerete Infarction, Dysphagia, Chronic Hepatitis Nutriti Prescription / Interventions (I): Change Ensure Nutrition Shake to Med Plus 2.0 @ 120 mL po BID between meals to allow for increased po intake at meals, mechanically altered diet, malnutrition prevention Monitor / Evaluation			x	(EACH CORRECTIVE ACTION SHOULD E		(X5) COMPLETION DATE	
495193 B. WING 10/04/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE HENRICO HEALTH & REHABILITATION CENTER STREET ADDRESS, CITY, STATE, ZIP CODE MENRICO HEALTH & REHABILITATION CENTER STREET ADDRESS, CITY, STATE, ZIP CODE (X4) ID SUMMARY STATEMENT OF DEFICIENCIES STREET ADDRESS, CITY, STATE, ZIP CODE (X4) ID SUMMARY STATEMENT OF DEFICIENCIES STREET ADDRESS, VA 23075 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX PROVIDER'S PLAN OF CORRECTION (CACH DEFICIENCY MUST BE PRECEDED BY FULL TAG SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (CACH DEFICIENCY MUST BE PRECEDED BY FULL TAG CONTINUE (FOR page 87 F 692 F 692 F 692 F assure Nutrition Shake BID." F 692 Height: 67 inches, IBW [Ideal Body Weight] F 692 ASS. Secreters allow for inches, IBW [Ideal Body Weight] F 692 Nutrition Shake DIMU [Ideal 10m]// (20-12) F <td co<="" td=""><td></td></td>			<td></td>					
1 002				09Z				
	InderLand SPRINGS, VA 23075 Summary statement of DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG PROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COMPLETION DATE 2 Continued From page 87 Ensure Nutrition Shake BID." F 692 Height: 67 inches, IBW [Ideal Body Weight] =148.0# Weight: 8/1/2023=130.0# BMI: 20.4 Estimated nutritional needs: 59 kg = 1700-1900 kcal (28-32 kcal/kg), 59-70 gms protein (1.0-1.2 gms/kg), 1700-1900 mL fluid (1 mL/kcal) Nutrition risk potential for weight fluctuations or malnutrition r/t recent hospitalization, mechanically altered diet, Encephalopathy, Asymptomatic HIV, Opioid Dependence, Cerebral Infarction, Dysphagia, Chronic Hepatitis Nutrition Prescription / Interventions (I): Change Ensure Nutrition Shake to Med Plus 2.0 @ 120 mL po BID between meals to allow for increased po intake at meals, mechanically altered diet, mainutrition prevention Monitor / Evaluation (M/E): Monitor weights, meal intake and provide follow up per protocol." ID							
		U						
	malnutrition r/t recent	hospitalization,						
	-							
	Prescription / Interver	ntions (I): Change Ensure						
		•						
	malnutrition preventio	n Monitor / Evaluation						
		•						
	Diet orders for Reside	ent #53 read as follows:						
		-						
		· · · ·						
	On 09/28/2023 at app	proximately 12:00 p.m., an						
	interview was conduc	ted with Resident #53 who						
		-						
	"They might have but	that is not what I get."						
	-							
	No further information	n was provided						
	3. For Resident #19,	the facility staff did not						

If continuation sheet Page 88 of 156

DEPARTMENT OF HEALTH ANI CENTERS FOR MEDICARE & M					FORM): 11/29/2023 APPROVED . 0938-0391
	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION		(X3) DATE COMP	LETED
	495193	B. WING		_	(10/(; 04/2023
NAME OF PROVIDER OR SUPPLIER		S	STREET ADDRESS, CITY, ST	TATE, ZIP CODE		
HENRICO HEALTH & REHABILITAT			61 NORTH AIRPORT DRI HIGHLAND SPRINGS, V			
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
resident with known dy insulin dependent Dial wounds. Resident #19 was adm 12/26/2022, and most hospitalization on 09/1 including, encephalopp oral cadidiasis, and C0 a medical history inclu acute gastrointestinal acute post hemorrhag from the 12/26/2022 a The resident's most re Data Set (MDS) asses assessment reference coded Resident #19 a impaired, required ext feeding, coded no wou risk for malnutrition, w and no swallowing issi in error as Resident # standing foot wounds known for years. It is notable to add tha MDS assessment was #19's readmission fror 09/19/2023 through th 10/04/2023 (15 days a #19 had a known sign hospitalization, and a resident's right buttock readmission at unstag	ignificant weight loss of a ysphagia following a stroke, betes Mellitus, and 3 nitted to the facility on recently readmitted after 19/2023 with diagnoses athy, urinary tract infection, OVID-19. Resident #19 had uding, stroke, diabetes, and bleeding with resulting ic anemia and weakness admission. ecent quarterly Minimum asment was dated with an e date of 06/21/2023, and s moderately cognitively ensive assistance with unds nor skin problems, at reight 148.0 lbs (pounds), ues. The assessment was 19 had 2 ongoing long from an original admission at no significant change s completed from Resident m the hospital on the time of survey ending after readmission). Resident ificant weight loss before new pressure sore on the c was found on the day of leable due to slough in the ues would require further wound healing and	F 692				

Facility ID: VA0100

If continuation sheet Page 89 of 156

		ID HUMAN SERVICES MEDICAID SERVICES		FORM APPROVE OMB NO. 0938-03				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	TIPLE	CONSTRUCTION	(X3) DATE		
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG _		COMF	PLETED	
		495193	B. WING				C	
NAME OF PI	ROVIDER OR SUPPLIER	400100		S	TREET ADDRESS, CITY, STATE, ZIP CODE	10/	04/2023	
					61 NORTH AIRPORT DRIVE			
HENRICO	HEALTH & REHABILITA	TION CENTER		н	IGHLAND SPRINGS, VA 23075			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 692	regulation, a significal should be conducted decline in 2 or more a weight loss and a new wound. On 01/02/2023, the R evaluated the residen "Nutrition Assessmen diet level 4 pureed tex consistency. Po (oral meals, supplement no medications named Prescription/intervent with minerals to aid in ensure compact 4 our variable oral intake, ir healing, malnutrition p Monitor/Evaluation (M intake and provide fol On 06/20/2023, the la was completed in the "Nutrition Assessmen Diagnosesregul liquids consistency. F most meals, supplem milliliters by mouth wi medications named interventions Monitor/ weights, meal intake a protocol. weight 148.3 On 09/07/2023 and 00 indicated significant w however, no new inte added.	nt change assessment within 14 days of a known areas such as unplanned v unstageable pressure egistered Dietician (RD) it and documented: t (A)Diagnoses regular kture, regular liquids b) intake 25-75% of most one,pressure wound, , Nutrition ions (1) add multivitamin a wound healing (2) Add nces by mouth due to ncreased needs for wound orevention, advanced age M/E): Monitor weights, meal low up per protocol." ast RD evaluation document clinical record and stated, t (A) quarterly ARD 6-21-23 ar diet regular texture, thin Po (oral) intake 50-100% of ent med plus 2.0 at 120 th (hs) bedtime labs, , continue current (Evaluation (M/E): Monitor and provide follow up per B lbs (pounds)."	F	692				

If continuation sheet Page 90 of 156

	OF DEFICIENCIES	MEDICAID SERVICES		IPLE CONSTRUCTION	(X3) DATE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION	COMPLETED
					С
		495193	B. WING		10/04/2023
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	CODE
HENRICO	HEALTH & REHABILITA	TION CENTER		561 NORTH AIRPORT DRIVE HIGHLAND SPRINGS, VA 2307	75
(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 THE APPROPRIATE DATE
F 692	Continued From page	e 90	F 6	92	
	09/25/2023 and ended on 10/04/2023. Resident #19's weight document was reviewed and revealed the following:				
	loss in one month beg 3. 09/06/2023 - 131.6 (10 %) weight loss in 4. 09/11/2023 - 129.0 weight loss 9 weeks) the hospital on 09/16/ 09/19/2023. 5. 09/19/2023 - 135.0 during hospitalization 6. 09/25/2023 - 126.0 loss begins again) 7. 09/27/2023 - 119.4	2 pounds (5 pound weight gins) 5 pounds (now a 14 pound a 2 months) 9 pounds (now a 16 pound Resident #19 went out to /2023 and returned on			
	revealed that from 01 ordered and discontin regular diet was disco the Ensure Compact discontinued on 06/0	1/2023. The Med Plus 2.0 ted on 06/01/2023, and			
	06/30/2023 discontinu a significant weight lo ongoing for months. T Plus 2.0 were restarte the Med Plus 2.0 sup nine days later on 09/	s for supplements after the uance until 09/19/2023 after oss had occurred and been The multivitamin, and Med ed on 09/19/2023; however, plement was discontinued /28/2023 by a physician's s were obtained beginning a knowledge of the			

Facility ID: VA0100

If continuation sheet Page 91 of 156

DEPARTMENT OF HEALTH AND CENTERS FOR MEDICARE & M					FORM	APPROVED 0. 0938-0391	
	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
	495193	B. WING _			C 10/04/2023		
NAME OF PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	•		
HENRICO HEALTH & REHABILITATI	ION CENTER			61 NORTH AIRPORT DRIVE IIGHLAND SPRINGS, VA 23075			
PREFIX (EACH DEFICIENCY I	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL IC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI, DEFICIENCY)		(X5) COMPLETION DATE	
 however, no intervention weight loss. The medication administ documented that the M daily after 09/228/2023 discontinued, and on 09 changed to mechanical staff indicated meant of 06/30/2023 until 09/19/ weight loss, and the RE intervene during a sign Resident #19's nutrition initiated on 01/02/2023 09/18/2023 by the RD. nor any other care plan the time of survey on 0 09/27/2023 (9 days afted documents were obtain care plan was "in devel nurses when asked to relectronic clinical record Resident #19 did not haplan even though the redehydration in the facilit resuscitation instilled staff indications, which rem Activities of Daily Living reviewed and revealed 	 (10 days) before 6/2023 for Resident #19; ons were added for the stration record (MAR) led plus 2.0 was given even after being 9/28/2023, the diet was lly altered, which dietary hopped. eceive supplements from (2023 during a significant D did not evaluate nor ificant weight loss. n care plan, completed and was canceled on No new nutrition care plan n had been completed at 9/25/2023, nor through er readmission) when ned. The new readmission lopment" according to staff review the care plan in the d. ave a dehydration care esident had experienced ity and received Clysis fluid ubcutaneously on several 19 did not receive diuretic nove fluid from the body. g (ADL) records were that the Resident needed eived extensive assistance. 	F	692				

Facility ID: VA0100

If continuation sheet Page 92 of 156

	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		E CONSTRUCTION	(X3) DATE	
		495193	B. WING				C 04/2023
NAME OF PR	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
				5	561 NORTH AIRPORT DRIVE		
HENRICO	HEALTH & REHABILITA	TION CENTER		ŀ	HIGHLAND SPRINGS, VA 23075		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 692	was an Licensed Pract that Resident #19 had accept things in her h sandwiches; however them. The family was resident's care and wa almost every day. The received a baseline ca invited to a care plan was readmitted on 09 concerned about the f Staff interviews revea be fed, and that she w Observations conduct p.m., revealed Resided dining room on the nu sitting at a table with 3 trays in front of them, assisted by one staff of the residents at the ta observed to have 1/2 inch chopped cubes of potatoes and gravy. T and CNA (Certified Ne sitting with the resident feeding Resident #19 Observations were co teaspoonful of potatoe Resident #19's mouth half into her mouth an	%. holude the Resident's aughter, who stated she ctical Nurse (LPN), revealed to be fed and will at times ands to eat, such as r, she must be cued to eat s very involved with the ere there in the facility e family stated they had not are plan nor had they been meeting since the resident /19/2023, and they were resident's weight loss. led that Resident #19 had to vould stop eating if not fed. ted on 09/29/2023 at 12:00 ent #19 in the communal ursing unit. The resident was 3 other residents with meal and they were being member to set up and feed uble. Resident #19's tray was inch cubed turkey meat, 1/2 of cabbage, mashed The resident was not eating ursing Assistant) D who was hts stated she would be ontinued and only one es was placed up to h, of which, the resident took ad swallowed. At 1:00 p.m.,	F	692			
	all trays were loaded	id swallowed. At 1:00 p.m., onto the cart to return to the 's tray was observed to					

Facility ID: VA0100

If continuation sheet Page 93 of 156

	-					FORM	APPROVED
STATEMENT O	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			(X3) DATE COMP	SURVEY LETED
		495193	B. WING		_		
NAME OF PI	ROVIDER OR SUPPLIER		5	STREET ADDRESS, CITY, ST	TATE, ZIP CODE		
HENRICO	HEALTH & REHABILITA	TION CENTER					
			I	-			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRE) CROSS-REFERE	CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA		(X5) COMPLETION DATE
F 692	PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING COMPLETED 495193 B. WING 10/04/2023 ME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE StRECT ADDRESS, CITY, STATE, ZIP CODE 561 NORTH AIRPORT DRIVE INRICO HEALTH & REHABILITATION CENTER STREET ADDRESS, VA 23075 X4) ID SUMMARY STATEMENT OF DEFICIENCIES REFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REFIX REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (x5) COMPLETION DATE						
	and the other half of t spoon, indicating no c	n., CNA D was interviewed and asked ad not fed Resident #19. CNA D stated ident#19) was very sleepy so I told the N D) and didn't offer her any more food. nsed Practical Nurse) D was					
	why she had not fed F "She (Resident#19) w nurse (LPN D) and did LPN (Licensed Practic interviewed and state changing the resident "would receive anothe thrush so she probabl surveyor told LPN D t sleepy and that is why stated "she didn't tell observed for the rest received another tray. Resident 19's finger s testing that morning in	Resident #19. CNA D stated vas very sleepy so I told the dn't offer her any more food. cal Nurse) D was d, "the speech therapist was 's diet" and Resident #19 er tray, but the resident has ly won't eat anyway." The hat CNA D stated she was y she was not eating. LPN D me that." The resident was of the shift, and never . It is notable to mention tick blood sugar (FSBS)					
	Resident #19's room the search for Reside were missing. The res cups; however, all thr was in the floor behin resident's bed, one was the bedside cabinet, a upper drawer of the b cabinet door and draw cockroaches ran out (and all over the sides cabinet. CNA D stated maintenance come im area with insecticide.	was entered with CNA D, in nt #19's dentures which sident had 3 plastic denture ee were empty. One cup d the headboard of the as in the large lower door of and the third was in the edside cabinet. When the ver were opened (approximately 5-10 insects) and top of the bedside d she would have mediately and spray the					

Facility ID: VA0100

If continuation sheet Page 94 of 156

	S FOR MEDICARE &	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIF	LE CONSTRUCTION	OMB NO. 0938-039 (X3) DATE SURVEY		
and plan of	CORRECTION	DENTIFICATION NUMBER:		<u> </u>	COMPLETED		
		495193	B. WING		C 10/04/2023		
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
HENRICO	HEALTH & REHABILITA	TION CENTER		561 NORTH AIRPORT DRIVE			
				HIGHLAND SPRINGS, VA 23075			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE COMPLÉTION		
F 692	Continued From page	94	F 69	2			
	conducted with the Ad	end of day debriefing, dministrator and Regional s, they were notified of #19.					
F 695	On 10/04/2023 at approximately 2:00 p.m., the Administrator, Corporate Nurse Consultant, and Regional Director of Operations were again notified of findings, and they stated they had nothing further to provide. Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i)		F 69	15	11/19/23		
	The facility must ensu- needs respiratory car care and tracheal suc- care, consistent with practice, the compre- care plan, the resider and 483.65 of this sul This REQUIREMENT by: Based on observatio record review, and fa the facility staff failed consistent with profes	d tracheal suctioning. ure that a resident who e, including tracheostomy stioning, is provided such professional standards of hensive person-centered hts' goals and preferences, bpart. is not met as evidenced n, staff interview, clinical cility documentation review, to provide respiratory care, ssional standards of hts (Residents #37 and #71)		F695 Respiratory/Tracheostomy Care and Suctioning !! 1. Resident #37 and resident #71 no longer reside in the facility. 2. Current residents in the facility have potential to be affected. An audit by th	e the		
				 unit managers to verify resident receiving jet nebulizer t tubing was changed. 3. The DON will inform the medical providers of the facility policy regardin changing jet nebulizer tubing every week , if the medical providers 	g		

Event ID: EB1X11

Facility ID: VA0100

If continuation sheet Page 95 of 156

		ID HUMAN SERVICES MEDICAID SERVICES				FOR	ED: 11/29/20 RMAPPROVE <u>O. 0938-03</u>
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l`´´		CONSTRUCTION		E SURVEY IPLETED
		495193	B. WING			10	C)/ 04/2023
NAME OF PI	ROVIDER OR SUPPLIER	•		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
	HEALTH & REHABILITA			56	61 NORTH AIRPORT DRIVE		
HENRICO		THOM CENTER		н	IGHLAND SPRINGS, VA 23075		
(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)	3E	(X5) COMPLETIO DATE
	• • • •	g the initial tour of the ttely 12:50 p.m., there was	F	695	does not agree then the jet nebulizer v be changed		
	bedside table and the were in a bag that wa				per the frequency of the medical provious order.4. The SDC or designee will educate t licensed nurses on the policy and procession.	he	
	09/25/2023 and 09/26	record was conducted on 6/2023. 37's physician's orders			for jet nebulizer and oxygen tubing changes for infection control prevention. The jet nebulizer tubing is change	on	
	revealed the following				weekly per policy. A physician order is required to change medical equipment tubing, place		
	0.5-2.5 (3) MG/3 ML 3 ml inhale orally eve	(3 milligrams per 3 milliliters) ry 4 hours as needed for reath) or wheezing via			on care plan for tubing changes. The DON will inform the medical providers the facility policy regarding changing jet nebulizer tubing	g	
	11/10/2022 - Nebulize M-W-F (Night Shift) e Mon,Wed, Fri for infe				every week , if the medical provider do not agree then the jet nebulizer will be changed per th frequency of the medical provider orde 5. The unit manager or designee will a	ne er.	
	interview was conduc Nurse (LPN C) who s supposed to change				weekly x 4 weeks then monthly x 2 months to verify jet nebulizer tubing was changed weekly. Results of the review will be presented		
	and change oxygen t nurse should label an opened and used. Wi	rs, Wednesdays, and Fridays ubing weekly. She stated the id date the tubing when hen asked about the risks of ng as ordered or by the			the QAPI committee for review and recommendation. Once the committee determines the problem no longer exist and sustained the review		
	protocol, LPN-C state infection.				be conducted on a random basis6. Date of compliance: 11/19/2023		
	interview was conduct (RN) B who stated the tubing should be date	proximately 2:45 p.m., an ated with Registered Nurse at the nebulizer and oxygen ad and stored at the bedside. ulizer tubing should be					

Facility ID: VA0100

If continuation sheet Page 96 of 156

		ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		495193	B. WING				C 04/2023
NAME OF P	ROVIDER OR SUPPLIER		I	5	STREET ADDRESS, CITY, STATE, ZIP CODE		
HENRICO	HEALTH & REHABILITA	TION CENTER			561 NORTH AIRPORT DRIVE HIGHLAND SPRINGS, VA 23075		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 695	changed every Monda on the night shift. RN- an order for nebulizer When asked if the net tubing at the bedside stated "Yes, but I hop the date prior to using should be changed as protocol. During the end of day the Facility Administra Corporate Nurse Con- findings. A copy of the Facility's was requested and re Review of the facility's and Procedure, effect 155, number 5 include and bags must be cha Wednesday and Frida Another copy of the fa Care entitled "Respira Effective date: 3/13/2 surveyor on 09/28/200 revealed documentati Nebulizer Treatment" stated:"Nebulizers a weekly."	ay, Wednesday and Friday ¹⁹ B stated Resident #37 had treatments as needed. bulizer equipment and was available for use, RN-B e the nurses would check g it." RN-B stated the tubing s ordered and as per ¹⁰ debriefing on 09/26/2023, ator, Director of Nursing and sultant were informed of the s Policy on Respiratory Care eccived on 09/27/2023. S Respiratory Care Policy tive date 08/04/2015, page ed the excerpt: "Nebulizers anged every Monday, ay and dated." acility Policy on Respiratory atory/Oxygen Equipment, 023" was presented to the 23. Review of the policy on under "medicated number 5 nd bags should be changed acility Policy on Respiratory atory/Oxygen Equipment, 023" was presented to the 23. Review of the policy on under "medicated number 5 nd bags should be changed	F	695			

Facility ID: VA0100

If continuation sheet Page 97 of 156

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495193	B. WING				C 04/2023
NAME OF P	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE		
HENRICO	HEALTH & REHABILITA	TION CENTER			561 NORTH AIRPORT DRIVE HIGHLAND SPRINGS, VA 23075		
(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)		(X5) COMPLETION DATE
F 695	- 15	nd bags should be changed	F	695			
	change the nebulizer	the facility staff failed to tubing three times per week r the facility's protocol.					
	an observation of a n	tely 12:50 p.m., there was ebulizer machine on the tubing and mouthpiece					
	On 09/26/2023 at 9:3 was made of the neb mouthpiece in a bag	•					
	Review of the clinical 09/25/2023 and 09/26	record was conducted on 5/2023.					
	Review of Resident # revealed the following	71's physician's orders g:					
		(3 milligrams per 3 milliliters) Ily every 4 hours as needed					
	11/10/2022- Nebulize M-W-F (Night Shift) e Mon,Wed, Fri for infe						
	interview was conduc	proximately 2:00 p.m., an sted with Licensed Practical tated that night shift was and date tubing for					

Facility ID: VA0100

If continuation sheet Page 98 of 156

		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	
		495193	B. WING				_ 04/2023
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
HENRICO	HEALTH & REHABILITA	TION CENTER		561 NORTH AIRPORT DRIVE HIGHLAND SPRINGS, VA 23075			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 695	Nebulizer on Monday and change oxygen tr nurse should label an opened and used. Wh not changing the tubin protocol, LPN-C state infection. On 09/26/2023 at app interview was conduct who stated that the ne- should be dated and s stated the nebulizer tr every Monday, Wedn night shift. During the end of day the facility Administrat Corporate Nurse Con- findings. A copy of the facility's was requested and re Review of the facility's and Procedure, effect 155, number 5 include and bags must be cha Wednesday and Frida Another copy of the fac Care entitled, "Respir Effective date: 3/13/2 surveyor on 09/28/200 revealed documentati Nebulizer Treatment"	s, Wednesdays and Fridays ubing weekly. She stated the d date the tubing when hen asked about the risks of ng as ordered or by the d there was a risk of proximately 2:45 p.m., an ted with Registered Nurse B ebulizer and oxygen tubing stored at the bedside. RN-B ubing should be changed esday and Friday on the the debriefing on 09/26/2023, tor, Director of Nursing, and sultant were informed of the the Policy on Respiratory Care eceived on 09/27/2023. Is Respiratory Care Policy tive date 08/04/2015, page ed the excerpt: "Nebulizers anged every Monday, ay and dated." acility Policy on Respiratory atory/Oxygen Equipment, 023" was presented to the 23. Review of the policy on under "medicated	F	695	5		

Facility ID: VA0100

If continuation sheet Page 99 of 156

STATEMENT	DF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´			(X3) DATE SURVEY COMPLETED		
		495193	B. WING			C 10/04/2023		
	ROVIDER OR SUPPLIER	TION CENTER	•	STREET ADDRESS, CITY, STATE, ZIP CODE 561 NORTH AIRPORT DRIVE				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		GHLAND SPRINGS, VA 23075 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 695 F 699 SS=G	No further information Trauma Informed Cat CFR(s): 483.25(m) §483.25(m) Trauma-i The facility must ensu- trauma survivors rece trauma-informed care professional standard for residents' experied order to eliminate or r cause re-traumatizati This REQUIREMENT by: Based on observatio review, and facility do staff failed to ensure trauma survivors rece mitigate triggers for 2 and #53) in a survey The findings included 1. For Resident #53, provide trauma-inform has experienced sexu- facility. Resident #53 was ad 08/01/2023 with diag not limited to schizoa after CVA (Cerebrova	n was provided. re nformed care are that residents who are eive culturally competent, a in accordance with as of practice and accounting nces and preferences in mitigate triggers that may on of the resident. ' is not met as evidenced n, interview, clinical record ocumentation, the facility that residents who are eive trauma-informed care to residents (Residents #22 sample of 48 residents. : the facility staff failed to ned care for a resident who ual assault by CNA C at the mitted to the facility on noses that include but are ffective disorder, hemiplegia iscular Accident or stroke) nan Immunodeficiency nd Hypertension.		595 599	F699 Trauma Informed Care !! 1. Resident #53 no longer resides in the facility. Resident #22 still resides in the facility. Resident #22 received psych services 11/1/2023 2. Current residents with PTSD (Post Traumatic Stress Disorder) diagnosis in the facility have the potential to be affected. An audit by the DON or designee conducted to verify residents with diagnosis of PTSD or Trauma Informed Care completed with identified trauma have a care plan identify problem with triggers to avoid s triggering feelings from past trauma and causing emotional distress or emotional harm. 3. The Administrator or designee will educate social service /discharge plann staff and nursing management DON, unit managers on documentation and completion of traum	taff d	11/19/23	

Event ID: EB1X11

Facility ID: VA0100

If continuation sheet Page 100 of 156

		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 11/29/20 FORM APPROV OMB NO. 0938-03
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495193	B. WING		C 10/04/2023
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	
HENRICO	HEALTH & REHABILITA	TION CENTER		561 NORTH AIRPORT DRIVE	
				HIGHLAND SPRINGS, VA 2307	5
(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 COMPLETIO THE APPROPRIATE DATE
F 699	Continued From page	e 100	F 69	9	
	Name redacted] for e MD made aware. Pat understanding the rea "8/10/2023 - 5:15 pm Patient made a state that took place this m given from patient to the south unit nursing to nonemergent servi official statement and "8/12/2023 4:51 - Ale concerns r/t behavior and threatening staff bed when in room/be aware to possibly cor nurses' station." "8/15/2023 2:41 pm (Resident Note Text: [redacted] spoke with	Patient sent to [Hospital evaluation r/t alleged assault, tient verbalized ason for transfer." I Health Status Note Text: ment in regard to an assault norning, a statement was myself dictated at 2:11 pm at g station. Phone call placed ices so patient could give an		care plan for PTSD diagner and trauma identified on t informed screening and care plan w attempt to avoid staff trigg from past trauma and causing emotional dis emotional harm. if applica The SDC or designee will facility staff on PTSD and preventing behaviors and/or emotion associated with triggering past or current trauma. Management, monitoring, behaviors and avoiding tri cause risk for or actual emotional harm for behavioral healthcare nee residents with substance abuse. Identified residents planned with problem and attempt avoid staff triggering feelings from pa causing emotional distres	the trauma with triggers to gering feelings stress or able. educate all triggers to avoid harm events from preventing iggers that may residents with eds and s will have care d triggers to ast trauma and
	[Resident #53] admitt he can come up with [name redacted] mac (psych) aware." "8/17/2023- 5:50 AM Text: Per reports, res day shift. Hourly chec throughout the shift, n plan or intention to co multiple encounter, re impatient, combative	 to harm self, to which ted. [Resident #53] says that a plan to harm himself de Dr. [name redacted] - Health Status Note-Note ident was suicidal during the cks done on resident resident stated he had no pommit suicide. During esident was noted to be towards staff such as re staff or yelling for not 		 harm. 4. The Director of discharged designee will audit weekly monthly x 2 months to verify residents diagnosis, behavioral hears substance abuse or trauma identified on the tr care form have a care plar and trigger to avoid staff triggering feeling trauma and causing emotional harm. Results of the revier 	y x 4 weeks then s with PTSD lthcare needs, rauma informed in with problems ngs from past ional distress or

Facility ID: VA0100

If continuation sheet Page 101 of 156

	PF DEFICIENCIES	MEDICAID SERVICES			ONSTRUCTION	OMB NO. 0938-0 (X3) DATE SURVEY	
	CORRECTION	IDENTIFICATION NUMBER:				· /	PLETED
							С
		495193	B. WING			10/	04/2023
NAME OF P	ROVIDER OR SUPPLIER			STR	REET ADDRESS, CITY, STATE, ZIP CODE		
HENRICO	HEALTH & REHABILITA	TION CENTER					
				HIG	GHLAND SPRINGS, VA 23075		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETIO DATE
F 699	Continued From page	e 101	F 69	99			
		s needs as soon as he asked			presented to the QAPI committee for		
	for them. Nurse provi			review and			
	0	espond, also he needs to			recommendation. Once the committee		
	communicate with his				determines the problem no longer exis	t	
	violently/physically at	ided every 2 hours and as			and sustained the review will be conducted on a random		
		ons followed and maintained,			basis.		
		ng in bed at this time."					
		-			5. Date of compliance: 11/19/2023		
		nterview was conducted with					
		ked if they have psych ng and she stated that they					
		he thought it would be					
		nt #53 to have seen psych					
	services after such a	n incident, she stated that					
	she thought he did ar from psych services.	nd would supply the notes					
		al record revealed that order dated 08/01/2023 that					
		as needed" however, was					
	•	ervices until 08/23/2023. The					
		as not prompted by the					
		iew of the psych notes					
	revealed the following	g:					
	"Resident was referre	ed today for stabilization in					
		r nurses' notes and report,					
	•	b be verbally abusive to staff,					
	-	netimes, Resident was met					
	in his room, in bed, ca engaged. Resident re	alm, alert, speech clear and					
		tions to include Lithium,					
	Haldol, Risperidone,						
	Methadone, Seroque	l, Hydroxyzine and					
	Trazadone. Reported	l he has not been sleeping					
		wake the whole night; I					
	cannot sleep." Reside	ent also reported he feels		1			

Facility ID: VA0100

If continuation sheet Page 102 of 156

	-	ID HUMAN SERVICES				FORM	APPROVED
		MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	TIPLI	E CONSTRUCTION	(X3) DATE	0. 0938-0391 SURVEY
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG _		COMF	LETED
		495193	B. WING				C 04/2023
NAME OF P	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE	1 10/	04/2023
				ę	561 NORTH AIRPORT DRIVE		
HENRICO	HEALTH & REHABILITA			ł	HIGHLAND SPRINGS, VA 23075		
(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 699	Continued From page	≥ 102	F	699	3		
	On 08/23/2023 after t given for Trazadone 5	he psych visit, the order was 50mg for insomnia.					
	conducted with the St Coordinator who was PTSD, she stated the that subject. When as trauma-informed care not. When asked if sl healthcare needs rela she stated that she di your staff care for res or all those issues an On 10/04/2023 during Administrator was ma No further information 2. For Resident #22, provide trauma-inform	asked about training for by do not tell me to train on sked if she trained on e, she stated that she did he trained on behavioral ated to substance abuse, id not. When asked does idents in this facility with any d she stated that they do.					
	05/02/2023 with diagr not limited to incompl peripheral neuropathy substance abuse and On 09/25/2023 at app interview was conduct	smoking. proximately 1:00 p.m., an ted with Resident #22 who					
	us, I have PTSD and to me." When asked t	es not know how to deal with they don't know how to talk to elaborate, he stated the and rude and that "triggers"					

Facility ID: VA0100

If continuation sheet Page 103 of 156

	-	ND HUMAN SERVICES			PRINTED: 11/29/2 FORM APPRO OMB NO. 0938-0	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495193	B. WING		C 10/04/2023	
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CC	•	
HENRICO	HEALTH & REHABILITA	ATION CENTER		561 NORTH AIRPORT DRIVE		
				HIGHLAND SPRINGS, VA 23075		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE COMPLETI TE APPROPRIATE DATE	
F 699	Continued From page	e 103	F 69			
1 000		e roo ressive." When asked if he	F 09:	9		
		ut this, he stated he has				
		and the Administrator about it,				
		Resident #22 also stated he				
		ise problem prior to coming				
		t the facility staff "use that				
	information against n meant by that, he sta	ne." When asked what he				
	,	because he had a substance				
		coming to the facility. He				
	-	labeled him as "drug				
	seeking."					
	On 00/28/2022 at 11	:00 a.m., an interview was				
	conducted with the S					
		s asked about training for				
		ey do not tell me to train on				
		sked if she trained on				
		e, she stated that she did				
		he trained on behavioral ated to substance abuse,				
		lid not. When asked does				
		esidents in this facility with				
		es and she stated that they				
	do.					
	On 10/04/2023 durin	a the end of the day				
		histrator was made aware of				
	the concerns.					
	No further informatio	n was provided.				
F 726	Competent Nursing S	-	F 720	6	11/19/23	
SS=G	CFR(s): 483.35(a)(3)					
	§483.35 Nursing Ser	vices				
		e sufficient nursing staff with				
	the appropriate comp	petencies and skills sets to				
	provide pureipa and	related services to assure				

Event ID: EB1X11

Facility ID: VA0100

If continuation sheet Page 104 of 156

		ID HUMAN SERVICES MEDICAID SERVICES			FOF	ED: 11/29/2023 RM APPROVED IO. 0938-0391
STATEMENT (OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495193	B. WING _		1	C 0/04/2023
NAME OF P	ROVIDER OR SUPPLIER		•	STREET ADDRESS, CITY, STATE, ZIP CODE		
HENRICO	HEALTH & REHABILITA	TION CENTER		561 NORTH AIRPORT DRIVE HIGHLAND SPRINGS, VA 23075		
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 726	practicable physical, well-being of each re- resident assessments and considering the r diagnoses of the facil accordance with the f at §483.35(a)(3) The fac licensed nurses have and skill sets necessaneeds, as identified th assessments, and de §483.35(a)(4) Providi limited to assessing, implementing resident to resident's needs. §483.35(c) Proficience The facility must ensu- to demonstrate comp techniques necessary needs, as identified th assessments, and de This REQUIREMENT by: Based on resident in facility documentation ensure 5 of 5 nursing Staff #21, Staff #22, C [CNA]-H and CNA-K) competent to provide	ttain or maintain the highest mental, and psychosocial sident, as determined by s and individual plans of care number, acuity and ity's resident population in facility assessment required cility must ensure that the specific competencies ary to care for residents' nrough resident scribed in the plan of care. Ing care includes but is not evaluating, planning and it care plans and responding ey of nurse aides. ure that nurse aides are able etency in skills and y to care for residents' nrough resident scribed in the plan of care.	F 7	F726 Competent Nursing Staf 1. Resident #22 still resides in Resident #22 received psych s 11/1/2023. SDC initiated education and tra facility staff on PTSD (Post tra stress disorder) with triggers on 9/27/2023. 2. Current residents in the facil potential to be affected. The D designee will	the facility. services aining for all umatic lity have the	

Event ID: EB1X11

Facility ID: VA0100

If continuation sheet Page 105 of 156

		ND HUMAN SERVICES MEDICAID SERVICES			FOF	ED: 11/29/202 MAPPROVE O. 0938-039
TATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
		495193	B. WING		1	C)/04/2023
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO		
				561 NORTH AIRPORT DRIVE		
HENRICO	HEALTH & REHABILITA	TION CENTER		HIGHLAND SPRINGS, VA 23075		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETIO DATE
F 726	Continued From page	e 105	F 72	26		
1 120					2022 on	
		d to ensure nursing staff had sluding knowledge, skills, and		conduct an audit from 10/4/2 residents that have a PTSD		
	-	o meet the resident's needs		have identified	ulayilusis Ul	
	· · · ·	trauma/Post-traumatic		trauma on the Trauma Infor	med	
		SD) in accordance with the		Screening to verify were not		
		esulting in expression of		the staff triggering	5	
	psychological harm for	or Resident #22.		feelings of past trauma or ca	ausing	
				aggressive behaviors emotion	onal distress	
		of the facility on 09/25/2023		or emotional harm.		
		ent #22 approached the		3. The SDC or designee will		
		C and Surveyor D) and		training for all facility staff or	n PTSD and	
		and the facility staff "did not		triggers,	amatianal	
		re of people diagnosed with 2 stated he was upset about		preventing behaviors and/or harm associated with trigge		
		y was diagnosed with PTSD.		from past or	ing events	
		t like they don't know how to		current trauma. Managemer	nt. monitorina.	
		esident #22 stated the staff		preventing behaviors and av	-	
		vas "pretending." Resident		triggers that may	·	
	#22 stated "this is set	rious." The resident stated		cause risk for or actual emo	tional harm for	
		stood by the staff. Resident		residents with behavioral he	althcare	
		elings more in depth with		needs and		
	Surveyor D during the	e survey.		residents with substance ab		
	On 00/26/2022 -+ 0-2	E a m an intenviewwar		residents will have care plan	nned with	
		5 a.m., an interview was sed Practical Nurse B who		problem and interventions it identify trigge	ers to attempt	
		sidents in the facility who had		to avoid/ prevent emotional		
		and other behavioral health		emotional harm		
	-	ated she had not received		and understand how to care	for, manage	
		n caring for residents with		and respond to the resident	-	
	trauma/PTSD.	-		with feelings		
				from past trauma or exhibiti		
		55 p.m., an interview was		behaviors to help with copin	g skills, to	
		ied Nursing Assistant-L who		calm and	.	
		eceived any special training		empower resident to expres		
	on caring for resident	ts with trauma/PISD.		promote trust to prevent furt	ner emotional	
	Doviou of the Feeling	Apparent revealed a		distress/harm.	Loudit woolds	
	review date of 08/31/	Assessment revealed a		4. The DON or designee wil x 4 weeks then monthly x 2	-	
1			1		1100000510	

Facility ID: VA0100

		MEDICAID SERVICES	(X2) MULT	PIF	CONSTRUCTION		D. 0938-039 E SURVEY
	F CORRECTION	IDENTIFICATION NUMBER:	. ,			· · ·	PLETED
							С
		495193	B. WING			10	/04/2023
NAME OF P	ROVIDER OR SUPPLIER			ST	IREET ADDRESS, CITY, STATE, ZIP CODE		
HENRICO	HEALTH & REHABILITA			56	1 NORTH AIRPORT DRIVE		
TENNOO				HI	IGHLAND SPRINGS, VA 23075		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETIO DATE
F 726	Continued From page	e 106	F 7	26			
		leeds (on page 1 of 2)			hires and any identified staff not receive	ed	
		Section 2.1 General Care and Specific Care or			had education and training on PTSD,		
	Practices" listed the			behavioral			
		and under "Specific Care or			healthcare management and substance		
	Practices" was writte			was completed with documentation and	ł		
		cation-related issues causing s and behavior, identify and			care plan reflects triggers to avoid/prevent feelings of pas	. +	
	implement intervention				trauma causing emotional distress or	51	
	individuals with issue				emotional harm.		
	withtrauma/PTSD,				Results of the review will be presented	to	
	diagnoses"				the QAPI committee for review and		
					recommendation.		
		l5 p.m., an interview was			Once the committee determines the	u	
	conducted with the S	ed she provided in-service			problem no longer exist and sustained t review will be	ine	
	education and trainin	-			conducted on a random basis.		
		Development Coordinator					
	stated staff members	•			5. Date of compliance: 11/19/2023		
		ning on required subjects.					
		aware the facility accepted					
		on who were diagnosed with					
		ues to include but not limited					
	disorder, a history of	cial, or substance use trauma and/or					
	post-traumatic stress						
	behavioral health cor						
	-	ity assessment. The Staff					
		nator stated the facility					
		zed to ensure residents					
	their well-being. The	e and services necessary for					
		he was not told to include					
		training topics but would					
	immediately begin to						
		pled employee training					
		documentation of training on					
		staff members were hired in					
	2022 or 2023 (Staff #	≉6 LPN hired in 2023, Staff					

Facility ID: VA0100

If continuation sheet Page 107 of 156

		ID HUMAN SERVICES MEDICAID SERVICES					RINTED: 11/29/2023 FORM APPROVED /IB NO. 0938-0391
STATEMENT (DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X:	3) DATE SURVEY COMPLETED
		495193	B. WING				C 10/04/2023
NAME OF PI	ROVIDER OR SUPPLIER	l		STREET AD	DDRESS, CITY, STATE, ZIP COL	DE	
HENRICO	HEALTH & REHABILITA	TION CENTER					
				HIGHLAN	ND SPRINGS, VA 23075		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 726	Continued From page	e 107	F 7	26			
		aff #22 hired in 2022, CNA-H		20			
	the facility Administra Corporate Nurse Con findings of no behavio trauma/PTSD. They v its staff members had training/education or the provision of care trauma/PTSD. The re	were informed that none of I received any met competencies regarding to residents diagnosed with esidents' needs were not them to reach their highest					
	Coordinator provided curriculum including t orientation and trainir curriculum revealed t	a copy of the training					
	the facility Administra Corporate Nurse Con of Operations were in	v debriefing on 10/03/2023, tor, Director of Nursing, isultant, and Vice President formed of the findings. They veyor D that one resident f psychosocial harm.					
F 742 SS=G		tal/Psychoscial Concerns	F 7	42			11/19/23
	§483.40(b) Based on assessment of a resid that- §483.40(b)(1)	the comprehensive dent, the facility must ensure					

Facility ID: VA0100

If continuation sheet Page 108 of 156

CENTER	S FOR MEDICARE &	ND HUMAN SERVICES MEDICAID SERVICES				OMB NO	M APPROVE D. 0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		495193	B. WING			10/04/2023	
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
HENRICO	HEALTH & REHABILITA	TION CENTER			61 NORTH AIRPORT DRIVE		
				Н	IGHLAND SPRINGS, VA 23075		1
(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 742	Continued From page	e 108	F	742			
		ays or is diagnosed with					
		sychosocial adjustment					
	-	a history of trauma and/or					
	post-traumatic stress						
		t and services to correct the					
	assessed problem or						
		nd psychosocial well-being; Γ is not met as evidenced					
	by:	I is not met as evidenced					
	-	on, interview, clinical record			F742 Treatment/Svrcs		
		ocumentation, the facility			Mental/Psychosocial Concerns		
		residents who display or are			1. Resident #53 no longer resides in	the	
	diagnosed with menta	al disorder, or history of			facility.		
		s Disorder (PTSD) receives			2. Current residents in the facility hav		
		t and services to attain the			potential to be affected. An audit by t	he	
	highest practical mer				DON or		
	÷	ent (Resident #53) in a			designee to verify residents with men		
	survey sample of 48	residents.			disorder or PTSD (post-traumatic stre disorder)	ess	
	The findings included	4.			diagnosis have psych services ordered	be	
	ine mange moladee	•			per physician had psych services visi		
	For Resident #53, the	e facility staff failed to ensure			3. The SDC or designee will educate		
		appropriate services post			social service/discharge planners and	b	
	sexual assault by a s	taff member at the facility.			licensed nurses on the		
	_				process for psych services per physic		
		Imitted to the facility on			order for residents with mental disord	ers,	
		noses that include but are iffective disorder, hemiplegia			PTSD,		
		ascular Accident or stroke)			substance abuse or trauma and verify psych services visits occur. Discharg		
		nan Immunodeficiency			planners and licensed	0	
	Virus), Hepatitis C, a	-			nurses will assess, monitor for		
	,, p				psychosocial wellbeing changes,		
	A review of the clinica	al record revealed the			emotional distress and/or		
	following:				emotional harm with MD and RP		
					notification and documentation.		
	"8/10/2023 5:06 pm T	•			4. The unit manager will audit weekly	x 4	
	-	Patient sent to [hospital			then monthly x 2 months to verify		
		valuation r/t alleged assault,			residents with mental		
	MD made aware. Pat	tient verbalized			disorder or PTSD have psych service	per	1

Facility ID: VA0100

If continuation sheet Page 109 of 156

			()(0) 10 10				<u>D. 0938-039</u>
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION		E SURVEY PLETED
			7 DOILDING	° <u> </u>			С
		495193	B. WING			10/04/2023	
NAME OF PI	ROVIDER OR SUPPLIER	•		REET ADDRESS, CITY, STATE, ZIP CODE			
	HEALTH & REHABILITA			56 ⁻	1 NORTH AIRPORT DRIVE		
HENRICO		TION CENTER	HIGHLAND SPRINGS, VA 23075				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 742	Continued From page	a 109	F 74	12			
	understanding the rea			+2	physician orders and psych service vi	eite	
		asun iur ulansiei.			physician orders and psych service vi occurred with	อแอ	
	"8/10/2023 - 5:15 pm			documentation. Results of the review	will		
	Patient made a stater			be presented to the QAPI committee	or		
	that took place this m			review and			
	given from patient to			recommendation. Once the committee			
		station. Phone call placed			determines the problem no longer exis	st	
		ices so patient could give an			and sustained the review will be conducted on a random		
	official statement and	i press charges.			basis.		
	"8/12/2023 4·51 -Aler	rt Note Text: Due to safety			Dasis.		
		al issues; constant yelling			5. Date of compliance: 11/19/2023		
	and threatening staff			• • • • • • •			
	bed when in room/be						
	aware to possibly cor nurses' station."	nsider moving room closer to					
	· ·	COMMUNICATION - with					
		name redacted] and [name					
		[Resident #53] about his 3. Therapy reported that					
		to harm self, to which					
		ted. [Resident #53] says that					
		a plan to harm himself					
		le Dr. [name redacted]					
	(psych) aware."						
	"8/17/2023- 5:50 AM	-Health Status Note-Note					
		ident was suicidal during the					
	day shift. Hourly chec						
		resident stated he had no					
	plan or intention to co	-					
		esident was noted to be					
	-	towards staff such as					
		e staff or yelling for not s needs as soon as he asked					
		ded education that he needs					
		espond, also he needs to					
	communicate with his	-					

Facility ID: VA0100

If continuation sheet Page 110 of 156

DEPARTMENT OF HEALTH AN CENTERS FOR MEDICARE & M				FOR	D: 11/29/2023 MAPPROVED D. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	. ,	E SURVEY PLETED
	495193	B. WING		10	C / 04/2023
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZI	P CODE	
HENRICO HEALTH & REHABILITAT			561 NORTH AIRPORT DRIVE HIGHLAND SPRINGS, VA 230	75	
PREFIX (EACH DEFICIENCY	ITEMENT OF DEFICIENCIES 7 MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	CTION SHOULD BE	(X5) COMPLETION DATE
 needed, fall precaution he is stable and restine On 09/27/2023, an interpret the DON who was ask services in the building. When asked if she that for Resident #53 to hat after such an incident, did and would supply is services. A review of the clinical Resident #53 had and read "Psych Consult aresident was not seen 08/23/2023. The visit of prompted by the sexual psych notes revealed "Resident was referred depressed mood. Per resident is reported to and refusing care som in his room, in bed, carengaged. Resident represed mod. Per resident is reported to and refusing care som in his room, in bed, carengaged. Resident represed mod. Resident represed mode is reported to and refusing care som in his room, in bed, carengaged. Resident represed mode is reported to and refusing care som in his room, in bed, carengaged. Resident represed mode is reported to and refusing care som in his room, in bed, carengaged. Resident represed mode is reported to and refusing care som in his room, in bed, carengaged. Resident represed mode is set and the set	empting to hit staff. ded every 2 hours and as ns followed and maintained, g in bed at this time." erview was conducted with ked if they have psych g and she stated they did. bught it would be beneficial ave seen psych services , she stated she thought he the notes from psych I record revealed that order dated 08/01/2023 that as needed"; however, the by psych services until on 08/23/2023 was not al assault. A review of the the following: d today for stabilization in nurses' notes and report, be verbally abusive to staff, netimes, Resident was met alm, alert, speech clear and ported in on multiple ons to include Lithium, Diazepam, Ativan, , Hydroxyzine and he has not been sleeping vake the whole night; I nt also reported he feels	F 742			

If continuation sheet Page 111 of 156

	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C 10/04/2023	
		495193	B. WING			
AME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
			:	561 NORTH AIRPORT DRIVE		
IENRICO	HEALTH & REHABILITA	TION CENTER		HIGHLAND SPRINGS, VA 23075		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLÉTIO	
F 742 F 745 SS=D	Resident #53 was int on 08/10/2023 involv CNA C. Resident #53 have male staff anym unable to sleep at all prescribed Trazadom was in tears when ex made him feel helple has contractures that himself. Resident #53 CNA would no longer did not want any mal When asked if he wa support or psych sen the incident, he state On 10/04/2023 during Administrator was ma No further information Provision of Medicall CFR(s): 483.40(d) §483.40(d) The faciliti medically-related soor maintain the highest and psychosocial we This REQUIREMENT by: Based on interview, facility documentation provide medically related	proximately 3:00 p.m., erviewed about the incident ing the sexual assault by 3 stated that he was afraid to hore. He stated he was after the incident and was e as a result. Resident #53 plaining how the incident ss and fearful because he prevent him from defending 3 stated he was aware the be in the building but still e CNA staff to work with him. s provided with emotional vices immediately following d that he did not. g the end of day meeting, the ade aware of the concerns. h was provided. y Related Social Service	F 742	F745 Provision of Medically Related Social Service 1. Resident #22 still resides in the facility. Discharge planner has assisted		
	The findings included	Ŀ		Resident #22 has received both social security care and state identification of	ıl	

Event ID: EB1X11

Facility ID: VA0100

If continuation sheet Page 112 of 156

	OF DEFICIENCIES	MEDICAID SERVICES		PIF	CONSTRUCTION		E SURVEY	
	CORRECTION	IDENTIFICATION NUMBER:	. ,				PLETED	
							С	
		495193	B. WING			10/04/2023		
NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE			
	HEALTH & REHABILITA			56	1 NORTH AIRPORT DRIVE			
HENKICO		TION CENTER		HI	GHLAND SPRINGS, VA 23075			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETIO DATE	
F 745	Continued From page	e 112	F 74	15				
		e Social Worker failed to			2. Current residents in the facility have	ve		
		obtaining his social security			the potential to be affected. An audit by			
		ication card that was lost			DON or designee to identify if other	-		
		lmission prior to admission			resident required assistance with			
	to the facility.				identifications. Resident #103 was			
	On 00/25/2022 at any				identified and discharge planner assist			
		proximately 3:00 p.m., erviewed and stated he has			with process to obtain social security c No other residents were identified.	ard.		
		ial Security card since he			3. The Administrator or designee will			
		le stated it was lost during			educate the discharge planners to the			
	-	n prior to entering the facility.			process for resident right to be assisted	d		
		d made the staff aware of			with obtaining personal identifications			
	the need for assistant			such social security card, state				
		ware a few times but a lot of			identification card as needed to have	- -		
		both quit on Friday." When hem, he stated, "I have been			available and/or help with retuning to the community.	ne		
	asking since I got her				4. The Director of discharge planner			
	doning onloo r got hor				audit weekly x 4 weeks and monthly x			
	A review of the clinica	al record revealed there was			months to identify resident that require			
	no documentation at	all from social services since			assistance with obtaining a social secu	ırity		
	arriving at the facility	on 05/03/2022.			card and/or state identification card we	ere		
					assisted and obtained. Results of the			
		terview was conducted with			review will be presented to the QAPI			
		s asked if there are no notes services in the chart what			committee for review and recommendation. Once the committee			
		ployee O stated the social			determines the problem no longer exis			
		are no longer at the facility.			and sustained the review will be			
		previous Friday, so they			conducted on a random basis.			
	could not tell whether	Resident #22 had any						
	interaction with them	regarding his identification.			5. Date of compliance: 11/19/2023			
	9/26/2023 4:00 pm -	DISCHARGE PLANNING						
		Text: [Discharge planner						
	name redacted] called	d [County Social Services						
	-	ce and left a voicemail for						
		redacted] (LTC benefits)						
		n (copy of his ID or birth						
		nt #22 name redacted]						
	neeus lo some type o	of Identification to replace his					1	

If continuation sheet Page 113 of 156

	-	ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 11/29/202 FORM APPROVE OMB NO. 0938-039		
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CC A. BUILDING		(X3) DATE SURVEY COMPLETED		
495193		B. WING		C 10/04/2023			
	ROVIDER OR SUPPLIER	TION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 561 NORTH AIRPORT DRIVE HIGHLAND SPRINGS, VA 23075				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE COMPLETION		
F 745 F 755 SS=D	lost ID." When asked substance abuse issu and a diagnosis of PT Social Worker at leas facility, she stated, "h admission note." On 10/04/2023 during Administrator was ma No further information Pharmacy Srvcs/Proc CFR(s): 483.45(a)(b) §483.45 Pharmacy S The facility must prov drugs and biologicals them under an agree §483.70(g). The facil personnel to administ permits, but only und a licensed nurse. §483.45(a) Procedure pharmaceutical servic that assure the accur dispensing, and admi biologicals) to meet th §483.45(b) Service C must employ or obtai pharmacist who- §483.45(b)(1) Provide	if a resident who has ues, mental health concerns, ISD should have seen the at 1 time since arrival at the le should have at least an g the end of day meeting, the ade aware. In was provided. cedures/Pharmacist/Records (1)-(3) ervices ride routine and emergency to its residents, or obtain ment described in lity may permit unlicensed ter drugs if State law er the general supervision of es. A facility must provide ces (including procedures ate acquiring, receiving, inistering of all drugs and he needs of each resident. consultation. The facility in the services of a licensed	F 745		11/19/23		

Facility ID: VA0100

If continuation sheet Page 114 of 156

	-	ND HUMAN SERVICES				FORM	0: 11/29/202 1 APPROVE 0. 0938-039
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /		CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		495193		B. WING			_ 04/2023
NAME OF PI	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE	•	
HENRICO	HEALTH & REHABILITA	TION CENTER			31 NORTH AIRPORT DRIVE IGHLAND SPRINGS, VA 23075		
(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 B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 755	sufficient detail to ena reconciliation; and §483.45(b)(3) Detern order and that an acc is maintained and pe This REQUIREMENT by: Based on interview, facility documentation ensure medications w (Resident #103) in a residents. The findings included For Resident #103, the ensure the resident h Morphine 15mg for h wound. On 09/25/2023 at app interview was conduct stated the facility kee medicine (Morphine 1 knew why this was has	able an accurate hines that drug records are in count of all controlled drugs riodically reconciled. Γ is not met as evidenced clinical record review, and h, the facility staff failed to vere available for 1 resident survey sample of 48 I: he facility staff failed to had an adequate supply of er pain control due to a proximately 4:30 p.m., an cted with Resident #103 who appening out of her pain 15 mg). When asked if she appening, she stated she did pened again this morning."	F	755	F755 Srvcs/Procedures/Pharmacist/Records 1. Resident #103 still resides in the facility. Resident #103 has medication available. 2. Current residents in the facility have potential to be affected. An audit by the DON or designee to review current residents medications required hard scripts obtained, ordered, delivered and available to administer p physician order. 3. The SDC or designee will educate licensed nurses on process for timely reordering medication to have delivered and available, hard scri obtained, medication order, delivered at available to prevent unavailable medications and to	is the e er pts and	
	A review of the clinica "9/25/2023-4:13 pm H Spoke with Resident that medication MS e	II has to wait to get that. al record read: Health Status - Note Text: this AM due to complaints every four prn was not a nurse and pharmacy and			 administer per physician order. 4. The unit manager or designee audit weekly x 4 weeks then monthly x 2 months to verify medications are reordered or required hard scripts obtained, ordered, delivere and available to administer per physician order. Results 	ed	
	medication requiring	prior authorization. Physician sign PA, in the meantime			the review will be presented to the QAI committee for		

Facility ID: VA0100

STATEMENT (OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DA	NO. 0938-039 TE SURVEY	
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		CO	MPLETED	
		495193	B. WING		1	C 0/04/2023	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
HENRICO	HEALTH & REHABILITA	TION CENTER		561 NORTH AIRPORT DRIVE HIGHLAND SPRINGS, VA 23075			
(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 APF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 755	Continued From pag	e 115	F 755	5			
	 F 755 Continued From page 115 new order for Tramadol 50 mg every six hours ordered." A review of the Medication Administration Record (MAR) revealed that Resident #103 did have a valid order for Morphine 15mg every 4 hours for pain. This medication was unavailable. Resident #103 did not receive morphine from 2:51 p.m. on 09/21/2023 until 09/26/2023 at 7:30 a.m. "9/26/2023 05:35 - Orders - Administration Note-Note Text: Tramadol 50mg every six hours routine every 6 hours related to SUBACUTE OSTEOMYELITIS, LEFT ANKLE AND FOOT Medication in route per pharmacy, unable to pull from omnicel at this time, MD aware that medication required script." On the afternoon of 09/26/2023, an interview was 			review and recommendation. On committee determines the proble longer exist and sustained the review will be cond a random basis. 5. Date of compliance: 11/19/2	m no lucted on		
	for reordering medica the pharmacy for refi script, they contact th DON was asked if th she indicated they di have a physician har from the back-up pha who is responsible for obtained, she stated On the morning of 09 conducted with LPN #103's morphine is n the resident would ha to receive it. When a cart on 09/25/2023, s	ON who stated the process ations is that the staff notify Ils and if it requires a hard he physician to get it. The ey use a back-up pharmacy, d have one but if they do not d script they cannot get it armacy either. When asked or ensuring a new script is the nurses are. 0/27/2023, an interview was B who stated that Resident ot scheduled, it is PRN, so ave to ask for the medication sked if it was available in the she stated it was not. When Omnicell (stat box), she					

Facility ID: VA0100

If continuation sheet Page 116 of 156

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION	(X3) DATE COMF	
		495193	B. WING _				04/2023
NAME OF PF	ROVIDER OR SUPPLIER		•	ST	IREET ADDRESS, CITY, STATE, ZIP CODE	-	
HENRICO	HEALTH & REHABILITA	TION CENTER			31 NORTH AIRPORT DRIVE IGHLAND SPRINGS, VA 23075		
(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 755	Omnicell, but needed ordered because they A review of the Medic (MAR) for Sept. 2023 nurses notes docume unavailable, yet it is s 09/25/2023 at 6:00 p. 6:00 a.m. It was left b was signed off as bein Resident #103 reports Tramadol pain medica 6:00 p.m. A review of the Residurevealed that during the through August, residured medications not being running out of resider On the morning of 09 conducted with LPN E #103's morphine is not resident would have the receive it. When asket cart on 09/25/2023, si asked if it was in the 0	a script at the time it was v only had a verbal order. action Administration Record revealed that although ent the Tramadol was signed off as given on m., and on 09/26/2023 at lank, but at 12:00 noon it ng given. s not receiving any ordered ation until 09/26/2023 at ent Council minutes he months of March ents complained about g on time and the facility nts' medications. /27/2023, an interview was 8 who stated Resident ot scheduled, it is PRN. The o ask for the medication to bd if it was available on the he stated it was not. When Omnicell (stat box), she	F7	755			
F 803	Administrator was ma	g the end of day meeting, the ade aware of the concerns. In was provided. t Nds/Prep in Adv/Followed	F8	202			11/19/23
F 803 SS=F	CFR(s): 483.60(c)(1)-	-		503			11/19/23

Facility ID: VA0100

If continuation sheet Page 117 of 156

	-	ID HUMAN SERVICES				FORM	M APPROVED
		MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE	ECONSTRUCTION	(X3) DATE	D. 0938-0391 SURVEY
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING_		COMPLETED	
		495193	B. WING			10/	04/2023
NAME OF PI	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
HENRICO	HEALTH & REHABILITA	TION CENTER		5	61 NORTH AIRPORT DRIVE		
				F	HIGHLAND SPRINGS, VA 23075		
(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 B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
E 903		- 447					
F 803	Continued From page	e 117	F	803			
	Menus must-						
	\$402.00(a)(4) Ma at th						
		ne nutritional needs of nce with established national					
	guidelines.;						
	J,						
	§483.60(c)(2) Be prep	pared in advance;					
	§483.60(c)(3) Be follo	owed;					
	§483.60(c)(4) Reflect	based on a facility's					
		e religious, cultural and					
		esident population, as well as					
	input received from re						
	groups;						
	§483.60(c)(5) Be upd	ated periodically;					
	§483.60(c)(6) Be revi	ewed by the facility's					
		cally qualified nutrition					
	professional for nutrit	ional adequacy; and					
ĺ	8483 60(c)(7) Nothing	g in this paragraph should be					
		resident's right to make					
	personal dietary choic						
		is not met as evidenced					
	by:						
	Based on observatio	n, resident interviews, staff			F803 Menus Meet Resident Nds/Prep	in	
		documentation review, the			Adv/Followed		
	facility staff failed to p				1. Resident #17 still resides in the facil	-	
		menu, which affected the			Resident #65 still resides in the facility		
	residents residing on	2 of 2 nursing units.			Resident #49	~~	
	The findings included	ŀ			still resides in the facility. Timeframe h passed to correct.	a5	
					2. Current residents in the facility have	the	
	On 09/25/2023 and 0	9/26/2023 during the initial			potential to be affected.		
		nber of residents, residing			3. The Dietary Manager or designee w	ill	
	on both nursing units,	-			educate all dietary staff on processes f		
	regarding the food to				meal tray		

Event ID: EB1X11

Facility ID: VA0100

If continuation sheet Page 118 of 156

		ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 11/29/202 MAPPROVE D. 0938-039
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF A. BUILDING		TRUCTION	(X3) DATE	E SURVEY PLETED
		495193	B. WING			C 10/04/2023	
NAME OF PF	ROVIDER OR SUPPLIER			STREET	ADDRESS, CITY, STATE, ZIP CODE	1	
				561 NO	RTH AIRPORT DRIVE		
HENRICO HEALTH & REHABILITATION CENTER			HIGHL	AND SPRINGS, VA 23075			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 803	Continued From page	e 118	F 80	03			
	1 0				paration with accurate diet, per me	enu	
	On 09/27/2023 during			n resident likes and no dislikes. Me			
	made observations of			ostitutions			
	trays. The findings we			l logged in menu substitution book istered dietitian review substitutior			
	For Resident #17, the			nu book on			
	was to get scrambled		visi		_		
	onions, biscuit, grits, was a notation at the			e SDC or designee will educate the nsed nurses, and CNAs on the	9		
		hardboiled egg]. The meal			cess for accurate diet,		
		ardboiled eggs, 2 pieces of			menu and residents likes and dis	ikes	
	toast, and a bowl of c			with	n verification of meal tray accuracy		
	During the above obs	servation of Resident #17's			or to delivery neal tray to resident. Dietary will b	0	
		nt said, "I don't eat grits, but			prmed if not accurate and another		
	we never get what is			tray	/ prepared. Dietary manager will conduct	incu	
	Additional observatio	ns were made, which			servation audit weekly x 4 weeks th	ne	
		t limited to Resident #65 and			nthly x 2 months of		
	Resident #49. Both re	esidents' meal ticket		die	tary staff preparing 10 meal trays	for	
	indicated they were to	o have scrambled eggs,		acc	curacy of diet, menu items prepare	d	
		s, biscuit, grits, and sausage			n likes and no		
	0	n had any slivered onions,			likes on meal tray. Any findings wil		
	biscuits, grits, or saus				nediately corrected. The unit mana	ager	
		st, and oatmeal. Resident			audit 10		
	#49 said, "While you				meal trays being served to verify	nd no	
		ext week it will go back to the no consistency. We never			curacy of diet, menu items, likes ar likes on meal		
		ournt on the ends, and we			/. Any findings will be corrected.		
	never have sausage			Re	sults of the review will be presente QAPI	d to	
	On 09/27/2023, Surve	eyor F reviewed the menu,			nmittee for review and		
		s "Day 18" and the menu			ommendation. Once the committe	е	
		"Scrambled eggs, slivered			ermines the problem no		
		, grits, and sausage gravy."		lon	ger exist and sustained the review	will	
	On 00/27/2022 at 0.2			be	conducted on a random basis.		
	On 09/27/2023 at 9:2	ew with the cook, Employee		5.	Date of compliance: 11/19/2023		
	J. When asked what	w with the cook, Employee		1 0.	Date of compliance. 11/19/2023		

Facility ID: VA0100

If continuation sheet Page 119 of 156

DEPARTMENT OF HEALTH CENTERS FOR MEDICARE				PRINTED: 11/29/2023 FORM APPROVED OMB NO. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495193	B. WING		C 10/04/2023
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE	, ZIP CODE
			561 NORTH AIRPORT DRIVE	
HENRICO HEALTH & REHABII	LITATION CENTER		HIGHLAND SPRINGS, VA 2	23075
PREFIX (EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORRECTIN CROSS-REFERENCE	AN OF CORRECTION (X5) /E ACTION SHOULD BE COMPLETION D TO THE APPROPRIATE DATE ICIENCY)
hard boiled eggs, what is the purpos stated, "It tell you diet." The cook wa the menu for the ob binder with the me sausage gravy an why these items v said, "The biscuits don't do sausage menu, we do saus because they con anymore." The dietary mana Employee J during dietary manager v to see the menu s manager was una indicated she wou cook. At the end confirmed she had menu substitution On 09/27/2023 at manager (DM), En dietician (RD),Em conference room and RD were aske regarding the resi at the least, discu meetings. The su abundance of cor regarding the food aware of the obse asked if she had a menu. The RD sa	I said, "eggs, oatmeal, toast, and sausage." When asked se of the meal ticket, the cook what they are eating and their as asked to let the surveyor see day. The cook pulled out a enu which listed the biscuits and do atmeal. When questioned were not prepared, the cook is didn't come on the truck, we gravy, when you see that on the sage and grits. We changed hplained they didn't like it ger joined Surveyor F and g the above interview. The was asked to allow Surveyor F substitution log. The dietary able to locate the log and all have to call the evening of the day, the dietary manager d never been able to locate the	F	803	

Facility ID: VA0100

If continuation sheet Page 120 of 156

HUMAN SERVICES				FORM	APPROVED 0. 0938-0391
(1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,			(X3) DATE SURVEY COMPLETED C	
495193	B. WING				04/2023
		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
ON CENTER		561 NORTH AIRPORT DRIVE HIGHLAND SPRINGS, VA 23075			
SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		FIX (EACH CORRECTIVE ACTION SHOULD BE			(X5) COMPLETION DATE
20 In not formally been that their current menu lanuary 5, 2022, and that ned about always getting and DM both stated they nenus now. The breakfast meal ain noted that the iving the meal items that al tickets. hid-morning, the e aware of the above ns regarding the menus residents' concerns with the mid-day/lunch meal, e of residents' meal trays. the items listed on the erved. Squash casserole rved according to the had that item crossed out en in, but the residents ary manager presented ary Menu Substitution or the lunch meal, d squash was omitted. age was noted as, ere was no indication in wed that the residents had or were previously made	F	803			
	EDICAID SERVICES 1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495193 DN CENTER MENT OF DEFICIENCIES IDENTIFYING INFORMATION) 20 1 not formally been hat their current menu anuary 5, 2022, and that hed about always getting and DM both stated they henus now. The breakfast meal ain noted that the iving the meal items that al tickets. hid-morning, the a ware of the above hs regarding the menus residents' concerns with the items listed on the erved. Squash casserole ved according to the had that item crossed out any manager presented ary Menu Substitution or the lunch meal, d squash was omitted. Ige was noted as, are was no indication in wed that the residents had	EDICAID SERVICES 1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULT A. BUILDI 495193 B. WING 495193 B. WING ON CENTER ID EMENT OF DEFICIENCIES IUST BE PRECEDED BY FULL DENTIFYING INFORMATION) ID 20 F I not formally been F hat their current menu anuary 5, 2022, and that ned about always getting and DM both stated they nenus now. F ne breakfast meal ain noted that the iving the meal items that il tickets. In nid-morning, the e aware of the above ns regarding the menus residents' concerns with In ne mid-day/lunch meal, e of residents' meal trays. the items listed on the erved. Squash casserole ved according to the had that item crossed out in in, but the residents In ary manager presented ary Menu Substitution for the lunch meal, d squash was omitted. In or the that the residents had In	EDICAID SERVICES 1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE A. BUILDING 495193 B. WING 495193 B. WING 50N CENTER ID PREFIX INCENTER ID PREFIX 20 F 803 21 Int formally been hat their current menu anuary 5, 2022, and that ned about always getting and DM both stated they henus now. he breakfast meal ain noted that the iving the meal items that il tickets. hid-morning, the e aware of the above ns regarding the menus residents' concerns with he mid-day/lunch meal, e of residents' meal trays. the items listed on the erved. Squash casserole ved according to the had that item crossed out on in, but the residents ary manager presented ary Menu Substitution or the lunch meal, d squash was omitted. toge was noted as, the was no indication in wed that the residents had	DI PROVIDERISUPPLIENCIA IDENTIFICATION NUMBER: (x2) MULTIPLE CONSTRUCTION A BUILDING 495193 B. WING 900 CENTER STREET ADDRESS, CITY, STATE, ZIP CODE 561 NORTH AIRPORT DRIVE HIGHLAND SPRINGS, VA 23075 INT OF DEFICIENCIES UST BE PRECEDED BY FULL IDENTIFYING INFORMATION) D PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIN DEFICIENCY) 20 F 803 1 not formally been F 803 hat their current menu anuary 5, 2022, and that teed about always getting and DM both stated they terrus now. F 803 in noted that the ving the meal items that it in cold that the ving the meal items that it it kets. I id concerns with B e aware of the above the items listed on the erved. Squash casserole ved according to the rad that time crossed out in in, but the residents I ary manager presented ary Menu Substitution or the lunch meal, d squash was omitted. ge was noted as, tre was not indication in we do that the residents had I	EDICAID SERVICES OME NC 1) PROVIDERSUPPLERICLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A BUILDING (X3) DATE COME 495193 B. WING (10) 20 CENTER STREET ADDRESS, CITY, STATE, ZIP CODE S61 NORTH AIRPORT DRIVE HIGHLAND SPRINGS, VA 23075 10/ DIN CENTER D PROVIDER'S PLAN OF CORRECTION (EQC) CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) ID PROVIDER'S PLAN OF CORRECTION (EQC) CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) 20 10/ F 803 F 803 20 20 20 20 20 20 30 not formally been F 803 20 40 20 40 about always getting and DM both stated they ienus now. F 803 20 40 about always getting and DM both stated they ienus now. F 803 20 50 residents' meal items that in noled that the twing the meal items that in trade about always getting and DM both stated they ienus now. F 803 20 60 residents' concerns with F 803 20 70 70 70 70 70 70 70 70 70 70 70 70 70

Facility ID: VA0100

If continuation sheet Page 121 of 156

	-	ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 11/29/20 FORM APPROVE OMB NO. 0938-039
	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING		(X3) DATE SURVEY COMPLETED C
		495193	B. WING		10/04/2023
NAME OF PF	OVIDER OR SUPPLIER		STR	EET ADDRESS, CITY, STATE, ZIP CODE	
HENRICO	HEALTH & REHABILITA	TION CENTER		NORTH AIRPORT DRIVE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE COMPLETIO
F 803	Continued From page	e 121	F 803		
		ent Council meeting minutes			
	1. During the August	5			
	Residents expressed	, "What is on meal tickets			
	are not servedWron	ng diets served." The se was, "Dietary staff will			
		there are menu changes."			
	2. During the meeting				
	residents expressed, improved."	"Quality of the food has not			
	•	the residents expressed,			
	"Alternate meals and	sandwiches are not			
		ition section it was noted,			
		ed dietary company name oonsible for posted menu y Manager."			
		ce that the Resident Council oncerns regarding the or biscuits.			
	conducted. This polic	policy titled, "Menus" was y read, "It is the center planned in advance, and to			
	meet the nutritional n	eeds of the			
		Il be developed utilizing an			
		guideline. 6. Menus are less changed in response to			
		pility of an items, or a special			
	meal. 7. A menu subs maintained on file."	stitution log will be			
		e end of the survey day, the was made aware of the			
	No further information	n was provided.			
F 804 SS=F		ar, Palatable/Prefer Temp	F 804		11/19/23

Facility ID: VA0100

If continuation sheet Page 122 of 156

		ID HUMAN SERVICES MEDICAID SERVICES				FORM): 11/29/2023 1 APPROVED). 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		495193	B. WING				_ 04/2023
NAME OF PF	ROVIDER OR SUPPLIER	I		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
HENRICO	HEALTH & REHABILITA	TION CENTER			61 NORTH AIRPORT DRIVE HIGHLAND SPRINGS, VA 23075		
(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 804	Continued From page 122		F	804			
	CFR(s): 483.60(d)(1)	(2)					
	§483.60(d) Food and drink Each resident receives and the facility provides-						
		repared by methods that ue, flavor, and appearance;					
	attractive, and at a sa temperature.						
	by:	is not met as evidenced n, resident interview, staff			F804 Nutritive Value/Appear,		
	facility staff failed to s	documentation review, the erve food that was palatable on 2 of 2 nursing units.			Palatable/Prefer Temp1. Timeframe has passed to correct.2. Current residents in the facility have	the	
	Findings include:	-			potential to be affected. 3. The Dietary manager will educate th dietary staff on the process for meal	e	
	facility staff failed to s	g on both nursing units, the erve food in a manner to at a preferred temperature			preparation to ensure hot food temperatures are maintained. The SDC or designee will educate CN/	٨٥	
	when it reached the r	esidents.			licensed nurses, department managers the process to		
	process, an abundan	6/2023 during the initial tour ce of residents on both ed concerns about the food			ensure hot food temperatures are maintained, distributed timely, Styrofoa and open carts are	ım	
	not being hot.				delivered prior to meal carts with close doors until meal trays passed.		
	distribution was cond	rvation of breakfast tray ucted. For residents residing eakfast trays were not			 4. The dietary manager or designee wi audit weekly x 4 weeks then monthly x months 		
	served until 10:00 a.r cart of meal trays hel	n. It was noted that each d approximately 25-30 meal , which served residents in			temperature checks of 10 meal trays to verified hot food temperature is maintained after serving)	
	rooms 1-12, were all containers, like a rest				maintained after serving meal trays. Results of the review will be presented to the QAPI committee for review and	е	

Facility ID: VA0100

		ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 11/29/2023 MAPPROVED D. 0938-0391	
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· , ,		CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED	
		495193	B. WING				C 104/2023	
	ROVIDER OR SUPPLIER	TION CENTER		56	TREET ADDRESS, CITY, STATE, ZIP CODE 61 NORTH AIRPORT DRIVE IGHLAND SPRINGS, VA 23075			
(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)	ЗE	(X5) COMPLETION DATE	
F 804	13-24, approximately regular dinnerware pl in the same Styrofoan On 09/28/2023 at app breakfast trays were residents, interviews and CNA G. When as their responses were plates" and "Sometim Styrofoam." Resident interviews w numerous residents of was not hot. Residen did not mind the Styro keep the food warm. On 09/28/2023 at app Surveyor F went to th cook. The cook was a meal trays, and he im- left the kitchen about asked if this was norr the meals being late f "No, everything went problems." The cook being served on Styro did not have enough During the above inter joined the conversation stated, "When late tra- kitchen timely at nigh they aren't available if manager also stated leaves the kitchen, bu and when staff do nor	half of the trays were on ates and the other half were m containers. Droximately 10:05 a.m., while being distributed to were conducted with CNA B sked about the Styrofoam, , "They must have run out of nes they are all served on were conducted, and complained that the food t #65 commented that she ofoam so much as it did not proximately 10:25 a.m., he kitchen to interview the asked about the timing of dicated the last cart had just 10-15 minutes ago. When mal or if something impacted this morning, the cook said, smooth, we had no was asked about residents ofoam, and he said that they	F	804	recommendation. Once the committee determines the problem no longer exis and sustained the review will be conducted on a random basis 5. Date of compliance: 11/19/2023	st		

Facility ID: VA0100

If continuation sheet Page 124 of 156

		ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·		E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		495193	B. WING				C /04/2023
NAME OF P	ROVIDER OR SUPPLIER		•	5	STREET ADDRESS, CITY, STATE, ZIP CODE		
HENRICO	HEALTH & REHABILITA	TION CENTER			561 NORTH AIRPORT DRIVE HIGHLAND SPRINGS, VA 23075		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	EFIX (EACH CORRECTIVE ACTION SHOULD BE			(X5) COMPLETION DATE
F 804	one of the carts has a latch for the South win escape and that main the cart. On 09/29/2023, meal observed on the Sout residents again comp hot. Review of the Reside conducted. This revie Concern Report" was the Resident Council Review of the facility's the survey team were not address the palata at the time of meal de On 09/29/2023, the fa made aware of the ab No additional informa Frequency of Meals/S CFR(s): 483.60(f)(1)-0 §483.60(f) Frequency §483.60(f)(2)There m hours between a subs breakfast the following	 broken door and will not ng, so it allows the heat to tenance is going to work on trays for lunch were h wing and multiple lained that the food was not nt Council minutes was w revealed a "Service submitted in April following meeting for food being cold. s dietary policies provided to reviewed. The policies did ability and food temperature elivery. acility Administrator was pove findings. tion was provided. Snacks at Bedtime (3) of Meals sident must receive and the it least three meals daily, at able to normal mealtimes in ccordance with resident equests, and plan of care. ust be no more than 14 stantial evening meal and 		804			11/19/23

Facility ID: VA0100

If continuation sheet Page 125 of 156

		ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 11/29/2023 MAPPROVED D. 0938-0391	
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495193	B. WING			C 10/04/2023		
NAME OF PI	ROVIDER OR SUPPLIER	•		S	TREET ADDRESS, CITY, STATE, ZIP CODE	_		
	HEALTH & REHABILITA			5	61 NORTH AIRPORT DRIVE			
HENKICO		TION CENTER		ŀ	IIGHLAND SPRINGS, VA 23075			
(X4) ID PREFIX TAG			ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 809	hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span. §483.60(f)(3) Suitable, nourishing alternative		F	809				
	who want to eat at no of scheduled meal set the resident plan of c This REQUIREMENT by: Based on interview, facility documentation	 is not met as evidenced clinical record review, and n, the facility staff failed to idents who wish to eat 			F809 Frequency of Meals/Snacks at Bedtime 1. The Dietary Manager on 9/28/2023 verified snacks were available on both units.			
	mealtimes, the facility were available on the On 09/26/2023 at app the Resident Council	sh to eat outside of regular / failed to ensure snacks			 Current residents in the facility have potential to be affected. The Dietary Manager or designee wi educate the dietary staff on the process ensure snacks are available on each unit for the reside 4. The Dietary Manager or designee at approval of resident council next reside council meeting to ensure the concerns and pla for snack availability for the residents. 	ll s to ent. the ent an		
	brought up in 4 of the On 09/28/2023 at 10: conducted with Emplo sends snacks to the f pudding, applesauce juices, and milk. She know why there is no	being unavailable has been e last 6 meetings. 00 a.m., an interview was oyee K who stated that she loor including cookies, , peanut butter crackers, stated that she does not			dietary manger or designee will conduct observation rounds weekly x 4 weeks th monthly x 2 months to ensure snacks are available on each unit. Results of the review will be presented to the QAPI committee for review and recommendation. Once the committee determines the problem no longer exist and sustained the review w be conducted on a random basis.	hen		

Facility ID: VA0100

If continuation sheet Page 126 of 156

	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 11/29/2023 MAPPROVED D. 0938-0391	
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·		CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED	
		495193	B. WING			C 10/04/2023		
NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE			
HENRICO	HEALTH & REHABILITA	TION CENTER			1 NORTH AIRPORT DRIVE GHLAND SPRINGS, VA 23075			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE	
F 809	worked. An observation was n each unit on 09/28/20 were snacks available Resident Council min stocked every shift." On 10/04/2023 during Administrator was ma No further information Facility Assessment CFR(s): 483.70(e)(1) §483.70(e) Facility as The facility must cond facility-wide assessm resources are necess competently during be and emergencies. Th update that assessme least annually. The fa update this assessme facility plans for, any substantial modification assessment. The faci address or include: §483.70(e)(1) The faci including, but not limit (i) Both the number of resident capacity; (ii) The care required	ever any snacks for ted she has worked d not have any when she hade of the "pantry" area on 023 at 12:50 p.m., and there e at that time. Per the utes "pantries should be the end of day meeting, the de aware of the concerns. In was provided. -(3) sessment. duct and document a ent to determine what ary to care for its residents oth day-to-day operations e facility must review and ent, as necessary, and at cility must also review and ent whenever there is, or the change that would require a on to any part of this lity assessment must cility's resident population,		309	5. Date of compliance: 11/19/2023		11/19/23	

Facility ID: VA0100

If continuation sheet Page 127 of 156

	MENT OF HEALTH AN S FOR MEDICARE & I	D HUMAN SERVICES				FORM): 11/29/2023 APPROVED). 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE COMP	SURVEY LETED
		495193	B. WING		_		C 04/2023
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	ATE, ZIP CODE	•	
HENRICO	HEALTH & REHABILITA	TION CENTER		561 NORTH AIRPORT DRIV HIGHLAND SPRINGS, V			
(X4) ID PREFIX TAG	TIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOL				CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA		(X5) COMPLETION DATE
F 838	physical and cognitive and other pertinent fa that population; (iii) The staff compete provide the level and resident population; (iv) The physical envir services, and other ph that are necessary to (v) Any ethnic, cultura may potentially affect facility, including, but food and nutrition serv §483.70(e)(2) The face but not limited to, (i) All buildings and/or and vehicles; (ii) Equipment (medica (iii) Services provided pharmacy, and speciff (iv) All personnel, incl employees and those contract), and volunte education and/or train related to resident car (v) Contracts, memora or other agreements v services or equipmen normal operations and (vi) Health informatior such as systems for e patient records and el information with other	e disabilities, overall acuity, cts that are present within incies that are necessary to types of care needed for the ronment, equipment, hysical plant considerations care for this population; and al, or religious factors that the care provided by the not limited to, activities and vices. sility's resources, including r other physical structures al and non- medical); , such as physical therapy, ic rehabilitation therapies; uding managers, staff (both who provide services under ers, as well as their ing and any competencies re; andums of understanding, with third parties to provide t to the facility during both d emergencies; and n technology resources, electronically managing lectronically sharing organizations. y-based and a assessment, utilizing an	F 83	8			

If continuation sheet Page 128 of 156

		ID HUMAN SERVICES MEDICAID SERVICES			F	TED: 11/29/2023 DRM APPROVED NO. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) D	ATE SURVEY OMPLETED
		495193	B. WING			C 10/04/2023
NAME OF PI	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE	, ZIP CODE	
				561 NORTH AIRPORT DRIVE		
HENRICO	HEALTH & REHABILITA	HON CENTER		HIGHLAND SPRINGS, VA 2	23075	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PL/ (EACH CORRECTIV CROSS-REFERENCE DEFI	(X5) COMPLETION DATE	
F 838	This REQUIREMENT by: Based on resident in	is not met as evidenced terview, staff interview, and	F 83	F838 Facility Assessr		
	facility documentation failed to update the fact the needs of its reside resources to provide residents need resulti psychological harm b #22) in the survey sat Findings included: The facility failed to d plan to provide care a education, training, at the care of residents Post-traumatic Stress in one resident (Resid	evelop and implement a and services to include nd services to include nd services to include and services to include nd competencies related to diagnosed with bisorder (PTSD) resulting		 Resident #22 still re Resident #22 received 11/1/2023. Current residents in potential to be affected 3. The VPO (vice press will educate the Admir process for annual review, assessing, upd assessment, and as n needs of its resident population, the require provide the care and s residents to prevent psychological harm ca include education, trai competencies related 	esides in the facility. If psych services in the facility have the d. sident of operations) histrator on the dating the facility eeded to meet the ed resources to services the are and services to ining, and to	
	of the facility, Resider surveyors (Surveyor (stated he had Post-tra (PTSD), and the facilit take care of people d Resident #22 stated h stated he "really was (facility staff) act like handle it (PTSD)." Re treated him as if he w #22 stated, "this is se he did not feel unders resident discussed hi Surveyor D during the	50 a.m. during the initial tour nt #22 approached the C and Surveyor D) and aumatic Stress Disorder ity staff "Did not know how to iagnosed with PTSD." ne was upset about it. He diagnosed with PTSD. They they don't know how to esident #22 stated the staff ras "pretending." Resident rious." Resident #22 stated stood by the staff. The s feelings more in depth with e survey.		 the care of residents of Traumatic Stress Diso The Administrator will (staff development coorstaff education, training, and related to the care of rewith Post Traumatic Stress Diso triggers. 4. The DON or design x 4 weeks then month verify for new hires and any identified had education and transistentiation behavioral healthcare management was completed with do Results of the review of 	order (PTSD) educate the SDC ordinator) on facility ad competencies residents diagnosed order (PTSD) with ee will audit weekly ly x 2 months to d staff not received ining on PTSD, ent and substance ocumentation.	

Facility ID: VA0100

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA		LE CONSTRUCTION		OMB NO. 0938-039 (X3) DATE SURVEY	
	CORRECTION	IDENTIFICATION NUMBER:	. ,	3	· · · ·	MPLETED	
					с		
		495193	B. WING		1	0/04/2023	
NAME OF PI	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CO	DE		
HENRICO	HEALTH & REHABILITA			561 NORTH AIRPORT DRIVE			
				HIGHLAND SPRINGS, VA 23075			
(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 C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BE E APPROPRIATE	(X5) COMPLETIO DATE	
F 838	Continued From pag	e 129	F 83	8			
		or C. Review of the Facility	100	the QAPI committee for revie	ew and		
		d the Assessment was		recommendation.			
	updated on 08/31/20	23 and reviewed with Quality		Once the committee determi	nes the		
		ent/Quality Assurance		problem no longer exist and	sustained the		
	Performance Improv	. ,		review will be			
	committee on 09/26/	2023.		conducted on a random basi	S.		
	Committee on 09/26/2023. On 09/27/2023, an interview was conducted with the Staff Development Coordinator who stated she was responsible for the education of the employees. The Staff Development Coordinator stated she did not provide any training on behavioral health to include Post-traumatic Stress Disorder because she was not aware of the requirement to provide that training to the staff members. She stated she had not been told that particular training was required. When asked if staff members were expected to know how to provide care for the residents accepted in the facility, the Staff Development coordinator stated "yes." Resident #22 reported the facility staff did not know how to take care of him with his diagnosis of PTSD. Resident #22 reported experiencing undue stress related to the staff not taking him seriously.		5. Date of compliance: 11/	19/2023			
	the Facility Administr Corporate Nurse Con the Facility Assessm accepted residents w diagnoses. The Faci	vith behavioral health lity Assessment did not aining and competencies					

Facility ID: VA0100

If continuation sheet Page 130 of 156

		MEDICAID SERVICES			OMB NO. 0938-03
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING		(X3) DATE SURVEY COMPLETED
		495193	B. WING		C 10/04/2023
NAME OF P	ROVIDER OR SUPPLIER		STR	EET ADDRESS, CITY, STATE, ZIP CODE	10/04/2023
HENRICO	HEALTH & REHABILITA	TION CENTER		NORTH AIRPORT DRIVE HLAND SPRINGS, VA 23075	
(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 COMPLETIO
F 838	the Facility Administr Corporate Nurse Cor	e 130 ator, Director of Nursing, nsultant, and Regional Vice ons were informed of the	F 838		
F 867 SS=D		nent Activities	F 867		11/19/23
	monitoring. A facility must establi policies and procedu collections systems, adverse event monito	feedback, data systems and sh and implement written res for feedback, data and monitoring, including oring. The policies and ude, at a minimum, the			
	systems to obtain an from direct care staff resident representation information will be us	v maintenance of effective d use of feedback and input , other staff, residents, and ves, including how such ted to identify problems that lume, or problem-prone, and rovement.			
	systems to identify, c information from all d not limited to the faci §483.70(e) and inclu	v maintenance of effective ollect, and use data and lepartments, including but lity assessment required at ding how such information op and monitor performance			
	and evaluation of per	ology and frequency for such			

Facility ID: VA0100

If continuation sheet Page 131 of 156

		D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		495193	B. WING				04/2023
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	•	
HENRICO	HEALTH & REHABILITA	TION CENTER			61 NORTH AIRPORT DRIVE IIGHLAND SPRINGS, VA 23075		
(X4) ID PREFIX TAG	SUMMARY ST, (EACH DEFICIENC' REGULATORY OR L	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI, DEFICIENCY)		(X5) COMPLETION DATE	
F 867	including the methods systematically identify analyze and use data adverse events in the facility will use the da prevent adverse even	adverse event monitoring, by which the facility will r, report, track, investigate, and information relating to facility, including how the ta to develop activities to	F	867			
	aimed at performance						
	determine underlying impacting larger syste (ii) How they will dever will be designed to eff level to prevent qualit safety problems; and (iii) How the facility wi of its performance im- ensure that improvem §483.75(e) Program a §483.75(e)(1) The fac- performance improve	Idressing: a systematic approach to causes of problems ems; elop corrective actions that fect change at the systems y of care, quality of life, or Ill monitor the effectiveness provement activities to hents are sustained. activities.					
	consider the incidenc	e, or problem-prone areas; e, prevalence, and severity areas; and affect health					

Facility ID: VA0100

If continuation sheet Page 132 of 156

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 11/29/2023 APPROVED D. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		495193	B. WING		_		C 04/2023
NAME OF P	ROVIDER OR SUPPLIER		S	STREET ADDRESS, CITY, S	TATE, ZIP CODE		
HENRICO	HEALTH & REHABILITA	TION CENTER		61 NORTH AIRPORT DRI HGHLAND SPRINGS, \			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 867	resident choice, and o §483.75(e)(2) Perform activities must track m resident events, analy implement preventive that include feedback facility. §483.75(e)(3) As part improvement activities distinct performance in number and frequence conducted by the faci and complexity of the available resources, a assessment required Improvement projects annually a project tha problem-prone areas collection and analysi (c) and (d) of this sect §483.75(g)(2) The qu assurance committee governing body, or de functioning as a gove activities, including im program required und (e) of this section. The (ii) Develop and imple action to correct ident (iii) Regularly review a	afety, resident autonomy, quality of care. nance improvement nedical errors and adverse /ze their causes, and actions and mechanisms and learning throughout the of their performance s, the facility must conduct mprovement projects. The y of improvement projects lity must reflect the scope facility's services and as reflected in the facility at §483.70(e). must include at least t focuses on high risk or identified through the data s described in paragraphs tion. sessment and assurance. ality assessment and reports to the facility's esignated person(s) ming body regarding its oplementation of the QAPI ler paragraphs (a) through	F 867				

Facility ID: VA0100

If continuation sheet Page 133 of 156

TATEMENT C	OF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í			(X3) D/	NO. 0938-039 ATE SURVEY DMPLETED	
		495193	B. WING	_		С		
	ROVIDER OR SUPPLIER	495195	D. WING		STREET ADDRESS, CITY, STATE, ZIP CODE		10/04/2023	
	CONDER OR SOFFLIER				61 NORTH AIRPORT DRIVE			
HENRICO	HEALTH & REHABILITA	TION CENTER			HIGHLAND SPRINGS, VA 23075			
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 867	Continued From page	e 133	Í F	867				
	resulting from drug re available data to mak This REQUIREMENT by: Based on observatio interview, clinical reco documentation review measure the success their Quality Assurand Improvement (QAPI) protocols resulting in involving abuse policy residents (Residents 01/20/2023, and agai residents (Residents 01/20/2023, and agai residents (Residents months later. Immediate Jeopardy survey of the facility of and conducted throug abatement of the Imm was achieved for the (Resident #53, #85, a large. The findings included On 01/20/2023, Imme identified at 3:55 p.m Administrator and Dir aware. Following veri immediacy, the facilit 4:07 p.m. The scope a level 2, pattern. At that time, the facilit abuse policy for 2 res	egimen reviews, and act on the improvements. It is not met as evidenced on, staff interview, resident ord review, and facility w, the facility staff failed to a and track performance in ce and Process program for their abuse Immediate Jeopardy y implementation for 2 #12 and #13) on in on 09/27/2023 for 3 #53, #85, and #103) 8 was found during a standard commencing on 09/25/2023 gh 10/04/2023 when an nediate Jeopardy finding three new residents and #103), and the facility at the inter the facility rector of Nursing were made ification of the removal of y abated IJ on 01/26/2023 at and severity was lowered to ty failed to implement their sidents (Resident #13 and			F867 QAPI/QAA Improvement Activi 1. Residents #53 and resident #85 no longer reside in the facility. Resident still resides in the facility. A facility reported incident submitted on 9/27/2 regarding Resident #103 allegation. 2. Current residents in the facility have potential to be affected. 3. The VPO (vice present of operation will educate the Administrator on the Quality Assurance and Process Improvement (QAPI) program for their abuse policy protocols to implement measures to protect residents from abuse, screen employees, report allegations of abuse, conduct investigations of allegations provide education to staff on abuse and mandated reporting The SDC or designee will educate the facility staff on the QAPI process, abu policy and protocols, protecting residents, mandated reporters, reporting allegations of abuse to the Administrator or DON. 4. The VPO or RDCS (regional direct clinical services) with audit QAPI process monthly x 3 months to verify QAPI process followed with plan for adherina abuse	2023 2023 re the ns) t / and ng. e use tion cor of cess		
	#12) in a survey sam				policy and protocol s and other identi areas in QAPI. Results of the review			

Facility ID: VA0100

If continuation sheet Page 134 of 156

		ND HUMAN SERVICES MEDICAID SERVICES				FORM	D: 11/29/202 MAPPROVE D. 0938-039
STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING			SURVEY PLETED
		495193	B. WING			C 10/04/202	
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
HENRICO	HEALTH & REHABILITA			50	61 NORTH AIRPORT DRIVE		
				н	IIGHLAND SPRINGS, VA 23075		
(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 F CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ЗE	(X5) COMPLETION DATE
F 867	Continued From page	e 134	F	867			
1 007		having direct contact with	L L	007	be		
	residents on 1 of 2 n				presented to the QAPI committee for		
		J			review and recommendation. Once the	е	
		plan of correction, the QAPI			committee		
	committee was taske	-			determines the problem no longer exis	st	
	measuring, tracking of compliance performa				and sustained the review will be conducted on a		
	prevention programm				random basis.		
	p p g						
		as again invoked by the state			5. Date of compliance: 11/19/2023		
	survey agency for fai abuse program.	lure to implement their					
	The facility staff failed	d to implement measures to					
		n abuse as evidenced by					
		employees, failure to take					
		residents from alleged					
		o report allegations of abuse,					
		estigations of allegations of provide education to staff on					
	abuse and mandated						
	On 08/10/2023, Resi	dent #53 reported an					
		buse by a CNA C, stating					
	that the CNA C, "Cov						
		is penis back and forth," and					
		o shave his pubic hair," to yell out for help, which					
	caused CNA C to ab						
	Resident #53 reporte	d the allegations to the					
		T) at 7:50 a.m. The therapist					
		egations immediately to					
		n. CNA C was permitted to					
	continue to provide c evidenced by being s	are to Resident #53 as					
		Resident #53 the wrong diet					
		amounts of food being fed					
		Therapist had to intervene					

Facility ID: VA0100

If continuation sheet Page 135 of 156

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED D. 0938-0391	
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMF	E SURVEY PLETED	
		495193	B. WING				C / 04/2023	
NAME OF P	ROVIDER OR SUPPLIER		•	5	STREET ADDRESS, CITY, STATE, ZIP CODE			
HENRICO	HEALTH & REHABILITA	TION CENTER			561 NORTH AIRPORT DRIVE HIGHLAND SPRINGS, VA 23075			
(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 867	as she felt it was not a to conduct an investig and protect the reside perpetrator immediate On 08/10/2023 at app Resident #103 report behalf of her roomma #103 stated the same Resident #85's pubic 11:57 a.m., a CNA wa Resident #85 about w "down there." The face failed to conduct an ir allegation of abuse in The facility staff failed perpetrator, CNA C, u the allegation(s). Facility staff were una mandated reporter is. On 09/27/2023 during record reviews, it was currently has 2 sampl actively working, and their criminal background of The facility staff had fi implement their abus report, and investigate facility staff had also f prior to their employm The facility staff were action to protect reside	safe. The facility staff failed gation into the allegations ent by removing the alleged ely. proximately mid-day, ed an allegation of abuse on ite, Resident #85. Resident e CNA, (CNA C), had shaved area. On 08/10/2023 at as heard questioning why she had been shaved cility staff failed to report and nvestigation into the volving Resident #85. It to remove the alleged until 5 hours after learning of able to verbalize what a g a review of employee s noted that the facility led employees that are the facility is unaware of ound status because a check was not obtained. Failed to take measures to e policy to identify, protect, e allegations of abuse. The failed to screen employees	F	867				

Facility ID: VA0100

If continuation sheet Page 136 of 156

		ID HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILDI		E CONSTRUCTION	(X3) DATE COMF	
		495193	B. WING				04/2023
NAME OF P	ROVIDER OR SUPPLIER		•	S	STREET ADDRESS, CITY, STATE, ZIP CODE		
HENRICO	HEALTH & REHABILITA	TION CENTER			61 NORTH AIRPORT DRIVE HIGHLAND SPRINGS, VA 23075		
(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 867 F 880 SS=E	employees, thus adhe mandated abuse prot would place all reside which could result in p and/or psychosocial h The facility was made proceeded during the the immediacy, and L No further information abatement; however, the end of the inspect correction in the surve survey agency. The p QAPI involvement, an failed practice in rega 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 g483.80(a) Infection p program. The facility must esta and control program (a minimum, the follow §483.80(a)(1) A syste reporting, investigatin and communicable di	ering to a federally ocol. Failure to do this ents at risk for further abuse, obysical, sexual, mental, narm. e aware of all findings and course of survey to abate J on 10/04/2023. In was provided after the facility was tasked at tion with producing a plan of ey report issued by the state plan of correction will require and correction, to the QAPI rd to their abuse program. & Control (2)(4)(e)(f) Introl blish and maintain an ind control program e safe, sanitary and nent and to help prevent the asmission of communicable ins. prevention and control blish an infection prevention (IPCP) that must include, at		867			11/19/23

Facility ID: VA0100

If continuation sheet Page 137 of 156

	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391			
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	SURVEY LETED			
		495193	B. WING				C 04/2023			
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE					
HENRICO	HEALTH & REHABILITA	TION CENTER			61 NORTH AIRPORT DRIVE IIGHLAND SPRINGS, VA 23075	075				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		E ATE	(X5) COMPLETION DATE				
F 880	conducted according accepted national sta §483.80(a)(2) Written procedures for the pro- but are not limited to: (i) A system of surveil possible communicab- infections before they persons in the facility; (ii) When and to whor communicable disease reported; (iii) Standard and tran- to be followed to prev (iv)When and how iscor resident; including bu (A) The type and dura- depending upon the in involved, and (B) A requirement that least restrictive possil circumstances. (v) The circumstances must prohibit employed disease or infected sk contact with residents contact will transmit th (vi)The hand hygiene by staff involved in dir	der a contractual pon the facility assessment to §483.70(e) and following ndards; standards, policies, and ogram, which must include, lance designed to identify ble diseases or can spread to other can spread to other can spread to other can spread to other can spread to infections; ble diseases or can spread of infections; blation should be used for a t not limited to: ation of the isolation, infectious agent or organism t the isolation should be the ble for the resident under the s under which the facility ees with a communicable cin lesions from direct or their food, if direct he disease; and procedures to be followed rect resident contact.	F	880						

Facility ID: VA0100

If continuation sheet Page 138 of 156

TATEMENT (DF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>'</i>		CONSTRUCTION	(X3) DAT	O. 0938-039 E SURVEY IPLETED	
		495193	B. WING			C 10/04/2023		
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		5/04/2025	
					61 NORTH AIRPORT DRIVE			
HENRICO	HEALTH & REHABILITA	TION CENTER			IGHLAND SPRINGS, VA 23075			
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETIO DATE	
F 880	Continued From page 138 Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.		F	880				
	IPCP and update the This REQUIREMENT by: Based on observatio review, and facility do staff failed to maintain control program desig sanitary, and comfort help prevent the deve of communicable dise residents using the sl The findings included On 09/26/2023 at 2:0 Council meeting, the stated the shower roor shower in those roor would rather have a st the shower rooms, an agreed. A review of th revealed that facility of ongoing complaint in Observations were m 09/26/2023. On 09/27 shower rooms were r stalls had orange and chairs had brown stai well.	Act an annual review of its ir program, as necessary. T is not met as evidenced on, interview, clinical record boumentation, the facility in an infection prevention and gned to provide a safe, able environment and to elopment and transmission eases and infections for hower rooms on 2 of 2 units. It: 10 p.m. during the Resident 6 of 6 residents present oms "are filthy, who wants to ns?" Resident #42 stated she sponge bathe daily than use and the other 5 participants he Resident Council minutes cleanliness has been an			F880 Infection Prevention & Control 1. Shower rooms were detailed clear and disinfected on both units. 2. Current residents in the facility hav potential to be affected. The director environmental services observed sho rooms on both units to verify cleaning was maintained. 3. The Director of Environmental Ser educated all housekeepers on the cleaning process and scheduling for both show rooms. The SDC will educate the fac staff on cleanliness of shower rooms or resid rooms report to the director of environmental Services or housekeeping staff if clear required and will be clean/disinfected scheduled by housekeeping. The CN will clean and disinfect shower room between resident showers, prevent infection a transmission of communicable disear 4. The Director of Environmental Ser or designee will conduct weekly x4, t monthly x2 months to verify both sho rooms are cleaned. Results of the refer will	ve the of ower g and vices wer ility ent aning l as lAs lAs lAs ses. vices hen wer		

Event ID: EB1X11

Facility ID: VA0100

If continuation sheet Page 139 of 156

		ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 11/29/2023 APPROVED 0. 0938-0391
STATEMENT C	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CL IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495193	B. WING _				C 04/2023
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY,	STATE, ZIP CODE		
HENRICO	HENRICO HEALTH & REHABILITATION CENTER			561 NORTH AIRPORT D	RIVE		
TIEI TITO O				HIGHLAND SPRINGS	, VA 23075		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH COR	R'S PLAN OF CORRECTION RECTIVE ACTION SHOULD BE RENCED TO THE APPROPRIAT DEFICIENCY)		(X5) COMPLETION DATE
F 880 F 883 SS=E	stains in the shower s thought the black stai asked how often the s she stated, "Houseke rooms, but we use the shower chairs betwee The Centers for Disea (CDC) recognizes in f Disease Article Volum November 2019, "Ser can cause nosocomia tract and wound infect environments. It can b bathrooms, including where it appears as a discoloration, due to t prodigiosin." Article a https://wwwnc.cdc.go rticle. On 10/04/2023 during Administrator was ma No further information Influenza and Pneum CFR(s): 483.80(d)(1)	at the black and orange stall were. CNA D stated she ns might be dirt. When shower stalls were cleaned, eping cleans the shower e wipes and wipe down the en each resident." ase Control and Prevention their Emerging Infectious the 25, Number 11 - tratia marcescens, which al outbreaks, and urinary tions, is abundant in damp be easily found in shower corners and basins, pink-orange-red he pigment known as ccessed online at: v/eid/article/25/11/et-2511_a the end of day meeting, the ide aware of the concerns. was provided. ococcal Immunizations (2) and pneumococcal za. The facility must develop es to ensure that-	F 8	be presented to review and recor committee deter longer exist and be conducted on a n 5. Date of com	the QAPI committee for mmendation. Once the mines the problem no sustained the review wi random basis. apliance: 11/19/2023		11/19/23
	each resident or the r						

Facility ID: VA0100

If continuation sheet Page 140 of 156

	MENT OF HEALTH AN S FOR MEDICARE & I					FORM	APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		495193	B. WING				C 04/2023
NAME OF P	ROVIDER OR SUPPLIER		•	S	STREET ADDRESS, CITY, STATE, ZIP CODE		
HENRICO	HEALTH & REHABILITA	TION CENTER			561 NORTH AIRPORT DRIVE HIGHLAND SPRINGS, VA 23075		
(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 883	immunization October annually, unless the in contraindicated or the immunized during this (iii) The resident or the has the opportunity to (iv)The resident's med documentation that in following: (A) That the resident of was provided education and potential side effe- immunization; and (B) That the resident of immunization or did n immunization due to r refusal. §483.80(d)(2) Pneum must develop policies that- (i) Before offering the immunization, each re representative received benefits and potential immunization; (ii) Each resident is of immunization, unless medically contraindica already been immuniz (iii) The resident or the has the opportunity to (iv)The resident or the has the opportunity to (iv) The res	r 1 through March 31 mmunization is medically resident has already been a time period; e resident's representative refuse immunization; and dicat record includes dicates, at a minimum, the or resident's representative on regarding the benefits ects of influenza either received the influenza nedical contraindications or cococcal disease. The facility and procedures to ensure pneumococcal esident or the resident's es education regarding the side effects of the fered a pneumococcal the immunization is ated or the resident has zed; e resident's representative refuse immunization; and dical record includes dicates, at a minimum, the pror resident's representative or resident's representative or resident's representative	F	883			

If continuation sheet Page 141 of 156

TATEMENT (DF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION		TE SURVEY MPLETED
			A. BUILD	UILDING			С
		495193	B. WING		10/04/2023		
NAME OF PI	ROVIDER OR SUPPLIER			s	TREET ADDRESS, CITY, STATE, ZIP CODE		
HENRICO	HEALTH & REHABILITA	TION CENTER	561 NOR		61 NORTH AIRPORT DRIVE		
				F	IIGHLAND SPRINGS, VA 23075		
(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 E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(X5) COMPLETION DATE
F 883	Continued From page	e 141	F	883			
	immunization; and						
	(B) That the resident						
		nization or did not receive					
	I	munization due to medical					
	contraindication or re						
	by:	is not met as evidenced					
		iew, clinical record review,			F883 Influenza and Pneumococcal		
		ation review, the facility staff			Immunizations		
		ent and provide education			1. Residents #43, #47, #20, and #42		
		ation of the flu vaccine for			received education of the flu vaccination		
		ents #43, #47, #20, and #42)			2. Current residents in the facility have		
	in a survey sample of immunizations.	f 5 residents reviewed for			potential to be affected. Audit of current residents who received the flu vaccine		
					the infection preventionist had education	-	
	The findings included	l:			provided. Findings will be corrected. 3. SDC or designee will educate licens		
	For Residents #43, #	47, #20 and #42, the facility			nurses on the process for Flu (influenz	za)	
		education regarding the			vaccinations, education, consents,		
		the immunization to be			accuracy of documentation for consen	its	
	administered and fail	ed to obtain consent prior to			and administration, offered and administer	od	
					or declines with education provided an		
	On 09/26/2023, a clir	nical record review was			documented in the resident medical		
		pled residents reviewed for			record.		
		Surveyor was not able to			4. The infection preventionist or design		
		garding the administration of			will audit weekly x 4 then monthly x 2 t	to	
	immunizations.				verify	l	
	0n 09/26/2023 at 4.0	0 p.m., Surveyor F met with			flu vaccination offered, consent, declin education provided with accurate	iea,	
		Preventionist (Employee C).			documentation. Results of the review v	will	
		Employee C accessed the			be presented to the QAPI committee for		
		n of the residents and the			review		
	following was noted:				and recommendation. Once the		
					committee determines the problem no		
		administered the influenza			longer exist and	1 02	
	immunization on 10/1	7/2022. Consent for the			sustained the review will be conducted	i on	
	immunization was no	t obtained until 10/18/2022,			a random basis.		

Facility ID: VA0100

If continuation sheet Page 142 of 156

		D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION		LETED
		495193	B. WING				C 04/2023
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
HENRICO	HEALTH & REHABILITA			56	61 NORTH AIRPORT DRIVE		
HEIRicoo		HON GENTER		Н	IIGHLAND SPRINGS, VA 23075		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B) CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 883	Continued From page being provided. 2. Resident #47 was a on 10/17/2022. There education being provi obtained until 10/18/2 3. Resident #20 was a on 10/18/2022. On 12 obtained for the immu was provided. 4. Resident #42 recei 12/13/2022 and educa 07/14/2023. During this review, the were shared with the who confirmed the fin education and conser be obtained/provided any immunizations.	e 142 administered the flu vaccine was no evidence of any ded, and consent was not 022. administered the flu vaccine 2/08/2022, consent was unization and no education ved the flu vaccine on ation was not provided until e above noted concerns Infection Preventionist (IP), dings. The IP stated that of for immunizations are to prior to the administration of		883			
	Vaccination," effective conducted. It stated u "Procedure: item 1, e administering the flux complete the following and/or RP [Responsit Vaccination Information education in the elect Obtain informed cons electronic medical records On 09/26/2023 during	, read, "Prior to vaccine to patients, g: 1. Educate the patient ole Party] using the CDC's on Sheet (VIS). Document ronic medical record. 2. ent and document in the cord." g an end of day meeting, the nd Corporate staff were					

Facility ID: VA0100

If continuation sheet Page 143 of 156

	MENT OF HEALTH AN S FOR MEDICARE & I	D HUMAN SERVICES			FOR	M APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DAT	E SURVEY PLETED
		495193	B. WING		10	C / 04/2023
NAME OF P	ROVIDER OR SUPPLIER		•	STREET ADDRESS, CITY, STATE, ZIP CODE	•	
HENRICO	HEALTH & REHABILITA	TION CENTER		561 NORTH AIRPORT DRIVE HIGHLAND SPRINGS, VA 23075		
(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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 883	Continued From page		F 88	3		
F 887 SS=F	COVID-19 Immunizat	ion	F 88	7		11/19/23
	LTC facility must deve and procedures to en (i) When COVID-19 v facility, each resident is offered the COVID- immunization is media resident or staff memi immunized; (ii) Before offering CC members are provide regarding the benefits effects associated wit (iii) Before offering CC resident or the resider receives education re risks and potential sid the COVID-19 vaccine (iv) In situations when requires multiple dose resident representativ provided with current additional doses, inclu- benefits or risks and p associated with the C requesting consent for additional doses; (v) The resident, resident member has the oppor COVID-19 vaccine, an (vi) The resident's me documentation that in the following:	accine is available to the and staff member .19 vaccine unless the cally contraindicated or the ber has already been .0VID-19 vaccine, all staff d with education and risks and potential side h the vaccine; .0VID-19 vaccine, each nt representative garding the benefits and le effects associated with e; e COVID-19 vaccination es, the resident, re, or staff member is information regarding those uding any changes in the potential side effects .0VID-19 vaccine, before r administration of any tent representative, or staff ortunity to accept or refuse a nd change their decision;				

Facility ID: VA0100

If continuation sheet Page 144 of 156

		ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 11/29/2023 FORM APPROVED OMB NO. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495193	B. WING		C 10/04/2023
NAME OF P	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP CODE	
HENRICO	HEALTH & REHABILITA	TION CENTER		61 NORTH AIRPORT DRIVE IIGHLAND SPRINGS, VA 23075	
(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 APPROPF DEFICIENCY)	BE COMPLETION
F 887	COVID-19 vaccine; a (B) Each dose of COV to the resident; or (C) If the resident did vaccine due to medic contraindications or r (vii) The facility maint to staff COVID-19 vac includes at a minimur (A) That staff were pr the benefits and pote associated with COV (B) Staff were offered information on obtain (C) The COVID-19 vac related information as Disease Control and Healthcare Safety Net This REQUIREMENT by: Based on staff interv and facility document failed to provide COV 5 residents (Resident #42) and 5 staff in a s and 5 employees revi immunizations. They education and obtain administration of COV of 5 Residents (Resident #42). The findings included 1. The facility staff fai COVID-19 bivalent im	on regarding the risks associated with nd VID-19 vaccine administered not receive the COVID-19 al efusal; and ains documentation related ccination that n, the following: ovided education regarding ntial risks ID-19 vaccine; the COVID-19 vaccine or ing COVID-19 vaccine; and accine status of staff and a indicated by the Centers for Prevention's National twork (NHSN). is not met as evidenced iew, clinical record review, ation review, the facility staff (ID-19 bivalent vaccines for s #43, #47, #1, #20, and survey sample of 5 residents iewed for COVID-19 also failed to provide informed consent prior to /ID-19 immunizations, for 4 lent #43, #47, #20, and	F 887	F 887 COVID-19 Vaccination 1. Residents #43, #47, #1, #20 and were offered the bivalent COVID-19 v education on risk/benefits for COVID- bivalent immunization consent obtain offered /declined, administered if meet criteria with documentation in the resi medical record. The infection preventionist will schedu staff COVID-bivalent vaccination clini- with education risks/benefits, consent obtained or declined, if accepts administered if meets criteria. 2. Current residents in the facility has the potential to be affected. Audit of current residents by the infection	vith 19 ed, ets dent ule cs s

Facility ID: VA0100

If continuation sheet Page 145 of 156

	OF DEFICIENCIES	MEDICAID SERVICES		LE CONSTRUCTION	(X3) DATE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	· · ·	B	COMPLETED
					С
		495193	B. WING		10/04/2023
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	CODE
HENRICO	HEALTH & REHABILITA	TION CENTER		561 NORTH AIRPORT DRIVE	
				HIGHLAND SPRINGS, VA 2307	⁷⁵
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TC DEFICIEN	CTION SHOULD BE COMPLET D THE APPROPRIATE DATE
F 887	Continued From page	e 145	F 88	37	
		sidents #43, #47, #1, #20,		preventionist or designee	to verify if the
	and #42.			resident⊡s received educ	-
				risk/benefits of COVID-19	
		ical record review was		vaccine, offered or decline	
		pled residents reviewed for		obtained/administered if r	
		Surveyor was not able to		receive COVID-19 bivaler	
		garding the administration of		completion of documenta	
		e was no indication that any		resident⊡s medical record	
	-	ents had been educated on educated on educated on educated been educated on educated on educated on educated on		3. SDC or designee will licensed nurses and infect	
	immunization.			preventionist on the proce	
				resident immunization rec	Ĵ,
	2. The facility staff fai	led to offer/provide		new admits identify immu	nization status
		nmunization information to		for COVID-19 bivalent an	
	all 5 sampled employ	ees reviewed.		immunizations and docun resident clinical record or	
	On 09/26/2023, a sar	nple of 5 employees was		COVID19 bivalent vaccir	
		being educated on the		education to risk/benefits	•
	benefit of immunization	on and/or offering of		offered/declined, if accept	ted ,consent
		ions. For the 5 employees		obtained and administere	
		-19 immunization status of 2		criteria with documented	
		nd Employee Q) was not		medical record and plann	
		survey and there was no		staff COVID-19 vaccinatio	
		en provided any education) immunizations. The other 3		facility staff will include ec	
		NA E, and CNA F) had no		risk/benefits , offered / de accepts administered if m	
		ceived, offered, or having		The SDC will educate the	
	•	e benefit of receiving a		COVID-19 bivalent vaccir	-
	COVID-19 bivalent in	•		education to risks/benefits	
				vaccination clinics schedu	uled with dates
		0 p.m., Surveyor F met with		posted, staff will be offere	
	•	Preventionist (Employee C).		administered if meets crite	eria with
		mployee C accessed the		documentation.	4
	clinical record of each			4. The infection prevent	
		ed the COVID-19 bivalent		designee will audit weekly	
	vaccine being offered			monthly x 2 to verify resid COVID-19 bivalent vaccir	
	The facility's Infection	Preventionist said, "I have		to risk/benefits, consent c	
		sting, and I go from there."		declined/offered/provided	

Facility ID: VA0100

If continuation sheet Page 146 of 156

			0.00		OMB NO. 0938-0		
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495193	B. WING		C 10/04/2023		
NAME OF P	ROVIDER OR SUPPLIER	I		STREET ADDRESS, CITY, STATE, ZIP CODE			
HENRICO	HEALTH & REHABILITA	TION CENTER		561 NORTH AIRPORT DRIVE HIGHLAND SPRINGS, VA 23075			
(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 COMPLET		
F 887	vaccine, the IP said, ' have one [a clinic] bu When asked what kin referring to, the IP sa in." The IP also stated at the bit for COVID v again. I told them we soon as possible. I has the vaccine and set a anyone had been offe vaccine since it has b IP said, "No, not at th to work on and will be [Administrator's name to order, where to ord On 09/26/2023 at app review of the facility p Vaccinations," effective conducted. It stated u "Procedure," item 1, " Control and Prevention everyone stay up to co vaccination. b. Recom who have received or monovalent COVID-1 a bivalent mRNA vacca any monovalent COV The above policy also administering any CC each dose) complete Provide the Emergen "Fact Sheet for Recip patient and/or RP and and potential side effe	ally about the bivalent 'Last year we were going to t we had issues and didn't." d of issues she was id, "State [surveyors] came d, "A lot of them are jumping vaccine, since it is on the rise will get a clinic started as ave to find out how to order II of this up." When asked if ered the COVID bivalent ween out for a year now, the is point, that's what we have a investigating when a redacted] gets back, how ler, etc." proximately 5:00 p.m., a policy entitled, "COVID-19 ye date 05/01/2023, was inder the subtitle, CDC [Centers for Disease on] recommends that late with COVID-19 nmendations: Individuals ne or more doses of a 9 vaccine: A single dose of cine, at least 2 months after 'ID-19 vaccine."	F 88	 documentation in resident □s c record and verify staff COVID- vaccination clinics scheduled w education and documentation of for staff COVID-19 vaccination the review will be presented to committee for review and recommendation. Once the con determines the problem no lon and sustained the review will b conducted on a random basis. 5. Date of compliance: 11/19 	19 with completed . Results of the QAPI mmittee ger exist e		

If continuation sheet Page 147 of 156

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391	
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495193	B. WING				C 04/2023	
NAME OF PI	ROVIDER OR SUPPLIER		-	5	STREET ADDRESS, CITY, STATE, ZIP CODE	1		
HENRICO	HEALTH & REHABILITA	TION CENTER		561 NORTH AIRPORT DRIVE HIGHLAND SPRINGS, VA 23075				
(X4) ID PREFIX TAG				IX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	D BE COMPLETION		
F 887	7 Continued From page 147		F	887	7			
	(CDC) document title Considerations for Us the United States," up 2, "Recommendations vaccines," read, "COV recommended for eve older in the United St COVID-19" and "CDC ages 6 months and of bivalent mRNA COVID	se of COVID-19 Vaccines in odated May 12, 2023, page s for the use of COVID-19 VID-19 vaccination is eryone ages 6 months and ates for the prevention of C recommends that people Ider receive at least 1 D-19 vaccine." g an end of day meeting, the ursing and Corporate staff the findings.						
		led to provide education and ent prior to the administering						
	conducted of the sam immunizations. The S	ical record review was pled residents reviewed for Surveyor was not able to garding the administration of						
	the facility's Infection During this meeting, I	0 p.m., Surveyor F met with Preventionist (Employee C). Employee C accessed the n of the residents and the						
		administered a Pfizer ooster on 12/17/2021. ınization was not obtained						

Facility ID: VA0100

If continuation sheet Page 148 of 156

	MENT OF HEALTH AN S FOR MEDICARE & I					FORM	D: 11/29/2023 APPROVED D: 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		495193	B. WING		_	C 10/04/2023	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	TATE, ZIP CODE		
HENRICO	HEALTH & REHABILITA	TION CENTER	561 NORTH AIRPORT DRIVE HIGHLAND SPRINGS, VA 23075				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 887	 any education being p 2. Resident #47 was a monovalent COVID b 12/17/2021. There was education being provioi obtained until 04/06/2 3. Resident #20 was a monovalent booster do on 12/17/2021. On 04 obtained for the immu was provided. 4. Resident #42 receit COVID booster vaccint Education was not proore obtained until 04/05/2 During this review, the were shared with the who confirmed the fine education and consert be obtained/provided any immunizations. The facility policy entit Vaccinations," effective reviewed. It stated un "Procedure," item 1, "Control and Preventice everyone stay up to d vaccination. b. Recom who have received or monovalent COVID-1 	there was no evidence of provided. administered the Pfizer poster vaccine dose on as no evidence of any ded, and consent was not 022. administered a Pfizer ose of the COVID vaccine /06/2022, consent was inization and no education wed the Pfizer monovalent ne on 12/17/2021. ovided, and consent was not 022. e above noted concerns Infection Preventionist (IP), dings. The IP stated that at for immunizations are to prior to the administration of tted, "COVID-19 re date 05/01/2023, was der the subtitle, CDC [Centers for Disease in] recommends that ate with COVID-19 imendations: Individuals are or more doses of a 9 vaccine: A single dose of cine, at least 2 months after	F 887	7			

Facility ID: VA0100

If continuation sheet Page 149 of 156

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	PLE CONSTRUCTION	OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED	
	CONTRECTION	IDENTIFICATION NOMBER.	A. BUILDING	3	C	
		495193	B. WING		10/04/2023	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO)DE	
HENRICO	HEALTH & REHABILITA	TION CENTER		561 NORTH AIRPORT DRIVE HIGHLAND SPRINGS, VA 23075		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF C	CORRECTION (X5)	
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTI CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE COMPLETION HE APPROPRIATE DATE	
F 887	Continued From page	e 149	F 88	37		
	The above policy also		1.00			
		VID-19 Vaccine (and for				
		the following for patients: a.				
	•	cy Use Authorization (EUA) ients and Caregivers" to				
	-	d educate regarding benefits				
	and potential side effe	ects. 3. Obtain consent from				
		sible party and fill out the				
	consent form."					
	On 09/26/2023 during	g an end of day meeting, the				
	facility's Director of N	ursing and Corporate staff				
	were made aware of	the findings.				
	No further information	-				
	Maintains Effective P CFR(s): 483.90(i)(4)	est Control Program	F 92	25	11/19/23	
	•	n an effective pest control				
	program so that the far rodents.	acility is free of pests and				
		is not met as evidenced				
	by:					
		n, interview, clinical record ocumentation, the facility		F925 Maintains Effective Po Program	est Control	
		n an effective pest control		1. Resident #19 still resides	in the facility	
	program so that the fa			and pest control treated the	•	
	involving 2 of 2 units	in the facility.		pest control team		
	The findings included			was notified and exterminate		
	The infunds included			identified on both units. The team did a		
	For 2 of 2 units in the	facility, roaches and/or		follow-up visit regarding the	bed bugs and	
	bedbugs have been r	eported.		rooms #32, #37 and #54, th	ere were no	
	On 09/29/2023 at apr	proximately 1:15 p.m.,		other concerns of bed bugs.		
		Resident #19's room with		2. Current residents in the fa	acility have the	
	-	for Resident #19's dentures		potential to be affected . An		
		When the cabinet door and			,	

Facility ID: VA0100

If continuation sheet Page 150 of 156

		ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 11/29/2023 FORM APPROVED OMB NO. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495193	B. WING _		C 10/04/2023
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
HENRICO	HEALTH & REHABILITA			561 NORTH AIRPORT DRIVE	
TIEIT(100				HIGHLAND SPRINGS, VA 23075	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETION
F 925	and top of the bedside A review of the pest of 08/04/2023 rooms #3 for bed bugs; howeve was done to ensure a were treated for, which bedbug treatment. On 09/28/2023, the re complaining of itching bugs. The facility did 09/29/2023. On 10/04/2023 during	cockroaches ran out nsects) all over the sides e cabinet. control log revealed that on 2, #37 and #54 were treated er, no follow-up treatment ony eggs that have hatched ch is standard practice for esident in Room #8 was g and stated he had bed treat that room on	F9	25 director was conducted for pest s Any findings were treated by the control vendor. 3. The Regional Director of Maint educated the Maintenance Direct process of pest control, review of pest control boo bug management and maintenan repairs, with followup to ensure all areas of concerns at resolved. The SDC will educate the facility ensuring all and any pest control are logged in the Pest Control book and work of submitted for maintenance repair 4. The Maintenance Director or d will conduct audits weekly x 4 we monthly x 2 months to review pest control boo verify pest sightings were treated of the review will be presented to the QAPI cor for review and recommendation. committee determines the problem no longe and sustained the review will be conducted on a random basis.	pest tenance tor on the ok, bed nce re staff on services orders 's. lesignee teks then ok to l. Results mmittee Once the
F 949 SS=E	CFR(s): 483.95(i) §483.95(i) Behavioral A facility must provide consistent with the re		F 9	5. Date of compliance: 11/19/20	023 11/19/23

Facility ID: VA0100

If continuation sheet Page 151 of 156

	-	ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 11/29/2023 FORM APPROVED OMB NO. 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495193	B. WING		C 10/04/2023
NAME OF P	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE	10/04/2020
HENRICO	HEALTH & REHABILITA	TION CENTER		61 NORTH AIRPORT DRIVE IIGHLAND SPRINGS, VA 23075	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION
F 949	§483.70(e). This REQUIREMENT by: Based on interview, of facility documentation provide behavioral he caring for the residen behavioral healthcare staff members (Staff a Certified Nursing Assi in the sample. The findings included 1. For all residents ide healthcare needs, the training to staff to care A review of the facility form 672 - Census an that there are 46 resid behavioral healthcare document entitled "Fa facility is equipped to behavioral healthcare	is not met as evidenced clinical record review, and b, the facility staff failed to ealth training for all staff ts identified as having e needs for 5 of 5 nursing #6, Staff #21, Staff #22, istant [CNA]-H and CNA-K) : entified as having behavioral e facility failed to provide e for such residents. v assessment and "CMS ad Condition Form" revealed dents identified with e needs. A review of the acility Assessment," the care for residents with e needs, PTSD	F 949	F949 Behavioral Health Training 1. SDC initiated education and training all facility staff on behavioral healthcar and PTSD (Post traumatic stress disorder) with triggers 9/27/2023 including identified staff. 2. Current residents in the facility have potential to be affected. 3. The SDC or designee will educate a training for all facility staff on behavior healthcare needs and PTSD and triggers, preventing behaviors and/or emotional harm associated with triggering events from past or current trauma. Management, monitoring, preventing behaviors and avoiding triggers that may cause risk for or actu emotional harm for residents with behavioral healthcare needs and residents with substance abuse. Identified residents will have cause	re s on e the and al
	 (Post-traumatic Stress Disorder), and substance abuse issues. On 09/25/2023 at approximately 1:00 p.m., an interview was conducted with Resident #22 who stated the facility, "Does not know how to deal with us. I have PTSD and they don't know how to talk to me." When asked to elaborate, he stated the facility staff are loud and rude and that "triggers" him to become "aggressive." When asked if he has told anyone about this, he stated he has spoken to the DON and the Administrator about it, but nothing is done. He also stated he had a substance abuse problem prior to coming 			 planned with problem and triggers. 4. The DON or designee will audit week x 4 weeks then monthly x 2 months to verify for new hires and any identified staff not receive had education and training on PTSD, behavioral healthcare management and substance was completed with documentation. Results of the review will be presented to the QAPI committee committee 	ved

Facility ID: VA0100

							O. 0938-039	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION	· · ·	E SURVEY IPLETED	
			A. BUILDING	G		с		
		495193	B. WING			1	0/04/2023	
NAME OF P	ROVIDER OR SUPPLIER			STR	REET ADDRESS, CITY, STATE, ZIP CODE	10/04/2023		
				561	NORTH AIRPORT DRIVE			
HENRICO	HEALTH & REHABILITA	ATION CENTER		HIG	GHLAND SPRINGS, VA 23075			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETIOI DATE	
F 949	Continued From pag	e 152	F 94	49				
		t the facility staff "use that			determines the problem no longer ex	kist		
		ne." When asked what he			and sustained the review will be			
	meant by that, he sta	•			conducted on a random			
		because he had a substance			basis.			
		coming to the facility. He			E Data of compliances 11/10/2022			
	stated the staff have seeking."	labeled him as "drug			5. Date of compliance: 11/19/2023			
	On 09/26/2023 at ap	proximately 3:00 p.m., an						
		cted with Resident #103 who						
	stated she had a sub	ostance abuse problem that						
	she was addressing							
	She stated she also							
	to past trauma. She i							
	-	stand how to care for her.						
		on't know how to talk to me. nd what triggers me and how						
	-	ne." She stated they say she						
		he stated she had a PRN						
		she sometimes only took 1						
	time a day. She said	, "If I was drug seeking, I						
	would be asking for i	t every 4 hours."						
		:00 a.m., an interview was						
	conducted with the S	-						
		s asked about training for						
		They don't tell me to train on asked if she trained on						
		e, she stated she did not.						
	When asked if she tr							
	healthcare needs rel	ated to substance abuse,						
		ot. When asked does your						
		ts in this facility with any or						
	all those issues, and	sne stated they do.						
	On 09/28/2023 at ap	proximately 3:00 p.m., an						
		cted with the Administrator						
		e facility accepts residents						
	∣ with PTSD, substand	e abuse, or other behavioral						

Facility ID: VA0100

If continuation sheet Page 153 of 156

	-	D HUMAN SERVICES				FORM	APPROVED
	S FOR MEDICARE & I	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPI	LE CONSTRUCTION	(X3) DATE	0. 0938-0391
	CORRECTION	IDENTIFICATION NUMBER:	· /				LETED
							C
		495193	B. WING			10/	04/2023
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
HENRICO	HEALTH & REHABILITA	TION CENTER			561 NORTH AIRPORT DRIVE HIGHLAND SPRINGS, VA 23075		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BI TAG CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)			(X5) COMPLETION DATE
F 949	healthcare issues, an asked if she expected with the training to ca stated she did. When the Staff Developmen conducting training or that she was not. On 10/04/2023 during the Administrator was concerns. No further information 2. The facility failed to education/training and trauma and Post-trau (PTSD) for its staff me On 09/25/2023 at 11:3 of the facility, Resider surveyors and stated facility staff, "Did not I people diagnosed with stated he was upset a was diagnosed with F like they don't know h Resident #22 also sta if he was "pretending. is serious." The reside understood by the sta On 09/26/2023 at 9:0 conducted with Licens B) who stated there w who had diagnoses o	d she stated they did. When I the staff to be equipped re for those residents, she asked if she was aware that t Coordinator was not in those areas, she stated the end of day debriefing, made aware of the was provided. b was provided. competencies to include matic Stress Disorder embers. 50 a.m. during the initial tour at #22 approached the he had PTSD and the know how to take care of h PTSD." Resident #22 about it. He stated he "really PTSD. They (facility staff) act ow to handle it (PTSD)." ated the staff treated him as " Resident #22 stated "this ent stated he did not feel ff. 5 a.m., an interview was sed Practical Nurse B (LPN vere residents in the facility f PTSD and other behavioral N-B stated she had not	F	94\$			

Facility ID: VA0100

If continuation sheet Page 154 of 156

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		495193	B. WING				C 104/2023
NAME OF P	ROVIDER OR SUPPLIER			ŝ	STREET ADDRESS, CITY, STATE, ZIP CODE		
					561 NORTH AIRPORT DRIVE		
HENRICO	HEALTH & REHABILITA	TION CENTER		I	HIGHLAND SPRINGS, VA 23075		
(X4) ID PREFIX TAG						(X5) COMPLETION DATE	
F 949	residents with trauma On 09/27/2023 at 12: conducted with Certif stated she had not re on caring for resident Review of the Facility review date of 08/31/2 Assessment, Part 2.3 Based on Resident N Section 2.1 General of Practices listed the ge health and behavior" Practices" was writter conditions and medic psychiatric symptoms implement intervention individuals with issue trauma/PTSD, other p On 09/27/2023 at 2:1 conducted with the Si Coordinator who state	/PTSD. 55 p.m., an interview was ied Nursing Assistant who ceived any special training s with trauma/PTSD. Assessment revealed a 2023. The Facility Services and Care Offered eeds (on page 1 of 2) care and Specific Care or eneral care area of "Mental and under "Specific Care or n, "Manage the medical ation-related issues causing and behavior, identify and ns to help support s such as dealing with osychiatric diagnoses." 5 p.m., an interview was taff Development ed she provided in-service	F	949			
	stated staff members computer-based train She stated she was a residents for admission behavioral health issue to mental, psychosocc disorder, a history of post-traumatic stress behavioral health com according to the facili Development Coordir assessment was utilized	Development Coordinator also complete ing on required subjects. ware the facility accepted on who were diagnosed with ues to include but not limited ial, or substance use trauma and/or disorder, or other					

Facility ID: VA0100

If continuation sheet Page 155 of 156

		ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		JLTIPLE CONSTRUCTION DING			SURVEY LETED
		495193	B. WING			10/	04/2023
NAME OF PI	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
HENRICO	HEALTH & REHABILITA	TION CENTER			1 NORTH AIRPORT DRIVE GHLAND SPRINGS, VA 23075		
(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 949	trauma/PTSD in the tr immediately begin to Review of the 5 samp records revealed no of trauma/PTSD. On 09/27/2023 during the facility Administrat Corporate Nurse Con findings of no behavio trauma/PTSD. On 09/28/2023, the S Coordinator provided curriculum including to orientation and trainin curriculum revealed th of the topic of trauma. During the end of day the facility Administrat Corporate Nurse Con	Staff Development we was not told to include raining topics, but would train on that topic. All demployee training documentation of training on the end of day debriefing, tor, Director of Nursing, and sultant were informed of the bral health training on taff Development a copy of the training opics covered during to sessions. Review of the here was no documentation /PTSD. The debriefing on 10/3/2023, tor, Director of Nursing, sultant, and Vice President formed of the findings.	F 9	149			

Facility ID: VA0100

If continuation sheet Page 156 of 156