STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495308	A. BUILDING _____ B. WING _____	C 08/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERVIEW HEALTH & REHAB CENTER	**414 ALGONQUIN RD HAMPTON, VA 23661**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 8-22-23 through 8-25-23. The facility was in substantial compliance with 42 CFR Part 483.73, Requirements for Long-Term Care facilities.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 08/22/23 through 08/25/23. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. Fourteen complaints were investigated during the survey. VA00059018 - Substantiated with deficiency. VA00059076 - Substantiated with deficiency. VA00059168 - Substantiated with deficiency. VA00059412 - Substantiated with deficiency. VA00058990 - Substantiated with deficiency. VA00058434 - Substantiated with deficiency. VA00057768 - Substantiated with deficiency. VA00057771 - Substantiated with deficiency. VA00054138 - Substantiated with deficiency. VA00054519 - Substantiated with deficiency. VA00054823 - Substantiated with deficiency. VA00055389 - Substantiated with deficiency. VA00056209 - Substantiated with deficiency. VA00057580 - Substantiated with deficiency. The census in this 130 certified bed facility was 106 at the time of the survey. The survey sample consisted of 62 resident reviews.	F 000		
F 552 SS=D	Right to be Informed/Make Treatment Decisions CFR(s): 483.10(c)(1)(4)(5) §483.10(c) Planning and Implementing Care.	F 552		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Roger Wilson NHA 9/15/2023

program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1)PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495308	A. BUILDING _____ B. WING _____	C 08/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERVIEW HEALTH & REHAB CENTER	**414 ALGONQUIN RD HAMPTON, VA 23661**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 552		F 552		

Continued From page 1

The resident has the right to be informed of, and participate in, his or her treatment, including:

§483.10(c)(1) The right to be fully informed in language that he or she can understand of his or her total health status, including but not limited to, his or her medical condition.

§483.10(c)(4) The right to be informed, in advance, of the care to be furnished and the type of care giver or professional that will furnish care.

§483.10(c)(5) The right to be informed in advance, by the physician or other practitioner or professional, of the risks and benefits of proposed care, of treatment and treatment alternatives or treatment options and to choose the alternative or option he or she prefers.
This REQUIREMENT is not met as evidenced by:
Based on staff interviews, facility document review, and clinical record review, the facility staff failed to afford a Resident the ability to make decisions in concerning their care for 1 of 64 residents (Resident #87), in the survey sample.

The findings included:

The facility staff failed to transfer Resident #87 to an acute care setting even after a significant change had been observed. Resident #87's Responsible Representative (RR) called non-emergent transportation who transported the resident to the local hospital on 02/02/23. Resident #87 was transferred to another acute care setting on 02/03/23. Resident #87 was readmitted to the nursing facility on 02/08/23. Resident #87 was originally admitted to the

1.Resident #87 returned from hospital on 2/8/2023 and has been afforded the ability to make informed decisions concerning her healthcare.
2.All residents with decision making abilities have the potential to be affected. Residents with a BIMS of 13 or greater were interviewed on 9/12/23 and 9/13/23 concerning their ability to make decisions concerning their healthcare. No concerns voiced.
3.The Nursing Departments education on Residents Rights and ability to make choices was completed on 9/7/2023. Whole House Education was completed on 9/13/2023.
4.The facility Director of Nursing/designee will interview 6 residents per week to determine that decisions concerning healthcare are afforded to the resident, x 6 weeks. All results and trends will be reviewed at the Monthly Quality Assurance Performance Improvement Meeting to determine compliance.
5.9/22/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495308	A. BUILDING _____ B. WING _____	C 08/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERVIEW HEALTH & REHAB CENTER	**414 ALGONQUIN RD HAMPTON, VA 23661**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 552		F 552		

Continued From page 2

nursing facility on 01/24/23. Diagnosis for Resident #87 include but are not limited to rectal prolapse, Atrial Fibrillation (A-Fib), and lymphedema.

Resident #87 Minimum Data Set (MDS - an assessment protocol), a quarterly with an Assessment Reference Date (ARD) of 06/26/23 coded Resident #87's Brief Interview for Mental Status (BIMS) score of 15 out of a possible score of 15 indicating no cognitive impairment. The MDS coded Resident #87 total dependent of two with bathing, extensive assistance of two with bed mobility, extensive assistance of one with transfer, dressing, toilet use and personal hygiene and supervision with eating for Activities of Daily Living (ADL) care.

On 08/24/23 at 11:00 a.m., an interview was conducted with Resident #87's representative. She stated she received a call from (a family friend) on 02/02/23, who informed her that Resident #87 was not responding. She said Resident #87 was unable to open her eyes, lift her head off the pillow, eat, or acknowledged that she was in the room. She stated she contacted Resident #87's nurse, License Practical Nurse (LPN) - L., requesting for Resident #87 to be transferred to the hospital for evaluation. She stated the LPN said Resident #87's vital signs were within normal limits and did not appear to be in distress. She stated there was no reason to notify the physician or send the resident to the hospital. She said the nurse told her she could call 911 but she was not going to. The RR stated she called non-emergent transportation who arrived at the facility (time uncertain) and transferred Resident #87 to the local Emergency Room (ER). She stated Resident #87 was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495308	A. BUILDING _____ B. WING _____	C 08/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERVIEW HEALTH & REHAB CENTER	**414 ALGONQUIN RD HAMPTON, VA 23661**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 552		F 552		

Continued From page 3 transferred to another hospital on 02/03/23 where she stayed for an extra 5 days.

An interview was conducted with Visitor #2 on 08/24/23 at 4:49 p.m. She stated she came to visit Resident #87 on 02/02/23 around 5:00 p.m. She stated Resident #87 was not herself. She was not able to lift her head off the bed, speak or eat her dinner. She stated she had to put her ear to the resident's mouth when she spoke but was unable to understand what she was saying. She stated Resident #87's words were mumbled. She stated she spoke with Certified Nursing Assistant (CNA)-C who agreed Resident #87 had a change in condition. She stated she spoke with License Practical Nurse LPN-L who stated she saw no reason to send Resident #87 to the hospital because her vital signs were okay. The complainant stated she contacted Resident #87's representative (RR) and informed of the changes she witnessed in Resident #87. She stated RR called transportation to have Resident #87 taken to the hospital. She stated, Emergency Medical Transport (EMT) arrived at the facility, who asked Resident #87 if she wanted to go to the hospital, she replied, "Yes." She stated Resident #87 was transferred to (name of hospital) and admitted.

On 08/24/23 at 2:51 p.m., an interview was conducted with Certified Nursing Assistant (CNA) -C. She stated on 02/02/23, Resident #87 was not her normal self. She stated Resident #87 usually feeds herself but, on that day, she was very confused and unable to feed herself. She said Resident #87 was not aware her food was in front of her. When Resident #87 spoke, her words were mumbled. Resident #87 had a visitor who was very concerned of the changes seen in Resident #87. She stated she obtained vital

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495308	A. BUILDING _____ B. WING _____	C 08/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERVIEW HEALTH & REHAB CENTER	**414 ALGONQUIN RD HAMPTON, VA 23661**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 552		F 552		

Continued From page 4 signs and gave them to LPN-L. She stated there was an obvious decline in Resident #87.

A phone interview was conducted with LPN-L on 08/24/23 at 11:24 a.m. She stated she remembered Resident #87 as a patient but really did not recall what occurred on 02/02/23 (3-11 shift). The surveyor read the nurses note to the LPN that she wrote on 02/02/23 at 9:29 p.m. She stated based on the nurses note, the resident's vital signs were stable so there was no reason to send Resident #87 to the hospital. She stated she did receive a phone call from Resident #87 RR requesting for Resident #87 to be transferred to the hospital. She stated she informed the RR that Resident #87 was not in distress, her vitals were stable and saw no reason to send the resident to the hospital. She stated she informed the RR that she would not be calling 911 but she could not stop her from calling 911. She stated the resident's representative called non-emergent transportation who arrived at the facility who transferred Resident #87 to the local hospital and admitted.

A review of Resident #87's clinical record revealed a nurses' note written on 02/02/23, by LPN-L. The note documented the following: on 02/02/23, Resident #87's visitor informed LPN-L that Resident #87 was non-responsive and in distress. A head-to-assessment was completed, and the resident was without signs/symptoms (s/s) of distress. Resident #87 did however, verbalized she felt under the weather and Tramadol (pain medication) was administered. The resident's vital signs were (BP) 124/64, (P) 82, (R) 17, (T) 98.9 and oxygen saturation at 98% on room air. A COVID-19 test was performed with negative results. A phone call was received from

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495308	A. BUILDING _____ B. WING _____	C 08/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERVIEW HEALTH & REHAB CENTER	**414 ALGONQUIN RD HAMPTON, VA 23661**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 552		F 552		

Continued From page 5

Resident #87's RR who requested for Resident #87 to be transferred to the ER for evaluation. It was documented that the resident and the resident's visitor were both educated it was not necessary to send Resident #87 to ER for evaluation due to the results of the assessment. The note revealed LPN-L stated she would not call 911 but informed the RR she could call, which she did. Resident #87 was transferred to hospital and admitted.

Resident #87 was transferred to the hospital on 02/02/23, then transferred to another acute care facility on 02/03/23. The hospital record from 02/02/23 was requested but not received. However, a review of the second hospital record from 02/03/23-02/08/23 revealed the following: Resident #87 had complained of having nausea/vomiting and dizziness prior to being transferred to the first hospital on 02/02/23. Resident underwent a perineal proctectomy and levatorplasty for a rectal prolapse on 01/09/23. She had been having liquid stool draining without continence since admitted to the nursing facility on 01/24/23. At the ER she had a low-grade fever (not documented), white blood count (12k) normal range (4,500-11,000), hypochloremia - low chloride (83) normal range (less than 95), hyponatremia - low sodium (128) normal range (135-145) and hypokalemia - low potassium (2.5) normal range (3.5-5.0). During the hospital stay, Resident #87 received intravenous (IV) antibiotic (Zosyn), IV dextrose 5% and sodium chloride 0.9% with KCL (potassium) 20 mEq/L. There was a concern for perirectal abscess and rectovaginal fistula but the findings were not transferred from the ER and was not accessible. The Zosyn (IV abx) was used for possible perirectal abscess.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495308	A. BUILDING _____ B. WING _____	C 08/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERVIEW HEALTH & REHAB CENTER	414 ALGONQUIN RD HAMPTON, VA 23661

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 552	Continued From page 6 An interview was conducted with Director of Nursing (DON) on 08/25/23 at 5:00 p.m. She stated when Resident #87's visitor voiced concerns to the nurse that she observed a deterioration in Resident #87, the nurse should have completed an assessment, notified the physician right away with the findings. She stated if the resident's representative requested for Resident #87 to be transferred to the hospital via 911, the nurse should have called 911. The DON stated, "The family should never be told they can call 911 in order to have their loved one transferred to the hospital." A final meeting was held with the Administrator, Director of Nursing and Corporate on 08/25/23 at 6:00 p.m., who were informed of the above findings. An opportunity was offered to the facility's staff to present additional information, but no further information was provided.	F 552		
F 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part.	F 561	1.Resident #98 secured an appointment on 8/23/23 with the provider for 10/17/23 at 10:30 a.m. The resident was made aware of appointment details and desires to schedule his own transportation. Resident #98 was seen by psych services on 9/7/23. 2.Residents who have recommendations/orders to be seen by a specialist can be affected by this deficient practice. Orders were reviewed on 9/12/23 for a specialist and psych services orders to determine if others had been affected by this deficient practice. 3.Staff education was completed on 9/13/2023 on behavioral health services, appointment scheduling and resident rights. 4.Director of Nursing/designee will review new order report 3x per week for 6 weeks	

			to validate if new orders for specialist or psych services ordered, and that appointments are scheduled timely. All results and trends will be reviewed at the Monthly Quality Assurance Performance Improvement Meeting to determine compliance. 5. 9/22/2023	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495308	A. BUILDING _____ B. WING _____	C 08/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERVIEW HEALTH & REHAB CENTER	**414 ALGONQUIN RD HAMPTON, VA 23661**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 561		F 561		

Continued From page 7

§483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident.

§483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility.

§483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility.
This REQUIREMENT is not met as evidenced by:
Based on interview, clinical record review and facility documentation the facility staff failed to promote and facilitate resident self-determination through support of Resident's choice, for 1 Resident in a survey sample of 64 Residents.

The findings included:

For Resident #98 the facility staff failed to schedule the appointments that the Resident had ordered by his physician.

On 8/23/23 at approximately 9:58am, an interview was conducted with Resident #98. Resident #98 stated he needs psych services but has not had them since arrival at facility. He stated that his physician had written an order for him to be seen by a back specialist he had been to in the past when he had back issue. He stated the facility was supposed to be making an appointment with the specialist and he has not received a date and time of appointment yet either.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495308	A. BUILDING _____ B. WING _____	C 08/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERVIEW HEALTH & REHAB CENTER	**414 ALGONQUIN RD HAMPTON, VA 23661**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 561	Continued From page 8 A review of the clinical record revealed that the physician wrote the following orders that read: "7/31/23 - Refer to [facility name redacted] clinic for neuropathy and back pain." "8/10/23 - Refer to [psych services name redacted] On the afternoon of 8/24/23 an interview was conducted with LPN C, and she was asked what the process is when a physician writes an order for psych services. She stated that they have an appointment book the nurses make the appointments and put them on the calendar or in the book. When asked if Resident #98 had any scheduled appointments, LPN C stated that he did not. When asked if Resident #98 had an order for a consult with the back specialist written on 7/31/23, LPN C stated that he did. When asked if Resident #98 had an order to see psych services written on 8/10/23, LPN C stated that he did. When asked if there was any reason the orders were not carried out, LPN C stated that she did not know. On 8/25/23 during the end of day meeting, the Administrator was made aware of the concerns and no further information was provided.	F 561		
F 565 SS=E	Resident/Family Group and Response CFR(s): 483.10(f)(5)(i)-(iv)(6)(7) §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner.	F 565	1.The Local Ombudsman attended the last resident council meeting on **9/6/2023** and reviewed regulations and processes for an affective resident council group. All resident grievances have been closed per Facility Policy and Procedure. 2. All residents have the potential to be affected by this deficient practice. A special resident council meeting was held on 9/13/2023 to review the grievance process. 3. Education was provided to all departments reviewing the regulations related to the facilities policies and	

			procedures on our grievance program on 9/13/23. 4. The Social Service Director will audit all grievances to ensure the Regulation and organizations program meets the expectation x 6 weeks. All results and trends will be reviewed at the Monthly Quality Assurance Performance Improvement Meeting to determine compliance. 5.9/22/2023	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495308	A. BUILDING _____ B. WING _____	C 08/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERVIEW HEALTH & REHAB CENTER	**414 ALGONQUIN RD HAMPTON, VA 23661**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 565		F 565		

Continued From page 9

i.Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation.
iiThe facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility.
(A) The facility must be able to demonstrate their response and rationale for such response.
(B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group.

§483.10(f)(6) The resident has a right to participate in family groups.

§483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility.
This REQUIREMENT is not met as evidenced by:
Based on Resident interview, staff interview, facility documentation review, the facility staff failed to respond to Resident Council grievances These grievance included A) laundry not being returned timely B) items being lost, C) food not being good, D) lack of showers, E) cleanliness of the facility, and F) lack of cleaning in their rooms.

The findings included:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495308	A. BUILDING _____ B. WING _____	C 08/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERVIEW HEALTH & REHAB CENTER	**414 ALGONQUIN RD HAMPTON, VA 23661**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 565		F 565		

Continued From page 10

The Resident Council President gave permission on 8/22/23 for surveyors to review the Resident Council minutes prior to a meeting with the Council, planned for 8/23/23.

Resident Council minutes were reviewed. The minutes revealed ongoing concerns and complaints regarding laundry not being returned timely and items being lost, food not being good, lack of showers, and cleanliness of the facility and lack of cleaning in their rooms. These concerns persisted over the course of the year, and during the survey.

On 8/23/23 at 2:00 P.M., a surveyor met with 13 members of the Resident Council. The Council stated that "a lot of people no longer attend the council meetings because it is a waste of time, and nothing is going to be done." The Residents verbalized that the same issues and complaints remain with no resolution. This is borne out by the repetition of the same grievances across multiple months of council minutes that were reviewed by surveyors.

Throughout the survey, conducted from 8/22/23 through 8/25/23, other residents expressed the same concerns about the same issues.

During the survey, Resident #26 called a surveyor to his room and said he had to purchase a broom to clean his room himself, because they don't clean. Resident #26 had swept his side of the room and there was a significant pile of dirt and debris noted.

Throughout the survey, multiple Residents were observed to have bags of soiled clothing in their rooms. Resident #32 was asked about the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495308	A. BUILDING _____ B. WING _____	C 08/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERVIEW HEALTH & REHAB CENTER	414 ALGONQUIN RD HAMPTON, VA 23661

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 565	Continued From page 11 multiple bags, and he stated, "They are my clothes, you hate to send them down because you never get them back". Observations on all 4 days of the survey revealed that the dining room was not being used for meals, only activities. Interviews with facility staff revealed that the dining room has been closed for over a year. Throughout the survey an abundance of Residents had concerns with regards to the meals not being good. On 8/25/23, the facility Administrator was made aware of the concern that Resident Council expresses the same concerns for months with no resolution. No additional information was received.	F 565		
F 576 SS=E	Right to Forms of Communication w/ Privacy CFR(s): 483.10(g)(6)-(9) §483.10(g)(6) The resident has the right to have reasonable access to the use of a telephone, including TTY and TDD services, and a place in the facility where calls can be made without being overheard. This includes the right to retain and use a cellular phone at the resident's own expense. §483.10(g)(7) The facility must protect and facilitate that resident's right to communicate with individuals and entities within and external to the facility, including reasonable access to: (i) A telephone, including TTY and TDD services; (ii) The internet, to the extent available to the facility; and (iii) Stationery, postage, writing implements and the ability to send mail.	F 576	1. All mail has been delivered to the residents. 2. All residents have the potential to be affected by this deficient practice. The receptionist and Activities department will collaborate on delivering mail 7 days a week including holidays. 3. Education was provided to the Business Office, and the Activity department regarding resident mail delivery on 9/13/23. 4. The Life Enrichment Director will audit resident mail delivery daily x6 weeks. All results and trends will be reviewed at the Monthly Quality Assurance Performance Improvement Meeting to determine compliance. 5.9/22/2023	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495308	A. BUILDING _____ B. WING _____	C 08/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERVIEW HEALTH & REHAB CENTER	**414 ALGONQUIN RD HAMPTON, VA 23661**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 576		F 576		

Continued From page 12

§483.10(g)(8) The resident has the right to send and receive mail, and to receive letters, packages and other materials delivered to the facility for the resident through a means other than a postal service, including the right to:
(i) Privacy of such communications consistent with this section; and
(ii) Access to stationery, postage, and writing implements at the resident's own expense.

§483.10(g)(9) The resident has the right to have reasonable access to and privacy in their use of electronic communications such as email and video communications and for internet research.
(i) If the access is available to the facility (ii) At the resident's expense, if any additional expense is incurred by the facility to provide such access to the resident.
(iii) Such use must comply with State and Federal law.
This REQUIREMENT is not met as evidenced by:
Based on Resident interview and staff interview the facility staff failed to uphold Resident Rights regarding the right to receive mail and receive mail unopened affecting 14 Residents (Resident #7, #13, #23, #41, #44, #47, #53, #58, #61, #67, #82, #84, #92, and Resident #98) in a survey sample of 64 Residents.

The findings included:

1. During a Resident Council meeting, 13 Residents (Resident #7, #13, #23, #41, #44, #47, #53, #58, #61, #67, #84, #92, and Resident #98), stated they do not receive mail on the weekends. On 8/23/23 at 2PM, a Resident Council meeting

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495308	A. BUILDING _____ B. WING _____	C 08/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERVIEW HEALTH & REHAB CENTER	**414 ALGONQUIN RD HAMPTON, VA 23661**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 576		F 576		

Continued From page 13 was held with 13 Residents. During the meeting all the Residents stated they did not receive any mail on Saturdays, only Monday through Friday.

On 8/25/23 at 1:23 PM, an interview was conducted with Employee N, the receptionist. Employee N was asked about the distribution and delivery of mail on weekends. Employee N said, "The receptionists that work the weekends do not do the mail, they sit it on a desk back there [pointing to the Administrative offices]".

On 8/25/23 at approximately 1:40 PM, an interview was conducted with Employee F, the activities director. Employee F said she gets the mail out of her mailbox and writes down the Resident's names who receive mail and delivers it. When asked about weekends, Employee F said, "I'm not here on weekends, I just do it Monday through Friday".

On 8/25/23, the facility Administrator was asked to provide any facility policies with regards to the distribution of mail and reported they had no such policy. He was made aware of the above findings.

No further information was provided.

2. For Resident #82, the facility staff opened his personal mail and packages prior to the Resident receiving it.

On 08/22/23 at 03:06 PM, during an interview with Resident #82, he verbalized he was not happy that the facility opens his packages and mail before he receives them.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495308	A. BUILDING _____ B. WING _____	C 08/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERVIEW HEALTH & REHAB CENTER	**414 ALGONQUIN RD HAMPTON, VA 23661**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 576	Continued From page 14 On 8/25/23 at 1:23 PM, an interview was conducted with Employee N, the receptionist. Employee N was asked about Resident #82's receipt of packages. Employee N reported that Resident #82 "receives a lot of packages, I let the activities director give him his". On 8/25/23 at approximately 1:40 PM, an interview was conducted with Employee F, the activities director. Employee F was asked about Resident #82's mail and packages. Employee F said, "I deliver his mail and some packages I open because in the past he ordered a lot of sharp objects he couldn't have". When asked what time of items he received, Employee F said, "like knives and medicines, I gave it to the nurse, and we put it in a box so his brother can pick it up". Employee F confirmed that Resident #82 had "mentioned it to me once before", when asked if she was aware that Resident #82 did not want his mail opened prior to him receiving it. On 8/25/23 at approximately 2 PM, an interview was conducted with the facility Administrator. The Administrator stated he was not aware of Resident #82's packages being opened or the history of him ordering items that he wasn't permitted to have. No further information was provided.	F 576		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.	F 578	1.Resident #87 code status was corrected on 8/24/2023 2 All residents have the potential to be affected by this deficient practice. A house wide audit was completed on 9/12/2023 reviewing the residents code status for accuracy. No other discrepancies were noted. 3 Education was provided to the Social Service Department and Admissions department regarding code status by the	

			Administrator on 9/12/23. Code status will be reviewed on admission, re-admission, and through the care planning process. 4 The Social Service Director/designee will monitor code status upon admission/re-admission for accuracy x 6 weeks. All results and trends will be reviewed at the Monthly Quality Assurance Performance Improvement Meeting to determine compliance. 5.9/22/2023	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495308	A. BUILDING _____ B. WING _____	C 08/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERVIEW HEALTH & REHAB CENTER	**414 ALGONQUIN RD HAMPTON, VA 23661**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 578		F 578		

Continued From page 15

§483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate.

§483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives).
(i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive.
(ii) This includes a written description of the facility's policies to implement advance directives and applicable State law.
(iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met.
(iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law.
(v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time.
This REQUIREMENT is not met as evidenced by:
Based on staff interviews, clinical record review and facility documentation review, the facility staff

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495308	A. BUILDING _____ B. WING _____	C 08/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERVIEW HEALTH & REHAB CENTER	**414 ALGONQUIN RD HAMPTON, VA 23661**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 578		F 578		

Continued From page 16 failed to ensure 1 of 64 residents (Resident #87) had an accurate medical record for an advanced directive.

The finding included:

Resident #87 Minimum Data Set (MDS - an assessment protocol), a quarterly with an Assessment Reference Date (ARD) of 06/26/23 coded Resident #87's Brief Interview for Mental Status (BIMS) score of 15 out of a possible score of 15 indicating no cognitive impairment.

Resident #87's person-centered comprehensive care plan revised on 05/11/23 documented the resident is a Full Code. The goal set for the resident by the staff was that the resident's code status will be honored through the next review date of 09/20/23. The interventions/approaches the staff would use to accomplish this goal is for the resident's code status to be reviewed and updated as needed.

A review of Resident #87's Physician Order Sheet (POS) for August 2023 revealed the following order: Cardiopulmonary resuscitation (CPR) starting on 02/10/23.

On 08/24/23 at 11:00 a.m., a phone interview was conducted with Resident #87's Responsible Representative (RR.) She stated Resident #87's should be a do-not-resuscitate (DNR) but the facility still has Resident #87 as a full code.

An interview was conducted with the Social Worker (SW) on 08/24/23 at 1:37 p.m. She stated Resident #87 is a DNR and her code status should have been switched from being a full code to DNR in PointClickCare (PCC.) On

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495308	A. BUILDING _____ B. WING _____	C 08/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERVIEW HEALTH & REHAB CENTER	**414 ALGONQUIN RD HAMPTON, VA 23661**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 578		F 578		

Continued From page 17 the same day at 2:14 p.m., an interview was conducted with the Director of Social Services. She provided a copy of a DNR form that was signed and dated by Resident #87 on 02/24/23. She said Resident #87 is a DNR and not a full code. She stated the DNR form was in a soft file in her office. She stated once the DNR form was signed by Resident #87 on 02/24/23, the document should had been scanned in the resident's record and the DNR form given to nursing to adjust her order in PCC.

The Director of Nursing (DON) was interviewed on 08/25/23 at 4:47 p.m. She stated as soon as the DNR form was signed by Resident #87, her code status should have been changed immediately in PCC from being a full code to DNR.

A final meeting was held with the Administrator, Director of Nursing and Corporate on 08/25/23 at 6:00 p.m., who were informed of the above findings. An opportunity was offered to the facility's staff to present additional information, but no further information was provided.

The facility's policy titled Advance Directives noted to be without a created or revision date. It is the facility policy that Advance directives will be respected in accordance with state law and facility policy.

Specific procedures/guidance.
7. Information about whether or not the resident has executed an advance directive shall be displayed prominently in the medical record.

15. In accordance with current OBRA definitions and guidelines governing advance directives, our

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495308	A. BUILDING _____ B. WING _____	C 08/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERVIEW HEALTH & REHAB CENTER	414 ALGONQUIN RD HAMPTON, VA 23661

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 578	Continued From page 18 facility has defined advanced directives as preference regarding treatment options and include, but are not limited to: E. Do Not Resuscitate indicates that, in case of respiratory or cardiac failure, the resident, legal guardian health care proxy, or representative (sponsor) has directed that no cardiopulmonary resuscitation (CPR) or other life-sustaining treatments or methods are to be used.	F 578		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition;	F 584	1 Resident #32's ceiling tiles were replaced and the tile in the restroom was corrected on 8/24/23. 2 The Facility Interdisciplinary team completed a house audit of all ceiling tiles that need repaired or replaced. Any identified tiles in need of replacement or repair were corrected on 8/24/23. The facility room round program was updated to look for ceiling tile that needs to be repaired or replaced. 3 Education was provided to the Interdisciplinary team on what a homelike environment is according to FTag 584 (Safe, Clean, Comfortable homelike environment). Room round checklist was updated to include areas that are not home like. Facility staff were educated on a homelike environment and reeducated on the REQQER work order system on 9/13/2023. 4 The Maintenance Director/designee will Audit 3 rooms per week with a focus on ceiling tiles x6 weeks to ensure all tiles are being repaired or replaced. All results and trends will be reviewed at the Monthly Quality Assurance Performance Improvement Meeting to determine compliance. 5.9/22/2023	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495308	A. BUILDING _____ B. WING _____	C 08/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERVIEW HEALTH & REHAB CENTER	**414 ALGONQUIN RD HAMPTON, VA 23661**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 584		F 584		

Continued From page 19

§483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv);

§483.10(i)(5) Adequate and comfortable lighting levels in all areas;

§483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and

§483.10(i)(7) For the maintenance of comfortable sound levels.
This REQUIREMENT is not met as evidenced by:
Based on observation, Resident interview, staff interview and facility documentation review, the facility staff failed to maintain a homelike environment for one Resident (Resident #32) in a survey sample of 64 Residents.

The finding included:

For Resident #32, the facility staff failed to provide a homelike environment as evidenced by multiple ceiling tiles in his room were discolored and one in the bathroom was off the track, and appeared as though it may fall.

On 8/22/23, in the late morning, during a Resident interview, Resident #32 told the surveyor to look at the ceiling tiles. He pointed out how multiple tiles were stained and said they had been like that for several weeks. Resident #32 said, "I've told them for 3 weeks, but it goes in one ear and out the other". The resident then asked the surveyor to "look in the bathroom". A ceiling tile in the bathroom was noted to be off the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495308	A. BUILDING _____ B. WING _____	C 08/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERVIEW HEALTH & REHAB CENTER	**414 ALGONQUIN RD HAMPTON, VA 23661**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 584	Continued From page 20 track and appeared as though it could fall. Resident #32 said, "It's going to fall, I've told them, they do nothing". On 8/22/23, before going to lunch, Surveyor C shared the above findings with the facility Administrator. On 8/22/23 at 4PM, an observation was made of Resident #32's room with no changed noted, the ceiling tiles had not been changed. On 8/23/23, observations were made throughout the day, with the last observation being at 5 PM, and the ceiling tiles had not been replaced. On 8/23/23, during the end of day meeting, the facility Administrator was again made aware of the above findings. On 8/24/23 at 8:47 AM, Resident #32 was visited in his room and reported they "replaced them at 6:30 this morning". No further information was provided.	F 584		
F 602 SS=E	Free from Misappropriation/Exploitation CFR(s): 483.12 §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by:	F 602		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495308	A. BUILDING _____ B. WING _____	C 08/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERVIEW HEALTH & REHAB CENTER	**414 ALGONQUIN RD HAMPTON, VA 23661**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 602	Continued From page 21 Based on interview, clinical record, and facility documentation the facility staff failed to ensure residents are free from neglect and misappropriation of property for 21 Residents (#'s 42, 92, 23, 6, 363, 87, 52, 9, 38, 14, 97, 64, 7, 67, 78, 69, 56, 31, 364, 72, 88, 82 and 78), in a survey sample of 62 Residents. The findings included: For Resident #'s 42, 92, 23, 6, 363, 87, 52, 9, 38, 14, 97, 64, 7, 67, 78, 69, 56, 31, 364, 72, 88, 82 and 78, the facility staff failed to ensure the appropriate handling of medications to prevent misappropriation of Residents property. On 8/24/23 at 9:00 AM an interview was conducted with the DON (Director of Nursing) who stated that on 6/7/23, LPN N did not administer medications as she should have and there were controlled substances not accounted for. The proper authorities were notified, the OLC (Office of Licensure and Certification), DHP (Dept. of Health Professions), the Ombudsman, the Police, the pharmacy, physicians, and the Responsible Parties were all notified. LPN N refused to give a statement to the facility, however, she did speak with the police officers. The DON stated that LPN N said that she was resigning effective immediately. The DON stated that after the first incident of diversion of medication on 6/7/23, a second incident occurred on July 25th when the missing controlled substances involved 2 Residents (#'s 78 & 82) in that instance the Medication Cards for both Residents were taken. An investigation was conducted however, they were unable to determine when the cards were taken. There	F 602	Past noncompliance: no plan of correction required.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495308	A. BUILDING _____ B. WING _____	C 08/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERVIEW HEALTH & REHAB CENTER	**414 ALGONQUIN RD HAMPTON, VA 23661**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 602	Continued From page 22 was a common nurse that worked with both Residents, and she was an agency nurse. The DON requested she not return to the facility. The facility self-identified the problem and put together a QAPI plan for both incidents they submitted for consideration for PNC (Past Non-Compliance). They are as follows: QAPI Plan of action for Misappropriation of Medication 6/7/23 1. All identified residents assessed to determine if any ill effects of medication/Tx omissions. 2. Reviewed administration record of MAR/TAR on individual nurses' assignment to identify affected residents. 3.Facility staff re-educated on abuse policy/misappropriation, Licensed nurses educated on shift-to-shift narc count, signs and symptoms of impairment, reporting suspicions of impairment, reporting controlled med discrepancies, misappropriation and abuse policy review, documentation of medications/Tx on MAR/TAR validating med/to documentation during shift change with off going nurse. 4.DON or designee will review 6 nurse shift assignments weekly to validate medications and Tx administer (sic) per order X 6 weeks. DON or designee will visually inspect controlled accountability records to controlled supply in med cart weekly to validate accountability X 6 weeks. 5. DOC (Date of Compliance) 8/1/23 QAPI Plan of action for Misappropriation of Medication 7/25/23 1. All identified residents assessed to determine if any ill effects of medication/Tx omissions.	F 602		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495308	A. BUILDING _____ B. WING _____	C 08/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERVIEW HEALTH & REHAB CENTER	**414 ALGONQUIN RD HAMPTON, VA 23661**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 602	Continued From page 23 2. Reviewed administration record of MAR/TAR on individual nurses' assignment to identify affected residents. 3.Review documentation of medications / TX's on the MAR's / TAR's, new log education, documenting of controls received and completed, new books on unit for controlled delivery manifest and completed control accountability records and misappropriation. 4. Facility SW will interview 3 residents per week to validate no concerns with medication administration for 6 weeks. DON /Designee will audit controlled accountability records to controlled supply in med cart weekly to validate accountability X 6 Weeks. The results of Audits will be reviewed in QAPI to determine if there is a need for further monitoring. 5. DOC (Date of Compliance) 8/15/23 While on the survey the survey team reviewed the Past Non-Compliance QAPI plan and the education provided, as well as the proof of in-service and training sheets. The new pharmacy count sheet was reviewed with the DON and the counting of controlled substances was observed utilizing the new pharmacy drug reconciliation forms. The staff correctly counted and used the pharmacy sheet for tracking the acquiring of medication from pharmacy, as well as the dispensing and completion of medication (when a Resident has completed the course of medication and the order is completed or when the medication is re-ordered, and the medication card is empty). On 8/25/23 the Administrator was made aware, and no further documentation was provided.	F 602		
F 641 SS=D	Accuracy of Assessments	F 641		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495308	A. BUILDING _____ B. WING _____	C 08/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERVIEW HEALTH & REHAB CENTER	414 ALGONQUIN RD HAMPTON, VA 23661

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 641	Continued From page 24 CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on staff interviews, record review, and review of the Resident Assessment Instrument (RAI) Manual, the facility failed to provide an accurate resident assessment two residents (Resident (R) 92 and 98) out of a total sample of 64 residents. Findings include: Review of R92's quarterly "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) 04/06/23 located in the EMR under the "MDS" tab showed he was coded as independent with bed mobility, transfer, eating, and toileting. Review of R92's quarterly "MDS," with an ARD of 05/09/23 showed he was coded as requiring the extensive assistance of one person for bed mobility, transfer, and toileting; and he required supervision and oversight, and meal set up by staff. His Brief Mental Status Interview (BIMS) revealed a score of eight out of 15 indicating he was cognitively impaired. During an observation on 08/22/23 at 12:15 PM, R92 was observed sitting in a chair, rising without assistant devices, ambulating independently, closing the room door to enable him to open the bathroom door to discuss the floor. In an interview on 08/24/23 at 2:34 PM, the MDS Coordinator (MDSC) stated she had reviewed	F 641	1.The facility MDS Nurse corrected the MDS assessments for Resident R92 on 9/4/2023.On 9/12/2023 resident R98 MDS was reviewed for accuracy of coding for section G. This review included observation of resident and staff interviews and was validated that coding from 8/2/2023 MDS accurately reflects the resident's functional status. 2.All residents have the potential to be affected by this deficient practice. The Interdisciplinary Team reviewed residents with significant changes on 9/12/2023 and appropriate assessments have been completed. 3.The Nursing Department was educated by the Director of Nursing on 9/6/2023, 9/7/2023 and completed 9/13/2023 on accurately documenting ADL's. The MDS Department was educated by the Director of Nursing on accuracy of the assessment on 9/12/2023. The facility has a policy on MDS accuracy. 4.The Director of Nursing/designee will audit 3 resident MDS assessments a week for accuracy for 6 weeks. All results and trends will be reviewed at the Monthly Quality Assurance Performance Improvement Meeting to determine compliance. 5.9/22/2023	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495308	A. BUILDING _____ B. WING _____	C 08/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERVIEW HEALTH & REHAB CENTER	**414 ALGONQUIN RD HAMPTON, VA 23661**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 641	Continued From page 25 everything and confirmed R92 did not require extensive assistance as indicated on the quarterly "MDS" with an ARD of 05/09/23 and the "MDS" was incorrect. The MDSC clarified, the Certified Nursing Assistant's (CNA's) documentation was incorrect, and it was not caught prior to 05/09/23 "MDS" submission. During an interview on 08/24/23 at 6:27 PM, the Director of Nursing (DON) stated the facility did not have a policy regarding MDS accuracy, they use the (RAI) Manual. At 6:31 PM, the DON stated the MDSC should review the documentation and observations; and do their own assessment. The DON stated an expectation the MDS is coded accurately. Review of the October 2019 RAI Manual showed on page G-1: "Section G: Functional Status Intent: Items in this section assess the need for assistance with activities of daily living (ADLs), altered gait and balance, and decreased range of motion. In addition, on admission, resident and staff opinions regarding functional rehabilitation potential are noted. . . ." On Page G-3: "Steps for Assessment 1. Review the documentation in the medical record for the 7-day look-back period. 2. Talk with direct care staff from each shift that has cared for the resident to learn what the resident does for himself during each episode of each ADL activity definition as well as the type and level of staff assistance provided. Remind staff that the focus is on the 7-day lookback period only. 3. When reviewing records, interviewing staff, and observing the resident, be specific in evaluating each component as listed in the ADL activity	F 641		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495308	A. BUILDING _____ B. WING _____	C 08/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERVIEW HEALTH & REHAB CENTER	**414 ALGONQUIN RD HAMPTON, VA 23661**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 641		F 641		

Continued From page 26

definition. For example, when evaluating Bed Mobility, observe what the resident is able to do without assistance, and then determine the level of assistance the resident requires from staff for moving to and from a lying position, for turning the resident from side to side, and/or for positioning the resident in bed. To clarify your own understanding and observations about a resident's performance of an ADL activity (bed mobility, locomotion, transfer, etc.), ask probing questions, beginning with the general and proceeding to the more specific. . . ."

2. For Resident #98 the facility failed to accurately assess Resident #98 in the MDS (Minimum Data Set) with an ARD (assessment reference date of 8/2/23.

On 8/23/98 at approximately 9:58 AM Resident #98 was observed sitting in his wheelchair watching the TV. Resident #98 was asked about his mobility, and he stated I cannot feel my legs other than the spasms I get from my back to my legs and then from the legs down with the neuropathy pain too. When asked if he could safely transfer on and off the toilet he stated, " I manage ok, some days I need more." When asked if he could walk unassisted, he stated that he could not. The Resident stated that anything involving the legs down he needed assistance with. When asked does he get the assistance he needs when he requests it, he stated that he needs help with shower because if he bends over to wash his feet, he will fall out of the shower chair.

"A review of the MDS dated 8/2/23 Section G-0110 ADL (Activities of Daily Living)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495308	A. BUILDING _____ B. WING _____	C 08/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERVIEW HEALTH & REHAB CENTER	**414 ALGONQUIN RD HAMPTON, VA 23661**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 641		F 641		

Continued From page 27

Assistance:

B. Transfer- Resident 98 was coded as 0 (0 is Independent) and 0 (No set up or physical help from staff.
C. Walk in Room - Resident 98 was coded as 0 (0 is Independent) and 0 (No set up or physical help from staff
D. Walk in corridor- Resident 98 was coded as 0 (0 is Independent) and 0 (No set up or Physical help from staff
E. Locomotion on unit - Resident 98 was coded as 0 (0 is Independent) and 0 (No set up or physical help from staff [this is correct as resident can self-propel on and off unit]
F. Locomotion on unit -Resident 98 was coded as 0 (0 is Independent) and 0 (No set up or physical help from staff [this is correct as resident can self-propel on and off unit]
G. Dressing - Resident 98 was coded as 0 (0 is Independent) and 0 (No set up or physical help from staff
H. Eating - Resident 98 was coded as 0 (0 is Independent) and 0 (No set up or physical help from staff)
I Toilet use Resident 98 was coded as 0 (0 is Independent) and 0 (No set up or physical help from staff)
J Personal Hygiene - Resident 98 was coded as 0 (0 is Independent) and 0 (No set up or physical help from staff)"

"Section G 0120 -
Bathing Resident 98 was coded as 0 (0 is Independent) and 0 (No set up or physical help from staff)"

"G0300 - Balance During Transfers and Walking

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495308	A. BUILDING _____ B. WING _____	C 08/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERVIEW HEALTH & REHAB CENTER	**414 ALGONQUIN RD HAMPTON, VA 23661**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 641		F 641		

Continued From page 28

A. Moving from seated to standing position - Resident #98 was coded as 0. Steady at all times.
B. Walking with assistive device - Resident #98 was coded as 0. Steady at all times.
C. Turning around and facing the opposite direction while standing - Resident #98 was coded as 0. Steady at all times.
D. Moving on and off the toilet - Resident #98 was coded as 0. Steady at all times.
E. Surface to surface transfer (between the bed and chair or wheelchair) Resident #98 was coded as 0. Steady at all times."

"G0400 Functional Limitations in Range of Motion
A. Upper extremities Resident #98 was coded as 0 No impairment.
B. Lower extremities Resident #98 was coded as 0. Steady at all times."

"G0600- mobility devices
A. Cane or crutch - NO
B. Walker - NO
C. Wheelchair - Yes."

On 8/23/23 at approximately 12:30 PM an interview was conducted with CNA H who was asked if Resident #98 requires assistance with ADL care CNA H stated that Resident #98 does need assistance with dressing and getting on and off the toilet as well as showering and Hygiene. CNA H stated that," Resident #98 does as much as possible on their own and we help when he calls for us."

On 8/24/23 an interview was conducted with RN B who was shown the MDS G section and asked if that accurately reflects the condition of Resident #98 and she stated that it did not. When asked if this assessment would be considered inaccurate,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495308	A. BUILDING _____ B. WING _____	C 08/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERVIEW HEALTH & REHAB CENTER	414 ALGONQUIN RD HAMPTON, VA 23661

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 641	Continued From page 29 RN B stated that it would. On 8/25/23 during the end of day meeting the Administrator was made aware of the concerns and no further information was provided.	F 641		
F 644 SS=D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is not met as evidenced by: Based on facility staff interviews, clinical record review and facility documentation review, the facility staff failed to incorporate the recommendations from a level II PASARR (preadmission screening and resident review) into the Resident's assessment and care planning for one Resident (Resident #10) in a survey sample of 64 Residents.	F 644	1. Resident R10's PASARR was reevaluated by the Social Service Director and Corrected on 8/24/2023. 2. All residents of the facility have the potential to be affected by this deficient practice. A house audit of all residents PASARR's was completed on 9/12/2023 and updates/evaluations ongoing. 3. The Admissions Director, Social Service Director and Asst. Social Service Director was educated on the PASARR process from the Nursing Home Administrator on 9/12/2023. 4. The Social Service Director will audit all new admissions to ensure the PASARR and Assessments are accurate for all Admissions x6 weeks. All results and trends will be reviewed at the Monthly Quality Assurance Performance Improvement Meeting to determine compliance. 5.9/22/2023	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495308	A. BUILDING _____ B. WING _____	C 08/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERVIEW HEALTH & REHAB CENTER	**414 ALGONQUIN RD HAMPTON, VA 23661**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 644		F 644		

Continued From page 30

The findings included:

For Resident #10, who had a level II PASARR, the facility staff were unaware until requested by the survey team, that the Resident had a level II screening and failed to incorporate the recommendations into the Resident's assessment and care planning.

On 8/22/23-8/23/23, a clinical record review was conducted of Resident #10's electronic health record. Surveyor C was unable to find a PASARR. The care plan did not address a PASARR or any recommendations.

On 8/24/23, the facility Administration was asked to provide the PASARR for Resident #10.

On 08/24/23 at 02:19 PM, the Director of Nursing (DON) provided Surveyor C with a copy of the Level I PASARR for Resident #10. The level 1 PASARR indicated a level II was needed.

On the afternoon of 8/24/23, an interview was conducted with Employee D, the Social Services Director (SSD). The SSD said, "In going through I was able to find her level 1, I realized they checked yes she needed a level II. I found out a level 2 was done in 2018 by the hospital, but since I was here, I didn't know she had a level II [PASARR]. I called [the company that conducts level II PASARR's] and they were never notified where she went so it hasn't been updated".

The SSD further confirmed that the Level II PASARR was in a "soft file" in the office and not part of the clinical chart and therefore, Resident #10's assessment and care plan had not incorporated the recommendations within the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495308	A. BUILDING _____ B. WING _____	C 08/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERVIEW HEALTH & REHAB CENTER	414 ALGONQUIN RD HAMPTON, VA 23661

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 644	Continued From page 31 level II. Review of the facility policy titled, "Virginia Long-Term Services and Supports (LTSS) Screening, Preadmission Screening and Resident Review (PASRR) Policy" was conducted. Excerpts from this policy read as follows: "...LTSS. 1. Pursuant to 32.1-330 of the Code of Virginia, individuals shall be screened prior to admission to a NF [nursing facility] if they are already Medicaid members or are financially eligible by way of application as verified by the ePAS system... 2. The LTSS Screening is reviewed ensure that applicable NF admission criteria have been met, documented, and submitted unless the individual meets any of the special circumstances set out in 12VAC30-60-302 E [sic]...PASRR.... 6. The facility will act upon all recommendations resulting from PASSR evaluations. The resident-centered, interdisciplinary care plan for a resident who has had a Level II evaluation will be developed....". On 8/24/23, during an end of day meeting, the facility Administrator was made aware of the above findings. No further information was provided.	F 644		
F 645 SS=D	PASARR Screening for MD & ID CFR(s): 483.20(k)(1)-(3) §483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability. §483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental disorder as defined in paragraph (k)(3)	F 645	1.A Preadmission Screening and Resident Review (PASARR) has been completed for Resident #91 on 9/12/2023 and remains a Level I. 2 . An audit has been completed of current residents PASARR"s to ensure that all residents have a PASARR on admission or within 30 days of admission. The residents identified that do not have a PASARR evaluation on file will be resubmitted for a new PASARR screening. 3. The Facility Social Worker provided education to the admissions Coordinator	

			on the requirements of the PASARR prior to admission on 9/12/23. 4. The Social Service Director/designee will audit all new admissions to ensure the PASARR and Assessments are accurate for all Admissions x6 weeks. All results and trends will be reviewed at the Monthly Quality Assurance Performance Improvement Meeting to determine compliance. 5.2/2023	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495308	A. BUILDING _____ B. WING _____	C 08/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERVIEW HEALTH & REHAB CENTER	**414 ALGONQUIN RD HAMPTON, VA 23661**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 645	Continued From page 32 (i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission, (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services; or (ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission(A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability. §483.20(k)(2) Exceptions. For purposes of this section- (i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital. (ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual- (A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the	F 645		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495308	A. BUILDING _____ B. WING _____	C 08/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERVIEW HEALTH & REHAB CENTER	**414 ALGONQUIN RD HAMPTON, VA 23661**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 645		F 645		

Continued From page 33

hospital,

(B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and

(C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services.

§483.20(k)(3) Definition. For purposes of this section-

(i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1).

(ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter.

This REQUIREMENT is not met as evidenced by:

Based on record review, interview and facility policy review, the facility failed to ensure one of seven residents (Resident (R) 91) reviewed for Preadmission Screening and Resident Review (PASARR) had a Level One PASARR completed prior to admission. This failure had the potential for R91 to not receive services necessary for mental health and psychosocial well-being.

Findings include:

Review of R91's hard (paper) chart and EMR record (tabs labeled "Assessments," "Progress Notes," and "Misc [Miscellaneous]") showed no PASARR screening documentation.

On 08/23/23 at 5:30 PM, the Director of Nursing (DON) was asked to provide R91's PASARR

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495308	A. BUILDING _____ B. WING _____	C 08/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERVIEW HEALTH & REHAB CENTER	**414 ALGONQUIN RD HAMPTON, VA 23661**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 645		F 645		

Continued From page 34

documentation.

During an interview on 08/24/23 at 1:24 PM, the DON stated R91 "did not have a PASARR." When asked to clarify if that was a PASARR level I or level II, the DON responded, "There is no PASARR period."

In an interview on 08/24/23 at 2:00 PM, the Social Services Director (SSD) also confirmed R91 did not have a PASARR.

In a follow-up interview on 08/24/23 at 3:15 PM, the DON was asked if it was her expectation that all residents have a PASARR prior to admission and responded, "That's my understanding."

During an interview on 08/25/23 at 8:18 AM, the Administrator confirmed an expectation that all residents need a [PASARR] screening before admission.

Review of the undated facility policy titled "Virginia Long-Term Services and Supports (LTSS) Screening, Preadmission Screening and Resident Review (PASRR) Policy," read in pertinent part, "Policy:
The organization observes preadmission screening requirements to ensure that:
1) Prior to an individual's admission, The Social Worker, Admissions Coordinator, or designee will review the completed screening forms via e-PAS and obtain a copy for placement in the electronic medical record
i) Nursing Facilities shall not accept paper screening forms as proof that admission criteria have been met and documented
2) Because the Virginia PASRR screening is coupled with the LTSS Screening for Virginia's

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495308	A. BUILDING _____ B. WING _____	C 08/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERVIEW HEALTH & REHAB CENTER	414 ALGONQUIN RD HAMPTON, VA 23661

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 645	Continued From page 35 Medicaid program, the screening team responsible for conducting the PASRR screening prior to admission is determined by who is required to complete the LTSS Screening a) Prior to Admission (hospital- inpatient, community-residing in community/assisted living) i) Already Medicaid members ii) Financially eligible by way of application as verified by the ePAS system b) Nursing Facility i) Medicare ii) Private Pay . . ."	F 645		
F 657 SS=E	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-(A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff.(E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.	F 657	1. Resident 87's, person-centered care plan was updated to include the use of ace wrap dressings. 2. Residents with a current Lymphedema Diagnosis can be affected by this deficient practice. An audit was completed on 9/11/23 to determine if other residents had been affected by this deficient practice and no additional errors found. 3The MDS department was educated by the Director of Nursing on lymphedema interventions. The MDS Department reviewed and updated the Plan of Care for residents with Current lymphedema diagnosis per Diagnosis audit report. The MDS Nurse audited the Care Plan meetings for all residents who have had a Care Plan meeting within the last 14 days lookback starting 9/11/23 for accuracy. 4.The MDS Nurse/designee will audit and validate accuracy of Plan of Care prior to scheduled Care Plan meetings x 6 weeks. All results and trends will be reviewed at the Monthly Quality Assurance Performance Improvement Meeting to determine compliance. 5.9/22/2023	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495308	A. BUILDING _____ B. WING _____	C 08/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERVIEW HEALTH & REHAB CENTER	**414 ALGONQUIN RD HAMPTON, VA 23661**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657		F 657		

Continued From page 36

(iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.
This REQUIREMENT is not met as evidenced by:
Based on observation, Resident Interview, Facility staff interview and record review, the facility staff failed to revise 1 of 64 sampled residents care plan.

The findings include:

For Resident #87, the person-centered care plan failed to include the use of ace wrap dressings.

Resident #87 Minimum Data Set (MDS - an assessment protocol), a quarterly with an Assessment Reference Date (ARD) of 06/26/23 coded Resident #87's Brief Interview for Mental Status (BIMS) score of 15 out of a possible score of 15 indicating no cognitive impairment. The MDS coded Resident #87 total dependent of two with bathing, extensive assistance of two with bed mobility, extensive assistance of one with transfer, dressing, toilet use and personal hygiene and supervision with eating for Activities of Daily Living (ADL) care.

Resident #87's person-centered care plan with a revision date of 05/11/23 documented resident with impaired circulation related to lymphedema. The goal set for the resident by the staff was that the resident will be free from signs/symptoms of complications of poor circulation through the next review period dated 09/20/23. The interventions/approaches the staff would use to accomplish this goal is to keep legs elevated when resting.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495308	A. BUILDING _____ B. WING _____	C 08/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERVIEW HEALTH & REHAB CENTER	**414 ALGONQUIN RD HAMPTON, VA 23661**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 37 A review of Resident #87's Treatment Administration Record (TAR) for August 2023 revealed an order to apply ace wraps to bilateral lower extremities every other day as tolerated for edema starting on 07/22/23. The ace wraps are to be applied in the morning and remove at bedtime (night). During the initial tour on 08/22/23 at 2:37 p.m., Resident #87 was observed lying in bed. She stated she had a diagnosis of lymphedema (swelling in the arms or legs) and the nurse's had not wrapped her legs for several days. She stated she hope her legs are without any open areas or blisters. The resident removed the covers from her lower extremities. Both lower extremities had edema and were noted to be without ace wraps. An interview was conducted with the Director of Nursing (DON) on 08/25/23 at 4:50 p.m. She stated according to the physicians order, the ace wraps are used for edema. She stated MDS usually updates the care plans but any of the nursing staff can also update resident care plan. She stated Resident #87 has a diagnosis of lymphedema and the care plan should have included ace wraps, provide labs as ordered, and monitor for skin impairment. A final meeting was held with the Administrator, Director of Nursing and Corporate on 08/25/23 at 6:00 p.m., who were informed of the above findings. An opportunity was offered to the facility's staff to present additional information, but no further information was provided.	F 657		
F 658 SS=D	Services Provided Meet Professional Standards	F 658		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495308	A. BUILDING _____ B. WING _____	C 08/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERVIEW HEALTH & REHAB CENTER	414 ALGONQUIN RD HAMPTON, VA 23661

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 658	Continued From page 38 CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record review, the facility staff failed to follow physician orders for the application of ace wraps to the bilateral lower extremities. The findings include Resident #87 was originally admitted to the nursing facility on 01/24/23. Diagnosis for Resident #87 included but not limited to lymphedema. Resident #87 Minimum Data Set (MDS - an assessment protocol), a quarterly with an Assessment Reference Date (ARD) of 06/26/23 coded Resident #87's Brief Interview for Mental Status (BIMS) score of 15 out of a possible score of 15 indicating no cognitive impairment. The MDS coded Resident #87 total dependent of two with bathing, extensive assistance of two with bed mobility, extensive assistance of one with transfer, dressing, toilet use and personal hygiene and supervision with eating for Activities of Daily Living (ADL) care. Resident #87's person-centered care plan with a revision date of 05/11/23 documented resident with impaired circulation related to lymphedema. The goal set for the resident by the staff was that the resident will be free from signs/symptoms of	F 658	1.Resident #87 had the order for ace wraps discontinued on 8/24/23 per resident request. New orders obtained on 8/24/2023 for PRN TED Hose per resident request. 2.All residents who have orders for ace wraps can be affected by this deficient practice. An order report was pulled on 9/12/23 and reviewed for other residents who may have orders for ace wraps. No other residents have orders for ace wraps. 3.Facility nursing staff were educated on completion of treatment per MD order and best practices for documenting ordered treatments on 9/6/23 and completed education on 9/7/23. 4.Director of Nursing/designee will visually inspect the dressing or ace wrap of 6 residents per week to validate treatment performed as ordered x 6 weeks. All results and trends will be reviewed at the Monthly Quality Assurance Performance Improvement Meeting to determine compliance. 5.9/22/2023	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495308	A. BUILDING _____ B. WING _____	C 08/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERVIEW HEALTH & REHAB CENTER	**414 ALGONQUIN RD HAMPTON, VA 23661**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 658		F 658		

Continued From page 39 complications of poor circulation through the next review period dated 09/20/23. The interventions/approaches the staff would use to accomplish this goal is to keep legs elevated when resting.

A review of Resident #87's Treatment Administration Record (TAR) for August 2023 revealed an order to apply ace wraps to bilateral lower extremities every other day as tolerated for edema starting on 07/22/23. The ace wraps are to be applied in the morning and remove at bedtime (night).

During the initial tour on 08/22/23 at 2:37 p.m., Resident #87 was observed lying in bed. She stated she had a diagnosis of Lymphedema and the nurse's had not wrapped her legs for several days. She stated she hope her legs were without any open areas or blisters. The resident removed the covers from her lower extremities. Both lower extremities noted to be without ace wraps with edema present, but without any open areas or blisters.

On 08/23/23 at 10:40 a.m., Resident #87 observed without ace wraps to her bilateral lower extremities. On the same day at 4:14 p.m., Resident #87 stated the nurse never applied the ace wraps to her lower extremities. The resident denied pain to her extremities. The resident removed the covers from her lower extremities and the ace wraps were not present.

A review of Resident #87's TAR revealed the ace wraps were to be applied on 08/23/23 at 8:00 a.m., and to be removed at bedtime.

On 08/24/23 at 2:45 p.m., an interview was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495308	A. BUILDING _____ B. WING _____	C 08/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERVIEW HEALTH & REHAB CENTER	**414 ALGONQUIN RD HAMPTON, VA 23661**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 658	Continued From page 40 conducted with License Practical Nurse, LPN-K. She stated she was assigned to Resident #87 on 08/23/23 (7-3 shift). She stated she did not apply Resident #87's ace wraps to her bilateral lower extremities. She stated she went to the room to apply the resident's ace wraps to her lower extremities, but she was not in the room, and she forgot to go back. An interview was conducted with the Director of Nursing (DON) on 08/25/23 at 4:50 p.m. She stated the nurses are to apply Resident #87's ace wraps as ordered by the physician. A final meeting was held with the Administrator, Director of Nursing and Corporate on 08/25/23 at 6:00 p.m., who were informed of the above findings. An opportunity was offered to the facility's staff to present additional information, but no further information was provided.	F 658		
F 677 SS=E	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, Resident interview, staff interview, clinical record review, and facility documentation review, the facility staff failed to provide assistance with activities of daily living (ADL) for Residents who were dependent upon facility staff for such care, affecting 3 Residents (Resident #10, #29, and #87) in a survey sample of 64 Residents.	F 677		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495308	A. BUILDING _____ B. WING _____	C 08/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERVIEW HEALTH & REHAB CENTER	414 ALGONQUIN RD HAMPTON, VA 23661

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 677	Continued From page 41 The findings included: 1. For Resident #10, the facility staff failed to provide needed assistance so that the Resident could be out of bed into her wheelchair, which resulted in her being served lunch in the bed and she did not eat the meal. On 8/24/23 at approximately 10 AM, Resident #10 was visited in her room by Surveyor C. Resident #10 stated that she was waiting to get up. On 08/24/23 at 11:20 AM, CNA M was observed in Resident #10's room. Resident #10 was dressed, and CNA M said she was getting her up. On 08/24/23 at 12:37 PM, Surveyor C observed that Resident #10's call light was on. The unit manager, LPN C was observed to respond to the call light and the Resident was heard to say, "I want to get up". LPN C told the Resident meal trays were "up" [on the unit] and she would have to wait until after lunch. On 08/24/23 at 12:54 PM, Resident #10 was again asking to get up. An interview was conducted with CNA M who said, "She [Resident #10] wants to get up but the lift wasn't working, by the time I found the one that was working, the meal trays were out on the floor. I'm going to get her up after lunch". On 8/24/23 at 1:40 PM, Resident #10 was observed to still be in bed with her meal tray in front of her and it was noted the Resident had not eaten. When asked, Resident #10 said, she was unable to eat, while the roommate is in the room defecating. It was noted that there was a strong	F 677	1.Resident #10 is being offered assistance to get out of bed daily before lunch. Resident #29 is being offered showers 2x per week. Resident #87 was assisted with removal of facial hair on 8/24/23. 2.All residents requiring assistance with activities of daily living have the potential to be affected by this deficient practice. An audit was performed to determine who had facial hair and their preferences for removal and/or preference to not remove. Assistance was provided as needed/requested. Orders for showers have been placed to facilitate oversight of showers and to document residents' acceptance or declination on shower days. 3.Facility nursing staff were re-educated on shower schedules and removal of facial hair on 9/6/23 and completed on 9/7/23. Staff were educated on assistance with provision of care needs during mealtimes on 9/13/23. 4. Director of Nursing/designee will audit and visually monitor 6 residents weekly to validate assistance provided during mealtimes with needed ADL's and meeting needs of residents requiring assistance with removal of facial hair x 6 weeks. Director of Nursing or designee will also audit and review ADL record and /or TAR of 6 residents per week to validate showers being offered 2x weekly x 6 weeks. All results and trends will be reviewed at the Monthly Quality Assurance Performance Improvement Meeting to determine compliance. 5.9/22/2023	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495308	A. BUILDING _____ B. WING _____	C 08/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERVIEW HEALTH & REHAB CENTER	**414 ALGONQUIN RD HAMPTON, VA 23661**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 677	Continued From page 42 odor of feces within the room. On 08/24/23 at 01:46 PM, an interview was conducted with LPN D. LPN D confirmed that they only have 1 mechanical lift on the unit, and they have about 11 or 12 Residents who require the lift for transfers. When asked if something was wrong with the lift, LPN D said, "it stopped functioning properly. We tagged it out [took it out of service] and put it out back". LPN D then confirmed that there was only 1 functioning lift throughout the entire building, which would have to be shared between all 3 nursing units and across 2 levels. During the above conversation with LPN D, LPN C, the unit manager walked up. LPN C said she was unaware that it wasn't working. When LPN C was told Resident #10 wanted to get up and as a result had to eat in her room and had not eaten her lunch, LPN C said, "I was in there at breakfast, and she told me when she wanted to get up. I then answered her call light and she said she wanted to get up but that was right when the trays were out, I told her after lunch they could get her up. Once she comes out, I can get her something else from the kitchen, they will make her something". LPN C was asked to explain what the meal trays being "out" had to do with a Resident being able to get out. LPN C explained that when the meal trays are on the unit, all the staff work on distributing meal trays, so they can get the trays out faster. On 8/24/23 at 2:20 PM, Several CNAs were observed at Resident #10's room with a lift but reported to Surveyor C that Resident #10 said, she had taken her shoes off and everything and said she isn't getting up now.	F 677		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495308	A. BUILDING _____ B. WING _____	C 08/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERVIEW HEALTH & REHAB CENTER	**414 ALGONQUIN RD HAMPTON, VA 23661**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 677		F 677		

Continued From page 43

Review of Resident #10's clinical record was conducted. The care plan identified a focus area that read, "The resident has an ADL self-care performance deficit r/t [related to] hemiplegia". Interventions for this identified area, included but were not limited to, "Eating: The resident at times has fluctuations in eating provide supervision and when needed physical assistance... Resident requires physical assistance with ADLS. Staff to provide physical assistance as needed... [Resident #10's name redacted] requires a full hoyer lift by 2 staff to move between surfaces as requested and as necessary...".

The facility policy titled, "Activities of Daily Living (ADLs)" was received and reviewed. Excerpts from this policy read, "...4. Appropriate care and services will be provided for residents who are unable to carry out ADLS independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with: a. Hygiene (bathing, dressing, grooming, and oral care) ... b. Mobility (transfer and ambulation, including walking) ...".

On 8/24/23, during an end of day meeting, the facility Administrator was made aware of the above findings.

No further information was provided.

2. For Resident #29, the facility staff failed to provide assistance with showers/bathing so that the Resident would receive showers twice weekly.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495308	A. BUILDING _____ B. WING _____	C 08/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERVIEW HEALTH & REHAB CENTER	**414 ALGONQUIN RD HAMPTON, VA 23661**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 677		F 677		

Continued From page 44

On 08/23/23 at 10:37 AM, during a Resident interview, Resident #29 verbalized frustration that she is only getting showers once a week.

On 8/23/24-8/24/23, a clinical record review was conducted. This review revealed that according to the ADL sheet, Resident #29 had not received a shower from 7/25/23-8/24/23, only partial baths and bed baths were provided.

The facility policy titled, "Activities of Daily Living (ADLs)" was received and reviewed. Excerpts from this policy read, "...4. Appropriate care and services will be provided for residents who are unable to carry out ADLS independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with: a. Hygiene (bathing, dressing, grooming, and oral care) ... b. Mobility (transfer and ambulation, including walking) ...".

On 8/25/23, the facility Administrator and Director of Nursing (DON) were made aware of the above findings.

Following the end of day meeting, the DON provided Surveyor C with a report that indicated Resident #29 received showers on 8/16, 8/19, 8/20 and 8/25. However, according to the ADL sheet, a shower was noted but it was coded as 8/8, according to the legend the code 8/8 indicated "Activity itself did not occur or family and/or non-facility staff provided care 100% of the time for that activity".

No further information was provided.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495308	A. BUILDING _____ B. WING _____	C 08/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERVIEW HEALTH & REHAB CENTER	**414 ALGONQUIN RD HAMPTON, VA 23661**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 677	Continued From page 45 3. The facility staff failed to ensure Resident #87 received the necessary services to maintain good grooming and personal hygiene to include the removal of facial hair. Resident #87 Minimum Data Set (MDS - an assessment protocol), a quarterly with an Assessment Reference Date (ARD) of 06/26/23 coded Resident #87's Brief Interview for Mental Status (BIMS) score of 15 out of a possible score of 15 indicating no cognitive impairment. The MDS coded Resident #87 total dependent of two with bathing, extensive assistance of two with bed mobility, extensive assistance of one with transfer, dressing, toilet use and personal hygiene and supervision with eating for Activities of Daily Living (ADL) care. Resident #87's person-centered care plan with a revision date of 07/25/23 documented resident may have fluctuations in ADL's. The goal set for the resident by the staff was that the resident will maintain current level of function. The interventions/approaches the staff would use to accomplish this goal is that the resident requires physical assistance. During the initial tour on 08/22/23 at 2:34 p.m., Resident #87 was observed lying in bed with facial chin hair, approximately 1/4 inches long, gray, and black in color. The resident stated the facial chin hair is embarrassing and would remove it herself if someone would just give her a razor. She stated she had asked numerous	F 677		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495308	A. BUILDING _____ B. WING _____	C 08/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERVIEW HEALTH & REHAB CENTER	**414 ALGONQUIN RD HAMPTON, VA 23661**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 677		F 677		

Continued From page 46 times to be shaved but her request was never acted upon. The resident stated she would like to be shaved today if possible. On the same day at 3:45 p.m., Resident #87 was assessed by the Unit Manager (UM) with the surveyor present. Resident #87 informed the UM she had asked staff on several occasions to be shaved but the staff never shaved her. The UM stated Resident #87 need to be shaved and would make sure Resident #87 would be shaved right away. The UM stated all nursing staff are responsible for ensuring residents (male or females are shaved). She stated residents are to be shaved on their shower days and as needed.

On 08/23/23 at 9:55 a.m., Resident #87 was observed lying in bed without facial hair to her chin. She stated she feels so much better while rubbing her chin.

The Director of Nursing (DON) was interviewed on 08/25/23 at 4:45 p.m. She stated, first the staff must determine if Resident #87 wished to keep her facial hair or have her facial hair removed. She stated once her wish was determined, her wish must bed honored.

A final meeting was held with the Administrator, Director of Nursing and Corporate on 08/25/23 at 6:00 p.m., who were informed of the above findings. An opportunity was offered to the facility's staff to present additional information, but no further information was provided.

The facility's policy titled Activities of Daily Living (ADLs) noted to be without a created or revision date. It is the facility policy that residents will be provided with care, treatments, and services as appropriate to maintain or improve their ability to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495308	A. BUILDING _____ B. WING _____	C 08/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERVIEW HEALTH & REHAB CENTER	414 ALGONQUIN RD HAMPTON, VA 23661

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 677	Continued From page 47 carry out activities of daily living (ADLs). Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming and personal hygiene, and oral hygiene. Specific procedures/guidance. 3. Each resident shall be given proper daily personal attention and care, including skin, nail, hair, and oral hygiene, in addition to any specific care ordered by the attending physician.	F 677		
F 686 SS=G	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that(i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review and facility documentation review, the facility staff failed to provide care and services to prevent the development of a pressure ulcer at an advanced stage for one Resident (Resident #413) in a survey sample of 64 Residents, resulting in harm for Resident #413. The facility self-identified this deficient practice prior to the survey, resulting in	F 686	Past noncompliance: no plan of correction required.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495308	A. BUILDING _____ B. WING _____	C 08/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERVIEW HEALTH & REHAB CENTER	**414 ALGONQUIN RD HAMPTON, VA 23661**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686		F 686		

Continued From page 48 past non-compliance being achieved on 7/26/23.

The findings included:

For Resident #413, the facility staff failed to identify a pressure ulcer until it was at an advanced stage and then failed to initiate an appropriate treatment, this constituted harm.

On 8/22/23-8/23/23, a closed record review was conducted of Resident #413's chart. This review revealed the following:
A progress note dated 5/21/23, read, "Skin note: assessed resident sacrum a few days prior and no areas was open. Resident did have redness area to bottom initiated zinc and dressing to buttock. Was notified by cna area that was not seen before is open".

Wound evaluations dated 5/23/23, indicated Resident #413 was noted to have an unstageable sacral pressure ulcer to her right buttocks with 95% slough, that measured 8x7x0 centimeters (cm), and the wound bed was noted to have devitalized tissue. A second wound was noted on the left buttocks that was noted to be a stage III, with 70% slough that measured 2x2x.01cm. Treatment orders were obtained and initiated that day, which consisted of "Cleanse Lt [left] and Rt [right] Buttock with 1/4 strength Dakin's solution. Apply Santyl nickel thick directly to wound bed. Apply calcium alginate and cover w/ border foam gauze dressing, one time a day".

On the evening of 8/23/23, prior to the survey team sharing the concern noted above, the facility's Director of Nursing (DON) presented the survey team with a binder that contained information where they had self-identified the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495308	A. BUILDING _____ B. WING _____	C 08/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERVIEW HEALTH & REHAB CENTER	**414 ALGONQUIN RD HAMPTON, VA 23661**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 49 deficient practice with Resident #413 and implemented a plan of correction. The survey team requested a copy. Review of the facility's submitted documentation with regards to the self-identification of the deficient practice, they conducted staff interviews. Through this process it was noted that Resident #413 had a red area to her buttocks identified 5/19/23. Treatment orders were not obtained at that time and the family was not made aware. On 5/21/23, the area was identified by a CNA to be bleeding, the nurse was made aware and implemented zinc and a dressing, which the facility determined to not be an appropriate treatment. On 5/26/23, the facility conducted a skin sweep on the unit and conducted head to toe skin evaluations on each Resident, to identify if anyone else had been affected by the deficient practice. The facility then reviewed the treatment orders for all pressure ulcers. All the nursing staff were re-educated on wound prevention and change in condition. The facility then conducted weekly skin observations for 8 weeks to monitor compliance. The facility indicated their date of compliance was 7/26/23. The survey team reviewed all the credible evidence submitted and had no further concerns identified during the survey with regards to the prevention, identification of, or treatment of pressure ulcers. The facility achieved compliance for this deficient practice on 7/26/23.	F 686		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495308	A. BUILDING _____ B. WING _____	C 08/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERVIEW HEALTH & REHAB CENTER	**414 ALGONQUIN RD HAMPTON, VA 23661**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 50 CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on Resident interview, facility staff interview, clinical record review and facility documentation review, the facility staff failed to ensure that Residents were free from accident hazards, affecting one Resident (Resident #29) in a survey sample of 64 Residents. The findings included: For Resident #29, who went to an off-site dialysis clinic three days per week, the Resident was unable to gain entry to the facility for extended periods of time upon her return, resulting in her being left to sit outside, alone and at times in the dark. On 08/23/23 at 10:39 AM, during an interview with Resident #29, the Resident verbalized that frequently she waits 30 minutes or more when she arrives back at the facility at night because the facility staff won't answer the phone or doorbell. Resident #29 reported it is usually around 8:30-9 PM or later when she returns from dialysis, three days a week. The Resident said, she uses her cell phone and will call the facility before they ever arrive back at the facility, but facility staff do not answer the phone. Then, once	F 689	1.Resident #29 was supplied with a card badge on 8/24/23 to gain access into the facility after hours upon return from dialysis. 2.No other residents return from dialysis after 8pm. The facility will review newly admitted dialysis treatment hours to determine the need for an access card. 3.The facility nursing staff were re-educated on after-hours phone calls and doorbell response needs on 9/6/23 and completed on 9/7/23. Other facility staff received education on answering after-hours phone calls and responding to after-hours doorbell on 9/13/23. 4.The facility Director of Nursing/designee will interview resident #29 weekly x 6 weeks to validate prompt successful entry into the center after hours. All results and trends will be reviewed at the Monthly Quality Assurance Performance Improvement Meeting to determine compliance. 5. 9/22/2023	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495308	A. BUILDING _____ B. WING _____	C 08/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERVIEW HEALTH & REHAB CENTER	**414 ALGONQUIN RD HAMPTON, VA 23661**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689		F 689		

Continued From page 51 she arrives, she and/or the transportation driver will ring the doorbell multiple times and wait over 30 minutes for facility staff to respond to let her into the facility. The Resident also confirmed that there are times when the transport driver is unable to wait with her, leaving her unattended and unmonitored to wait to get into the facility.

During the above interview, Resident #29 said she has asked for a badge that would open the doors, but she was told it was a safety and security concern and they could not issue her a badge.

On 8/23/23, observations revealed a sign on the front door of the facility that indicated the doors were locked at 8 PM and to gain entry the doorbell had to be used.

On the evening of 8/23/23, Surveyors B and C returned to the facility at 8 PM, to observe what happened when Resident #29 returned from dialysis. The facility administration was still at the facility and was noted to be responding to the doorbell when visitors would press it to gain entry. However, Resident #29 did not return during the observations. During the observation, it was noted that a raccoon was at the front door around 8:40 PM, which startled 2 employees who were leaving the facility. The 2 employees exited the facility and ran to the parking lot, Surveyors B and C talked with them and they confirmed it was a raccoon.

On 8/24/23, during the morning, Resident #29 was interviewed. Resident #29 reported she did not return on 8/23/23, until 9:45 PM.

On 8/24/23, the receptionist, Employee N, was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495308	A. BUILDING _____ B. WING _____	C 08/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERVIEW HEALTH & REHAB CENTER	**414 ALGONQUIN RD HAMPTON, VA 23661**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689		F 689		

Continued From page 52 interviewed. The receptionist confirmed that the front doors are locked at 8 PM, nightly and to gain access a person would have to ring the doorbell.

On 8/24/23 at 1:30 PM, during an interview with the Administrator and Director of Nursing, they were asked how someone gains entry into the facility in the evenings. Both said, "After hours they have to press the door bell and wait for staff to answer".

On 8/24/23 at approximately 2 PM, Surveyor B conducted an interview with an emergency medical staff (EMS) who worked for the rescue squad. During this interview, the EMS personnel stated they had responded to a call one evening and were unable to gain access to the facility. The EMS said, "The dispatcher was calling the facility, but no one would answer the phone and they were ringing the doorbell with no response, for well over 15 minutes". The EMS went on to say that once entry was made, facility staff were observed at the nursing station not responding to the phone that was ringing and the call bell was engaged for the Resident they were responding to and staff were not responding to the call light.

On 8/24/23, during an end of day meeting, the facility Administrator was made aware of the above concern with Resident #29 having to wait outside for extended periods of time.

On 8/25/23, Surveyors C observed the facility Administrator ringing the doorbell, it was noted that the doorbell could be heard at the nursing station on the first floor. During this process, the unit manager, LPN C stated, "If the nurse is down the hall passing medications it may take them a while to get to it [to respond to the person

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495308	A. BUILDING _____ B. WING _____	C 08/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERVIEW HEALTH & REHAB CENTER	414 ALGONQUIN RD HAMPTON, VA 23661

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 53 requesting entry]". On 8/25/23, in the afternoon, Employee M, the Regional Facility Maintenance Director, reported to the survey team that they had made badges-like employee's wear, that will be provided to dialysis Residents so they can gain entry into the facility upon their return. When asked why this had not been considered previously, Employee M stated that he didn't think the facility staff were aware that this was an option, and they could make badges of this nature. No further information was provided.	F 689		
F 698 SS=D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and facility documentation review, the facility staff failed to A) coordinate services to ensure she arrived at dialysis timely and B) provide meals and snacks for one (Resident #29) in a survey sample of 64 Residents. Findings include: For Resident #29, who received dialysis treatments at an outside dialysis center, the facility staff failed to A) coordinate transportation so that she would be at dialysis on-time to receive	F 698	1.Resident #29 is now receiving a bag lunch and snacks when she goes LOA to dialysis. A formal complaint was filed with LogistiCare on 8/23/23 regarding timeliness of dialysis transportation, complaint # 52780534. 2.All dialysis residents have the potential to be affected by this deficient practice. A review of all dialysis residents was performed on 9/11/23 and verification of LOA meals/snacks verified. All residents receiving dialysis were interviewed to determine if transportation timeliness has been an issue. No other concerns voiced. 3.Facility staff were educated on LOA meals/snacks for dialysis residents on 9/13/23. Facility staff were re-educated 9/13/23 on transportation timeliness for dialysis and steps to take if recurrent. 4.The facility Director of Nursing/designee will interview all dialysis residents weekly to validate compliance with receiving meal/snack while LOA to dialysis and timeliness of dialysis transportation x 6 weeks. All results and trends will be reviewed at the Monthly Quality	

			Assurance Performance Improvement Meeting to determine compliance. 5.9/22/2023	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495308	A. BUILDING _____ B. WING _____	C 08/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERVIEW HEALTH & REHAB CENTER	**414 ALGONQUIN RD HAMPTON, VA 23661**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 698		F 698		

Continued From page 54 her full session and B) failed to send a meal and snacks with the Resident to accommodate her while she was out of the facility.

On 08/23/23 at 10:39 AM, an interview was conducted with Resident #29. Resident #29 reported that she goes to dialysis three days per week on Monday, Wednesday, and Fridays. Resident #20 said she is scheduled to leave the facility at 3 PM and doesn't return until usually 8:30-9 PM, at night. The Resident said they do not send any food or snacks with her; they just save the evening meal tray for when she returns.

The Resident went on to say that she is late often, and her treatments have to be "cut short", as a result.

On 8/23/23 at 3 PM, Resident #29 was seen in the front lobby, awaiting transport to dialysis. There was no facility provided snacks, meal, or any type of items being sent from the facility for her since she would be absent for the evening meal.

On 8/23/23 at 4 PM, Resident #29 was observed to be out front of the facility, still waiting for transport to pick her up. The unit manager, LPN C was with the Resident confirmed this is a chronic problem and they have filed complaints. LPN C also confirmed that the scheduled pick-up time was 3 PM. When asked who handles the complaints, LPN C said the social worker did, but that she had personally called before to report concerns with how the driver talked to the Resident.

On 08/23/23 at 04:09 PM, an interview was conducted with the social worker, Employee D.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495308	A. BUILDING _____ B. WING _____	C 08/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERVIEW HEALTH & REHAB CENTER	**414 ALGONQUIN RD HAMPTON, VA 23661**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 698		F 698		

Continued From page 55

Employee D was asked about transportation and who handles that, she said, "nursing handles the transportation, we assist as needed if they ask, but for the day to day they handle it". When asked how concerns regarding transport are handled, Employee D said, "If there are issues with transport, nursing will handle. Nursing has handled filing complaints if they don't get here on time or don't show".

During the above interview, the social worker was asked if she was aware of the transportation issues with regards to Resident #29's dialysis appointments. The social worker said, "I was personally not aware. I have no record of any complaints being filed. Thank you for making me aware that timeliness is an issue".

Review of the clinical record for Resident #29 revealed a care plan focus area that read, "The resident needs dialysis (HD) [hemo dialysis] r/t [related to] renal failure". Interventions for this care plan focus area included, but were not limited to, "Resident to be transported to dialysis via wheelchair medical transport three days a week. Facility to assist with arranging transport as needed...". There was no mention about sending snacks or meals with the Resident on the care plan. The care plan did also identify Resident #29 as being at "nutritional risk and has had an unplanned/unexpected weight loss".

The progress notes revealed one entry with regards to a complaint being made with the transportation company. The entry was dated 06/27/2023 at 12:08 PM, and read, "Resident returned from appointment today that the driver was unprofessional with her. Resident's insurance contacted and a complaint was filed.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495308	A. BUILDING _____ B. WING _____	C 08/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERVIEW HEALTH & REHAB CENTER	**414 ALGONQUIN RD HAMPTON, VA 23661**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 698		F 698		

Continued From page 56

Complaint ID 52739891". There were no other entries with regards to complaints being filed about the delay in getting to dialysis.

On the afternoon of 8/23/23, Surveyor C called and spoke with staff at the dialysis center where Resident #29 attends. The dialysis employee confirmed that Resident #29 would be permitted to eat and have snacks and/or a meal in their lobby while she waits for her transport after her treatment session.

On 8/23/23 at approximately 4:20 PM, the facility Administrator was made aware of the above findings. The administrator was asked to provide any evidence they had with regards to complaints being filed with regards to the transportation being late.

On 8/23/23 at 4:30 PM, the facility Administrator and dietary manager (DM) came to talk with Surveyor C. The DM stated they [the kitchen staff] "At one point we were sending a bagged lunch but when we started sending sandwiches on her lunch tray, I assumed that was for dialysis. I told her we would get back on it. We were sending 2 sandwiches on lunch tray to have to take with her.

On 8/24/23, Resident #29 was interviewed. The Resident stated that she didn't return from dialysis on 8/23/23, until 9:45 PM. Therefore she went from lunch that day until after her return with no nourishment.

Review of the facility policy titled, "End Stage Renal Disease - Care of Resident" was conducted. Excerpts from this policy stated, "...3. Agreements between this facility and the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495308	A. BUILDING _____ B. WING _____	C 08/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERVIEW HEALTH & REHAB CENTER	**414 ALGONQUIN RD HAMPTON, VA 23661**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 698	Continued From page 57 contracted ESRD facility will include all aspects of how the resident's care will be managed including but not limited to: ... e. nutritional and fluid management... 4. The nursing facility will assist the resident requiring hemodialysis with arrangement for safe transportation to and from the hemodialysis center..." No further information was provided.	F 698		
F 730 SS=D	Nurse Aide Peform Review-12 hr/yr In-Service CFR(s): 483.35(d)(7) §483.35(d)(7) Regular in-service education. The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. In-service training must comply with the requirements of §483.95(g). This REQUIREMENT is not met as evidenced by: Based on staff interview and facility documentation review, the facility staff failed to perform annual performance reviews for 2 (CNA's) Certified Nursing Assistants (CNA B, and CNA C) to provide regular education based upon the review outcome. The findings included: On 8-24-23 at 5:00 p.m., the Administrator was notified that the annual reviews for CNA (B), and CNA (C) had not been completed for the employees as per regulation. On 8-25-23 at 3:00 p.m., the Human Resources Director stated no reviews could be found for the employees. At approximately 5:00 p.m. the	F 730	1. C.N.A B and C.N.A. C performance evaluation have been completed. 2.The Human Resource Director completed an audit of all C.N.A's to ensure the C.N.A's were evaluated per F30. The performance evaluations were completed on 9/13/2023. 3. The Human Resource Director was educated on F Tag 730 and the organization's expectation for evaluations from the Nursing Home Administrator. A tracking system will be implemented and maintained by the HR department to ensure that CNA performance evaluations are scheduled and completed. 4. The Facility H.R Director will audit CNA performance evaluations monthly and will notify the Administrator/designee of performance evaluations that have not been completed. All results and trends will be reviewed at the Monthly Quality Assurance Performance Improvement Meeting to determine compliance. 5. 9/22/2023	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495308	A. BUILDING _____ B. WING _____	C 08/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERVIEW HEALTH & REHAB CENTER	414 ALGONQUIN RD HAMPTON, VA 23661

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 730	Continued From page 58 Administrator stated they had no further information to provide. No further information was provided by the facility staff.	F 730		
F 742 SS=D	Treatment/Srvcs Mental/Psychoscial Concerns CFR(s): 483.40(b)(1) §483.40(b) Based on the comprehensive assessment of a resident, the facility must ensure that- §483.40(b)(1) A resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder, receives appropriate treatment and services to correct the assessed problem or to attain the highest practicable mental and psychosocial well-being; This REQUIREMENT is not met as evidenced by: Based on observation, interview, clinical record review and facility documentation the facility staff failed to ensure a resident who diagnosed with mental disorder or a history of trauma and/or post-traumatic stress disorder, receives appropriate treatment for 1 Resident (#98) in a survey sample of 64 Residents. The findings included: For Resident #98, the facility staff failed to assess and provide mental health services for a Resident who was admitted with a diagnosis of PTSD (Post Traumatic Stress Disorder). On 8/23/23 at approximately 9:58 an interview was conducted with Resident #98 who stated that	F 742	1.Resident #98 was offered to be seen by LCSW from Deer Oaks on 9/1/23, resident declined due to LOA plans. Resident #98 was seen by psychology group LCSW on 9/7/23. 2.All residents with a PTSD diagnosis have the potential to be affected by this deficient practice. The facility social worker reviewed the medical record for those residents who are affected by PTSD to determine their desire to receive psychiatric services on 9/12/23. Referrals were made as indicated. 3.Facility nursing staff have been re-educated on behavioral health services on 9/6/23 and completed on 9/7/23. The facility SW's have also been re-educated on referrals to psychiatric/behavioral health services for residents who have mental health disorders on 9/12/23. 4.The facility social worker will develop a log and review all new admissions for a diagnosis of a mental health disorder and offer referral for services x6 weeks. Residents who consent to services will have a referral made to mental health provider for services. All results and trends will be reviewed at the Monthly Quality Assurance Performance Improvement Meeting to determine compliance. 5.9/22/2023	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495308	A. BUILDING _____ B. WING _____	C 08/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERVIEW HEALTH & REHAB CENTER	**414 ALGONQUIN RD HAMPTON, VA 23661**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 742	Continued From page 59 he feels that some staff and Residents in the facility are intimidated by his appearance and shy away from him. He stated that he felt that there was only 1 or 2 staff members he could trust. On 8/23/23 at approximately 9:58 an interview was conducted with Resident #98 who discussed his diagnosis of PTSD (Post Traumatic Stress Disorder). Resident #98 stated that he had been institutionalized for many years and he does not relate well to the staff and Residents. When asked if he had any psychiatric diagnoses, he stated that he had PTSD and ADHD (attention deficit hyperactivity disorder) When asked if he was seeing any therapist or psychiatric services, he stated that he was not. When asked if the facility was aware of the diagnoses, he stated that they were aware because it was in his clinical record when he was admitted. He stated he needs psych services but has not had them since arrival at facility. A review of the clinical record revealed that Resident #98 was admitted with a diagnoses that include PTSD and ADHD. The clinical record also revealed that the facility physician wrote an order on 8/10/23 Psych services. On 8/23/23 at approximately 2:00 PM an interview was conducted with the Director of Social Services who was asked if she was familiar with Resident #98, and she indicated that she was. When asked if a Resident has a diagnosis of PTSD should he or she receive services, she indicated that if the Resident wishes to he or she can. When asked if a Resident has a psychiatric diagnosis such as PTSD should he or she be expected to reach out and ask for services or should they be offered to him or her. She stated that if the facility knows about the diagnosis, then they should inquire if the Resident	F 742		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495308	A. BUILDING _____ B. WING _____	C 08/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERVIEW HEALTH & REHAB CENTER	414 ALGONQUIN RD HAMPTON, VA 23661

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 742	Continued From page 60 would like those services. On the afternoon of 8/24/23 an interview was conducted with the DON who was asked what the expectation is if a Resident is admitted with a diagnosis of PTSD. The DON stated that they have therapists that come to the facility to see patients and they have psychiatrists as well if medications need to be prescribed. When asked if Resident #98 receives those services she stated she was not sure. On 8/25/23 during the end of day meeting the Administrator was made aware of the concerns and no further information was provided.	F 742		
F 757 SS=E	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons	F 757	1.Resident #107 had the order to discontinue the antibiotic on 8/24/23. Resident #413 no longer resides at the facility. 2.All residents receiving antibiotic therapy have the potential to be affected by this deficient practice. A review of all current residents receiving ABT was conducted on 9/13/23 to validate an appropriate stop date, and culture sensitivities if apply. No other issues were noted. 3.The facility Infection Preventionist was re-educated on antibiotic stewardship and unnecessary drugs on 9/6/23. Facility nursing staff were also re-educated on antibiotic stewardship and unnecessary drugs on 9/6/23 and completed on 9/7/23. Facility nursing staff were re-educated to monitor for stop dates for antibiotics when transcribing and/or reviewing orders for antibiotics. 4.The facility Director of Nursing/designee will review new order report 3x per week x 6 weeks to validate appropriate stop date for antibiotics and review culture	

			sensitivities as apply to validate appropriate drug use. All results and trends will be reviewed at the Monthly Quality Assurance Performance Improvement Meeting to determine compliance. 5. 9/22/2023	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495308	A. BUILDING _____ B. WING _____	C 08/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERVIEW HEALTH & REHAB CENTER	**414 ALGONQUIN RD HAMPTON, VA 23661**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 757		F 757		

Continued From page 61 stated in paragraphs (d)(1) through (5) of this section.
This REQUIREMENT is not met as evidenced by:
Based on resident and staff interviews, clinical record review and facility's documentation, the facility staff failed to ensure 2 of 64 residents (Resident #107 and #413) in the survey sample were free from the use of unnecessary medications.

The findings included:

1. The facility staff failed to ensure Resident #107's antibiotic was discontinued on 07/26/23 as directed on the hospital discharge summary dated 07/18/23. Resident #107 received an extra 47 doses of the antibiotic (Cefadroxil).

Resident #107 was admitted to the nursing facility on 07/18/23. Diagnosis for Resident #107 included but not limited to periprosthetic fracture around internal left hip and left ankle joint.

The Minimum Data Set (MDS - an assessment protocol) an admission assessment with an Assessment Reference Date (ARD) of 07/22/23 coded Resident #107 with a 12 out of a possible score of 15 on the Brief Interview for Mental Status (BIMS), indicating moderate cognitive impairment. The MDS coded Resident #107 total dependence of one with bathing, extensive assistance of two with bed mobility, extensive assistance of one with dressing, limited assistance of one with transfer, toilet use and personal hygiene and supervision with one assist with eating for Activities of Daily Living (ADL) care.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495308	A. BUILDING _____ B. WING _____	C 08/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERVIEW HEALTH & REHAB CENTER	**414 ALGONQUIN RD HAMPTON, VA 23661**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 757		F 757		

Continued From page 62

Resident #107's person-centered care plan created on 07/19/23 and revised on 07/27/23 identified the resident on antibiotic therapy related to post-op surgery. The goal set for the resident by the staff was that the resident will be free of any discomfort or adverse side effects of antibiotic therapy. Some of the interventions/approaches the staff would use to accomplish this goal is to administer antibiotic medications as ordered by the physician, monitor/document side effects of effectiveness every shift.

An interview was conducted with Resident #107 on 08/22/23 at 12:11 p.m. He stated he is currently getting antibiotic on a routine basis but not sure how long he is scheduled to receive the antibiotic.

A review of Resident #107's hospital discharge summary dated 07/18/23 revealed an order for Cefadroxil (antibiotic) 500 mg capsule - take 2 capsules daily for 7 days.

The Physician Order Summary (POS) for August 2023 revealed an order starting on 07/19/23 for Cefadroxil 500 mg capsule - give one capsule twice a day for post-op prophylactic. The order also included clarification of a stop date by pharmacy.

A review of Resident #107's Medication Administration Record (MAR) for July and August 2023 indicated Resident #107 received an extra 47 doses of the antibiotic Cefadroxil 500 mg.

On 08/24/23 at 5:00 p.m., an interview was conducted with the Nurse Practitioner (NP.) She stated she was not aware Resident #107 was still

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495308	A. BUILDING _____ B. WING _____	C 08/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERVIEW HEALTH & REHAB CENTER	**414 ALGONQUIN RD HAMPTON, VA 23661**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 757		F 757		

Continued From page 63 on antibiotic therapy until she was informed by the DON on 08/23/23. She stated Resident #107's antibiotic should have been discontinued according to the resident's hospital discharge summary.

An interview was conducted with the Director of Nursing (DON) on 08/25/23 at 5:00 p.m. After she reviewed Resident #107's hospital discharge orders, POS and MARs for July and August 2023, she stated Resident #107's antibiotic should have been discontinued after receiving the antibiotic for 7 days based on the resident's hospital discharge summary.

A final meeting was held with the Administrator, Director of Nursing and Corporate on 08/25/23 at 6:00 p.m., who were informed of the above findings. An opportunity was offered to the facility's staff to present additional information, but no further information was provided.

2. For Resident #413, the facility staff ordered and administered an antibiotic that was unnecessary, because the infection being treated was resistive to the antibiotic ordered.

On 8/23/23-8/24/23, a closed clinical record review was conducted of Resident #413's medical chart. This review revealed the following:

A urinalysis sample was obtained on 3/21/23, and the results were reported to the facility that evening which was indicative of a urinary tract infection. There were no notes proceeding this to indicate the Resident's symptoms.

A progress note entered by the nurse practitioner

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495308	A. BUILDING _____ B. WING _____	C 08/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERVIEW HEALTH & REHAB CENTER	414 ALGONQUIN RD HAMPTON, VA 23661

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 757		F 757		

Continued From page 64 on 3/22/23 at 7:14 PM, that read, "...Patient seen today for UTI [urinary tract infection]. Per nursing staff, her yelling out has decreased. Patient is non-verbal but did not appear to be in distress. New order for Levaquin 500mg daily x 7 days, will continue to monitor." There were no notes proceeding this to indicate the Resident's symptoms.

Review of the Medication Administration record (MAR) revealed Resident #413 received the Levaquin on 3/22/23 and 3/23/23. On 3/24/23, the order for Levaquin (antibiotic) was discontinued and a new order for "Cipro Oral Tablet 500 MG (Ciprofloxacin HCl) Give 1 tablet by mouth two times a day for uti for 3 Days" was entered. Resident #413 received the Cipro for one dose on 3/24/23, 2 doses on 3/25/23 and 3/26/23, and one dose on 3/27/23.

Review of the Urine culture and sensitivity report that was received by the facility on 3/23/23 at 8:14 AM, revealed that the infection was resistive to "Levofloxacin", also known as Levaquin and "Ciprofloxacin", also known as Cipro.

On 08/24/23 at 04:58 PM, an interview was conducted with Employee C, the nurse practitioner (NP) and ordering provider of the antibiotics noted above with regards to Resident #413. When asked about the order for Levaquin being changed to an alternate antibiotic that the infection was still resistive to, the NP said, "It must have been a mistake, I wouldn't have had a reason to order an antibiotic it was resistive to, it didn't hurt her but didn't do any good". When asked about the unnecessary use of antibiotics and if that was upholding antibiotic stewardship, the NP said, "absolutely not. We don't want

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495308	A. BUILDING _____ B. WING _____	C 08/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERVIEW HEALTH & REHAB CENTER	414 ALGONQUIN RD HAMPTON, VA 23661

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 757	Continued From page 65 people taking unnecessary antibiotics". Review of the facility's "Antibiotic Stewardship Program" was conducted. This policy defined antibiotic stewardship as "refers to a set of commitments and actions designed to optimize the treatment of infections while reducing the adverse events associated with antibiotic. This can be accomplished through improving antibiotic prescribing, administration, and management practices thus reducing inappropriate use to ensure the residents receive the right antibiotic for the right indication, dose, and duration...". On 8/24/23, during an end of day meeting, the facility Administrator and Director of Nursing were made aware of the above findings. No further information was provided.	F 757		
F 760 SS=D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review and facility document review, the facility staff failed to ensure 2 of 64 residents (#34 and #85) in the survey sample were free of significant medication errors. The findings included: 1. For Resident # 34 the facility staff failed to discontinue the order for Metoprolol 50 mg (blood pressure medication) daily, when the order was	F 760	1.On 8/23/23, residents #34 responsible representative and provider was made aware of medication error. Resident was assessed and new orders obtained. On 8/24/23, provider/resident #85 were made aware of medication error and new orders obtained. Medications are being administered per provider order for residents. 2.All residents have the potential to be affected by this deficient practice. A facility audit was performed by Pharmacy Consultant on 9/12/23 to validate no other duplicate orders. 3.On 9/6/23 and 9/7/23, facility nursing staff were educated on prevention of medication errors. The nurse responsible for transcription error for resident #34 was re-educated on 9/6/23 by the Director of Nursing. The nurse responsible for	

			transcription error for resident #85 is no longer employed at the center. 4.The Director of Nursing/designee will review 10 resident medications orders weekly x 6 weeks to audit for duplicate medication orders. All results and trends will be reviewed at the Monthly Quality Assurance Performance Improvement Meeting to determine compliance. 5. 9/22/2023	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495308	A. BUILDING _____ B. WING _____	C 08/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERVIEW HEALTH & REHAB CENTER	**414 ALGONQUIN RD HAMPTON, VA 23661**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 760		F 760		

Continued From page 66

increased to 100 mg every day, thus Resident #34 was given 150 mg of Metoprolol instead of 100 mg on two occasions.

On 8/24/23 a review of the clinical record revealed that Resident #34 had the following orders for Metoprolol:

Metoprolol 50 mg. Give 1 Tablet two times per day for HTN [Hypertension]. HOLD for SBP [Systolic Blood Pressure] of 100 or pulse below 60.

On 8/22/23 at 2:48 PM the following orders were put in the system:

"8/22/2023 2:48 PM-Note Text: Resident received new orders for increase metoprolol to 100mg BID, give metoprolol 50mg one time r/t elevated blood pressure, start Lasix 20mg daily for edema."

On 8/23/23 at approximately 10:00 AM a review of the clinical record revealed the following order transcribed to the MAR:

8/22/23 Metoprolol Oral Tablet 25 mg. Give 50 mg by mouth one time only for HTN for 1 day.

A review of the MAR (Medication Administration Record) Resident #34 was given the following doses of Metoprolol:

8/22/23 50 mg given at 8:00 AM
8/22/23 50 mg given at 2:48 PM
8/22/23 50 mg given at 9:00 PM
8/22/23 100 mg given at 9:00 PM
8/23/23 50 mg given at 8:00 AM
8/23/23 100 mg given at 8:00 AM

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495308	A. BUILDING _____ B. WING _____	C 08/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERVIEW HEALTH & REHAB CENTER	**414 ALGONQUIN RD HAMPTON, VA 23661**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 760		F 760		

Continued From page 67

On 8/23/23 at approximately 8:45 AM an interview was conducted with LPN C (Unit Manager) who was asked about Resident #34's new orders. She was asked if she was aware of the change in orders and she stated that she was. When asked what the orders where she stated they are increasing his Metoprolol due to increased blood pressure. When asked what the process is when you receive new orders, she stated that the nurse would put it in the system. When asked if the order is for an increase to a current medication how would that affect the process, she stated the nurse would have to discontinue the old order put in the new order for the new amount. When asked to pull up Resident #34's MAR and see if that process was carried out, she looked at the MAR and stated, "no it was not." When asked if this would constitute a medication error, she answered yes. When asked what the process is to follow for a medication error, she stated we first notify the physician and see what he wants us to do. Then we notify the RP and Resident, and we notify the pharmacy, then we document and carry out whatever the physician wants us to do. When asked what the danger is of getting too much Metoprolol, she stated that since Resident #34 is on Diltiazem 180 mg (anti-hypertensive) as well as Clonidine (anti-hypertensive medication), the Resident could "bottom out." When asked what "bottoming out" meant she stated that he could have a sudden drop in his blood pressure and metoprolol can slow your heart rate and can cause fainting or dizziness and more serious cardiac issues.

A review of the progress notes revealed the following :

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495308	A. BUILDING _____ B. WING _____	C 08/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERVIEW HEALTH & REHAB CENTER	**414 ALGONQUIN RD HAMPTON, VA 23661**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 760		F 760		

Continued From page 68

"8/22/2023 2:44 PM Nurses Note Text: Resident received new orders for increase metoprolol to 100mg BID, give metoprolol 50mg one time r/t elevated blood pressure, start Lasix 20mg daily for edema."

"8/23/2023 1:36 PM Nurses Note Text: Resident received an increased dose of metoprolol in error. Orders corrected. Resident assessed. VS WNL 100/72 80 16 97.4 98.0. RR/NP notified. New orders received to monitor BP x 2. "

On 8/25/23 during the end of day meeting the Administrator was made aware of the concerns and no further information was given.

2. For Resident #85, the facility staff failed to discontinue an order for gabapentin when a new order was obtained with a dose change, which resulted in the Resident having a significant medication error, extra/unintended doses of gabapentin were given.

On 08/24/23, a clinical record review was conducted. This review revealed a duplicate therapy/order for Gabapentin that was administered concurrently for 8 days in August 2023.

The medication administration record (MAR) revealed on order for Gabapentin Capsule 300 mg, 1 capsule to be given three times a day for pain. There was another order for Gabapentin 100 mg, that read, "give 300 mg by mouth every 8 hours for neuropathy". Both were recorded as being administered 8/11/23-8/18/23.

On 08/24/23 at 10:53 AM, an inspection of the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495308	A. BUILDING _____ B. WING _____	C 08/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERVIEW HEALTH & REHAB CENTER	**414 ALGONQUIN RD HAMPTON, VA 23661**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 760		F 760		

Continued From page 69 medication cart was conducted with LPN E. It was noted that Resident #85 had the 300 mg capsules of Gabapentin, a total of 45 capsules were present and available in the medication cart. The 100 mg capsules were also present, with a total of 71 capsules in the medication cart. LPN E and LPN C, the unit manager accessed Resident #85's orders.

LPN C explained that the order for the 300 mg of Gabapentin started July 3, 2023. LPN C said the pharmacy was out of the 300 mg capsules, so an order was obtained for the 100 mg capsules and 3 were to be given, which totaled the 300 mg, but the 100 mg "has been discontinued, they told me they didn't come in until Sunday and were supposed to be here Friday". LPN C was made aware that it appears the Resident received both doses on multiple occasions and LPN C said, "It does appear that way".

On 8/24/23 at 11:15 AM, LPN C retrieved the controlled medication count sheets, where the gabapentin is signed out each time it is administered. These documents were reviewed and revealed that on 8/12/23, Resident #85 received 3 capsules of the 100 mg of Gabapentin at 5:13 AM, and then at 8 AM, 5 PM and 9 PM, she was given 1 capsule of the 300 mg. On 8/13/23, Resident #85 received 3 capsules of the 100 mg at 6 AM, then at 8 AM 1 capsule of the 300 mg was given, and 3 additional doses were given. This same thing happened again on 8/16/23. LPN C, the unit manager confirmed there were a few days of duplicate treatment.

On 8/24/23 at 11:17 AM, an interview was conducted with LPN D. LPN D explained the risks of getting too much gabapentin as, "signs of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495308	A. BUILDING _____ B. WING _____	C 08/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERVIEW HEALTH & REHAB CENTER	414 ALGONQUIN RD HAMPTON, VA 23661

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 760	Continued From page 70 lethargy, I have seen some people experience hallucinations, and dry mouth". On the afternoon of 8/24/23, an interview was conducted with the nurse practitioner (NP)/ Employee C. The NP said that the 100 mg was ordered when the pharmacy was not able to fill the 300 mg capsules and there was no intention of the Resident receiving duplicate therapy. The facility policy titled, "General Guidelines for Medication Administration" was requested and received. An excerpt from this policy read, "...7. Always employ the MAR during medication administration. Prior to the administration of any medication, the medication and dosage schedule on the resident's MAR are compared with the medication label... When a medication order is changed and the remainder of the current supply can still be used, the container should be flagged right away and the order change communicated to the provider pharmacy so that the next supply of the medication is labeled with the current directions, when applicable..." On the afternoon of 8/24/23, the facility Administrator and Director of Nursing were made aware of the above findings. No further information was provided.	F 760		
F 804 SS=E	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance;	F 804	1.The Dietary Department cannot change the prior dining experience for Residents R7, R61, R36, R69, and R35. Dietary team will meet with residents R7, R61, R36, R69, and R35 to review their dietary preferences. 2. All residents have the potential to be affected by this deficient practice. A food committee was formed to discuss the menu options and collect feedback from residents related to meals delivered from the kitchen.	

			3. The Nursing Home Administrator provided education to the Food Service Director on the regulation associated with F Tag 804 on 9/13/23. The facility is working collaboratively with the food vendor to ensure variety with the menu. Administrator and Food Service Director developed a satisfaction survey that will be reviewed with the residents during mealtimes for ongoing feedback. 4. The Nursing Home Administrator/designee will complete a test/satisfaction survey tray 3 times a week for 6 weeks to ensure value, temperature, and Palatability. All results and trends will be reviewed at the Monthly Quality Assurance Performance Improvement Meeting to determine compliance. 5. 9/22/2023	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495308	A. BUILDING _____ B. WING _____	C 08/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERVIEW HEALTH & REHAB CENTER	**414 ALGONQUIN RD HAMPTON, VA 23661**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 804		F 804		

Continued From page 71

§483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature.
This REQUIREMENT is not met as evidenced by:
Based on observation, interview, record review, and policy review, the facility failed to ensure palatable food was served to six (of 104 residents Resident (R) 61, R36, R69, R35, R7, R87). Specifically, the food did not look appetizing and lacked flavor, the variety of menu offerings was limited, and an established recipe was not being followed correctly. This failure contributed to residents' ongoing reluctance to consume their meals, an overall dissatisfaction with their dining experience and the deviation from established recipes left residents' health and well-being at risk.

Findings include:

Review of the undated paper "Food and nutrition services" policy revealed, "Each resident is provided with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs, taking into consideration the preferences of each resident ... Food and nutrition services staff will inspect food trays to ensure that the correct meal is provided to each resident, the food appears palatable and attractive, and it is served at a safe and appetizing temperature ...If an incorrect meal is provided to a resident, or a meal does not appear palatable, nursing staff will report it to the Food Service Manager so that a new food tray can be issued."

1. Interviews with residents during the survey

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495308	A. BUILDING _____ B. WING _____	C 08/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERVIEW HEALTH & REHAB CENTER	**414 ALGONQUIN RD HAMPTON, VA 23661**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 804		F 804		

Continued From page 72 process revealed the following complaints about food palatability:

a. On 08/22/23 at 11:48 AM, R61 stated that the food is not good, they've gotten warmers for plates, but the food comes cold. She can't get corned beef hash or sausage links or omelets. They only serve bacon and sausage patties. Review of the quarterly "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of 07/24/23 in the Electronic Medical Record (EMR) under the "MDS" tab indicated R61 had a "Brief Interview for Mental Status (BIMS)" score of 15 out of 15, indicating the resident was cognitively intact.

b. On 08/22/23 at 12:25 PM, R36 stated "The food is disgusting, there's never anything different. The quality is lacking." Review of the annual "MDS" with an ARD of 06/19/23 in the EMR under the "MDS" tab revealed a BIMS score of 13/15, indicating the resident was cognitively intact.

c. On 08/22/23 at 12:32 PM R69 stated that the food is "terrible, there's either too much seasoning or not enough." She further stated that she never eats breakfast because she does not like it. Review of the quarterly "MDS" with an ARD of 06/28/23 in the EMR under the "MDS" tab revealed was unimpaired in cognition with a BIMS score of 15 out of 15.

d. On 08/22/23 at 2:21 PM R35 stated, "The food is too salty, there are too many starches on the plate, there is too much sugar, and the chicken is dry as a bone." Review of the quarterly "MDS" with an ARD of 05/09/23 in the EMR under the "MDS" tab revealed was unimpaired in cognition

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495308	A. BUILDING _____ B. WING _____	C 08/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERVIEW HEALTH & REHAB CENTER	**414 ALGONQUIN RD HAMPTON, VA 23661**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 804		F 804		

Continued From page 73 with a
BIMS score of 15 out of 15.

2. The paper "Resident Council Minutes" revealed the following comments from anonymous residents and some staff who attended the meetings:

08/03/22 - The food is not good, and it is always cold. The residents would also like a different cereal.

09/02/22 - An ongoing concern was food choices. The residents requested that they bring back the buffet because they were tired of the same stuff being served. The residents inquired about switching to a new food vendor.

06/07/23 - Residents complained about 1) not having hot coffee and 2) not being able to have coffee at any time of the day, not just breakfast. 3) food was being wasted because residents were not eating the current food choices, their choices needed to be revised. 4) They needed new hot plates because food was cold when received.

06/28/23 - Residents had general complaints about the food.

07/05/23 - Residents formed a food committee.

08/02/23 - Residents complained that were 1) no longer getting sodas and 2) now were getting less variety of snacks.

3. Observations revealed concerns with meal palatability, attractiveness/appearance of food,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495308	A. BUILDING _____ B. WING _____	C 08/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERVIEW HEALTH & REHAB CENTER	**414 ALGONQUIN RD HAMPTON, VA 23661**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 804		F 804		

Continued From page 74

and accuracy of recipes:

a. On 08/24/23 at 1:08 PM a test tray was done with the Food Service Director (FSD) (Employee H) and the Regional FSD (Employee L): Temperatures were taken on the Skilled nursing "North" unit. The FSD took the following temperatures of the test tray food items: turkey - 146 degrees Fahrenheit (F), noodles 153 degrees F, carrots - 144 degrees F and dinner roll - 125 degrees F. The FSD stated that the carrots were frozen, steamed and then placed on steamed table, the noodles were made onsite and then placed in the steam table, and the turkey came raw and was cooked down and then sliced and placed on the steam table. Prior to tasting, the FSD took a package of salt and pepper and sprinkled it all over the plate. The carrots were found to be mushy and bland and overall lacking in discernible carrot flavor, the noodles were overcooked and bland and had a waterlogged texture, the turkey tasted extremely salty, more like a processed meat product (as opposed to a fresh turkey). The meal also came with a pink powdered drink mix which the FSD indicated was "like a Crystal Light" meaning that it was sugar free. All the residents in the facility were now being offered this drink in place of soda, as they [sodas] were deemed "empty calories" by the FSD. The FSD stated it was possible that the wrong type of turkey had been sent by his vendor. When the FSD was asked about the meal he stated, "It's not bad." The regional FSD (Employee L) declined to try the test tray citing a "turkey allergy."

b. On 08/24/23 at 5:48 PM a second test tray was conducted with survey team. A takeout box was brought to the conference room once the last

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495308	A. BUILDING _____ B. WING _____	C 08/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERVIEW HEALTH & REHAB CENTER	**414 ALGONQUIN RD HAMPTON, VA 23661**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 804		F 804		

Continued From page 75 resident meal had been delivered. The menu revealed that the dinner was a soft beef taco, chopped cilantro, Spanish rice, and buttered kernel corn. The taco meat appeared to be a broken-up hamburger (as opposed to browned ground meat) and was extremely bland. The recipe called for onion, chili powder, garlic powder, ground oregano and cayenne none of which was evident to the palate. The Spanish rice appeared as a clumpy mass and tasted overcooked, bland, and waterlogged and the texture fell apart in the mouth. The corn (which was from a can) was also overcooked, bland and waterlogged and the texture was devoid of the usual crispness of corn.

c. Interviews with residents were conducted after the first test tray:

On 08/24/23 at 1:52 PM R7 stated that the noodles had no flavor, and the turkey was salty.

On 08/24/23 at 1:54 PM R87 stated that the turkey was too salty, the carrots tasted off and that she didn't eat the noodles because they don't have any flavor.

08/24/23 at 1:57 PM R61 stated she ordered a chef's salad instead of the meal.

4. During an interview with Registered Nurse (RN) B on 08/23/23 at 11:34 AM she stated that sodas were taken away because of cost but also management said that they were "empty calories," it happened around two weeks ago. They do give out snacks to the residents: i.e. chips, crackers, peanut butter sandwich crackers.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495308	A. BUILDING _____ B. WING _____	C 08/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERVIEW HEALTH & REHAB CENTER	**414 ALGONQUIN RD HAMPTON, VA 23661**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 804		F 804		

Continued From page 76

She stated that snacks are given out mid-morning when they pass the ice, around 11:00 AM. The residents are not allowed to go into the pantry on their own to get snacks. When it was pointed out that the residents were seen sitting in the dining room currently with no obvious snacks or snack wrappers, she stated that the aides were busy with resident care currently. She then started asking the residents in the dining room if they wanted snacks.

During a follow up tour of the kitchen and interview with the FSD on 08/24/23 at 11:38 AM he stated that "Initially there was a five-week menu, and they [the residents] went down to four weeks. They are in the process of making changes, the main dining room is scheduled to open this coming Monday. The buffet had a soft opening about a month ago but there hasn't been another buffet since" and the Regional FSD stated that "We do order sodas but once that level is gone, that's it. The amount we order is two sodas per person per day. He stated that a 24 can case of soda is $11.00."

During an interview with the Administrator on 08/25/23 at 7:58 AM he stated that he has tried the food a few times and stated, "it wasn't bad." He agreed that the soda was not good for the residents. He was surprised to hear that the residents were not told about the sodas ahead of time. He stated that he was sorry that we [the facility] dropped the ball on the food quality and offering.

During a follow up visit to the kitchen on 08/25/23 at 9:48 AM the FSD confirmed that the turkey used for the "turkey a la king" was not the frozen, raw turkey breast with skin that the recipe called

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495308	A. BUILDING _____ B. WING _____	C 08/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERVIEW HEALTH & REHAB CENTER	**414 ALGONQUIN RD HAMPTON, VA 23661**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 804	Continued From page 77 for but rather a pressed turkey was used instead. The FSD stated that he was trying different things in order to accommodate the residents and that he did in fact order a different item than what the recipe stated. Upon further investigation of the drink mix, it was revealed that it was not sugar free but per serving contained 120 calories and 31 grams (g) of carbohydrate (30g added sugars.) The FSD pointed to the box where it stated that he thought it was crystal light because the box stated that it was "powdered crystals." During an interview with the Registered Dietitian (RD) on 08/25/23 at 1:31 PM it was revealed that the dietary department was on a "strict food budget" which only allowed the Food Service Director to make certain foods, etc. "It's only what can fit into the budget. They [the residents] may not like the menu sometimes. The paucity of sodas was the FSD's domain, and she was not able to speak to that.	F 804		
F 806 SS=E	Resident Allergies, Preferences, Substitutes CFR(s): 483.60(d)(4)(5) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(4) Food that accommodates resident allergies, intolerances, and preferences; §483.60(d)(5) Appealing options of similar nutritive value to residents who choose not to eat food that is initially served or who request a different meal choice; This REQUIREMENT is not met as evidenced by: Based on observations, resident interviews, record review and facility policy review the facility	F 806		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495308	A. BUILDING _____ B. WING _____	C 08/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERVIEW HEALTH & REHAB CENTER	**414 ALGONQUIN RD HAMPTON, VA 23661**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 806	Continued From page 78 failed to follow the prescribed diet and honor food preferences for two (Residents (R) 69 and 35) of two residents sampled for food preferences, out of a survey sample of 35 residents. Specifically, R69 was not aware of alternate food options and had not had her food preferences updated since admission and R35 was receiving food that did not meet her taste and nutrition preferences. The failure to accommodate the residents' dietary choices and preferences violates their right to person centered care, potentially resulting in a diminished quality of life and potential negative health consequences. Findings include: Review of the facility's undated policy titled, "Resident's Right to Make Personal Dietary, Food and Meal Choices," revealed, "The facility recognizes the resident's/resident representative's right to make personal dietary, food, and meal choices. The facility also promotes, with reasonable accommodation, the choice of alternate foods, and flexible mealtimes ...The resident and/or resident representative will be involved in choices about food and dining such as food selection to help them maintain a sense of dignity, control, and autonomy. 1. Review of the R69's admission "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of 05/07/23, located in the EMR under the "MDS" tab, revealed R69 had a "Brief Interview for Mental Status (BIMS]" score of 15 out of 15 which indicated the resident was cognitively intact. Her preferences for customary routines revealed that it was very important for the resident to have snacks available between meals.	F 806	1.The organization cannot change the deficient practice for R69, or R35. The dietary team has met with Residents R69 and R35 to review their dietary preferences. 2. All residents have the potential to be affected by this deficient practice. The Food Service Director or designee will complete a house audit of resident's preferences on 9/15/2023. 3. The Nursing Home Administrator provided education to the Food Service Director regarding F806 Resident Allergies, Preferences, and Substitutes on 9/13/2023. Menu alternatives and/or substitutions will be posted in resident dining areas. 4. The Food Service Director will interview 3 residents a week for food preferences x 6 weeks. All results and trends will be reviewed at the Monthly Quality Assurance Performance Improvement Meeting to determine compliance. 5. 9/22/2023	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495308	A. BUILDING _____ B. WING _____	C 08/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERVIEW HEALTH & REHAB CENTER	**414 ALGONQUIN RD HAMPTON, VA 23661**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 806		F 806		

Continued From page 79

Review of R69's "Physician Orders," dated 05/22/23, located in the EMR under the "Physician Orders" tab revealed that the resident was on a "No Added Salt diet, Regular texture, Regular/Thin consistency, cut meat per resident request."

Review of R69's "Nutrition Care Plan," dated 03/29/23, located in the EMR under the "Care Plan" tab, indicated R69 "Is at nutritional risk due to cardiovascular disease and cancer. Receives a therapeutic diet which is appropriate (NAS). Interventions included: Honor resident's preferences and requests within diet order. Honor resident's right to refuse food or fluids, Offer alternative meals or substitutions if poor po[by mouth] is observed"

Review of R69's "Dietary Profile," dated 05/17/23, located in the EMR under the "Assessments" tab, indicated R69 had no food preferences, allergies, intolerances, or dislikes.

Review of R69's "Kardex" (a dietary profile card used in the kitchen on the tray line) revealed the resident had no likes or dislikes and no snacks requested.

On 08/22/23 at 12:32 PM, R69 stated that the food was "terrible" and she stated that she never eats breakfast because she does not like it.

On 08/23/23 at 9:04 AM, R69 was observed without her breakfast tray. She stated she sent it back. The breakfast meal that day was "Sausage gravy, parsley sprig, biscuit and oatmeal" She stated she was not offered any alternatives and generally does not eat breakfast. She recounted her dinner the previous evening which was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495308	A. BUILDING _____ B. WING _____	C 08/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERVIEW HEALTH & REHAB CENTER	**414 ALGONQUIN RD HAMPTON, VA 23661**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 806		F 806		

Continued From page 80 described as "burnt sausage, greens and carrots that she doesn't eat. "She stated that she only eats corn and green beans as vegetables but always gets vegetables that she doesn't like.

On 08/24/23 at 8:45 AM, R69 was observed without her breakfast tray, she stated she sent it back. The breakfast meal that day was, "Scrambled egg, slivered green onions, wheat toast and oatmeal." She added that she is never offered any snacks and must procure her own.

On 08/24/23 at 11:52 AM during an interview with the Food Service Director (FSD) it was revealed that the resident did not have any preferences noted on her Kardex. It was completely blank. He stated that he would follow up with R69.

During a follow up interview on 08/25/23 at 12:50 PM, R69 she thought when she first came someone did ask her preferences, but she stated she never saw a dietitian. She reiterated that she only liked corn and green beans, she liked ground beef, spaghetti, and hamburgers. She didn't like breakfast food as the food arrived cold in the morning. She stated she ordered takeout food the night before though if she had known that fish nuggets were an alternate menu option she would have chosen them. She stated that nobody comes to ask her what she might want to eat and she was not able to go and look at the list of alternates, she also wasn't allowed to fill out a menu. She stated that broccoli is always soggy, she doesn't get salt but she gets pepper, she is not given enough butter, she only gets one packet. She never gets any soda. She can get someone to go get a Pepsi out of the vending machine and it is $2.00. She stated that the sodas that they used to get were one little perk

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495308	A. BUILDING _____ B. WING _____	C 08/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERVIEW HEALTH & REHAB CENTER	**414 ALGONQUIN RD HAMPTON, VA 23661**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 806		F 806		

Continued From page 81 that they took away, it was still nice to have them. She liked having the Shasta, it was a little perk to make the meal a little bit better. She only ever saw snacks a few times when she first got here. At 1:13 PM R69's lunch tray arrived. "The peaches do not look fresh, I only received one sugar packet, one package of butter, there's squash on my tray but I don't like squash and I also don't eat the sweet potato fries."

During a follow up interview with the FSD on 08/25/23 at 9:48 AM he stated that he had not yet visited R69 to discuss her food preferences.

On 08/25/23 at 1:48 PM during an interview with the Registered Dietitian (RD) it was revealed that R69 told her that she wants her meat cut up and indicated that she doesn't like peas or okra. The RD stated that when she meets with the residents she talks to them about the alternate menu, though this is not documented anywhere. She stated that all "she has to do is request a menu and someone would print one out and get one to her."

2. Review of R35's quarterly "MDS" with an ARD of 05/09/23 located in the EMR under the "MDS" tab revealed R35 was unimpaired in cognition with a BIMS score of 15/15. Her preferences for customary routines revealed that it was very important for the resident to have snacks available between meals.

Review of R35's "Physician Orders" located in the EMR under the "Physician Orders" tab revealed that the resident was on a "No Added Salt diet, Mechanical Soft texture, Regular/Thin

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495308	A. BUILDING _____ B. WING _____	C 08/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERVIEW HEALTH & REHAB CENTER	**414 ALGONQUIN RD HAMPTON, VA 23661**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 806		F 806		

Continued From page 82 consistency" on 05/26/22. R35 also had an order for "fortified foods to be served at all meals for added protein and calories for weight loss prevention."

Review of R35's "Nutrition Care Plan," initiated date 05/25/21 and located in the EMR under the "Care Plan" tab, indicated R35 "is at nutritional risk due to cardiovascular disease. Receives a mechanically altered, therapeutic diet due to cardiovascular disease (NAS) and is mechanical soft due to dentures/chewing concerns. Diet is also therapeutic due to receiving Ensure and fortified foods added to promote weight gain plan. Is at risk for weight loss due to hx. of weight loss. Goals: "Ms. Johns will maintain adequate nutritional status as evidenced by maintaining weight without significant loss with no s/sx of malnutrition through the next assessment review date." Interventions included: "Honor dietary preferences and requests within diet order, offer meal alternative or substitutions if poor intake is observed."

Review of R35's "Dietary Profile" dated 08/21/22, located in the EMR under the "Assessments" tab, indicated R35 had no food preferences, allergies, or intolerances. Dislikes were noted as "no gravy, butter, syrup, oatmeal, sugar, salt and pepper" R35's comments revealed "She doesn't really care for the food because it is salty."

Review of R35's "Kardex" revealed that the resident liked orange juice and one boiled egg with meal, and "no oatmeal," for lunch and dinner the Kardex indicated "No gravy, no sugar, no salt and no pepper."

On 08/22/23 at 2:21 PM, R35 stated that her food

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495308	A. BUILDING _____ B. WING _____	C 08/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERVIEW HEALTH & REHAB CENTER	414 ALGONQUIN RD HAMPTON, VA 23661

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 806	Continued From page 83 was "too salty, there were too many starches on the plate and too much sugar and the chicken was dry as a bone." On 08/23/23 at 9:00 AM, R35 sent her biscuit and meat back stating that it was too salty, she only had the milk, juice, and an egg. On 08/23/23 at 2:38 PM, R35 was seen after lunch. She reported that she received corn, but she didn't eat it, the hamburger steak had too much sauce on it, the rice pilaf was overcooked, so she only had a tablespoon, and the sherbet was too sweet. During a follow up interview with the FSD on 08/25/23 at 10:20 AM he stated that the "Kardex" system generally works to ensure residents get their food preferences but if they don't read the card while the tray line is going it is possible for errors to occur. During an interview on 08/25/23 at 1:51 PM with the RD she stated that R35 on a No Added Salt (NAS) diet and receives fortified foods like soup, oatmeal with powder and additional food items. She stated that she was very underweight when she came to the facility. She lost weight when she first came and then she lost some weight, but recently her weight has increased. When this writer brought it to her attention that one of the resident's issues was that there were too many "carbohydrates" on her tray, she stated she would "take a look."	F 806		
F 807 SS=D	Drinks Avail to Meet Needs/Prefs/Hydration CFR(s): 483.60(d)(6) §483.60(d) Food and drink	F 807		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495308	A. BUILDING _____ B. WING _____	C 08/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERVIEW HEALTH & REHAB CENTER	**414 ALGONQUIN RD HAMPTON, VA 23661**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 807	Continued From page 84 Each resident receives and the facility provides- §483.60(d)(6) Drinks, including water and other liquids consistent with resident needs and preferences and sufficient to maintain resident hydration. This REQUIREMENT is not met as evidenced by: Based on observation, Resident interview, staff interview and facility documentation review, the facility staff failed to provide beverages in accordance with Resident's preferences for one Resident (Resident #85) in a survey sample of 64 Residents. The findings included: For Resident #85, the facility staff failed to provide coffee with meals as per her preference. On 8/23/23 at approximately 12:45 PM, during an interview with Resident #85, the Resident said, "I really miss my coffee, I don't like juice. I want milk, especially with breakfast". Resident #85's lunch tray was in the room and observations revealed that there was a cup of juice on the tray, no coffee or milk was noted. Review of the meal/tray ticket on the lunch tray indicated Resident #85 was to have "Whole Milk- 8 oz and Hot Coffee or Hot Tea- 6 oz". On 8/23/23, a clinical record review of Resident #85's chart was conducted. This review revealed a care plan that Resident #85 "is at nutritional risk due to diagnose of cardiovascular disease [sic]/HTN [hypertension] and diabetes...". Interventions for this care plan focus area included, "Honor resident's preferences or requests within diet order...".	F 807	1. The organization cannot change the outcome of the deficient practice for resident R85. The dietary team met with resident R85 to review beverage preferences. Beverages are being provided during meals to honor the resident's preference. 2All residents have the potential to be affected by this deficient practice. The Food Service Director/designee will complete a house audit of resident's preferences by 9/15/23. 3. The Nursing Home Administrator provided education to the food Service Director regarding F806 Resident Allergies, Preferences, and Substitutes on 9/13/23. 4. The Food Service Director will interview 3 residents a week for food/beverage preferences x 6 weeks. All results and trends will be reviewed at the Monthly Quality Assurance Performance Improvement Meeting to determine compliance. 5. 9/22/2023	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495308	A. BUILDING _____ B. WING _____	C 08/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERVIEW HEALTH & REHAB CENTER	**414 ALGONQUIN RD HAMPTON, VA 23661**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 807		F 807		

Continued From page 85

On 8/23/23 at 4:30 PM, the facility Administrator and dietary manager (DM) came to talk with Surveyor C. The DM was asked if coffee is available for Residents. The DM said, "We send coffee down in the morning and we can send more, if they [nursing staff] ask".

On 08/24/23 at 12:40 PM, Resident #85 was observed in her room with her lunch tray. It was noted that she had a cup of juice and no milk or coffee. Resident #85 said, "I miss having my coffee".

On 8/24/23 at 12:47 PM, an interview was conducted with CNA J. CNA J said, "all of the Residents get juice with meals, but the kitchen puts coffee in the day room in the morning, we [the CNA's who distribute the trays] can get coffee but the Residents have to ask". CNA J went on to say, "I know one Resident that wants coffee with all of her meals". When asked who that was, CNA J identified Resident #85 by name. CNA J further confirmed that the meal/tray ticket identifies what items the Residents are supposed to get with meals.

On 8/25/23 at 5:30 PM, Resident #85's evening meal tray was observed and there was no coffee, only a cup of juice. When asked, Resident #85 said, "I got one earlier [referring to a cup of coffee], but I would like 2".

On 8/25/23, during an end of day meeting, the facility Administrator and Director of Nursing were made aware of the above findings.

No further information was provided.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495308	A. BUILDING _____ B. WING _____	C 08/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERVIEW HEALTH & REHAB CENTER	**414 ALGONQUIN RD HAMPTON, VA 23661**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 809 F 809 SS=E	Continued From page 86 Frequency of Meals/Snacks at Bedtime CFR(s): 483.60(f)(1)-(3) §483.60(f) Frequency of Meals §483.60(f)(1) Each resident must receive and the facility must provide at least three meals daily, at regular times comparable to normal mealtimes in the community or in accordance with resident needs, preferences, requests, and plan of care. §483.60(f)(2)There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except when a nourishing snack is served at bedtime, up to 16 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 meals and snacks must be provided to residents who want to eat at non-traditional times or outside of scheduled meal service times, consistent with the resident plan of care. This REQUIREMENT is not met as evidenced by: Based on Resident interviews, staff interviews, and facility documentation review, the facility staff failed to provide snacks to Residents affecting multiple Residents on 3 of 3 nursing units. The findings included: The facility staff stopped providing snacks between meals and at bedtime which affected multiple Residents residing on each of the nursing units. On 8/22/23 and 8/23/23, during Resident interviews conducted by the entire survey team,	F 809 F 809		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495308	A. BUILDING _____ B. WING _____	C 08/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERVIEW HEALTH & REHAB CENTER	**414 ALGONQUIN RD HAMPTON, VA 23661**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 809	Continued From page 87 on both nursing units, multiple Residents verbalized concern and frustration that their "snack and drinks" were taken away. Multiple Residents stated they were told "They were a luxury". On 8/23/23 at 2 PM, a Resident Council meeting was held with 13 Residents in attendance (Resident #7, #13, #23, #41, #44, #47, #53, #58, #61, #67, #84, #92, and Resident #98). The Residents unanimously verbalized concern that the snacks and drinks were taken away and they don't receive any between meal or at bedtime snacks. The group collectively gave permission for the minutes from prior Resident council meetings to be reviewed. On 8/23/23, Surveyor C observed the pantry on the first floor and observed there were no drinks, snacks, or any type of substance items for staff to be able to distribute to Residents who requested a snack. Review of the Resident Council meeting minutes revealed the following: During the August 2, 2023, meeting, it was noted that the report from dietary included... "there will be no more soda and less variety of snacks". On 8/24/23, an interview was conducted with a staff member who requested to remain anonymous. The employee was asked about the availability of snacks. The employee said that "there are no snacks". They said, "we make sandwiches and bring items from home to give our Residents". On 8/24/23, during an end of day meeting, the facility Administrator was made aware of the	F 809	1. The organization cannot change the outcome of the deficient practice for resident R85. R85 is being offered bedtime snacks. 2. All residents have the potential to be affected by this deficient practice. The Food Service Director/designee will complete a house audit of resident's preferences by 9/15/23. A variety of bedtime snacks will be offered to residents. 3. The Nursing Home Administrator provided education to the food Service Director regarding F806 Resident Allergies, Preferences, and Substitutes on 9/13/23. A tracking sheet was developed to offer and document acceptance/declination of Nighttime snacks. 4. The Food Service Director/designee will interview 5 residents a week to ensure that bedtime snacks are being offered x 6 weeks. All results and trends will be reviewed at the Monthly Quality Assurance Performance Improvement Meeting to determine compliance. 5. 9/22/2023	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495308	A. BUILDING _____ B. WING _____	C 08/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERVIEW HEALTH & REHAB CENTER	414 ALGONQUIN RD HAMPTON, VA 23661

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 809	Continued From page 88 above findings.	F 809		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions	F 880	1.Maintenance E was re-educated on isolation precautions and donning/doffing procedures on 8/24/23. No other issues concerning neutropenic precautions were noted. 2.All residents who have isolation requirements have the ability to be affected by this deficient practice. No other residents had isolation requirements in place at that time. 3.Facility maintenance E was re-educated on isolation precautions and donning/doffing procedure on 8/24/23. Facility nursing staff were re-educated on 9/6/23 and 9/7/23 on isolation requirements. Facility staff were re-educated on isolation requirements on 9/13/23. 4.The facility infection preventionist/designee will visually audit all residents who are on isolation precautions, and staff's adherence to precautions upon entering/exiting room to validate appropriate precautions being utilized. Each resident on precautions will have 2 staff observations per week x6 weeks to validate compliance. All results and trends will be reviewed at the Monthly Quality Assurance Performance Improvement Meeting to determine compliance. 5. 9/22/2023	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495308	A. BUILDING _____ B. WING _____	C 08/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERVIEW HEALTH & REHAB CENTER	**414 ALGONQUIN RD HAMPTON, VA 23661**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880		F 880		

Continued From page 89 to be followed to
prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and
(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.

§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.

§483.80(e) Linens.
Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.

§483.80(f) Annual review.
The facility will conduct an annual review of its IPCP and update their program, as necessary.
This REQUIREMENT is not met as evidenced by:
Based on observation, interview, and record review, the facility failed to ensure all staff followed neutropenic precautions for one of one resident (Resident (R)163) by not donning personal protective equipment (PPE) prior to entering the R163's room. This failure had the potential of exposing R163 to an infectious disease.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495308	A. BUILDING _____ B. WING _____	C 08/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERVIEW HEALTH & REHAB CENTER	**414 ALGONQUIN RD HAMPTON, VA 23661**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880		F 880		

Continued From page 90

Findings include:

Review of R163's Electronic Medical Record (EMR) under the "Face Sheet" tab indicated R163 was admitted to the facility with the diagnoses myelodysplastic syndrome, acute and chronic respiratory failure, sever sepsis, heart disease, spinal stenosis, and acute embolism and thrombosis of deep veins of lower extremities.

During an observation on 08/24/23 at 10:00 AM, R163 was located in a private room on the first floor of the facility. There were two signs placed on R163's door stating, "STOP Neutropenic Precautions (In addition to standard precautions) Visitors, Staff, and Physicians Mask for all room entry if recovering from a respiratory illness. Visitors ask nursing for mask instructions. When you enter and each time you leave the room you must either: Use waterless foam or wash hands." There were masks, gloves, and gowns located immediately outside of R163's room in the hallway.

During an observation on 08/24/23 at 12:40 PM, Maintenance, E, knocked on R163's door and went into R163's room to retrieve a television. When asked if Maintenance E had noticed the two neutropenic precaution signs posted on R163's door and he stated, "No." Maintenance Staff E explained he did not notice the signs because he was in a hurry due to R163 wanting his television fixed. Maintenance E stated he should have donned a gown, gloves and a mask prior to entering R163's room.

Review of R163's EMR under the "Orders" tab indicated an order "08/23/23 neutropenic isolation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495308	A. BUILDING _____ B. WING _____	C 08/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERVIEW HEALTH & REHAB CENTER	414 ALGONQUIN RD HAMPTON, VA 23661

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 91 precautions every shift active." During an interview on 08/25/23 at 2:20 PM, with the Director of Nursing (DON), the DON said she had been informed of the break in infection control with Staff E not washing his hands or wearing a mask upon entering R163's room. Review of the facility's undated policy titled, "Infection Control Program", stated, "Policy: The facility has an infection control program and committee that addresses the surveillance, prevention and control of disease and infection, that is consistent with the guidelines from the CDC ..."	F 880		
F 881 SS=E	Antibiotic Stewardship Program CFR(s): 483.80(a)(3) §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(3) An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to implement a comprehensive antibiotic stewardship program. This failure had the possibility of negatively impacting all residents in the facility. In addition, the facility staff failed to follow their antibiotic stewardship program by ensuring the Resident did not receive antibiotics that were inappropriate for 2 (residents 107 and 413) of 64 sampled	F 881	1.Resident #107 had the order to discontinue the antibiotic on 8/24/23. Resident #413 no longer resides at the facility. 2.All residents on ABT have the potential to be affected by this deficient practice. A new monthly tracking log has been developed that includes the antibiotic used to treat the infection, the organism (if apply), McGreers information, and symptoms. 3.The facility infection preventionist was re-educated on antibiotic stewardship program on 9/6/23 by Director of Nursing. Facility nursing staff were re-educated on antibiotic stewardship on 9/6/23 and 9/7/23 by the Director of Nursing. The facility is working collaboratively with the providers and pharmacy to ensure compliance with Antibiotic Stewardship. 4.The facility Director of Nursing/designee will review new order report 3x per week x 6 weeks to validate appropriate stop date for antibiotics and review culture sensitivities as apply to validate	

			appropriate drug use. The facility Director of Nursing/designee will review the infection preventionist new infection logs, mapping, and McGreers tracking weekly x 6 weeks to validate compliance with program. All results and trends will be reviewed at the Monthly Quality Assurance Performance Improvement Meeting to determine compliance. 5. 9/22/2023	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495308	A. BUILDING _____ B. WING _____	C 08/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERVIEW HEALTH & REHAB CENTER	**414 ALGONQUIN RD HAMPTON, VA 23661**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 881		F 881		

Continued From page 92

residents.

Findings include:

During an interview on 08/25/23 at 2:20 PM with the Director of Nursing (DON), the DON stated the Infection Control Preventionist (ICP) was on vacation this week. The DON said she had not reviewed the ICP's infection control binder prior to today. The DON stated they do have a monthly care meeting (Clinical Operations Meeting) where they review tracking and trending, where infections are located within the building and what has been done in relation to those infections. The DON was unable to provide any "maps" tracking the location/types of infections in the facility. The DON stated, recently, the majority of the infections in the facility had been urinary tract infections. The DON was unable to locate a line listing for every month during 2023. The DON stated a review of all infections are held at the monthly clinical operations review. The DON said the Medical Director was at the facility every Wednesday and the ICP would review any infection/antibiotic concerns with the Medical Director at that time.

Review of the Clinical Operations Reports from January 2023 through June 2023 indicated a review of the type and number of infections occurring in the facility, but no review of the antibiotic prescribed/used to treat the infections.

Review of the facility's undated policy, "Antibiotic Stewardship Program," stated, "Policy: This organization is committed to providing sufficient resources to establish and maintain systems and processes fa facility wide system to monitor the use of antibiotics through an interdisciplinary

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495308	A. BUILDING _____ B. WING _____	C 08/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERVIEW HEALTH & REHAB CENTER	**414 ALGONQUIN RD HAMPTON, VA 23661**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 881		F 881		

Continued From page 93

Antibiotic Stewardship Program. Improving the use of antibiotics in the nursing facility to protect residents and reduce the threat of antibiotic resistance is a priority. The goals for the program include: Ensuring that residents who require an antibiotic, are prescribed the appropriate antibiotic, reducing the risk of adverse events, including the development of antibiotic-resistant organisms, from unnecessary antibiotic utilizations, and adverse outcomes monthly and feedback will be provided to the QAPI committee regarding antibiotic stewardship practices ...Specific Procedures/Guidance: 1. The facility will establish and maintain an interdisciplinary Antibiotic Stewardship Program that will at a minimum include participation by the medical director, prescribing physicians/non-physician practitioners, consulting pharmacist, administrator, nursing leadership and infection control preventionist. 2. The Antibiotic Stewardship team will meet monthly to review antimicrobial regimens ...4. A standard of criteria for defining various infections, (i.e. McGeer's Criteria) will be adopted and utilized for classifying infections ...5.When symptoms of infection are identified, the clinical team ...will complete an evaluation of the resident and communicate findings to the resident's physician for orders related to diagnostic testing and/or treatment ...6. The initial tracking/surveillance tool will be initiated by the infection control preventionist ...and will be completed for each resident ...7. Infection and antibiotic therapy usage will be maintained for each unit ...monthly ....12. A summary of the monthly tracking, analysis and actions taken will be communicated to the QAPI Committee for additional oversight ...13. At least on an annual basis, the facility will obtain and review an antibiotic algorithm ..."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495308	A. BUILDING _____ B. WING _____	C 08/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERVIEW HEALTH & REHAB CENTER	**414 ALGONQUIN RD HAMPTON, VA 23661**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 881		F 881		

Continued From page 94

2. The facility staff failed to ensure Resident #107 received the antibiotic (Cefadroxil) for the length of time as ordered by the physician.

Resident #107 was admitted to the nursing facility on 07/18/23. Diagnosis for Resident #107 included but not limited to periprosthetic fracture around internal left hip and left ankle joint.

A review of Resident #107's hospital discharge summary dated 07/18/23 revealed an order for Cefadroxil (antibiotic) 500 mg capsule - take 2 capsules daily for 7 days.

The Physician Order Summary (POS) for August 2023 revealed an order starting on 07/19/23 for Cefadroxil 500 mg capsule - give one capsule twice a day for post-op prophylactic. The order also included clarification of a stop date by pharmacy.

The antibiotic Cefadroxil was first administered to Resident #107 on 07/19/23 and was administered until 08/22/23. A review of Resident #107's Medication Administration Record (MAR) for July and August 2023 indicated Resident #107 received an extra 47 doses of the antibiotic Cefadroxil 500 mg.

An interview was conducted with the Director of Nursing (DON) on 08/05/23. She stated the Antibiotic Stewardship Program is monitored by the Assistant Director of Nursing (ADON) who is also the Infection Preventions (IP). She stated the IP is currently not available at this time. She stated when the nurse transcribed the order indicating the antibiotic was being used prophylactic, the ADON/IP did not have a reason

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495308	A. BUILDING _____ B. WING _____	C 08/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERVIEW HEALTH & REHAB CENTER	**414 ALGONQUIN RD HAMPTON, VA 23661**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 881		F 881		

Continued From page 95 to review the hospital discharge summary. On the antibiotic order, the pharmacy also requested to clarify the stop date. She stated in order for the nurse to see the pharmacy request for the a stop date, they would have to click the + sign in the order but again, since the order read prophylactic, no one expanded the order.

A final meeting was held with the Administrator, Director of Nursing and Corporate on 08/25/23 at 6:00 p.m., who were informed of the above findings. An opportunity was offered to the facility's staff to present additional information, but no further information was provided.

3. For Resident #413, the facility staff failed to follow their antibiotic stewardship program by ensuring the Resident did not receive antibiotics that were inappropriate.

On 8/23/23-8/24/23, a closed clinical record review was conducted of Resident #413's medical chart. This review revealed the following:

A urinalysis sample was obtained on 3/21/23, and the results were reported to the facility that evening which was indicative of a urinary tract infection. There were no notes proceeding this to indicate the Resident's symptoms.

A progress note entered by the nurse practitioner on 3/22/23 at 7:14 PM, that read, "...Patient seen today for UTI [urinary tract infection]. Per nursing staff, her yelling out has decreased. Patient is non-verbal but did not appear to be in distress. New order for Levaquin 500mg daily x 7 days, will continue to monitor." There were no notes

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495308	A. BUILDING _____ B. WING _____	C 08/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERVIEW HEALTH & REHAB CENTER	**414 ALGONQUIN RD HAMPTON, VA 23661**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 881		F 881		

Continued From page 96 proceeding
this to indicate the Resident's symptoms.

Review of the Medication Administration record (MAR) revealed Resident #413 received the Levaquin on 3/22/23 and 3/23/23. On 3/24/23, the order for Levaquin (antibiotic) was discontinued and a new order for "Cipro Oral Tablet 500 MG (Ciprofloxacin HCl) Give 1 tablet by mouth two times a day for uti for 3 Days" was entered. Resident #413 received the Cipro for one dose on 3/24/23, 2 doses on 3/25/23 and 3/26/23, and one dose on 3/27/23.

Review of the Urine culture and sensitivity report that was received by the facility on 3/23/23 at 8:14 AM, revealed that the infection was resistive to "Levofloxacin", also known as Levaquin and "Ciprofloxacin", also known as Cipro.

On 08/24/23 at 04:58 PM, an interview was conducted with Employee C, the nurse practitioner (NP) and ordering provider of the antibiotics noted above with regards to Resident #413. When asked about the order for Levaquin being changed to an alternate antibiotic that the infection was still resistive to, the NP said, "It must have been a mistake, I wouldn't have had a reason to order an antibiotic it was resistive to, it didn't hurt her but didn't do any good". When asked about the unnecessary use of antibiotics and if that was upholding antibiotic stewardship, the NP said, "absolutely not. We don't want people taking unnecessary antibiotics".

Review of the facility's "Antibiotic Stewardship Program" was conducted. This policy defined antibiotic stewardship as "refers to a set of commitments and actions designed to optimize

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495308	A. BUILDING _____ B. WING _____	C 08/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERVIEW HEALTH & REHAB CENTER	414 ALGONQUIN RD HAMPTON, VA 23661

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 881	Continued From page 97 the treatment of infections while reducing the adverse events associated with antibiotic. This can be accomplished through improving antibiotic prescribing, administration, and management practices thus reducing inappropriate use to ensure the residents receive the right antibiotic for the right indication, dose, and duration...". On 8/24/23, during an end of day meeting, the facility Administrator and Director of Nursing were made aware of the above findings. No further information was provided.	F 881		
F 883 SS=D	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and	F 883	1.Resident #80's responsible representative received risk benefit education on the pneumococcal vaccine on 9/5/23 and was offered the vaccine for resident. Resident #97 is not currently eligible for the influenza vaccine but will be offered once flu season opens. 2.All residents have the potential to be affected by this deficient practice. A house wide immunization audit was completed on 9/5/23. Residents noted to have omissions in the pneumococcal vaccine have been offered vaccinations and orders have been placed to administer. Current residents/representatives will be provided education on influenza vaccine and will be offered influenza vaccination during the 2023 flu season. 3.The facility infection preventionist was re-educated on the influenza and pneumococcal requirements on 9/6/23 by the Director of Nursing. Facility nursing staff were re-educated on vaccination requirements on 9/6/23 and 9/7/23. Resident offering, acceptance and/or declination of pneumococcal and/or	

			influenza vaccinations will be documented and maintained in the resident's medical record. 4.The initial vaccination audit will be utilized and updated 5x per week by facility infection preventionist, to include newly admitted residents. The Director of Nursing/designee will review audit results and validate required immunizations offered as needed and appropriate resident records updated weekly x6 weeks. All results and trends will be reviewed at the Monthly Quality Assurance Performance Improvement Meeting to determine compliance. 5. 9/22/2023	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495308	A. BUILDING _____ B. WING _____	C 08/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERVIEW HEALTH & REHAB CENTER	**414 ALGONQUIN RD HAMPTON, VA 23661**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 883		F 883		

Continued From page 98

(B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal.

§483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that-
(i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization;
(ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized;
(iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following:
(A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and
(B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal.
This REQUIREMENT is not met as evidenced by:
Based on medical record review and interview the facility failed to ensure all residents received or were offered an influenza and pneumococcal vaccinations for two (Resident (R) 80 and R97) out of five sampled residents.

Findings include:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495308	A. BUILDING _____ B. WING _____	C 08/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERVIEW HEALTH & REHAB CENTER	**414 ALGONQUIN RD HAMPTON, VA 23661**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 883		F 883		

Continued From page 99

1. Review of R80's "Face Sheet" located under the "Profile" tab of the electronic medical record (EMR) revealed R80 was admitted to the facility on 10/05/21.

Review of R80's Annual "Minimum Data Set (MDS)" with an "Assessment Reference Date (ARD)" date of 06/16/23 , located under the "Resident Assessment Instrument(RAI)" tab indicated R80 was independent with bed mobility, toileting, dressing, and transfers. The MDS showed Brief Interview for Mental Status (BIMS) score of three out of 15 indicating R80 was severely cognitively impaired.

Review of R80's EMR under the "Vaccination" tab indicated R80 had not received or been offered a pneumococcal vaccination since his admission to the facility.

2. Review of R97's "Face Sheet" located under the "Profile" tab of the electronic medical record (EMR) revealed R97 was admitted to the facility on 10/20/22.

Review of R97's quarterly "MDS" with an ARD date of 08/08/23, located under the "RAI" tab indicated R97 was supervision of one staff member with transfers, toileting, and dressing; supervision of one staff member with bed mobility. The MDS showed a BIMS score of 12 out of 15 indicating R97 as cognitively intact.

Review of R97's EMR under the "Vaccination" tab indicated R97 had not received or been offered an influenza vaccination during 2022.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495308	A. BUILDING _____ B. WING _____	C 08/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERVIEW HEALTH & REHAB CENTER	**414 ALGONQUIN RD HAMPTON, VA 23661**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 883		F 883		

Continued From page 100

During an interview on 08/25/23 at 12:30 PM with the Director of Nursing (DON) confirmed that R80 did not receive a pneumococcal vaccination and R97 did not receive an influenza vaccination. The DON did not know why the vaccinations were not given or offered.

Review of the facility's undated policy, "Vaccination of Residents" stated, "Policy: All residents will be offered vaccines that aid in preventing infectious diseases unless the vaccine is medically contraindicated, or the resident has already been vaccinated ..."

Review of the facility's undated policy, "Pneumococcal Vaccine" stated, " ...Policy: Resident will be offered pneumococcal vaccines to aid in preventing pneumonia/pneumococcal infections ...Specific Procedures/Guidance 1. Prior to or upon admission, residents will be assessed for eligibility to receive the pneumococcal vaccine series and when indicated, will be offered the vaccine series within thirty (30) days of admission to the facility unless medically contraindicated or the resident has already been vaccinated. 2. Residents of the long-term care facility will be offered the pneumococcal vaccination upon initial admission to the nursing home in accordance with the guidelines set forth by the Center for Disease Control and/or ACIP ...21. The infection preventionist will oversee and monitor the influenza vaccination for residents ..."

Review of the facility's undated policy, "Influenza Vaccination" stated, " ...Policy: All residents ...who have no medical contraindications to the vaccine will be offered the influenza vaccine annually to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495308	A. BUILDING _____ B. WING _____	C 08/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERVIEW HEALTH & REHAB CENTER	**414 ALGONQUIN RD HAMPTON, VA 23661**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 883	Continued From page 101 encourage and promote the benefits associated with vaccinations against influenza ...Specific Procedures/Guidance 1. Residents ...of the long term care facility will be offered the influenza vaccination upon initial admission to the nursing home in accordance with the guidelines set forth by the Center for Disease Control and/or ACIP ...9. The infection preventionist will oversee and monitor the influenza vaccination for resident ..."	F 883		
F 908 SS=D	Essential Equipment, Safe Operating Condition CFR(s): 483.90(d)(2) §483.90(d)(2) Maintain all mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on observation, Resident interview and facility staff interviews, the facility staff failed to maintain equipment in a safe operating condition for one Resident (Resident #82) in a survey sample of 64 Residents. The findings included: For Resident #82 the facility staff failed to maintain his wheelchair, it had no arm rests and then several days later wash clothes were wrapped on the frame and taped to provide a barrier from the wheelchair frame and the Resident's arm. On 08/22/23 at 02:49 PM, during an interview with Resident #82, the Resident reported that he needed a new wheelchair because what he has been provided is not comfortable. Observations of the wheel chair revealed the chair had no arm rests and it was just bare metal for the Resident	F 908	1. Resident R82's wheelchair was evaluated by the Director of Rehab to ensure the residents wheelchair is set up and is consistent with the plan of care. Resident R82's wheelchair was repaired. 2. All residents that rely on a wheelchair can be affected by this deficient practice. A house audit was completed by the Director of Rehab to ensure wheelchairs are in good repair and function for resident safety. 3. The Director of Rehabilitation was educated on F Tag 908 by the Nursing Home Administrator on 9/13/2023. Nursing staff were re-educated on the process for reporting wheelchairs that need repair to the Rehabilitation Department. 4. The Director of Rehabilitation or designee will audit 5 resident wheelchairs a week x 6 weeks to ensure that chairs are in good repair and function for resident safety. All results and trends will be reviewed at the Monthly Quality Assurance Performance Improvement Meeting to determine compliance. 5. 9/22/2023	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495308	A. BUILDING _____ B. WING _____	C 08/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERVIEW HEALTH & REHAB CENTER	**414 ALGONQUIN RD HAMPTON, VA 23661**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 908		F 908		

Continued From page 102

to rests his arms on.

On 8/25/23, observations were made of Resident #82's wheelchair at the bedside. It was observed that washcloths had been put over the metal where arm rests would go and were taped with a medical tape. The Resident reported facility staff had done this but the Resident was not able to identify who had done this.

On 8/25/23 at 2:15 PM, an interview was conducted with Employee Q, the rehab manager. Employee Q said "maintenance does the routine maintenance of wheelchairs. If they are on caseload we can do minor things like adjust the brakes, but the nurse should put it into the system [referring to the maintenance work order system] for maintenance". Employee Q was asked about Resident #82's wheelchair. Employee Q said a lady from his insurance company came last week and said they would provide him with a chair if we picked him up on caseload and approve the chair. Employee Q was unaware that wash clothes were being used in place of arm rests. Employee Q went on to say they had a box full of spare/replacement arm rests available. When asked about the lack of arm rests, Employee Q said, "It could cause skin issues".

On 8/25/23 at 2:48 PM, Employee M, a maintenance employee accompanied Surveyor C to the room of Resident #82. Employee M saw the lack of arm rests and wash clothes that had been taped in place and said, "That's no good, therapy does minor wheelchair repairs". Employee M confirmed that they had a case of arm rests and could replace them immediately. Employee M removed the chair from the room.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495308	A. BUILDING _____ B. WING _____	C 08/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERVIEW HEALTH & REHAB CENTER	414 ALGONQUIN RD HAMPTON, VA 23661

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 908	Continued From page 103 On 8/25/23 at approximately 3:30-4 PM, Employee M approached Surveyor C and provided a copy of the maintenance work orders for the room Resident #82 resided in and stated that a maintenance work order had never been entered into the system for any work/repairs to be done to Resident #82's wheelchair. On the afternoon of 8/25/23, the facility Administrator was made aware of the above findings. No further information was provided.	F 908		
F 919 SS=D	Resident Call System CFR(s): 483.90(g)(1)(2) §483.90(g) Resident Call System The facility must be adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area from- §483.90(g)(1) Each resident's bedside; and §483.90(g)(2) Toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on interview, observation, record review, and facility policy review, the facility failed to ensure two of a sample of 64 residents (Resident (R) 27 and R81) were provided with a functional call light for use when assistance could be needed. This failure had the potential to adversely affect the timeliness of care or response time in case of an urgent or emergent need. Findings include:	F 919	1 Resident R27's and R81's call light was reset through the system and working. 2. All residents can be affected by this deficient practice. The Maintenance Director completed a House wide audit to ensure all call bells work on 9/12/23. 3.The Nursing Home Administrator will provide Education to all departments on 9/13/2023 regarding the call bell system and process to follow when the system has a failure. Nursing staff were educated on the process for call bell malfunction on 9/6/23 and 9/7/23. 4. The Maintenance Director/designee will audit 5 rooms a week for 6 weeks to ensure the call bell system operates correctly. All results and trends will be reviewed at the Monthly Quality Assurance Performance Improvement Meeting to determine compliance. 5. 9/22/2023	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495308	A. BUILDING _____ B. WING _____	C 08/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERVIEW HEALTH & REHAB CENTER	**414 ALGONQUIN RD HAMPTON, VA 23661**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 919		F 919		

Continued From page 104

1. Review of R27's "Order Summary Report" from the electronic medical record (EMR) "Orders" tab showed diagnoses that included blindness, hemiplegia and hemiparesis (paralysis) following a cerebral infarction (stroke).

Observation of R27's call light on 08/23/23 at 3:10 PM, showed after being pushed, no light appeared on the wall unit or above the door.

During an observation of R27's call light on 08/23/23 at 3:22 PM with Licensed Practical Nurse (LPN) H she confirmed R27 had no call light function at all, but that he could call out. LPN H continued to explain that R27 "did not usually use the call light but usually waits until he hears someone in the room and then ask for what he needs."

2. Review of R81's "Admission Record" from the facility EMR "Profile" tab showed diagnoses that included Parkinson's disease, abnormalities of gait and mobility.

During an observation and interview on 08/22/23 at 12:30 PM with R81, the resident demonstrated that while the light on the wall unit went on, nothing lit up above the door. R81 then entered the bathroom and pulled the call light, again he pointed out it worked at the wall but not above the door. R81 stated he had "advised the nurses and [name of maintenance employee]."

On 08/23/23 at 3:20 PM R81's call light was checked and found it was non-functional above the door. At 3:24 PM, LPN H confirmed R81's call light lit up on the wall but not above the door.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495308	A. BUILDING _____ B. WING _____	C 08/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERVIEW HEALTH & REHAB CENTER	**414 ALGONQUIN RD HAMPTON, VA 23661**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 919		F 919		

Continued From page 105

During an interview on 08/25/23 at 8:45 AM the Administrator stated "We just got a new system and I heard there was an issue with it. Maintenance showed a way to reset it in the event the call light is not operable, we have bells. My expectation is that everyone should have a call light and if they do not, they should have a bell."

A recheck of the call lights on 08/25/23 at 4:35 PM showed R27's call light was now functional. However, observation revealed R81 pressed his call button, and it lit up on the wall unit, but nothing displayed over the door.

On 08/25/23 at 4:40 PM, the Unit Manager (Registered Nurse (RN) B) went to R81's room, tested the call light, confirmed it was not working, and stated she would call maintenance immediately.

On 08/25/23 at 5:05 PM, observation and interview with the Administrator with RN B confirmed to the Administrator R81's call light did not work at 4:40 PM. The call light was pressed in R81's room and the light came on at the wall unit, but nothing above the door. The Administrator tested the bathroom call light, and nothing lit up above the door. The Administrator stated he was up there with maintenance earlier and the call light was working.

Review of the undated facility policy titled "Answering the Call Light" showed:
"Policy: The facility will maintain a functional call light system . . .
General Guidelines -
. . .7. Report all defective call lights to the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495308	A. BUILDING _____ B. WING _____	C 08/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERVIEW HEALTH & REHAB CENTER	**414 ALGONQUIN RD HAMPTON, VA 23661**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 919	Continued From page 106 licensed nurse and the maintenance promptly. . . . "	F 919		