PRINTED: 01/19/2024 FORM APPROVED OMB NO. 0938-0391

NAME OF PROVIDER OR SUPFLIER  RIVERSIDE LIFELONG H & R WARRWCK FOREST  RIVERSIDE LIFELONG H & R WARRWCK FOREST  REGIONAL REGIONAL WAS TRANSPORTED BY THE PROPERTY OF DEPOSITION OF DEPOSITION OF THE PROVIDERS PLAN OF COMPETION OF THE PROVIDERS PLAN OF COMPETION OF THE PROVIDER PLAN OF THE	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
RIVERSIDE LIFELONG H & R WARWICK FOREST  RIVATION OLD DENSIFIER SOULD SHAPE CONTROLL OF THE PROPERTY OF THE PR			495071	B. WING _				
PREFIX TAG			RWICK FOREST		1000 OLD DENBEIGH BOULEVARD	E		
An unannounced Emergency Preparedness survey was conducted 12/5/2023 through 12/8/2023. The facility was in substantial compilance with 42 CFR Part 463.73, Requirement for Long-Term Care Facilities.  F 000 INITIAL COMMENTS F 000  An unannounced Medicare/Medicaid standard survey was conducted 12/5/2023 through 12/8/2023. Thirteen complaints (VA00054007-substantiated without deficiency, VA00060092-substantiated without deficiency, VA00060092-substantiated without deficiency, VA00063093-substantiated without deficiency, VA0005303-substantiated with deficiency, VA0005303-substantiated with deficiency, VA0005303-substantiated with deficiency, VA0005314-substantiated with deficiency, VA0005314-substantiated with deficiency, VA0005314-substantiated with deficiency, VA0005314-substantiated with deficiency, VA0005318-substantiated with deficiency, VA0005318-substantiated with deficiency, VA00051153-substantiated with deficiency, VA00051153-substantiated with deficiency, VA00051570-substantiated with deficiency, VA00051670-substantiated with deficiency were investigated during the survey. Corrections are required for compliance with 42 CFR and 48 Techeral Long Term Care requirements. The Life Safety Code survey/report will follow.  The census in this 209 certified bed facility was 194 at the time of the survey. The survey sample consisted of 50 current resident reviews and 10 closed record reviews.  Reasonable Accommodations Needs/Preferences  F 558  S=D0 CFR(s): 483.10(e)(3)  §483.10(e)(3) The right to reside and receive services in the facility with reasonable	PRÉFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	N SHOULD BE APPROPRIAT		COMPLETION
survey was conducted 12/6/2023 through 12/8/2023. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities.  F 000  An unannounced Medicare/Medicaid standard survey was conducted 12/5/2023 through 12/8/2023. Thirteen complaints (VA00054007- substantiated without deficiency, VA00060092- substantiated without deficiency, VA00069938- substantiated with deficiency, VA00059938- substantiated with deficiency, VA0005303- substantiated with deficiency, VA0005472- substantiated with deficiency, VA00056165- substantiated with deficiency, VA0005314- substantiated with deficiency, VA0005314- substantiated with deficiency, VA00053183- substantiated with deficiency, VA00051153- substantiated with deficiency, VA00051153- substantiated with deficiency, VA00051153- substantiated with deficiency, VA00051570- substantiated with deficiency, VA00051570- substantiated with deficiency, VA00051570- substantiated with deficiency, VA00051570- substantiated with deficiency, VA0005150- substantiated with deficiency, VA00051650- substantiated with deficiency, VA0005	E 000	Initial Comments		E 0	00			
survey was conducted 12/5/2023 through 12/8/2023. Thirteen complaints (VA00054007- substantiated without deficiency, VA00060992- substantiated without deficiency, VA000659938- substantiated with deficiency, VA0005376- unsubstantiated with deficiency, VA0005303- substantiated with deficiency, VA00052472- substantiated with deficiency, VA00052472- substantiated with deficiency, VA00052462- substantiated with deficiency, VA00053514- substantiated with deficiency, VA00053514- substantiated with deficiency, VA00053128- substantiated with deficiency, VA00051153- substantiated with deficiency, VA00051570- substantiated with deficiency) were investigated during the survey. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow.  The census in this 209 certified bed facility was 194 at the time of the survey. The survey sample consisted of 50 current resident reviews and 10 closed record reviews.  F 558 Reasonable Accommodations Needs/Preferences  F F 558 CFR(s): 483.10(e)(3)  §483.10(e)(3) The right to reside and receive services in the facility with reasonable	F 000	survey was conducte 12/8/2023. The facilit compliance with 42 C Requirement for Long	d 12/5/2023 through y was in substantial FR Part 483.73, g-Term Care Facilities.	F 0	00			
194 at the time of the survey. The survey sample consisted of 50 current resident reviews and 10 closed record reviews.  F 558 Reasonable Accommodations Needs/Preferences SS=D CFR(s): 483.10(e)(3)  §483.10(e)(3) The right to reside and receive services in the facility with reasonable		survey was conducte 12/8/2023. Thirteen a substantiated without substantiated with de unsubstantiated with de substantiated with de during the survey. Compliance with 42 Complia	d 12/5/2023 through complaints (VA00054007-deficiency, VA00060092-deficiency, VA00059938-ficiency, VA00051376-but deficiency, VA00053003-ficiency, VA00052472-deficiency, VA00052472-ficiency, VA00053514-ficiency, VA00053128-ficiency, VA00051153-ficiency, VA00051570-ficiency) were investigated borrections are required for EFR Part 483 Federal Longents. The Life Safety Code					
services in the facility with reasonable		194 at the time of the consisted of 50 curre closed record reviews Reasonable Accomm	survey. The survey sample nt resident reviews and 10 s. odations Needs/Preferences	F 5	58			1/22/24
		services in the facility	with reasonable					

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

01/10/2024

**Electronically Signed** Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that

Facility ID: VA0204

other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MU IDENTIFICATION NUMBER: A. BUIL		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495071	B. WING		C 12/08/2023
NAME OF PI	ROVIDER OR SUPPLIER	L		STREET ADDRESS, CITY, STATE, ZIP CODE	1 12/00/2020
RIVERSID	E LIFELONG H & R WA	RWICK FOREST		1000 OLD DENBEIGH BOULEVARD	
KIVEKSID	L LII LLONG II & K WA	KWICK I OKLOT		NEWPORT NEWS, VA 23602	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION
F 558	Continued From pag	ue 1	F 558	3	
	accommodation of re	esident needs and			
	preferences except v	when to do so would			
	endanger the health	or safety of the resident or			
	other residents.				
	This REQUIREMEN	T is not met as evidenced			
	by:				
		on, resident interview, staff		The Christmas tree was removed	
		cord review and facility		from room by maintenance on 12/8/23	
		was determined that the		that resident #19 could move freely as	
	facility staff failed to	ensure reasonable eeds for one of 60 residents		desired. Resident #19 was asked 1/4 if they would like to attend PACE at he	·
in the survey sample				next scheduled session 1/10/24 and s	
	in the survey sample	, resident #15.		agreed. Resident #19 attended her P	
	The findings include:			seesion on 1/10/24.	/ (OL
				Maintenance / designee will measure as a second of the second of th	sure
	For Resident #19 (R	19), the facility staff failed to		and evaluate all semiprivate rooms to	
		ates personal belongings did		ensure roommates personal belonging	gs
	not hinder their abilit	y to leave the room if they		do not hinder their ability to leave the	
	chose.			room. All residents who have appointments on 1/4/23 were asked to	o get
	On the most recent I	MDS (minimum data set), a		up to attend, none-declined.	
	quarterly assessmer	nt with an ARD (assessment		3. The Clinical Educator/designee w	<i>i</i> ill
		14/2023, the resident scored		educate the clinical staff on notification	n to
		BIMS (brief interview for		maintenance of rooms that hinder the	
		ssment, indicating the		ability of residents to leave the room	
		vely intact for making daily		freely. Education will also include	.
		essment documented R19		notifying residents of appointments ar	
	being dependent on			assisting them out of bed to attend an	d
	_	manual wheelchair and		how to handle refusals.	4
	two turns.	o wheel at least 50 feet with		4. Maintenance/designee will audit 4 rooms per week x 8 weeks to ensure	†
	two turns.			semiprivate rooms personal belonging	ıs
	On 12/5/2023 at 12:	59 p.m., an interview was		do not hinder the ability of residents to	
		in their room. R19 was		leave the room. DON/designee will au	
		neir room on the right side of		residents per week x 8 weeks who ha	
		near the window. When		appointments and ensure they are	
		sisting them to get out of bed		assisted to get out of bed to attend. The	he
		get up, R19 stated that they		results of the audit will be reported at	
	did not get out of bed	d often but liked to get up on		QAPI meeting for evaluation of	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
				_			С	
		495071	B. WING			12/	08/2023	
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE			
DIVEDSID	ELIEELONG H & D WAI	DWICK EODEST		1	000 OLD DENBEIGH BOULEVARD			
KIVEKSID	E LIFELONG H & R WAI	RWICK FOREST		N	IEWPORT NEWS, VA 23602			
(X4) ID	SUMMARY ST	FATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFI TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI, DEFICIENCY)		COMPLETION DATE	
F 558	Continued From pag	F:	558					
		ut of the facility to (Name of			compliance and ongoing monitoring fo			
		am). R19 stated that they did			continuous improvement analysis.			
		sday but liked to go out when			continuous improvement unarysis.			
		he nursing staff had told						
	'	not get their wheelchair past						
	_	ristmas tree to get them out						
		the appointments so they had						
		19 stated that staff had to						
		to get them up and had to						
	have the wheelchair	right by the bed and could						
	not fit the chair past t	the end of the roommate's						
	bed and the Christma	as tree so she had not gotten						
	•	Observation of R19's						
	roommates side of th							
		tall artificial Christmas tree						
		d with glass ornaments and						
		ately 14 inches space						
	between the end of t							
		ked where their wheelchair						
		ed that the staff stored the ere outside of the room and						
		sure where. R19 stated						
		n up for at least two weeks						
		ne to the appointment last						
	, ,	the office was closed. R19						
	<del>.</del> .	hoping to be able to go on						
	12/6/2023.	1 3						
		p.m., an interview was						
		in their room in bed. R19						
		ot offer to get them out of						
		ent that day and they had						
		n." R19 stated that they						
	•	nyone had offered to get						
	them out of bed and	to the appointment.						
	The comprehensive	care plan for R19						
	•	"(Name of R19) has an ADL						
		ng) self-care performance						

AND BLAN OF CORRECTION IN INDEST.		PLE CONSTRUCTION  G	, ,	(X3) DATE SURVEY COMPLETED		
		495071	B. WING			C  2/08/2023
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE  1000 OLD DENBEIGH BOULEVARD  NEWPORT NEWS, VA 23602		2/06/2023
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 558	deficit r/t (related to) the knee amputation 09/27/2023. Revision The progress notes - "11/15/2023 09:06 (Name of staff) at (Na	for R19 documented in part, (9:06 a.m.) Note Text: Idame of outside health informed (Name of R19) ame of outside health staff) at (Name of outside ormed that (Name of R19) cription for her Percocet tab 25 mg."  11:45 a.m.) Note Text: (Name of R19) informed that (Name of R19) informed to attend the organ). No reason given."	F 5	58		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED		
		495071	B. WING _			C <b>12/08/2023</b>		
	ROVIDER OR SUPPLIER E LIFELONG H & R WA	ARWICK FOREST	1	STREET ADDRESS, CITY, STATE, ZIP COD 1000 OLD DENBEIGH BOULEVARD NEWPORT NEWS, VA 23602				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI) TAG	PROVIDER'S PLAN OF CO ( (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE		
F 558	communicate with the for the program where of time to set up the that the medical proto to the facility quarter re-certifications.  On 12/7/2023 at 9:0 to LPN #2 to observe into the room to the manual bariatric who behind the dining and wheelchair. She pur room and entered the foot of the room tree were and state not fit through the or R19 always refused health program) and that R19 may be us excuse why they we the CNA would never because of the tree to get out of bed the Christmas tree each	nesday and she would ne DON (director of nursing) en R19 planned to go ahead etransportation. She stated vider from the program came rly to see R19 for  66 a.m., a request was made re them take R19's wheelchair bedside. LPN #2 identified a eelchair located in an alcove rea on the unit as R19's shed the wheelchair to R19's he doorway to the area where mate's bed and the Christmas d that the wheelchair would pening. She stated again that to go to (Name of outside d to get out of bed and she felt ing the Christmas tree as an ere not getting out of bed and er leave them in the bed . She stated that if R19 asked ey would have to move the	F5	,				
	conducted with CNA #5. CNA #5 stated to go out to (Name of 12/6/2023 and norm them to get out of b She stated that R19 wanted to go on 12/1 them up. When ask fit in and out of the would have to move	A (certified nursing assistant) that they did not offer for R19 of outside health program) on hally the resident would ask ed when they wanted to go. I did not tell them that they 6/2023 so they had not gotten sed how the wheelchair would from, CNA #5 stated that they be the roommate's bed first.						

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	IPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED
		495071	B. WING _			C <b>12/08/2023</b>
	ROVIDER OR SUPPLIER  E LIFELONG H & R WA	RWICK FOREST		STREET ADDRESS, CITY, STATE, ZIP CO 1000 OLD DENBEIGH BOULEVARD NEWPORT NEWS, VA 23602	DDE	12/00/2020
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C ( (EACH CORRECTIVE ACTIVE) CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BI HE APPROPRIA	
F 558	on 12/7/2023 at 2:5 conducted with ASM member) #2, directo that R19 frequently attend (Name of out stated that the nursi they should ask R19 at least twice. She shave to ask to attenderefuse and the staff to get out of bed and barriers to get in and on 12/7/2023 at 1:5 conducted with OSM facilities director. Oshould be able to get He used a tape mean barriers to get in and the distance between the Christmas tree at inches and stated that it was 30 the distance between the Christmas tree at inches and stated that it was 30 the facility policy, "Responsibilities" data part, "The right to the facility with reason resident needs and do so would endang resident or other resident or other resident or other resident needs at 4:3 administrator, ASM is stated with ASM is administrator, ASM is at 2.5 conducted with OSM facilities director. On 12/7/2023 at 4:3 administrator, ASM is at 2.5 conducted with OSM facilities director. On 12/7/2023 at 4:3 administrator, ASM is at 2.5 conducted with OSM facilities director. On 12/7/2023 at 4:3 administrator, ASM is at 2.5 conducted with OSM facilities director. On 12/7/2023 at 4:3 administrator, ASM is at 2.5 conducted with OSM facilities director. On 12/7/2023 at 4:3 administrator, ASM is at 2.5 conducted with OSM facilities director. On 12/7/2023 at 4:3 administrator, ASM is at 2.5 conducted with OSM facilities director. On 12/7/2023 at 4:3 administrator, ASM is at 2.5 conducted with OSM facilities director. On 12/7/2023 at 4:3 administrator, ASM is at 2.5 conducted with OSM facilities director. On 12/7/2023 at 4:3 administrator, ASM is at 2.5 conducted with OSM facilities director. On 12/7/2023 at 4:3 administrator, ASM is at 2.5 conducted with OSM facilities director. On 12/7/2023 at 4:3 administrator, ASM is at 2.5 conducted with OSM facilities director. On 12/7/2023 at 4:3 administrator.	ded to evacuate, CNA #5 be difficult.  3 p.m., an interview was I (administrative staff or of nursing. ASM #2 stated refused to get out of bed and side health program). She ing staff had a schedule and and offer for them to attend stated that R19 should not d, that R19 does not always should be encouraging them d there should not be any d out of the room.  7 p.m., an interview was I (other staff member) #3, SM #3 stated all residents of in and out of their rooms. Issure and measured R19's identified by LPN #2 and inches wide. He measured in R19's roommate's bed and and stated that it was 17 at the tree needed to be  Resident Rights and and ded 6/20/2023 documented in reside and receive services in onable accommodation of preferences except when to er the health or safety of the idents"	F 5	558		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION  IG	(X3) DATE SURVEY COMPLETED
		495071	B. WING _		C 12/08/2023
	ROVIDER OR SUPPLIER E LIFELONG H & R WA	RWICK FOREST		STREET ADDRESS, CITY, STATE, ZIP CODE  1000 OLD DENBEIGH BOULEVARD  NEWPORT NEWS, VA 23602	12/00/2020
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRODEFICIENCY)	JLD BE COMPLETION
F 558	Continued From pag		F 5	58	
F 561 SS=D	No further information Self-Determination CFR(s): 483.10(f)(1)	n was presented prior to exit.	F 5	61	1/22/24
	promote and facilitat through support of re not limited to the righ (1) through (11) of the §483.10(f)(1) The rea	right to and the facility must e resident self-determination esident choice, including but hts specified in paragraphs (f)			
	waking times), healtl	n care and providers of health tent with his or her interests, an of care and other			
		sident has a right to make ets of his or her life in the licant to the resident.			
	with members of the	sident has a right to interact community and participate in both inside and outside the			
	religious, and comminterfere with the right facility. This REQUIREMEN by:	ctivities, including social, unity activities that do not nts of other residents in the			
		facility's documentation and determined that the facility		Resident # 154 was transferre     bed to her motorized wheelchair	ed out of

F 561 Continued From pag failed to promote and to self-determination choice in transferring residents in the surve.  The findings included Resident #154 was a 3/1/22 with diagnosis limited to: diabetes m gangrene.  The most recent MD assessment recoded the resident at the BIMS (brief intervindicating the resider impaired. A review of G-functional status of	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		495071	B. WING _			C <b>12/08/2023</b>
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	•	12/00/2020
DIVEDOIS	NE LIEEL ONO II A D.V	WARNING FORFOT		1000 OLD DENBEIGH BOULEVARD		
RIVERSIL	E LIFELONG H & R V	VARWICK FOREST		NEWPORT NEWS, VA 23602		
PREFIX	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (  (EACH CORRECTIVE ACTION  CROSS-REFERENCED TO THE  DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 561	Continued From p	age 7	F 5	561		
F 561	failed to promote a to self-determinatic choice in transferr residents in the surface of the findings included Resident #154 was 3/1/22 with diagnoral limited to: diabetes gangrene.  The most recent Massessment, a quantum ARD (assessment a quantum ARD (assessment a quantum ARD (brief intindicating the resident he BIMS (brief intindicating the resident and included and hygicational status requiring extensived dressing and hygicational dependence A review of the construction of the c	and facilitate the resident's right on by promoting resident's ing to wheelchair for one of 60 grey sample, Resident #154.  Ided:  Is admitted to the facility on asis that included but were not as mellitus (DM), paraplegia and IDS (minimum data set) graterly assessment, with an areference date) of 9/19/23, at as scoring a 15 out of 15 on erview for mental status) score, dent was not cognitively of the MDS Section as coded the resident as assistance for bed mobility, ene; supervision for eating and for transfers and bathing.  Imprehensive care plan dated realed, "FOCUS: Resident has RVENTIONS: Assist with ADLs arequired."  Is conducted with Resident #154 on PM. Resident #154 stated, are me to my wheelchair every zed wheelchair, I can go to the agroom and just travel around.	F §	12/8/2023 by the clinical starchoice.  2. Social Services/ design interview residents on the urassistance to transfer from the areable to move around factor preference when they would a clinical Educator / design educate facility staff on resident promote the resident school transferring them out of bed wish to.  4. Social Services / design residents weekly to validate are being met x 8 weeks. The the audit will be reported at meeting for evaluation of coongoing monitoring for contimiting provement analysis.	nee will nit who require the bed that cility as to their d like to be up. gnee will dent s right to ice in when they nee will audit 4 their choices ne results of the QAPI mpliance and	
	asked if a resident	nsed practical nurse) #7. When 's choices are being honored if pendent on staff for transfers to				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495071	B. WING _		12	C 2/08/2023
	ROVIDER OR SUPPLIER E LIFELONG H & R WA	RWICK FOREST		STREET ADDRESS, CITY, STATE, ZIP CODE  1000 OLD DENBEIGH BOULEVARD  NEWPORT NEWS, VA 23602	, ,	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETION DATE
F 622 SS=D	wheelchair daily, LP choices are not bein On 12/7/23 at 4:45 f member) #1, the addirector of nursing a officer were made at According to the face Responsibilities" pol "Self-Determination: and the facility must resident self-determ resident choice, including health care and prove consistent with his oplan of care and oth resident has the right aspects of his or her significant to the resident for the resident consistent with his oplan of care and oth resident has the right aspects of his or her significant to the resident for the resident consistent with his oplan of care and oth resident has the right aspects of his or her significant to the resident for the significant to the resident (a): 483.15(c)(1) Facility (i): The facility must premain in the facility discharge the resident (b): The transfer or corresident's welfare are cannot be met in the (B): The transfer or consistent of the consistent with the facility welfare are cannot be met in the (B): The transfer or consistent with the facility welfare are cannot be met in the (B): The transfer or consistent with the facility welfare are cannot be met in the (B): The transfer or consistent with the facility welfare are cannot be met in the facility the facility welfare are cannot be met in the facility the facility welfare are cannot be met in the facility the facility welfare are cannot be met in the facility the facility welfare are cannot be met in the facility the facility welfare are cannot be met in the facility the facility welfare are cannot be met in the facility the facility welfare are cannot be met in the facility the facility welfare are cannot be met in the facility the facility welfare are cannot be met in the facility the facility the facility welfare are cannot be met in the facility the facility the facility that the facility the facility that the	s not transferred to the N #7 stated, no, the resident's g honored.  PM, ASM (administrative staff ministrator, ASM #2, the nd ASM #3, the chief nursing ware of the findings.  Illity's "Resident Rights and icy, which revealed, The resident has the right to promote and facilitate ination through support of uding but not limited to: The to choose activities, g sleeping and waking times), viders of health care services or her interests, assessments, her applicable provisions. The set to make choices about to life in the facility that are ident."  In was provided prior to exit. If the facility that are ident."  In was provided prior to exit. If the facility that are ident. The facility unless to the facility that the facility the	F 5			1/22/24

PRINTED: 01/19/2024 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ` ′		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495071	B. WING	_		400	
NAME OF P	ROVIDER OR SUPPLIER	455071	5		STREET ADDRESS, CITY, STATE, ZIP CODE	12/	08/2023
					1000 OLD DENBEIGH BOULEVARD		
RIVERSID	E LIFELONG H & R WAR	RWICK FOREST			NEWPORT NEWS, VA 23602		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 622	services provided by (C) The safety of indivendangered due to the status of the resident; (D) The health of indivotherwise be endange (E) The resident has appropriate notice, to under Medicare or Me	ident no longer needs the the facility; viduals in the facility is the clinical or behavioral; viduals in the facility would the ed; failed, after reasonable and pay for (or to have paid edicaid) a stay at the facility. If the resident does not apperwork for third party third party, including the facility is eligible for Medicaid after and the facility may charge a seligible for Medicaid after and the facility may charge a sele charges under Medicaid; as to operate. The facility pursuant to poter, when a resident to the facility pursuant to seligible for deal is pending, pursuant to poter, when a resident to appeal a transfer or and the facility pursuant to second the facility pursuant to would endanger the health ent or other individuals in the facility of the facility pursuant the danger for discharge would pose.	F	622			

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED
		495071	B. WING		C 12/08/2023
	ROVIDER OR SUPPLIER	ARWICK FOREST		STREET ADDRESS, CITY, STATE, ZIP CODE  1000 OLD DENBEIGH BOULEVARD  NEWPORT NEWS, VA 23602	12/00/2020
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION
F 622	institution or provide (i) Documentation in must include: (A) The basis for th (i) of this section. (B) In the case of p. section, the specific be met, facility atterneeds, and the service facility to meet the resident (2)(i) of this section (A) The resident's p. discharge is necess (A) or (B) of this section. (ii) Information proving the section. (iii) Information proving the section. (iii) Information proving the section. (iii) Information proving the section. (C) Advance Direct (B) Resident representact information (C) Advance Direct (D) All special instruongoing care, as ap. (E) Comprehensive (F) All other necessionsistent with §48 any other documental safe and effective This REQUIREMENTS.	the receiving health care er.  In the resident's medical record  the transfer per paragraph (c)(1)  the aragraph (c)(1)(i)(A) of this eresident need(s) that cannot impts to meet the resident vice available at the receiving need(s).  It is not met aragraph (c)  In transfer or discharge is aragraph (c)(1)(i)(C) or (D) of evided to the receiving provider in transfer or discharge is aragraph (c)(1)(i)(C) or (D) of evided to the receiving provider in transfer or discharge is aragraph (c)(1)(i)(C) or (D) of evided to the receiving provider in the practitioner care of the resident.  The resident is applicable, and the transfer or propriate.  The resident is applicable, and the transition of care.  The resident is applicable, to ensure transition of care.  The resident is applicable, to ensure transition of care.  The resident is medical record review is a the resident in the residenced in the resident is applicable, and the residenced in the residenced in the residenced in the residenced in the residence in the reside	F 62	Required transfer discharge clinic	
		nt review, it was determined ed to provide evidence of		documents were faxed to the ED by the Director of Nursing on 1/5/2024 for	ne

F 622 Continued From page required resident infi transferred to the hoin the survey sample.  The findings include  The facility staff failer required resident infi at the time of dischar Resident #49 was the 10/16/23 and 11/7/2  Resident #49 was and 12/17/21 with diaground limited to: COPE pulmonary disease),	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		495071	B. WING _			C <b>12/08/2023</b>	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	I DDE	12/00/2023	_
				1000 OLD DENBEIGH BOULEVARD			
RIVERSID	E LIFELONG H & R W	ARWICK FOREST		NEWPORT NEWS, VA 23602			
PREFIX	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIAT		٧
F 622	Continued From pa	age 11	F6	22			
F 622	required resident in transferred to the hin the survey samp.  The findings included The facility staff fair required resident in at the time of disch. Resident #49 was 10/16/23 and 11/7/  Resident #49 was 12/17/21 with diagrant limited to: COP pulmonary disease (atherosclerotic care (peripheral vascular The most recent Massessment, a quate ARD (assessment coded the resident the BIMS (brief into indicating the resident assistance for bath	information when a resident is nospital, for one of 60 residents alle, Residents #49.  Ide:  Ide to evidence provision of information to a receiving facility marge for Resident #49.  It ransferred to the hospital on 123.  Ide to evidence provision of information to a receiving facility marge for Resident #49.  It ransferred to the hospital on 123.  Ide to evidence provision of information to a receiving facility marge for Resident #49.  Ide to evidence provision of information to a receiving facility marge for Resident #49.  Ide to evidence provision of ped information to a receive marginal status as requiring extensive marginal status and supervision for bed information.	F6	resident #49.  2. Director of Nursing / de audit all residents that requifrom the facility to the receivor after December 1, 2023, required documentation were 3. Clinical Educator / desieducate the clinical team or discharge process to includito send out with the residen the transfer/discharge check 4. Director of Nursing / de audit 4 residents transfers pweeks to ensure all required documentation were sent to facility to ensure safe and e transition of care. The resulwill be reported at the QAPI evaluation of compliance ar monitoring for continuous in analysis.	ired transfer ving facility o to ensure all re sent. gnee will in the transfer e what items its and use o klist. esignee will per week x 8 d in the receiving ffective its of the auding for ind ongoing	g it	
	7/3/23 revealed, "F remain in facility to INTERVENTIONS: care plans in an ef well-being. Sidera dressing, toileting a	reprehensive care plan dated FOCUS: Resident desires to receive continued services.  Provide services according to fort to enhance optimum ils x2, limited assist x1: and personal hygiene.  I showers and incontinence					

C 12/08/2023  (X5) COMPLETION DATE
(X5) COMPLETION
COMPLETION

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495071	B. WING			1	C / <b>08/2023</b>
	ROVIDER OR SUPPLIER E LIFELONG H & R WA	RWICK FOREST	•	1	STREET ADDRESS, CITY, STATE, ZIP CODE 000 OLD DENBEIGH BOULEVARD NEWPORT NEWS, VA 23602		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 623 SS=E	A review of the facility policy revealed, "Idea the receiving provide include: All informat resident's needs, who limited to: Resident's current mental, behave reason for transfer, rand allergies; Medica received); and Most diagnostic tests, and No further information Notice Requirements CFR(s): 483.15(c)(3) Separates of the resident, the facility rans resident, the facility rans resident, the facility rans resident, the reasons for the nanguage and manner facility must send a corepresentative of the Long-Term Care Om (ii) Record the reason discharge in the residence of the language and manner facility must send a corepresentative of the language and manner facility must send a corepresentative of the language in the reason discharge in the residuaccordance with paramand (iii) Include in the not paragraph (c)(5) of the Season of the language and the residuaccordance with paramand (iii) Include in the not paragraph (c)(5) of the Season of the language and manner facility must send a corepresentative of the language and the residuaccordance with paramand (iii) Include in the not paragraph (c)(5) of the Season of the language and lang	and ASM #3, the chief nursing ware of the findings.  ies "Transfer and Discharge" intify Information provided to a which at a minimum will into necessary to meet the ich includes, but may not be status, including baseline and vioral, and functional status, ecent vital signs; Diagnoses ations (including when last recent relevant labs, other recent immunizations."  In was provided prior to exit. Is Before Transfer/Discharge and the resident's the transfer or discharge and move in writing and in a cert they understand. The copy of the notice to a Office of the State budsman.  Ins for the transfer or dent's medical record in agraph (c)(2) of this section; sice the items described in his section.		622			1/22/24
	paragraph (c)(5) of the \$483.15(c)(4) Timing	nis section. I of the notice.					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		495071	B. WING			12/0	08/2023
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
RIVERSID	E LIFELONG H & R WAR	WICK FOREST		1	000 OLD DENBEIGH BOULEVARD		
1117211012				١	IEWPORT NEWS, VA 23602		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B) CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 623	discharge required un made by the facility at resident is transferred (ii) Notice must be made before transfer or disc (A) The safety of individual be endangered under this section; (B) The health of individual be endangered, under this section; (C) The resident's heallow a more immedia under paragraph (c)(10) An immediate transferred by the reside under paragraph (c)(10) (E) A resident has not days.  §483.15(c)(5) Contennotice specified in paramust include the following: (ii) The reason for transferred or dischartion (iv) A statement of the including the name, and telephone number receives such request to obtain an appeal for completing the form a hearing request;	the notice of transfer or ider this section must be at least 30 days before the lor discharged. In a soon as practicable charge when-viduals in the facility would a paragraph (c)(1)(i)(C) of viduals in the facility would a paragraph (c)(1)(i)(D) of viduals in the facility would a paragraph (c)(1)(i)(D) of viduals in the facility would a paragraph (c)(1)(i)(D) of viduals in the facility would a paragraph (c)(1)(i)(D) of viduals in the facility would a paragraph (c)(1)(i)(D) of viduals in the facility would a paragraph (c)(i)(B) of this section; ansfer or discharge is ent's urgent medical needs, ent's urgent medi	F	623			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION  G	COME	(X3) DATE SURVEY COMPLETED	
		495071	B. WING _			C /08/2023
	ROVIDER OR SUPPLIER  E LIFELONG H & R WA	RWICK FOREST		STREET ADDRESS, CITY, STATE, ZIP CODE  1000 OLD DENBEIGH BOULEVARD  NEWPORT NEWS, VA 23602	1 2	00/2020
(X4) ID PREFIX TAG	REFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 623	and developmental of disabilities, the mailitelephone number of the protection and adevelopmental disabilities. C of the Developmental disabilities of the demail address and the agency responsible advocacy of individuous established under the for Mentally III Individuous disabilities of the information in the effecting the transfer must update the receast practicable once abecomes available.  §483.15(c)(8) Notice In the case of facility the administrator of written notification put to the State Survey of State Long-Term Cathe facility, and the residual the plan for the relocation of the residual the residual than the plan for the relocation of the residual than the plan for the pl	ty residents with intellectual disabilities or related ing and email address and if the agency responsible for dvocacy of individuals with bilities established under Part intal Disabilities Assistance it of 2000 (Pub. L. 106-402, 15001 et seq.); and ity residents with a mental isabilities, the mailing and elephone number of the for the protection and als with a mental disorder in e Protection and Advocacy duals Act.  The pest to the notice of the facility pients of the notice as soon the updated information  The in advance of facility closure in advance of facility closure in advance of facility must provide from the impending closure and the impending closure are ombudsman, residents of the esident representatives, as the transfer and adequate dents, as required at §  The individual with the impending closure and the impending closure are ombudsman, residents of the impending closure are of the impending closure are of the impending closure are ombudsman, residents of the impending closure are	F 6		a mailed	
	and facility documer	view, clinical record review It review, it was determined It to provide evidence of		On 1/5/24 written notification wa by the Business Office Manager RP□s of Resident #49, Resident	to the	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3)	(X3) DATE SURVEY COMPLETED	
		495071	B. WING _			C <b>12/08/2023</b>	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C	ODE I	12/00/2023	
				1000 OLD DENBEIGH BOULEVARD			
RIVERSID	E LIFELONG H & R WAF	RWICK FOREST		NEWPORT NEWS, VA 23602			
	OLIMANA DV OT	ATEMENT OF DEFICIENCIES		· · · · · · · · · · · · · · · · · · ·	OODDEOTION	9.5	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 623	Continued From page	e 16	F 6	23			
F 623	written RP (responsible provided when four of sample who were trained Residents #49, Residents #49, Resident #60.  The findings include:  1. The facility staff fair required written RP (in notification at the time #49. Resident #49 won 10/16/23 and 11/7  Resident #49 was add 12/17/21 with diagnorated in the resident was add 12/17/21 with diagnorated in the resident was add 12/17/21 with diagnorated in the resident was assessment, a quarted ARD (assessment redicated the resident as the BIMS (brief intervindicating the resident as assistance for bathing mobility, transfer, dreindependent for locored A review of the comp 7/3/23 revealed, "FOO	ple party) notification was f 60 residents in the survey insferred to the hospital, dent #58, Resident #8 and led to evidence provision of responsible party) are of discharge for Resident ras transferred to the hospital f/23.  mitted to the facility on sis that included but were (chronic obstructive cellulitis, ASCVD ovascular disease) and PVD disease).  S (minimum data set) are frence date) of 11/28/23, as scoring a 15 out of 15 on riew for mental status) score, at was cognitively intact. A section G-functional status are quiring extensive g and supervision for bed ssing, hygiene and eating;	F 6.	Resident # 8, and Resident were transferred to the hos respective dates.  2. Business office manag will audited all residents that transfer or discharged from December 1, 2023, to ensu notification was sent to the 3. Director of Clinical Ser the business office staff and administrative staff on 12/7 requirement to provide evic RP notification of those restransferred to the hospital.  4. Administrator / designeresident weekly x 8 weeks transferred to the hospital for written RP notification. The audit will be reported at meeting for evaluation of congoing monitoring for contimprovement analysis.	pital on their  per / designee at required facility since are that written RP□s. vices educated d the //2023 of the dence of written idents who are ee will audit 4 who were or completion the results of the QAPI compliance and		
	INTERVENTIONS: F	Provide services according to to to enhance optimum					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					(X3) DATE COMF	SURVEY PLETED	
		495071	B. WING _				C (08/2023
	ROVIDER OR SUPPLIER  E LIFELONG H & R WAF	RWICK FOREST		10	REET ADDRESS, CITY, STATE, ZIP CODE 000 OLD DENBEIGH BOULEVARD EWPORT NEWS, VA 23602	1 12/	00/2020
(X4) ID PREFIX TAG	EFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 623	623 Continued From page 17		F 6	523			
	dressing, toileting and Extensive assist x1 s care."	d personal hygiene. howers and incontinence					
	written RP notification	ce of provision of required n when Resident #49 was n 10/16/23 and 11/7/23.					
	5:09 PM, revealed, "Nevaluation, and recorbumped into a chair wheelchair. A hemato	nmendations are: Resident with her motorized oma formed on RLE (right as evaluated by in house patient to go to ED					
	10:23 AM, revealed, for patient to be seen increased in size, firm Patient is sitting up in for her eye appointment stated right leg is infewill transfer back to e evaluation and drain procedure cannot be made aware that pati	n to touch and painful.  wheelchair ready dressed ent at 12 noon. patient octed and painful. discussed					
	PM with LPN (license asked for evidence of #4 stated, we call the do not provide any wiknow who does this.	ducted on 12/6/23 at 3:00 ed practical nurse) #4. When f written RP notification, LPN RP and document it, but we ritten notification. I do not					
	An interview was con	ducted on 12/6/23 at 3:10					

AND DUAN OF CODDECTION DESCRIPTION NUMBER:		` ′	PLE CONSTRUCTION  G		COMPLETED	
		495071	B. WING _			C 2/08/2023
	ROVIDER OR SUPPLIER	ARWICK FOREST		STREET ADDRESS, CITY, STATE, ZIP CODE  1000 OLD DENBEIGH BOULEVARD  NEWPORT NEWS, VA 23602		210012023
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 623	worker. When aske notification, OSM #* written notification. nurses do.  On 12/7/23 at 4:45 member) #1, the addirector of nursing a officer were made at A review of the facility policy revealed, "Bedischarges a reside resident and the resident and the resident and the resident in writing and they understand."  No further information 12. The facility staff for required written RP discharge for Resident are written RP discharge for Resident #58 was at 4/25/23 with diagnol limited to: COPD (cl disease), dysphagia 15 most recent ME assessment, a quark ARD (assessment a quark ARD (assessment a quark RD)	r staff member) #1, the social of for evidence of written RP I stated, we do not provide I do not know what the  PM, ASM (administrative staff ministrator, ASM #2, the and ASM #3, the chief nursing ware of the findings.  Ities "Transfer and Discharge" fore a facility transfers or not, the facility will notify the aident's representative(s) of large and the reasons for the in a language and manner  In was provided prior to exit.  I alled to evidence provision of notification at the time of lent #58. Resident #58 was obspital on 11/22/23.  I dmitted to the facility on sis that included but were not nonic obstructive pulmonary and acute respiratory failure.  I DS (minimum data set) terly assessment, with an eference date) of 11/7/23, as scoring a 05 out of 15 on review for mental status) score, ent was severely cognitively	F 6	23		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495071	B. WING _		12	C / <b>08/2023</b>
	ROVIDER OR SUPPLIER E LIFELONG H & R WAF	RWICK FOREST		STREET ADDRESS, CITY, STATE, ZIP C 1000 OLD DENBEIGH BOULEVARD NEWPORT NEWS, VA 23602	•	100/2023
(X4) ID PREFIX TAG			ID PREFI) TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE)	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 623	mobility; limited assis supervision for eating.  A review of the comp 8/22/23 revealed, "For remain in facility to re INTERVENTIONS: For care plans in an effor well-being. Siderails transfers, extensive a dressing, toileting and There was no eviden written RP notification sent to the hospital of the program of the progr	ssistance for bathing, bed stance for transfers and 3.  rehensive care plan dated DCUS: Resident desires to eceive continued services. Provide services according to to enhance optimum x2, total dependence x 2 assist x1: bed mobility, d personal hygiene."  ce of provision of required in when Resident #58 was	Fé	323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495071	B. WING		_	1	08/2023
	ROVIDER OR SUPPLIER  E LIFELONG H & R WAR	RWICK FOREST	•	STREET ADDRESS, CITY, S 1000 OLD DENBEIGH BO NEWPORT NEWS, VA	DULEVARD	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG	(EACH CORR	R'S PLAN OF CORRECTION ECTIVE ACTION SHOULD B ENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 623	member) #1, the admidirector of nursing an officer were made aw No further information  3. The facility staff fair required written RP nursipart discharge for Resider transferred to the host reasonable for transferred to the host resident #8 was admidited to: DM (diabet bladder and parapleg)  The most recent MDS assessment, a quarted ARD (assessment refunded the resident as the BIMS (brief intervindicating the resident review of the MDS Seconded the resident as assistance for bathing dressing, hygiene and eating.  A review of the computations.  A review of the computations.	M, ASM (administrative staff inistrator, ASM #2, the d ASM #3, the chief nursing rare of the findings.  In was provided prior to exit.  Iled to evidence provision of otification at the time of int #8. Resident #8 was spital on 10/31/23.  Initted to the facility on some that included but were not ess mellitus), neurogenic ia.  Is (minimum data set) erly assessment, with an ference date) of 10/17/23, as scoring a 15 out of 15 on iew for mental status) score, it was cognitively intact. A section G-functional status is requiring extensive g, bed mobility, transfer, ind limited assistance for rehensive care plan dated DCUS: Resident desires to ceive continued services. Provide services according to it to enhance optimum x2, overbed trapeze, iressing, toileting and stensive assist x1 showers	F	523			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		I DENTIFICATION NUMBER:		IPLE CONSTRUCTION	' '	(X3) DATE SURVEY COMPLETED	
		495071	B. WING _			C   <b>2/08/2023</b>	
	ROVIDER OR SUPPLIER  DE LIFELONG H & R WA	RWICK FOREST		STREET ADDRESS, CITY, STATE, ZIP COD 1000 OLD DENBEIGH BOULEVARD NEWPORT NEWS, VA 23602	· ·	210012023	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE	
F 623	written RP notification sent to the hospital of the programment of the	ess note dated 10/31/23 at Neurological Status Nursing observations, mmendations are: Primary ack: physician was present re activity, transport to ED."  aducted on 12/6/23 at 3:00 red practical nurse) #4. When for written RP notification, LPN re RP and document it, but we ritten notification. I do not staff member) #1, the social for evidence of written RP stated, we do not provide do not know what the  M, ASM (administrative staff ministrator, ASM #2, the and ASM #3, the chief nursing ware of the findings.  In was provided prior to exit.	F 6	23			

STATEMENT OF DEFICIENCIES  AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA  IDENTIFICATION NUMBER:		` '	PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED	
		495071	B. WING _			C <b>12/08/2023</b>
	ROVIDER OR SUPPLIER	ARWICK FOREST		STREET ADDRESS, CITY, STATE, ZIP CODE  1000 OLD DENBEIGH BOULEVARD  NEWPORT NEWS, VA 23602	<u> </u>	12/00/2023
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHOT CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 623	CVA (cerebrovascul hypertension.  The most recent ME assessment, a quar ARD (assessment recoded the resident at the BIMS (brief interindicating the resider review of the MDS seconded the resident afor bathing, bed mon hygiene and eating.  A review of the composition of the compo	nd stage renal disease), DM, lar accident) and DS (minimum data set) terly assessment, with an eference date) of 10/31/23, as scoring a 13 out of 15 on rview for mental status) score, ent was cognitively intact. A Section G-functional status as requiring limited assistance bility, transfer, dressing,  prehensive care plan dated FOCUS: Resident desires to receive continued services. Provide services according to out to enhance optimum s x2, limited assist x1: showers, incontinence care ne. Extensive assist x1:  unce of provision of required on when Resident #60 was on 8/16/23.  gress note dated 8/16/23 at "Resident was sent to the ER	F 6	23		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED	
		495071	B. WING _		C 12/08/2023
NAME OF P	ROVIDER OR SUPPLIER		, I	STREET ADDRESS, CITY, STATE, ZIP CODE	
RIVERSID	E LIFELONG H & R WAR	WICK FOREST		1000 OLD DENBEIGH BOULEVARD NEWPORT NEWS, VA 23602	
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETION
F 623	know who does this.		F 6	23	
	PM with OSM (other sworker. When asked	ducted on 12/6/23 at 3:10 staff member) #1, the social for evidence of written RP stated, we do not provide do not know what the			
	member) #1, the adm	M, ASM (administrative staff inistrator, ASM #2, the d ASM #3, the chief nursing are of the findings.			
F 641 SS=D	No further information Accuracy of Assessm CFR(s): 483.20(g)	was provided prior to exit. ents	F 6	41	1/22/24
	resident's status. This REQUIREMENT by: Based on observatio record review and fact determined the facility accurate MDS (minimfor two out of 60 resident #192 and R The findings include:  1.The facility staff faile MDS (minimum data assessment for Resident #192 was see the status of	t accurately reflect the is not met as evidenced is, staff interview, clinical ility document review, it was a staff failed to provide an an um data set) assessment lents in the survey sample, esident #129.		Resident #192 MDS was corre-submitted, and accepted on 12/7/2023. Resident #129 MDS assessment was corrected, re-suand accepted 12/7/2023 by the SMDS Coordinator.     Senior MDS Coordinator / dewill audit discharge assessments assessments requiring the use or restraints from 11/1/2023 □ 1/4/2 validate accuracy of the assessments MDSs ARD 1/1/23- 12/15/23 secuer validated for accuracy on 1.3. Director of Clinical Reimburs designed will advantable MDSs.	ubmitted, Senior  esignee s and of 2024 to ment. All ction P 2/15/23.
	record review for tran	sfer to hospital.		designee will educate the MDS	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDIN	PLE CONSTRUCTION  G		ATE SURVEY DMPLETED
		495071	B. WING			C <b>12/08/2023</b>
	ND PLAN OF CORRECTION IDENTIFICATION NUMBER:		STREET ADDRESS, CITY, STATE, ZIP CODE  1000 OLD DENBEIGH BOULEVARD  NEWPORT NEWS, VA 23602		12.00.2020	
PRÉFIX	(EACH DEFICIEI	NCY MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 641	Resident #192 was 10/3/23 with diagnor limited to: COPD (disease), chronic be failure.  The most recent Mi assessment, a Median ARD (assessment and ARD (assessment), a Median ARD (assessment), and social Resident will maintain stimulation, social as willing and able to date."  A review of the nursing 10/8/23 at 11:49 AND facility against median Original copy of AND is in her chart. On a Areview of the faci (AMA form)", reveal on 10-8-23.  An interview was copy with RN (register)	admitted to the facility on osis that included but were not chronic obstructive pulmonary ronchitis and acute kidney  DS (minimum data set) dicare 5-day assessment, with ent reference date) of 10/8/23, as scoring a 15 out of 15 on erview for mental status) score, ent was cognitively intact. A is Identification Information: Status, 04. Short term general ep."  Inprehensive care plan dated FOCUS: The resident is setting emotional, intellectual, I needs. INTERVENTIONS: ain involvement in cognitive activities at her leisure as she to tolerate through review  sing progress note dated of revealed, "Resident left ical advice with daughters. IA form with patient's signature	F 64	coordinators on the importance accuracy on MDS assessments relates to transferring to the hospital/discharge assessments those regarding the use of restra 4. Senior MDS Coordinator / owill audit 4 residents weekly x 8 ensure they are coded accurate transfer and those assessments the use of restraints. The results audit will be reported at the QAF for evaluation of compliance and monitoring for continuous improvanalysis.	as it  and aints. lesignee weeks to ly as regarding of the PI meeting d ongoing	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED		
		495071	B. WING _			1	08/ <b>2023</b>
	ROVIDER OR SUPPLIER E LIFELONG H & R WA	RWICK FOREST		100	EET ADDRESS, CITY, STATE, ZIP CODE O OLD DENBEIGH BOULEVARD WPORT NEWS, VA 23602	1 12/	00/2023
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 641	it documents that shicheck, no she did not must be a coding err standard is followed #2 stated, we follow  On 12/7/23 at 4:45 F member) #1, the adrifector of nursing ar officer were made as According to the RAI instrument) MDS Se Assessment: "Steps medical record includischarge orders for location. Coding Inscode that correspond status. Code 01, colboard/care, assisted discharge location is board and care, assisted discharge location is board and care, assisted discharge location for insengaged in providing related services for ror nursing care or reinjured, disabled, or beds. Code 03, acut location is an institut providing, by or under physicians for inpatie therapeutic services the treatment and casick persons."	ent #192, RN #2 stated, yes, e went the hospital, let me t go to the hospital, so it or. When asked what for completing the MDS, RN the RAI.  M, ASM (administrative staff ministrator, ASM #2, the and ASM #3, the chief nursing ware of the findings.  (resident assessment ction A2100 OBRA Discharge for Assessment: Review the ding the discharge plan and documentation of discharge tructions: Select the 2-digit dis to the resident's discharge mmunity (private home/apt., living, group home): if a private home, apartment, sted living facility, or group other nursing home or swing ation is an institution (or a titution) that is primarily g skilled nursing care and esidents who require medical habilitation services for sick persons. Includes swing the hospital: if discharge ion that is engaged in er the supervision of ents, diagnostic services, for medical diagnosis, and re of injured, disabled, or	F	541			
	No further informatio	n was provided prior to exit.					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED
		495071	B. WING _		C 12/08/2023
	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP CODE  1000 OLD DENBEIGH BOULEVARD  NEWPORT NEWS, VA 23602	12/00/2023
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	HOULD BE COMPLETION
F 641	Continued From pag	e 26	F 6	41	
	failed to maintain an data set) assessmer restraints.  On the most recent I assessment, with an date) of 9/7/2023, R	O (R129), the facility staff accurate MDS (minimum at regarding the use of MDS assessment, a quarterly ARD (assessment reference 129 was coded as using a			
	made of R129 in bed restraint was observe on 12/6/2023 at 2:48	08 a.m., an observation was If in their room, no trunk ed. Additional observations If p.m., 12/7/2023 at 8:22 a.m. 2 p.m. of R129 in bed			
	On 12/7/2023 at 8:26 conducted with LPN clinical coordinator.	nical record failed to tion of trunk restraint usage. 5 a.m., an interview was (licensed practical nurse) #2, LPN #2 stated that she nd she was not aware of any			
	interview was condu nurse) #2, MDS cool they followed the RA instrument) manual v assessments. RN # restraint free and wo	roximately 8:15 a.m., an cted with RN (registered rdinator. RN #2 stated that I (resident assessment when completing the MDS 2 stated that the facility was uld need to review R129's hy it was coded for restraint			
	I .	9 a.m., RN #2 stated that she arterly MDS with the ARD of			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495071	B. WING				C /08/2023
	OVIDER OR SUPPLIER	WICK FOREST		10	TREET ADDRESS, CITY, STATE, ZIP CODE 000 OLD DENBEIGH BOULEVARD EWPORT NEWS, VA 23602		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 655 SS=D	error. She stated that restraints. She stated MDS and resubmitted According to the RAI October 2018, section steps for assessment medical record (e.g., notes, nursing assistate determine if physical the 7-day look-back pon 12/7/2023 at 4:36 staff member) #1, the director of nursing anofficer were made aw No further information Baseline Care Plan CFR(s): 483.21(a)(1)-§483.21 Comprehens Planning §483.21(a) Baseline (§483.21(a)(1) The faction for the state of the instruction of the professional that includes the instruction of the professional that meet professional that meet professional that meet professional (i) Be developed within admission. (ii) Include the minimulation of the properly including, but not limit	k restraint coding was an t R129 had not utilized any d that she had corrected the d it.  Manual, Version 1.16, dated in P0100 documented in the polysician orders, nurses' ant documentation) to restraints were used during reriod"  p.m., ASM (administrative administrator, ASM #2, the d ASM #3, the chief nurse are of the concern.  In was provided prior to exit.  (3)  Sive Person-Centered Care  Care Plans  Sility must develop and care plan for each resident and care of the resident and standards of quality care.  In must-  In Manual, Version 1.16, dated in the concern in must-  In a standards of quality care.  In must-  In a standards of a resident's in the althcare information or care for a resident		641			1/22/24

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION IG		MPLETED
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	ROVIDER OR SUPPLIER	RWICK FOREST		STREET ADDRESS, CITY, STATE, ZIP CODE  1000 OLD DENBEIGH BOULEVARD  NEWPORT NEWS, VA 23602	<u> </u>	.2703/2020
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF ( (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AIDEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 655	§483.21(a)(2) The facomprehensive care care plan if the com (i) Is developed with admission. (ii) Meets the require (b) of this section (e) this section).  §483.21(a)(3) The facility resident and their resofthe baseline care limited to: (i) The initial goals of (ii) A summary of the dietary instructions. (iii) Any services are administered by the on behalf of the facility) Any updated infoof the comprehension the comprehension This REQUIREMEN by: Based on staff internand clinical record reto develop a complet of 60 residents in the #347.  The findings include For Resident #347 (e)	mendation, if applicable.  acility may develop a plan in place of the baseline prehensive care plan- nin 48 hours of the resident's ements set forth in paragraph excepting paragraph (b)(2)(i) of  acility must provide the presentative with a summary plan that includes but is not of the resident. e resident's medications and d treatments to be facility and personnel acting ity. ormation based on the details re care plan, as necessary. T is not met as evidenced  view, facility document review eview, the facility staff failed te baseline care plan for one er survey sample, Resident	F 6	1. The Baseline care plan for 347 was updated for dialysis ca 12/7/2023 by the Unit Manager 2. All residents admitted since have their baseline care plan a include initial goals based on a orders and all services provider resident by the DON/designee. 3. Clinical educator / designee educate the clinical team memb baseline care plan for each res	are on  e 1/1/24 will udited to dmission d to the ee will bers on the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  (X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED						
		495071	B. WING _			1	C /08/2023		
	ROVIDER OR SUPPLIER  E LIFELONG H & R WAF	RWICK FOREST		10	TREET ADDRESS, CITY, STATE, ZIP CODE 000 OLD DENBEIGH BOULEVARD EWPORT NEWS, VA 23602	1 1 <i>21</i>	00/2023		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		(EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 655	R347 was admitted to review of R347's clini physician's order for of Wednesday and Frida plan with an admission documented the resion fluctuations due to dia in the dietary section plan failed to docume R347's dialysis care.  On 12/6/23 at approximaterview was conduct practical nurse) #5. Lethe baseline care plan for the patient while the passeline care plan of care.  On 12/6/23 at 5:10 p. staff member) #1 (the	o the facility on 11/25/23. A cal record revealed a dialysis every Monday, ay. R347's baseline care on date of 11/25/23 only dent was at risk for weight alysis; this was documented of the care plan. The care ent any information regarding	F	655	includes development within 48 hours admission and provides person centers care of the resident and all services provided to meet their needs.  4. DON / designee will audit 4 baseling care plans per week to ensure they were implemented timely are person centered and all services provided are included meet their needs. The results of the auxillary be reported at the QAPI meeting for evaluation of compliance and ongoing monitoring for continuous improvement analysis.	ne re ed to dit			
F 656 SS=E	Policy" documented, development and imp Care plan within 48 h resident that includes effectively provide pe development of the concept (CFR(s): 483.21(b)(1) (S483.21(b)(1) The fact (S483.21(b)(1)) (S483.21(	. ,	F (	656			1/22/24		

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,			(X3) DATE SURVEY COMPLETED	
		495071	B. WING			C 2/08/2023	
	ROVIDER OR SUPPLIER	RWICK FOREST		STREET ADDRESS, CITY, STATE, ZIP COD 1000 OLD DENBEIGH BOULEVARD NEWPORT NEWS, VA 23602		2/00/2020	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE APPROPRIATE	(X5) COMPLETION DATE	
F 656	resident rights set for §483.10(c)(3), that in objectives and timefr medical, nursing, and needs that are identificated assessment. The correction describe the following (i) The services that or maintain the reside physical, mental, and required under §483. (ii) Any services that under §483.24, §483 provided due to the runder §483.10, include treatment under §483. (iii) Any specialized serenabilitative services provide as a result of recommendations. If findings of the PASA rationale in the reside (iv) In consultation wire resident's represental (A) The resident's good desired outcomes. (B) The resident's profuture discharge. Fact whether the resident's community was assellocal contact agencie entities, for this purpor (C) Discharge plans plan, as appropriate, requirements set fort section.	sident, consistent with the oth at §483.10(c)(2) and ocludes measurable ames to meet a resident's dimental and psychosocial fied in the comprehensive exprehensive care plan must grane to be furnished to attain ent's highest practicable dipsychosocial well-being as 24, §483.25 or §483.40; and would otherwise be required 25 or §483.40 but are not esident's exercise of rights ding the right to refuse 3.10(c)(6). Services or specialized as the nursing facility will final part of part of the resident and the attive(s)-the resident and the attive(s)-the resident and the attive(s)-the resident and the services and potential for collities must document as desire to return to the resident and reference and any referrals to the sest and/or other appropriate	F 6	56			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED
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F 656	Continued From pag		F 65	56	
	by the facility, as out care plan, must- (iii) Be culturally-con This REQUIREMEN by: Based on observation interview, facility door record review, the facility door record review, the facility and/or implement the residents in the surv #70, #49, #115, #60  The findings include  1. For Resident #59 to develop a care plate (activities of daily living the develop as care plate) to develop a care plate (activities of daily living the develop as care plate) to develop a care plate (activities of daily living the develop as care plate) to the develop as care plate (activities of daily living the develop as care plate) to the develop as care plate (activities of daily living the develop as care plate) to the develop as care plate (activities of daily living the develop as care plate) to the develop as care plate (activities of daily living the develop as care plate) the develop as care plate (activities of daily living the develop as care plate) as care plate (activities of daily living the develop as care plate) as care plate (activities of daily living the develop as care plate) as care plate (activities of daily living the develop as care plate) as care plate (activities of daily living the develop as care plate) as care plate (activities of daily living the daily l	Inned by the comprehensive Inpetent and trauma-informed. T is not met as evidenced In resident interview, staff It to the review, and clinical Incility staff failed to develop It is care plan for seven of 60 It is example, Residents #59, It is the facility staff failed In for the resident's ADL Ing) needs. Int MDS (minimum data set), Interview for mental status). Interview for mental status). Interview for mental status). Interview for his daily staff for his daily staff for his daily staff, and personal		1. Resident # 59 ADL care plan w developed and implemented on 12/by nursing leadership. Resident # 70 discharged from facil 12/6/2023. Resident # 49 care plan for medical administration was reviewed on 12/by the Unit Manager all medications administered as ordered on 12/8/20 nurse assigned to the resident □ s care plan was update the Director of Nursing 12/6/2023 to include dialysis. Orders for fistula assessment for bruit and thrill were corrected 12/7/2023 by nursing leadership. ADON Contacted dialys 12/7/2023 requesting return of documents. ADON called and educ both dialysis centers on the importar returning dialysis communications ti Resident # 115 care plan was update nursing leadership on 12/7/23 to inc PTSD. On 12/12/2023 Social Service met with resident # 115 who decline supportive services including licens clinical social worker but agreed to service including licens clinical social worker but agreed to service including licens clinical social worker but agreed to service including licens clinical social worker but agreed to service including licens clinical social worker but agreed to service including licens clinical social worker but agreed to service including licens clinical social worker but agreed to service including licens clinical social worker but agreed to service including licens clinical social worker but agreed to service including licens clinical social worker but agreed to service including licens clinical social worker but agreed to service including licens clinical social worker but agreed to service including licens clinical social worker but agreed to service including licens clinical social worker but agreed to service including licens clinical social worker but agreed to service including licens clinical social worker but agreed to service including licens clinical social worker but agreed to service including licens clinical social worker but agreed to service including licens clinical social worker but agreed to service including licens clinical social worker but agreed to ser	7/2023 ity tion 7/2023 s were 123 by are. ed by o its ated ince of imely. ted by clude ces ed ed
	12/1/22 revealed no assistance the reside performance.  On 12/7/23 at 8:19 at	ı.m., RN (registered nurse)		the chaplain for spiritual services. Resident # 23 pain care plan was u by the Unit Manager on 12/7/23 O 12/6/2023 resident was evaluated b nurse assigned to her care for pain received pain medications as ordere	n by the and
		ator, was interviewed. She open up the comprehensive		it was effective.  Resident # 134 care plan was upda	ted by

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495071	B. WING				C / <b>08/2023</b>	
NAME OF P	ROVIDER OR SUPPLIER	100011		STR	REET ADDRESS, CITY, STATE, ZIP CODE	12/	06/2023	
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F 656	Continued From pa	ge 32	F6	656				
		as possible after a resident is desired she interviews the resident,			nursing leadership for monitoring for th use of psychotropic medications to	е		
		mbers, reviews the information		- 1	include Trazadone monitoring for signs	<b>;</b>		
		nd looks at the diagnosis list,		- 1	and symptoms of depression,			
		and assessments from the			effectiveness, side effects and adverse	)		
	facility staff to formu	ulate the comprehensive care			reactions was corrected on 12/8/2023.			
	plan. After reviewing	g R59's care plan, she stated			IDT reviewed comprehensive care plan	1		
		ADL assistance anywhere on			1/4/2024.			
		stated his ADL assistance						
	should have been in	ncluded on the care plan.			2. Director of Clinical Reimbursemen	it /		
	On 10/07/02 at 1:23	3 p.m., ASM (administrative			designee will review LTC resident	ina		
		he administrator, ASM #2, the		- 1	comprehensive care plans in the follow areas: ADL care, anticoagulants, PTS	-		
	,	and ASM #3, the chief nursing		- 1	dialysis, pain, and psychoactive	٥,		
	_	ed of these concerns.			medication.			
	,				3. Director of Clinical Reimbursemen	ıt /		
	A review of the facil	lity policy, "Comprehensive			designee will educate IDT on the proce	ess		
	Care Planning," rev	ealed, in part: "The facility			for development and implementation of	f		
	must work with the			- 1	comprehensive care plans and updates			
		oplicable, to understand and			for ADL care, anticoagulants, medication			
		preferences, choices, and		- 1	administration, PTSD, dialysis, pain, ar	ıd		
		e at the facilityThe facility		- 1	psychoactive medication.			
		ument and implement the			4. Director of Nursing / designee will	lebe		
		o be provided to each resident g or maintaining his or her			audit 4 comprehensive care plans wee for 8 weeks. The results of the audit wi	-		
	highest practicable				be reported at the QAPI meeting for	11		
		e plan must be developed and		- 1	evaluation of compliance and ongoing			
	-	er than day 21 of the		- 1	monitoring for continuous improvement	t		
		n to the facilityThe facility			analysis.			
	must develop care i	plans that describe the			,			
	resident's medical,	nursing, physical, mental, and						
	1	and preferences and how the						
	, -	meeting these needs and						
	preferences. Care p							
		easurable objectives and						
		to evaluate the resident's						
	progress toward the	eir goal(s)."						
	No further informati	on was provided prior to exit.						

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	IPLE CONSTRUCTION  IG		(X3) DATE SURVEY COMPLETED	
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				STREET ADDRESS, CITY, STATE, ZIP CODE  1000 OLD DENBEIGH BOULEVARD  NEWPORT NEWS, VA 23602		12/00/2023	
PRÉFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CO ( (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD B E APPROPRIA		
F 656	2. For Resident #70 to develop a care pla anticoagulant.  A review of R70's ph 2023 MAR (medicat revealed R70 was reanticoagulant, every A review of R70's cato reveal any informaticoagulant, every anticoagulant, every A review of R70's cato reveal any informaticoagulant and the MDS staff care plan as soon as admitted. She stated interviews staff mem from the hospital, and physician's orders, a facility staff to formulan. After reviewing she did not see the lanywhere on the documents.	(R70), the facility staff failed an for the resident's use of an hysician's orders December ion administration record) eceiving Eliquis, and re plan dated 9/11/23 failed ation related to the resident's gulant.  A.m., RN (registered nurse) hator, was interviewed. She fopen up the comprehensive is possible after a resident is dishe interviews the resident, inbers, reviews the information and looks at the diagnosis list, and assessments from the late the comprehensive care in R70's care plan, she stated resident's anticoagulant cument. She stated the	F 6	556			
	On 12/07/23 at 4:33 staff member) #1, th director of nursing, a officer, were informed No further information.  3. The facility staff facility staff facility staff facility.	p.m., ASM (administrative e administrator, ASM #2, the and ASM #3, the chief nursing					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI	FIPLE CONSTRUCTION  NG		ATE SURVEY DMPLETED
		495071	B. WING _			C <b>12/08/2023</b>
	ROVIDER OR SUPPLIER E LIFELONG H & R WA	ARWICK FOREST		STREET ADDRESS, CITY, STATE, ZIP C 1000 OLD DENBEIGH BOULEVARD NEWPORT NEWS, VA 23602	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG		ION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 656	12/17/21 with diagn not limited to: COPE pulmonary disease) (atherosclerotic card (peripheral vascular)  The most recent ME assessment, a quar ARD (assessment recoded the resident at the BIMS (brief intelindicating the resident at the BIMS (brief intelindicating the resident assistance for bathi mobility, transfer, drindependent for local A review of the com 5/22/23 revealed, "Figrescribed fluoxetin depressive disorder anticoagulant theral fibrillation. INTERV medications as order side effects and effect ANTICOAGULANT physician. Monitor feffectiveness Q-SH A review of the physicians of the physician	dmitted to the facility on osis that included but were D (chronic obstructive, cellulitis, ASCVD diovascular disease) and PVD disease).  DS (minimum data set) terly assessment, with an eference date) of 11/28/23, as scoring a 15 out of 15 on rview for mental status) score, and was cognitively intact. A Section G-functional status as requiring extensive and supervision for bed dessing, hygiene and eating; comotion.  prehensive care plan dated FOCUS: Resident is efor diagnosis of major and Resident is enough (Eliquis) related to Atrial ENTIONS: Administer ered by provider. Monitor for extiveness. Administer medications as ordered by or side effects and IFT."  sician orders dated 12/4/22, the CAP 40MG (milligram) Give at time a day for Depression; revealed, "ELIQUIS TAB 5MG ablet orally two times a day	F	656		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				PLETED
		495071	B. WING			C /08/2023
	A. BUILDING  B. WING  NAME OF PROVIDER OR SUPPLIER  RIVERSIDE LIFELONG H & R WARWICK FOREST  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOU		12/00/2023			
PRÉFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 656	Continued From pag	ge 35	F 65	56		
	PM with Resident #4 November, they did and my antidepress:  A review of the Nove administration records Give 1 tablet of was coded "9-other 11/12/23 8 AM and 9 and Fluoxetine 40 m time a day for depreprogress note" for 1 A review of the progress note" for 1 tablet orally two time not given; Pharmacy notified; 11/13/23 at TAB 5MG Give 1 tablet orally two time not given; Pharmacy notified; 11/13/23 at TAB 5MG Give 1 tablet orally two time aday for Depression of the An interview was consistent of the care pla medications as order of the administration implemented, LPN # followed.  On 12/7/23 at 4:45 Finember) #1, the additional manufacture of the administration implemented with the administration implemented	49. Resident #49 stated, in not give me my anticoagulant ant for several shift.  ember 2023 MAR (medication d) revealed, "ELIQUIS TAB rally two times a day for Afib, see progress note" for 9 PM and 11/13/23 at 8 AM; ag give 1 capsule orally one ssion was coded "9-other see 1/13/23 8 AM.  ress note dated 11/12/23 at ELIQUIS TAB 5MG Give 1 es a day for Afib. Medication of did not send. Pharmacy 9:30 AM revealed "ELIQUIS olet orally two times a day for B/23 at 9:31 AM revealed MG Give 1 capsule orally one ession. Reorder."  Inducted 12/7/23 at 12:05 PM practical nurse) #5. When an reveals to administer red and there is no evidence and the care plan the care plan ession. It is not being PM, ASM (administrative staff ministrator, ASM #2, the and ASM #3, the chief nursing				
	No further information	on was provided prior to exit.				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
		495071	B. WING _			C 12/08/2023
	ROVIDER OR SUPPLIER	ARWICK FOREST		STREET ADDRESS, CITY, STATE, ZIP COD 1000 OLD DENBEIGH BOULEVARD NEWPORT NEWS, VA 23602	DE	12/00/2020
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC ( (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 656	Continued From pa	ge 36	F 6	556		
	comprehensive care ordered for Resider	railed to implement the e plan for dialysis care as nt #60.				
	1/15/21 with diagno	sis that included but were not nd stage renal disease), DM,				
	assessment, a qual ARD (assessment is coded the resident the BIMS (brief inte indicating the resident review of the MDS coded the resident	DS (minimum data set) rterly assessment, with an reference date) of 10/31/23, as scoring a 13 out of 15 on rview for mental status) score, ent was cognitively intact. A Section G-functional status as requiring limited assistance bility, transfer, dressing,				
	11/7/23 revealed, "If dialysis (hemodialymonday, Wednesda failure. INTERVEN' Monitor/document/r signs/symptoms of level of consciousnoral mucosa, chang Revised interventio "Monitor dialysis ac for bleeding or sign	aprehensive care plan dated FOCUS: Resident needs sis) HD three days a week on ay and Friday related to renal FIONS: report as needed for renal insufficiency: changes in ess, changes in skin turgor, les in heart and lung sounds." Insufficient arm every shift s/symptoms of infection. If povider and document."				
	revealed, "DIALYSI	sician orders dated 9/24/23, S - Attends Dialysis on y-Friday for dialysis time at				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
		495071	B. WING		1:	C 2/08/2023
	ROVIDER OR SUPPLIER  E LIFELONG H & R WA	RWICK FOREST		STREET ADDRESS, CITY, STATE, ZIP CODE  1000 OLD DENBEIGH BOULEVARD  NEWPORT NEWS, VA 23602	TY, STATE, ZIP CODE BOULEVARD	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 656	NOTIFY PROVIDER Every shift for fistula 10/5/23. Resident of Monday-Wednesday  A review of Resident communication book documentation 34 or appointments. Septe 9/18, 9/20, 9/22, 9/21 10/9, 10/11, 10/13, 1 10/25, 10/27, 10/30; 11/8, 11/10, 11/13, 11/24, 11/27, 11/29 at 12/4.  A review of Resident administration record and to December 6, shifts, 61-evening shows the statement of the series of t	for bruit and thrill every shift. immediately if not present.  " Discontinue date of orders ontinued to go to dialysis -Friday.  #60's dialysis revealed, missing at of 41 dialysis ember 2023: 9/1, 9/6, 9/11, 7; October 2023: 10/2, 10/6, 0/16, 10/18, 10/20, 10/23, November: 11/1, 11/3, 11/6, 11/15, 11/17, 11/20, 11/22, nd December: 12/1 and  #60's TAR (treatment and of 61-day ifts and 61-night shift.	F 65	66		
	with LPN (licensed p asked if the care plan and thrill and there is assessment, is the c #5 stated, no, it is no On 12/7/23 at 4:45 P member) #1, the adm director of nursing ar officer were made av	are plan implemented, LPN t being followed.  M, ASM (administrative staff ninistrator, ASM #2, the ad ASM #3, the chief nursing				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION  IG		(X3) DATE SURVEY COMPLETED		
		495071	B. WING _			C <b>12/08/2023</b>	
	ROVIDER OR SUPPLIER  E LIFELONG H & R W	ARWICK FOREST		STREET ADDRESS, CITY, STATE, ZIP CO 1000 OLD DENBEIGH BOULEVARD NEWPORT NEWS, VA 23602	•		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C ( (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE	
F 656	comprehensive car ordered for Reside Resident #115 was 4/26/23 with diagnoral limited to: PTSD (pCVA (cerebrovascu.)  The most recent M assessment, a quanch ARD (assessment a quanch ARD (assessment the BIMS (brief interioral indicating the resident the BIMS (brief interioral indicating the resident assistance for bath dressing, hygiene at 1: Medical Diagnosis Stress Disorder (PCA) areview of the con 8/10/23 revealed, "potential for alterat history of trauma, con INTERVENTIONS:	failed to implement the re plan for dialysis care as at #115.  admitted to the facility on posis that included but were not cost-traumatic stress disorder), alar accident) and hemiplegia.  DS (minimum data set) reference date) of 10/24/23, as scoring a 15 out of 15 on erview for mental status) score, ent was cognitively intact. A Section G-functional status as requiring extensive ing, bed mobility, transfer, and eating. A review of Section is: I6100. Post Traumatic TSD)-coded yes.  Inprehensive care plan dated FOCUS: Resident has a fon in wellbeing related to	F 6				
	Staff will use the appassessments to recommake referrals, as care, as needed."  An interview was comply with Resident # trauma or stress, R	g and positive self-image. opropriate screening tools and cognize past trauma and will necessary. Consult pastoral onducted on 12/5/23 at 3:15 #115. When asked about tesident #115 stated, there is ut. I do not want to talk about					

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION  B	(X3) DATE SURVEY COMPLETED
		495071	B. WING		C 12/08/2023
	ROVIDER OR SUPPLIER	ARWICK FOREST		STREET ADDRESS, CITY, STATE, ZIP CODE  1000 OLD DENBEIGH BOULEVARD  NEWPORT NEWS, VA 23602	12/00/2023
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETION
F 656	with LPN (licensed asked if the care pl interventions relate evidence of any int implemented, LPN followed.  On 12/7/23 at 4:45	onducted 12/7/23 at 12:05 PM practical nurse) #5. When an reveals to provide d to PTSD and there is no erventions, is the care plan #5 stated, no, it is not being PM, ASM (administrative staff dministrator, ASM #2, the	F 65	56	
	director of nursing a officer were made a	and ASM #3, the chief nursing aware of the findings. ion was provided prior to exit.			
	to implement the replan for pain.  On the most recent quarterly assessme reference date) of 15 out of 15 on the mental status), indicognitively intact for A review of R23's ophysician's order dacetaminophen (Tymilligrams by mout for pain. R23's cor 8/29/23 documente (related to) a histor colitis). Anticipate	3 (R23), the facility staff failed sident's comprehensive care  EMDS (minimum data set), a ent with an ARD (assessment 11/14/23, the resident scored BIMS (brief interview for cating the resident was r making daily decisions.  Ilinical record revealed a ated 3/15/23 for elenol) 325 milligrams- give 650 the every six hours as needed in prehensive care plan dated ed, "(R23) is at risk for pain r/t y of polio, UC (ulcerative the resident's need for pain immediately to any complaint			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		' '	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED		
		495071	B. WING		l	C / <b>08/2023</b>	
	ROVIDER OR SUPPLIER  PE LIFELONG H & R WA	RWICK FOREST		STREET ADDRESS, CITY, STATE, ZIP CODE 1000 OLD DENBEIGH BOULEVARD NEWPORT NEWS, VA 23602		12/00/2020	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 656	The resident stated the facility staff had pain. A note signed 12/5/23 documented She is alert and follo denies any fevers or right leg pain and rediscussed will ask not review of R23's clinicactaminophen was and failed to reveal interventions were of 12/6/23 at 8:29 a.m. resident stated the sanything to treat her.  On 12/6/23 at 2:43 producted with LPN (the nurse who care the nurse practitions stated the purpose of how to care for the rurses implement the physician's orders a could see residents' system. LPN #4 stanot aware of R23's repractitioner never reasked her to medical on 12/6/23 at 5:10 pstaff member) #1 (the signal of the purpose) with the purpose of the purpose	o.m., R23 was lying in bed. her right leg was hurting and not done anything for her by the nurse practitioner on d, "Seen today in bed resting. owing commands. She richills. She complains of quests for pian [sic] medicine, turse to medicate" Further cal record failed to reveal administered to the resident non-pharmacological affered to the resident. On the resident of the resident of the resident of the resident. On, R23 was lying in bed. The staff still had not done are pain.  o.m., an interview was (licensed practical nurse) #4 d for R23 on 12/5/23 when are wrote the note). LPN #4 of the care plan is to know the esident. LPN #4 stated the care plan by checking and she was not sure if she care plans in the computer the that on 12/5/23, she was ight leg pain, and the nurse ported the pain to her or	F 65				

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	PLE CONSTRUCTION  B	(X3) DATE SURVEY COMPLETED	
		495071	B. WING		C 12/08/2023	
	ROVIDER OR SUPPLIER	/ARWICK FOREST	STREET ADDRESS, CITY, STATE, ZIP CODE  1000 OLD DENBEIGH BOULEVARD  NEWPORT NEWS, VA 23602		12/00/2023	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROFIDERICLENCY)	D BE COMPLETION	
F 656	Continued From pa	age 41	F 65	56		
	follow the comprehemonitoring for the immedications.  A review of the climphysician's order of (1) Oral Tablet 50 I bedtime for per psy.  A review of the climphysician's order of Oral Tablet 0.5 MG Give 1 tablet by modisturbance."  Further review failed monitoring for the immonitoring for sign depression, effective adverse reactions; including behavior,	and for the use of Risperdal, effectiveness, side effects, ons to an antipsychotic				
	Record) and TAR ( Record) for August was conducted. To use of Trazodone t symptoms of depre effects and adverse that the required m there was no line if	AR (Medication Administration (Treatment Administration t 2023 through December 2023 there was no line item for the that included signs and ession, effectiveness, side e reactions for documenting nonitoring was done. Also, tem for monitoring for the use				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
		495071	B. WING _			C 12/08/2023
	ROVIDER OR SUPPLIER	ARWICK FOREST		STREET ADDRESS, CITY, STATE, ZIP COI 1000 OLD DENBEIGH BOULEVARD NEWPORT NEWS, VA 23602	•	12/00/2023
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	ON SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 656	A review of the progromsistent evidence the use of Trazodor symptoms of depreseffects and adverse notes also failed to that staff were monincluding behavior, and adverse reaction medication.  A review of the component dated 8/9/23 for psychotropic medication.  A review of the component dated 8/9/23 for psychotropic medication process (Vascular Desychotic Disturbar included an interver "Monitor/document/adverse reactions of medications: unstead EPS (Extrapyramidation in the process (Extrapyramidation in the process (Extrapyramidation) i	press notes failed to reveal that staff were monitoring for the, including signs and sision, effectiveness, side reactions. The progress reveal consistent evidence itoring the use of Risperdal, effectiveness, side effects, ons to an antipsychotic aprehensive care plan included r "(Resident #134) uses ations (Trazodone and ons) r/t (related to) Disease Dementia Severe with the ces)." This care plan intion dated 5/1/23 for report PRN (as-needed) any	Fé	556		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495071	B. WING			С	
NAME OF PR	ROVIDER OR SUPPLIER	495071	B. WING	S	TREET ADDRESS, CITY, STATE, ZIP CODE	12/	08/2023
RIVERSID	E LIFELONG H & R WAR	WICK FOREST		1	000 OLD DENBEIGH BOULEVARD		
KIVEKOID	L LII LLONG II G IX WAI	WORT OREST		N	IEWPORT NEWS, VA 23602		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 656	conducted with LPN # Nurse). When asked monitor and documer documentation of morplan being followed, sit was being followed any noted behaviors. more efficient if there for monitoring.  The facility policy, "Ca"Each resident will he comprehensive care pimplemented to meet goals, and address the physical, mental and On 12/7/23 at 4:50 PN ASM #1 (Administrator and AS were made aware of information was provisurvey.  (1) Trazodone is used Information obtained in the province of the conduction o	#9 (Licensed Practical if the care plan included to at, and there isn't consistent intoring then was the care she stated that she believed if they chart by exception She stated it would be was an order to check off  are Planning" documented, have a person-centered blan developed and his or her preferences and he resident's medical, psychosocial needs."  M at the end-of-day meeting, we Staff Member) the M #2 the Director of Nursing the findings. No further ded by the end of the  I to treat depression.  from by/druginfo/meds/a681038.h	F	656			
F 657 SS=D	tml Care Plan Timing and	ov/druginfo/meds/a694015.h I Revision	F	657			1/22/24
	§483.21(b) Comprehe §483.21(b)(2) A comp	ensive Care Plans orehensive care plan must					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION  G	, ,	(X3) DATE SURVEY COMPLETED	
		495071	B. WING		1	C 2/08/2023	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD		2.00.2020	
DIVEDSID	E LIFELONG H & R WAF	DWICK EODEST		1000 OLD DENBEIGH BOULEVARD			
KIVEKSID	E LIFELONG H & K WAR	WICK FOREST		NEWPORT NEWS, VA 23602			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE APPROPRIATE	(X5) COMPLETION DATE	
F 657	1 ' '	7 days after completion of	F 6	57			
	the comprehensive a (ii) Prepared by an in includes but is not lin (A) The attending phy	terdisciplinary team, that nited to					
		e with responsibility for the					
	resident. (D) A member of food (E) To the extent prac	d and nutrition services staff. cticable, the participation of					
	An explanation must medical record if the	resident's representative(s). be included in a resident's participation of the resident bresentative is determined					
	not practicable for the resident's care plan.						
	or as requested by th	ined by the resident's needs e resident. ised by the interdisciplinary					
		ssment, including both the					
	This REQUIREMENT by:	is not met as evidenced					
	interview, clinical rec	on, resident interview, staff ord review and facility was determined the facility		Resident # 24 care plan on 12/7/23 by nursing leaders include fall and interventions	ship to		
	staff failed to review a three of 60 residents	and revise the care plans for in the survey sample, ent #120 and Resident #145.		occurred on 10/27/23.  Resident # 120 care plan was nursing leadership to include dialysis catheter care on 12/6	s updated by ordered		
	The findings include:			Resident # 145 care plan wa nursing leadership to include	is updated by		
		(R24), the facility staff failed the comprehensive care plan		shingles on 12/7/23.  2. Director of Nursing / design audit comprehensive care pla	-		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495071	B. WING _				08/2023
	ROVIDER OR SUPPLIER	RWICK FOREST		10	TREET ADDRESS, CITY, STATE, ZIP CODE 000 OLD DENBEIGH BOULEVARD EWPORT NEWS, VA 23602		00/2020
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 657	assessment, a quarte (assessment reference resident scored 3 of interview for mental sindicating the resider making daily decision no falls.  Observations of R24 of the survey reveale the day area of the unactivities.  The comprehensive of documented in part, for falls r/t (related to Incontinence, Psychologials. Date Initiated 05/10/2023." The cologials. Date Initiated 05/10/2023. The cologials. Date Initiated 05/10/2023. The progress notes for "10/27/2023 09:03 (Residents room arou CNA (certified nursing resident is on the floor noom and observed harm on the mattress elbow. Right arm was mattress and the rail showed no sign of disgot on the floor he statistical sammand lowered and other nurse on shim was done. He shim was done.	MDS (minimum data set) erly assessment with an ARD ce date) of 10/5/2023, the 15 on the BIMS (brief status) assessment, it was severely impaired for is. Section J documented  conducted during the dates d R24 in their wheelchair in init or participating in	F	657	residents who have fallen, are on dialy or have a new diagnosis for accuracy.  3. Clinical Educator/ designee will educate the IDT team on process for collan timing and revision to include those who have fallen, on dialysis or new diagnoses.  4. Director of Nursing / designee will audit 4 residents who have fallen, on dialysis or new diagnosis weekly for 8 weeks. The results of the audit will be reported at the QAPI meeting for evaluation of compliance and ongoing monitoring for continuous improvement analysis.	are se	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  (X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED					
		495071	B. WING _				C 08/2023
	ROVIDER OR SUPPLIER  E LIFELONG H & R WA	RWICK FOREST		1000 OLD D	DRESS, CITY, STATE, ZIP CODE DENBEIGH BOULEVARD T NEWS, VA 23602	1 12/	00/2020
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG	-	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B ROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 657	Neuro (neurological) unwitnessed fall" evidence a review an after the fall on 10/2. The Fall investigation fall failed to evidence comprehensive care completed by LPN (I clinical coordinator.  On 12/7/2023 at 8:26 conducted with LPN #2 stated that the pushow any intervention for the resident and provided. She state reviewed and revised nursing staff and the	Residents vitals were taken, checks started as it was an The progress notes failed to ad/or revision of the care plan 7/2023.  In for R24 for the 10/27/2023 are a review of the plan. The investigation was idensed practical nurse) #2,  So a.m., an interview was #2, clinical coordinator. LPN rpose of the care plan was to ans that needed to be in place update the family of the care did that the care plan was did by her, the MDS staff, interdisciplinary team when	F	557			
	care plan was review after a fall by the lea investigation.  On 12/7/2023 at 9:19 conducted with RN ( coordinator. RN #2 the care plan were d nurse manager or th nursing. She stated care plan to be revie fall.  The facility policy, "C Planning" dated 7/1/."8. In between qua	ations. She stated that the wed and revised as needed dership team during the fall a.m., an interview was registered nurse) #2, MDS stated that daily updates to one by the nursing staff, e assistant director of that she would expect the wed and/or revised after a					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
		495071	B. WING _			C 12/08/2023
	ROVIDER OR SUPPLIER	ARWICK FOREST		STREET ADDRESS, CITY, STATE, ZIP COD 1000 OLD DENBEIGH BOULEVARD NEWPORT NEWS, VA 23602	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO ( (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 657	Continued From pa	ge 47	F6	557		
	be revised and upd to the resident's sta interventions, etc. in care current"  On 12/7/2023 at 4:3 staff member) #1, the director of nursing a officer were made at the company of the most recent assessment, a qual (assessment references and the company of the most recent assessment and care plan regarding on the most recent assessment, a qual (assessment references interview for mental indicating the resident making daily decision R120 receiving dial on 12/5/2023 at 2:4 conducted with R12 that they went to dial	ated with changes that occur tus, risk factors, orders, order to keep the plan of a pl				
	was observed to R' The catheter site was with a gauze dressi asked about cathete R120 stated that the the catheter or char stated that the dialy and changed the dr	A dialysis access catheter 120's chest on the left side. as observed to be covered ng that was not dated. When her care and dressing changes, a facility staff did not care for high the dressings. R120 has staff cared for the catheter ressings on dialysis days.				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495071	B. WING _			1	08/2023
	ROVIDER OR SUPPLIER	ARWICK FOREST	STREET ADDRESS, CITY, STATE, ZIP CODE  1000 OLD DENBEIGH BOULEVARD  NEWPORT NEWS, VA 23602				00/2020
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFII TAG	(	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 657	hemo-dialysis [sic] r failure. Date Initiated 07/18/2023." Under documented in part, daily at access site. 10/20/2022"  Review of the clinical evidence document catheter provided by On 12/7/2023 at 8:2 conducted with LPN clinical coordinator. purpose of the care interventions that no resident and update provided. She state reviewed and revise nursing staff and the there were changes treatments or medic facility staff did not purpose of the stated that the gauz dialysis and the site staff. She stated that	"(Name of R120) requires /t (related to) end stage renal d: 10/20/2022. Revision on: "Interventions" it "Check and change dressing Document. Date Initiated:  al record for R120 failed to ation of care of the dialysis y facility staff.  6 a.m., an interview was I (licensed practical nurse) #2, LPN #2 stated that the plan was to show any seded to be in place for the the family of the care at that the care plan was d by her, the MDS staff, e interdisciplinary team when	F	957			
	observed. She revidocumenting the introduced the access that it was not accurrevised.  On 12/7/2023 at 4:3 staff member) #1, the	enter or provider if any were ewed R120's care plan ervention to check and site dressing daily and stated rate and needed to be  6 p.m., ASM (administrative administrator, ASM #2, the nd ASM #3, the chief nursing					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING		(XX	(X3) DATE SURVEY COMPLETED			
		495071	B. WING			C
	ROVIDER OR SUPPLIER  E LIFELONG H & R WAF	L		STREET ADDRESS, CITY, STATE, ZIP CODE  1000 OLD DENBEIGH BOULEVARD  NEWPORT NEWS, VA 23602	I	12/08/2023
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 657	Continued From page officer were made aw No further information		F 65	57		
	revise the compreher the presence and treat A physician's order da "Valacyclovir Oral Tablet by mouth three 7 Days."	ated 11/9/23 documented, blet 1 (one) GM. Give 1 times a day for zoster form				
	documented, "Res Concerns? resident h wife skin changes on	eting note dated 11/8/23 that ident/Family Requests or usband express observe left arm: redness blister like see her. All requests been				
	rash on right wrist wh yesterday. Subjective to be determined due degenerative neurolo shows linear streaky vesicular lesions on r forearmShingles (times seven) days at	dent seen today for reported ich 1st (first) appeared experience of rash unable to patient's chronic gic conditionRight wrist macular erythema with a few ight distal recommend isolation x7 nd valacyclovir 3 times a day recautions can be removed ted over or 7 days				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '		, ,	(X3) DATE SURVEY COMPLETED	
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IDER OR SUPPLIER	/ARWICK FOREST		STREET ADDRESS, CITY, STATE, ZIP CODE  1000 OLD DENBEIGH BOULEVARD  NEWPORT NEWS, VA 23602			
(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION S	SHOULD BE	(X5) COMPLETION DATE	
relied upon not uruse's note date esident placed in ecautions for ship octor) Small blist ist."  nurse's note date esident in bed nurse's note date esident in bed nall redden bliste in contact precaut of (oral) Valtrex tall review of the convealed one date es the potential for the ericle of the ericle	sible, since patient is unable to to touch the area"  ed 11/9/23 documented, " room and place on contact ingles per M.D. (Medical ter-like areas noted on right ed 11/10/23 documented,	F 65	7			
	SUMMARY (EACH DEFICIE REGULATORY CONTINUED FROM THE REGULATORY CON	IDENTIFICATION NUMBER:  495071  IDER OR SUPPLIER  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  IDENTIFICATION PAGE OF THE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  IDENTIFICATION PAGE OF THE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  IDENTIFICATION PAGE OF THE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  IDENTIFICATION PAGE OF THE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  IDENTIFICATION PAGE OF THE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  IDENTIFICATION PAGE OF THE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  IDENTIFY INFORMATION INFORMATION INFORMATION INFORMATION  IDENTIFY INFORMATION INFORMATI	IDENTIFICATION NUMBER:  495071  B. WING	DER OR SUPPLIER  ### STREET ADDRESS, CITY. STATE, ZIP CODE  ### STREET ADDRESS, CITY. STATE, ZIP CODE  ### STREET ADDRESS, CITY. STATE, ZIP CODE  ### SUMMARY STATEMENT OF DEFICIENCIES  ### (EACH DEFICIENCY MUST BE PRECEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION)  ### PROVIDERS PLAN OF COR  ### (EACH DEFICIENCY MUST BE PRECEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION)  ### PREFIX  ### TAG  ### PROVIDERS PLAN OF COR  ### (EACH CORRECTIVE ACTION)  ### TAG  ### PROVIDERS PLAN OF COR  ### (EACH CORRECTIVE ACTION)  ### TAG  ### PROVIDERS PLAN OF COR  ### (EACH CORRECTIVE ACTION)  ### TAG  ### PROVIDERS PLAN OF COR  ### (EACH CORRECTIVE ACTION)  ### TAG  ### PROVIDERS PLAN OF COR  ### (EACH CORRECTIVE ACTION)  ### TAG  ### PROVIDERS PLAN OF COR  ### (EACH CORRECTIVE ACTION)  ### TAG  ### PROVIDERS PLAN OF COR  ### (EACH DEFICIENCY)  ### PROVIDERS PLAN OF COR  ### PROVIDERS PLAN OF CO	DER OR SUPPLIER    STREET ADDRESS, CITY, STATE, ZIP CODE	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING		PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED		
		495071	B. WING _		C 12/08/2023
	ROVIDER OR SUPPLIER	ARWICK FOREST		STREET ADDRESS, CITY, STATE, ZIP CODE  1000 OLD DENBEIGH BOULEVARD  NEWPORT NEWS, VA 23602	1 12/00/2020
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETION
F 657	Continued From page	ge 51 e resident developed	F 6	57	
	"In between quart the resident's care pand updated with chresident's status, risinterventions, etc. in care current."  On 12/7/23 at 4:50 ASM #1 (Administrator and A were made aware chinformation was prosurvey.	PM at the end-of-day meeting, ative Staff Member) the SM #2 the Director of Nursing of the findings. No further vided by the end of the sed to treat herpes zoster al herpes.			
F 658 SS=D	tml Services Provided M CFR(s): 483.21(b)(3) §483.21(b)(3) Comp The services provid as outlined by the c must- (i) Meet professiona This REQUIREMEN by: Based on staff inter and facility document the facility staff faile	gov/druginfo/meds/a695010.h  Meet Professional Standards B)(i)  prehensive Care Plans ed or arranged by the facility, comprehensive care plan, al standards of quality.  IT is not met as evidenced  rview, clinical record review nt review, it was determined d to meet professional f 60 residents, Resident #49.	F 6	1. Resident # 49 medication administration record was review 12/8/2023 by Director of Nursing medication were administered as on 12/8/2023.	and all

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION		DATE SURVEY COMPLETED	
		495071	B. WING _		1.	C 2/08/2023	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZI	•	.706/2023	
				1000 OLD DENBEIGH BOULEVAR	RD		
RIVERSID	E LIFELONG H & R W	ARWICK FOREST		NEWPORT NEWS, VA 23602			
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL PR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ( (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETION DATE	
F 658	Continued From pa	age 52	F 6	558			
	The findings includ	-		2. Director of Nursing /	_		
	standards by admin ordered, specificall (milligram), for Res Resident #49 was 12/17/21 with diagrant limited to: COP pulmonary disease (atherosclerotic cal (peripheral vascula). The most recent M assessment, a quant ARD (assessment coded the resident the BIMS (brief interindicating the resid	admitted to the facility on nosis that included but were D (chronic obstructive ), cellulitis, ASCVD rdiovascular disease) and PVD		audit MARS of residents antidepressants since Ja ensure they were admini ordered.  3. Clinical Educator / deducate licensed nursing medication administratio ensuring medications are ordered.  4. Director of Nursing / audit 4 residents on antic medication weekly for 8 they were given as order of the audit will be report meeting for evaluation of ongoing monitoring for comprovement analysis.	lesignee will g staff on the n process e administered as  / designee will depressant weeks to ensure red. The results ted at the QAPI f compliance and		
	assistance for bath	as requiring extensive ing and supervision for bed ressing, hygiene and eating; comotion.					
	A review of the con 5/22/23 revealed, "prescribed fluoxetin depressive disorde Administer medica Monitor for side eff A review of the phy revealed "Fluoxetir 1 capsule orally on An interview was c	nprehensive care plan dated FOCUS: Resident is ne for diagnosis of major r. INTERVENTIONS: tions as ordered by provider. ects and effectiveness."  rsician orders dated 12/4/22, ne CAP 40MG (milligram) Give e time a day for Depression".  onducted on 12/5/23 at 3:40 #49. Resident #49 stated, in					

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		495071	B. WING			C <b>12/08/2023</b>
	ROVIDER OR SUPPLIER	ARWICK FOREST		STREET ADDRESS, CITY, STATE, ZIP CODE  1000 OLD DENBEIGH BOULEVARD  NEWPORT NEWS, VA 23602	ľ	12/00/2020
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 658	A review of the Novadministration recommand give 1 capsule of depression was connote" for 11/13/23 8  A review of the progression and was review of the facility Listing" identified "Far level of eight (8) An interview was convith LPN (licensed asked if the medical medication and was medication have be stock, LPN #5 state administered if we have the constant of the medical for the medical for the medical formula of the constant of the medical formula of the constant of the c	not give me my I worry if I do not take it daily.  ember 2023 MAR (medication rd) revealed, "Fluoxetine 40 orally one time a day for ded "9-other see progress AM."  gress note dated 11/13/23 at "Fluoxetine CAP 40MG Give 1 ime a day for Depression.  ity's "MedBank Medication fluoxetine 10 mg tablet with a	F 65	58		
F 676 SS=E	officer were made at According to the fact Administration Polici "Medications will be with regulatory guid clinical practice star No further informations and according to the fact of the	ware of the findings.  cility's "Medication cy" which revealed, e administered in accordance elines, infection control and	F 67	76		1/22/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION  A. BUILDING  A. BUILDING		, ,	ATE SURVEY DMPLETED			
		495071	B. WING _			C <b>12/08/2023</b>
	ROVIDER OR SUPPLIER E LIFELONG H & R WA	RWICK FOREST		STREET ADDRESS, CITY, STATE, ZIP CODE  1000 OLD DENBEIGH BOULEVARD  NEWPORT NEWS, VA 23602	· · · · ·	12/00/2023
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 676	resident's needs and provide the necessal ensure that a resider daily living do not dir of the individual's clir that such diminution includes the facility of \$483.24(a)(1) A resident reatment and service or her ability to carry living, including those of this section  §483.24(b) Activities The facility must provaccordance with paractivities of daily living \$483.24(b)(1) Hygiet grooming, and oral of \$483.24(b)(2) Mobilitincluding walking,  §483.24(b)(3) Eliming \$483.24(b)(4) Dining snacks,  §483.24(b)(5) Committee (i) Speech, (ii) Language,	n the comprehensive ident and consistent with the choices, the facility must ry care and services to nt's abilities in activities of minish unless circumstances nical condition demonstrate was unavoidable. This ensuring that:  Ident is given the appropriate es to maintain or improve his out the activities of daily especified in paragraph (b)  of daily living.  vide care and services in agraph (a) for the following ng:  ne -bathing, dressing, are,  ty-transfer and ambulation,  ation-toileting,  n-eating, including meals and	F 6	76		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		495071	B. WING			C 2/08/2023	
NAME OF P	ROVIDER OR SUPPLIER	1000.1	<del>-1</del>	STREET ADDRESS, CITY, STATE, ZIP CODE		2/06/2023	
				1000 OLD DENBEIGH BOULEVARD			
RIVERSID	E LIFELONG H & R WAF	RWICK FOREST		NEWPORT NEWS, VA 23602			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 676	Continued From page	e 55	F 67	6			
	This REQUIREMENT by:	is not met as evidenced					
	Based on resident an record review and fact determined the facility evidence of providing			1. Resident # 49 received full on 12/6/2023, 12/7/2023, and a 12/8/2023 by clinical staff assig care. Resident # 8 received a sl 12/8/2023 and has documented hygiene on 12/6/23, 12/7/23 and by clinical staff assigned to her 2. Director of Nursing / design	shower on ned to her hower on I personal d 12/8/23 care nee will		
	bathing and showers Resident #49 was ad	mitted to the facility on sis that included but were		audit residents personal hygiender /grooming and bathing and show records from January 1, 2024, to residents were provided and do personal hygiene, grooming, bathing showers.  3. Clinical educator / designed	wer o ensure cumented thing, and		
	pulmonary disease), (atherosclerotic cardi (peripheral vascular o	cellulitis, ASCVD ovascular disease) and PVD disease).		educate clinical team members importance of accurate docume personal hygiene /grooming and and showers.	on the entation of d bathing		
	ARD (assessment recoded the resident as the BIMS (brief intervindicating the resident review of the MDS Secoded the resident as assistance for bathing	erly assessment, with an ference date) of 11/28/23, as scoring a 15 out of 15 on riew for mental status) score, at was cognitively intact. A section G-functional status is requiring extensive g and supervision for bed ssing, hygiene and eating;		4. Director of Nursing / design audit 4 residents care records for /grooming and bathing and show week for 8 weeks. The results of will be reported at the QAPI me evaluation of compliance and of monitoring for continuous improgranalysis.	or hygiene wers per of the audit eting for ngoing		
	7/3/23 revealed, "FOr remain in facility to re INTERVENTIONS: F	rehensive care plan dated CUS: Resident desires to eceive continued services. Provide services according to t to enhance optimum x2, limited assist x1:					

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	ROVIDER OR SUPPLIER  E LIFELONG H & R W.	ARWICK FOREST	STREET ADDRESS, CITY, STATE, ZIP CODE  1000 OLD DENBEIGH BOULEVARD  NEWPORT NEWS, VA 23602			
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO ( (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 676	Continued From pa	ge 56	F 6	376		
		nd personal hygiene. showers and incontinence				
	A review of Octobe documentation reverse are missing: 10/11,	ealed that three of eight days				
	documentation reve	oer 2023 shower ADL ealed that five of nine days are , 11/15, 11/18 and11/22.				
	PM with CNA (certiful When asked where documented, CNA showers in PCC (P book. When asked blanks in the document bathing and shower asked what it indicates	binducted on 12/7/23 at 12:30 fied nursing assistant) #2. bathing and showers are #2 stated, we document our oint Click Care) there is no what it indicates if there are nentation, CNA #2 stated, the rs were not done. When ates if NA is documented, CNA ot applicable, that does not				
	PM with CNA #3. Ware documented, Cdocumented in PCC indicates if there are	onducted on 12/7/23 at 4:00 When asked where showers NA #3 stated, they are C. When asked what it e blanks in the documentation, leans that the showers were				
	AM with CNA #4. We showers and where #4 stated, they are documented in PCC	onducted on 12/8/23 at 8:15 When asked the frequency of they are documented, CNA twice a week and are C. When asked what it blanks in the documentation, as not done.				

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F 676	Continued From pa	ge 57	F6	76		
	member) #1, the addirector of nursing a officer were made at A review of the facil Activities of Daily Li Provision of care ar comprehensive assigned routine care and act documented in the record) touchscreer in the state's RAI (Finstrument) manual	PM, ASM (administrative staff Iministrator, ASM #2, the and ASM #3, the chief nursing Iware of the findings.  Ity's "Routine Care and ving" policy revealed, "and services will be based on a essment and consistent with choices. Documentation of tivities of daily living will be EMR (electronic medical an and will align with definitions Resident Assessment.  Residents who are unable to of daily living will receive the				
	their functional abili	to maintain and maximize ties."  on was provided prior to exit.				
	2. The findings inclu					
	The facility staff fail bathing and shower	ed to provide evidence of s for Resident #8.				
	4/12/13 with diagno	Imitted to the facility on sis that included but were not etes mellitus), neurogenic egia.				
	assessment, a qual ARD (assessment r coded the resident the BIMS (brief inte indicating the reside	OS (minimum data set) terly assessment, with an reference date) of 10/17/23, as scoring a 15 out of 15 on rview for mental status) score, ent was cognitively intact. A Section G-functional status				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		· /	PLE CONSTRUCTION	, ,	COMPLETED	
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(X4) ID PREFIX TAG	(EACH DEFICIEI	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 676	assistance for bath dressing, hygiene a eating.  A review of the com 1/30/23 revealed, "remain in facility to INTERVENTIONS: care plans in an eff well-being. Siderai extensive assist x1 personal hygiene. and incontinence compared to the personal hygiene and incontinence of the personal hygiene/grevealed that five on 9/4, 9/8, 9/23, and the personal hygiene/grevealed that six of 10/10, 10/17, 10/26. A review of Novemidocumentation revealed that six of 10/10, 10/17, 10/26. A review of Novemidocumentation revealed that six of 10/10, 10/17, 10/26. A review of Novemidocumentation revealed that six of 10/10, 10/17, 10/26.	as requiring extensive ing, bed mobility, transfer, and limited assistance for aprehensive care plan dated FOCUS: Resident desires to receive continued services.  Provide services according to cort to enhance optimum ls x2, overbed trapeze, dressing, toileting and extensive assist x1 showers are."  The 2023 shower ADL ealed that six of eight days are 9/16, 9/20, 9/23 and 9/27; rooming documentation f 30 days are missing: 9/2, 9/25.  The 2023 shower ADL ealed that five of nine days are 0, 10/17, 10/27 and 10/31; rooming documentation 31 days are missing: 10/6,	F 67	76		
	PM with CNA (certi When asked where	onducted on 12/7/23 at 12:30 fied nursing assistant) #2. bathing and showers are #2 stated, we document our				

AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  (X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED			
		495071	B. WING		C 12/08/2023
	ROVIDER OR SUPPLIER E LIFELONG H & R WAF	RWICK FOREST		STREET ADDRESS, CITY, STATE, ZIP CODE  1000 OLD DENBEIGH BOULEVARD  NEWPORT NEWS, VA 23602	12/00/2023
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLÉTION
F 676	showers in PCC (Poi book. When asked what it indicate #2 stated, that is not make any sense.  An interview was con PM with CNA #3. What are documented, CN documented in PCC. indicates if there are CNA #3 stated, it menot done.  An interview was con AM with CNA #4. What showers and where the #4 stated, they are two documented in PCC.	ont Click Care) there is no what it indicates if there are entation, CNA #2 stated, the were not done. When we if NA is documented, CNA applicable, that does not ducted on 12/7/23 at 4:00 men asked where showers A #3 stated, they are When asked what it blanks in the documentation, and that the showers were ducted on 12/8/23 at 8:15 men asked the frequency of they are documented, CNA wice a week and are When asked what it blanks in the documentation,	F 67	76	
F 677 SS=D	member) #1, the adm director of nursing an officer were made aw No further information ADL Care Provided for CFR(s): 483.24(a)(2) §483.24(a)(2) A resident out activities of daily	n was provided prior to exit. or Dependent Residents  ent who is unable to carry living receives the necessary good nutrition, grooming, and	F 67	77	1/22/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495071	B. WING _			C <b>12/08/2023</b>	
NAME OF P	ROVIDER OR SUPPLIER		'	STREET ADDRESS, CITY, STATE	, ZIP CODE	12/00/2020	
				1000 OLD DENBEIGH BOULE	VARD		
RIVERSID	E LIFELONG H & R WA	RWICK FOREST		NEWPORT NEWS, VA 236	02		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	( (EACH CORRECTIVE CROSS-REFERENCE	AN OF CORRECTION VE ACTION SHOULD BE ED TO THE APPROPRIAT ICIENCY)	(X5) COMPLETION DATE	
F 677	clinical record review review, it was determ failed to provide ADL care to a dependent residents in the surve. The findings include:  For Resident #2 (R2 provide incontinence a.m. to 3:00 p.m.) of  On the most recent nanual assessment or reference date) of 10 as scoring 14 out of interview for mental indicating the resider assessment docume substantial/maximal being always incontinuon the MDS assessivith an ARD of 1/27/requiring extensive a persons for toileting. being always incontinuon 12/5/2023 at 3:44 conducted with R2. concerns with care restated that there were be cleaned up after if felt that they needed worked so hard.	nterview, staff interview, and facility document nined that the facility staff (activities of daily living) resident to one of 60 ey sample, Resident #2.  In the facility staff failed to exare on the day shift (7:00 3/13/2022.  MDS (minimum data set), an with an ARD (assessment 0/12/2023, R2 was assessed 15 on the BIMS (brief status) assessment, and was cognitively intact. The	F 6	1. Resident # 2 rece care on all three shifts 12/7/2023, and 12/8/2 assigned to her care. 2. Director of Nursir audit incontinent resider from January 1, 2024, incontinence care was documentation was considered as a clinical educator educate clinical team importance of providir documentation of incontinence caresidents per week for results of the audit will QAPI meeting for evaluation of the audit will quality incontinence and ongo continuous improvements.	s on 12/6/2023, 2023 by clinical starting /designee will dent care records, to ensure sprovided and completed. or designee will members on the eng and accurate continence care. In a few sprovided for 8 weeks. The luation of ing monitoring for	r 4	

AND DLAN OF CORRECTION IDENTIFICATION NUMBER		1 ' '	PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED	
						С
NAME OF D		495071	B. WING _	CTREET ADDRESS CITY STATE 71D CODE		12/08/2023
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE  1000 OLD DENBEIGH BOULEVARD		
RIVERSID	E LIFELONG H & R WAF	WICK FOREST		NEWPORT NEWS, VA 23602		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 677		e 61 ) has bowel and bladder itiated: 11/10/2022. Revision	F 6	77		
	Review of the facility 3/18/2022 documente 2022, resident's repre (activities of daily livir a timely manner and and DON (director of assessment was comstarted immediately 2022, daughters of rethat resident was not timely manner on the A head-to-toe assess there was no evidence injury noted Based there is no evidence of providing ADL care to document contained acconducted by the soc with four other reside statements from staff	(name of R2)" The				
	conducted with OSM director of social serv OSM #2 stated that the email correspondence the ADL care concern that the former admin nursing had conducte a follow up conference the concern. She stathe final investigation the director of nursing	(other staff member) #2, ices, grievance officer. ney had conversations and e with R2's family regarding as on 3/13/2022. She stated istrator and director of ed an investigation and had e call with the family after ted that she did not recall findings because usually and administrator take his after the concern was				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	FIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED	
		495071	B. WING			C 2/08/2023
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	•	2/06/2023
				1000 OLD DENBEIGH BOULEVARI	D	
RIVERSID	E LIFELONG H & R \	WARWICK FOREST		NEWPORT NEWS, VA 23602		
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFI TAG		CTION SHOULD BE ) THE APPROPRIATE	(X5) COMPLETION DATE
F 677	Continued From p	page 62	F	677		
	conducted with C #6. CNA #6 state 3/13/2022 on the she was a new Cl had ever worked She stated that shand she had to ta not want male CN R2 was one of the male CNA no She stated that shwith the residents day, got the residents day, got the residents on the L unit in half. She shospitality aide or beds, answer call out the trash but thands-on patient worked from 7:00 ring the call bell reshe had told them She stated that shover and told R2 next shift to make resident to be chat to leave at the enhad stayed over L #6 stated that she changed on her shave gone all day	2:44 p.m., an interview was NA (certified nursing assistant) d that they were working on Monticello unit. She stated that NA and it was the first time she the unit with only two CNAs. He was working with a male CNA ke the female residents who did As taking care of them and that longer worked at the facility. He did the best that she could do that were assigned to her that lents up that had to be up, trays and answered the call that there were about 58 whit and the two CNAs split the stated that they did have a short the floor who could make bells, tidy up rooms and take hey could not provide any care. She stated that she a.m. to 3:00 p.m. and R2 did requesting to be changed and at that she would come back. He came back after her shift was that she had passed it to the sure they were the first langed. She stated that she had do fher shift and the male CNA whill the next CNA came in. CNA and did not recall R2 getting thift and the resident should not and not been changed.				
		PN (licensed practical nurse) #8.				

	OF DEFICIENCIES CORRECTION	IDENTIFICATION NUMBER		JULTIPLE CONSTRUCTION ILDING		(X3) DATE SURVEY COMPLETED	
			7 50.25.	_		(	С
		495071	B. WING _			12/	08/2023
	ROVIDER OR SUPPLIER  E LIFELONG H & R WAR	RWICK FOREST		10	TREET ADDRESS, CITY, STATE, ZIP CODE 000 OLD DENBEIGH BOULEVARD EWPORT NEWS, VA 23602		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 690 SS=D	The administrator and incident no longer wo Incident no longer wo The facility policy "Ro Daily Living" dated 3/"Residents who are of daily living will receive to maintain and maxin Procedure: The facility services, to include: 1 dressing, grooming, at transfer and ambulatic Elimination-toileting  On 12/7/2023 at 4:36 staff member) #1, the director of nursing an officer were made aw No further information Bowel/Bladder Incont CFR(s): 483.25(e)(1) The fact resident who is continuadmission receives so maintain continence used to comprehensive assessed sure that-	not recall the incident.  If DON at the time of the rked at the facility.  Incutine Care and Activities of 31/2023 documented in part, unable to carry out activities eive the necessary services mize their functional abilities. Incutional abilities. Including walking, and oral care. 2. Mobilityon, including walking. 3.  If p.m., ASM (administrative administrator, ASM #2, the d ASM #3, the chief nursing are of the concern.  In was provided prior to exit. inence, Catheter, UTI (3)  Ince.  Incidity must ensure that the ent of bladder and bowel on ervices and assistance to unless his or her clinical es such that continence is ain.		690			1/22/24

AND DUAN OF CODDECTION IN INDED.		1 ` ′	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495071	B. WING _				C 08/2023
	ROVIDER OR SUPPLIER  E LIFELONG H & R WA	RWICK FOREST		10	TREET ADDRESS, CITY, STATE, ZIP CODE 000 OLD DENBEIGH BOULEVARD EWPORT NEWS, VA 23602	, 12,	00/2020
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 690	resident's clinical concatheterization was recited to a spessible unless the demonstrates that cand (iii) A resident who is receives appropriate prevent urinary tract continence to the existence of the existenc	anot catheterized unless the indition demonstrates that necessary; inters the facility with an information of the catheter as soon necessary; incontinent of the catheter as soon necessary; incontinent of bladder treatment and services to infections and to restore tent possible.  The facility must not who is incontinent of bowel treatment and services to mal bowel function as  This not met as evidenced on, resident interview, staff nument review and clinical cility staff failed to provide or a urinary catheter for one of the facility staff failed to ders and provide care per actions for the resident's	F	690	<ol> <li>Resident #23 orders for an extern urinary catheter device was updated of 12/6/2023 by the unit Manger. The caplan was updated on 12/7/2023 by the Unit Manager.</li> <li>Director of Nursing / designee with audit all residents with external urinary catheter devices for appropriate orders and care plans.</li> <li>Clinical educator / designee will educate clinical staff on the importance orders for external urinary catheter devices and their care.</li> <li>Director of nursing / designee will audit 4 residents with external urinary catheters weekly for 8 weeks to validate.</li> </ol>	n re	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED		
		495071	B. WING _			12/0	08/2023
	ROVIDER OR SUPPLIER  E LIFELONG H & R WAF	RWICK FOREST		STREET ADDRESS, CITY, STATE, ZIP CODE  1000 OLD DENBEIGH BOULEVARD  NEWPORT NEWS, VA 23602			00.2020
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 690	mental status), indical cognitively intact for recognitively into bed. The resident' canister was observed beside the bed. R23 catheter wick every docanister, "every so of A review of R23's clin any physician's order catheter. Further reversalled to reveal any intexternal urinary catheter. On 12/6/23 at 4:31 p. conducted with RN (pregarding care of R23 RN #1 stated the faci some nurses regarding.)	IMS (brief interview for ting the resident was making daily decisions.  m., R23 was observed lying is external urinary catheter d in a box on the floor stated the staff changes the ay and changes the ay and changes the ten."  nical record failed to reveal is for R23's external urinary item of R23's clinical record estructions for care of the eter.  m., an interview was egistered nurse) #1, 8's external urinary catheter.  lity has provided training to an R23's external urinary	F	690	orders are present and care is being provided as ordered. The results of the audit will be reported at the QAPI meet for evaluation of compliance and ongoi monitoring for continuous improvement analysis.	ing ng	
	RN #1 stated the repropportunity for nurses should be orders in the management of the element of	a report between nurses.  ort between nurses is an act to ask questions but there he chart for care and external urinary catheter.  m., ASM (administrative administrator) and ASM #2 administrator) and ASM #2 and ware of the facility did not have a policy ernal urinary catheters.  catheter manufacturer's atted the following, "The ademark) is an innovative rinary incontinence. It k (Trademark) Female					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495071	B. WING _			C / <b>08/2023</b>	
	ROVIDER OR SUPPLIER  E LIFELONG H & R WAF	RWICK FOREST		STREET ADDRESS, CITY, STATE, ZIP CODE  1000 OLD DENBEIGH BOULEVARD  NEWPORT NEWS, VA 23602	·		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORRECTIC  X (EACH CORRECTIVE ACTION SHOULD  CROSS-REFERENCED TO THE APPROF  DEFICIENCY)	) BE	(X5) COMPLETION DATE	
F 695 SS=D	Urine Collection System outside the body to dikeep skin dry. The PureWick (Trade System 2000cc (mL) before volume reached needed. Is the PureWick (Trade Catheter reusable? Note that the PureWick of the Catheter and the PureWick (Trade Catheter and the PureWick (Trade Catheter and that the PureWick (Trade Catheter and the PureWick (Trade Catheter a	d the PureWick (Trademark) em. The System works raw urine away, helping  emark) Urine Collection canister should be emptied es 1800cc (mL), or as  demark) Female External No. The wick should be ry 8 to 12 hours or sooner if lood. Skin should be been compromised, and be performed prior to vick. Ing should be replaced every you see signs of formation was obtained from athome.com/faq.html. Stomy Care and Suctioning  ry care, including and tracheal suctioning.  ure that a resident who e, including tracheostomy ctioning, is provided such professional standards of nensive person-centered ants' goals and preferences, bepart.  The is not met as evidenced  on, resident interview, staff ument review and clinical cility staff failed to provide		1. The mouthpiece for resident # 3 nebulizer was discarded by the unit Manager , and a new nebulizer mouthpiece was obtained and was s		1/22/24	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495071	B. WING _				C <b>12/08/2023</b>	
NAME OF P	ROVIDER OR SUPPLIER			STREET AD	DDRESS, CITY, STATE, ZIP CODE	<u> </u>	12/00/2023	
DIVEDOID	ELIEFI ONG U ® B.W	A DIMICK FOREST		1000 OLD	DENBEIGH BOULEVARD			
KIVEKSID	E LIFELONG H & R W	ARWICK FOREST		NEWPOR	RT NEWS, VA 23602			
(X4) ID PREFIX TAG	(EACH DEFICIEI	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 695	Continued From pa	nge 67	F 6	95				
	-	vey sample, Resident #344.			sanitary manner on 12/5/2023	3.		
	The findings include		2. E	Director of Nursing /designee all residents with nebulizers re that all mouth pieces are s	will to			
		(R344), the facility staff failed (1) mouthpiece in a sanitary		3. C	nitary manner. Clinical educator/ designee w ate all clinical staff on the pro ge of nebulizer mouth pieces	oper		
	was not complete. dated 11/27/23 doc oriented times three record revealed a p 11/27/23 for ipratro solution (2) 0.5-2.5 milliliters- three mill	minimum data set assessment A clinical admission form cumented R344 was alert and e. A review of R344's clinical ohysician's order dated pium-albuterol inhalation three milligrams/three ligrams inhale orally four times ostructive pulmonary disease.		4. C audit prope mouth be rep evalu	oment in a sanitary manner. Director of Nursing /designee 4 residents weekly for 8 wee er storage of respiratory hpieces. The results of the a ported at the QAPI meeting function of compliance and ong toring for continuous improve rsis.	eks for audit will for Joing		
	sitting in a wheelch resident's nebulizer and sitting on the n stated the staff had cover the nebulizer 4:10 p.m., the nebu	3 p.m., R344 was observed air in the bedroom. The mouthpiece was uncovered ebulizer machine. R344 never provided anything to mouthpiece. On 12/6/23 at ulizer mouthpiece remained on the nebulizer machine.						
	conducted with LPN LPN #4 stated a ne	p.m., an interview was N (licensed practical nurse) #4. ebulizer mouthpiece should be astic bag to prevent						
	staff member) #1 (t	p.m., ASM (administrative he administrator) and ASM #2 sing) were made aware of the						
	The facility policy ti	tled, "Infection Control:						

<b>495071</b> B. WING	C — 12/08/2023
l I	IZ/OO/ZOZO
NAME OF PROVIDER OR SUPPLIER  RIVERSIDE LIFELONG H & R WARWICK FOREST  STREET ADDRESS, CITY, ST.  1000 OLD DENBEIGH BOU  NEWPORT NEWS, VA 2	JLEVARD
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECT TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFEREN	S PLAN OF CORRECTION (X5) COMPLETION INCED TO THE APPROPRIATE DEFICIENCY)  (X5) COMPLETION DATE
complete pain management program for one of effective.  60 residents in the survey sample, Resident #23.  2. Residents who	by the nurse and cated as ordered and o have as needed pain ed will be interviewed by

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
		495071	B. WING _			C <b>12/08/2023</b>	
	ROVIDER OR SUPPLIER	ARWICK FOREST		STREET ADDRESS, CITY, STATE, ZIP CODE  1000 OLD DENBEIGH BOULEVARD  NEWPORT NEWS, VA 23602		12/00/2020	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 697	treat the resident's 12/5/23.  On the most recent quarterly assessme reference date) of 15 out of 15 on the mental status), indiccognitively intact for A review of R23's cophysician's order datacetaminophen (Tymilligrams by mouth for pain.  On 12/5/23 at 4:16 The resident stated the facility staff had pain. A note signed 12/5/23 documented She is alert and foll denies any fevers or right leg pain and rediscussed will ask review of R23's clin acetaminophen was and failed to reveal interventions were 12/6/23 at 8:29 a.m resident stated the anything to treat her on 12/6/23 at 2:43 conducted with LPN (the nurse who care	R23), the facility staff failed to reported right leg pain on  MDS (minimum data set), a ent with an ARD (assessment 11/14/23, the resident scored BIMS (brief interview for cating the resident was r making daily decisions.  Ilinical record revealed a ented 3/15/23 for elenol) 325 milligrams- give 650 enterery six hours as needed  p.m., R23 was lying in bed. If her right leg was hurting and entered to the nurse practitioner on end, "Seen today in bed resting, owing commands. She or chills. She complains of equests for pian [sic] medicine, nurse to medicate" Further ical record failed to reveal a sadministered to the resident non-pharmacological offered to the resident. On a, R23 was lying in bed. The staff still had not done	F 6	ensure pain is managed a 3. Clinical educator / deseducate clinical team mem response to resident verba and implementation of pain program per providers ord 4. Director of Nursing / daudit 4 residents per week as needed pain medication of pain and appropriatenes to the pain. The results of reported at the QAPI meet evaluation of compliance a monitoring for continuous analysis.	signee will abers on alization of pain a management ers. lesignee will for 8 weeks on a for presence as of responses the audit will be and ongoing		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		' '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495071	B. WING		C <b>12/08/2023</b>
	OVIDER OR SUPPLIER	RWICK FOREST		STREET ADDRESS, CITY, STATE, ZIP CODE 1000 OLD DENBEIGH BOULEVARD NEWPORT NEWS, VA 23602	,
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
F 698 SS=E	R23's right leg pain a never reported the pare medicate the resident on 12/6/23 at 5:10 p staff member) #1 (the (the director of nursing above concern.  The facility policy title Management" docume expresses pain/disconstruction will be parend/or the comprehe Dialysis CFR(s): 483.25(I) Dialysis. The facility must ensure dialysis receive with professional state comprehensive personal state c	3, she was not aware of and the nurse practitioner ain to her or asked her to at.  .m., ASM (administrative administrator) and ASM #2 ang) were made aware of the add, "Pain Assessment and mented, "When a resident amfort, treatment and/or rovided per physician order ansive care plan."  ure that residents who we such services, consistent and and preferences.  Γ is not met as evidenced and preferences.  T is not met as evidenced and facility document and facility document and facility staff are and services to dialysis residents; Residents	F 698		by

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		I DENTIFICATION NUMBER:		2) MULTIPLE CONSTRUCTION BUILDING			(X3) DATE SURVEY COMPLETED	
		495071	B. WING _				08/ <b>2023</b>	
NAME OF P	ROVIDER OR SUPPLIER		1	S	STREET ADDRESS, CITY, STATE, ZIP CODE	1 12/	00/2023	
					000 OLD DENBEIGH BOULEVARD			
RIVERSID	E LIFELONG H & R WAR	RWICK FOREST			NEWPORT NEWS, VA 23602			
				, T		0.47)		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 698	Continued From page	∍ 71	F 6	698				
	dialysis center on fou	r of nine dialysis visits.			vital signs, weights, dialysis care and communication sheets are being			
	Resident #72 was ad	mitted to the facility on			provided.			
	11/14/23 and discharg				3. Clinical educator / designee will			
	resident had nine dial	lysis visits during her stay.			educate facility clinical team members obtaining pre - post-dialysis weights, v			
	A review of the clinical				signs, dialysis care and use of appropr			
		ed 11/14/23 documented,			documentation tools to communicate v	/ith		
		Dialysis (address of dialysis			the dialysis centers when residents			
	, ,	ft every Mon (Monday), Wed			receive dialysis services.			
	(Wednesday), Fri (Fri	day)."			4. Director of Nursing / designee will audit 4 residents per week for 8 weeks			
	Δ review of the dialve	is communication sheets			ensure that pre and post vital signs,	ιο		
	_	the nine times the resident			weights, dialysis care and communicat	ion		
		the facility, the sheets were			sheets/book are being completed. The			
	_	s from the facility to the			results of the audit will be reported at t			
	dialysis center: On 1	1/17/23, the vital signs that			QAPI meeting for evaluation of			
	were written were cro				compliance and ongoing monitoring fo	r		
		was no new set written in.			continuous improvement analysis.			
		and 12/6/23, there were no						
	•	ed on the communication						
		to the dialysis center. The						
	area was left blank.							
	On 12/8/23 at 8:20 Al							
		#9 (Licensed Practical nat the communication						
	,	d out each time the resident						
		stated that there is also a						
	•	health record system that						
		dialysis. She stated that if						
		as not filled in then the						
	_	g efficient communication to				ĺ		
	the dialysis center.							
		alysis care and services was						
		s provided. Instead, the				ĺ		
		ırvey team to an external n the survey team did not						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	IPLE CONS	(X3) DATE SURVEY COMPLETED			
		495071	B. WING _				08/2023
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE  1000 OLD DENBEIGH BOULEVARD  NEWPORT NEWS, VA 23602			00/2023
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 698	ASM #1 (Administra Administrator and As were made aware of	PM at the end-of-day meeting, tive Staff Member) the SM #2 the Director of Nursing f the findings. No further vided by the end of the	F6	598			
	dialysis communicate dialysis center.  Resident #60 was an 1/15/21 with diagnost limited to: ESRD (errovascular hypertension.  The most recent MI assessment, a quark ARD (assessment recoded the resident at the BIMS (brief interindicating the reside review of the MDS Scoded the resident af for bathing, bed most hygiene and eating.  A review of the computatives of the computatives (hemodialysis (hemodialysi	DS (minimum data set) perly assessment, with an eference date) of 10/31/23, as scoring a 13 out of 15 on view for mental status) score, and was cognitively intact. A section G-functional status as requiring limited assistance polity, transfer, dressing, brehensive care plan dated OCUS: Resident needs is) HD three days a week on y and Friday related to renal					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495071	B. WING		C 12/08/2023
	ROVIDER OR SUPPLIER  DE LIFELONG H & R W	ARWICK FOREST		STREET ADDRESS, CITY, STATE, ZIP CODE  1000 OLD DENBEIGH BOULEVARD  NEWPORT NEWS, VA 23602	12/00/2020
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL RR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRI DEFICIENCY)	JLD BE COMPLETION
F 698	signs/symptoms of level of consciousn oral mucosa, chang Revised interventic "Monitor dialysis act for bleeding or sign observed, notify produced in the phyrevealed, "DIALYS Monday-Wednesda 0515. Assess fistul NOTIFY PROVIDE Every shift for fistul 10/5/23. Resident Monday-Wednesda A review of Reside communication bod documentation 34 appointments. Seg 9/18, 9/20, 9/22, 9/10/9, 10/11, 10/13, 10/25, 10/27, 10/30, 11/8, 11/10, 11/13, 11/24, 11/27, 11/29, 12/4.  A review of Reside administration record and to December 6 shifts, 61-evening segments. An interview was considered with LPN (licensed segments).	renal insufficiency: changes in ress, changes in skin turgor, ges in heart and lung sounds." ons dated 12/7/23 revealed, cress site left arm every shift as/symptoms of infection. If povider and document."  resician orders dated 9/24/23, IS - Attends Dialysis on any-Friday for dialysis time at a for bruit and thrill every shift. IR immediately if not present. It is a." Discontinue date of orders continued to go to dialysis any-Friday.  Int #60's dialysis on the service of the servic	F 69	8	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495071	B. WING				08/ <b>2023</b>
	NAME OF PROVIDER OR SUPPLIER  RIVERSIDE LIFELONG H & R WARWICK FOREST		1	1	STREET ADDRESS, CITY, STATE, ZIP CODE 1000 OLD DENBEIGH BOULEVARD NEWPORT NEWS, VA 23602		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		1	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD I TAG CROSS-REFERENCED TO THE APPROPR DEFICIENCY)			(X5) COMPLETION DATE
F 698	complete and send to updated resident inforcare is provided for a stated, we monitor the bruit and thrill. When documented, LPN #8.  On 12/7/23 at 4:45 F member) #1, the addrector of nursing an officer were made as According to the faci Clinical Skills" for dia information was provided. No further information 3. For Resident #120 failed to evidence conservices.  On the most recent in assessment, a quart (assessment referent resident scored 15 of interview for mental sindicating the resident making daily decision R120 receiving dialy.  On 12/5/2023 at 2:48 conducted with R120 that they went to dial three days a week of Fridays. R120 state for the dialysis accesside of their chest are	ed, there is paperwork we of the dialysis center, with permation. When asked what a dialysis resident, LPN #5 heir fistula site for bleeding, in asked where this is 5 stated, it is on the TAR.  PM, ASM (administrative staff ministrator, ASM #2, the had ASM #3, the chief nursing ware of the findings.  Ility, they follow "Elsevier alysis care. No further vided.  In was provided prior to exit. O (R120), the facility staff amplete dialysis care and  MDS (minimum data set) erly assessment with an ARD accedate) of 11/23/2023, the factor of the BIMS (brief status) assessment, int was cognitively intact for ins. Section O documented	F	698			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED		
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	ROVIDER OR SUPPLIER	ARWICK FOREST		STREET ADDRESS, CITY, STATE, ZIP CODE  1000 OLD DENBEIGH BOULEVARD  NEWPORT NEWS, VA 23602	<u> </u>	12/00/2023	
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETION DATE	
F 698	they returned from dialysis center had time and they had safter breakfast.  The comprehensive documented in part hemo-dialysis [sic] failure. Date Initiate 07/18/2023." Unde documented in part daily at access site 10/20/2022"  The physician orde part, - "10/12/2023 Reco evening shift every - "10/12/2023 Reco evening shift every Mon, Wed, Fri." - "10/12/2023 Take shift every Mon, Wed The eTAR (electror record) for R120 da failed to evidence p11/6/2023 and 11/1 signs on 11/3/2023 11/27/2023. It furth post-dialysis weight 11/13/2023, 11/20/23 and 12/4/2023	or check vital signs when dialysis. R120 stated that the recently changed their dialysis switched from early morning to e care plan for R120 requires r/t (related to) end stage renaled: 10/20/2022. Revision on: er "Interventions" it r, "Check and change dressing Document. Date Initiated:  ars for R120 documented in ard Post-dialysis vitals every Mon, Wed, Fri."  ard Post-dialysis weight every Pre-dialysis vitals every day	F 69	8			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED		
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	ROVIDER OR SUPPLIER  E LIFELONG H & R WA	RWICK FOREST		STREET ADDRESS, CITY, STATE, ZIP CODE  1000 OLD DENBEIGH BOULEVARD  NEWPORT NEWS, VA 23602			12/00/2020		
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F 698	dates, the eTAR legal evidence the meaning. Review of the clinical evidence documental catheter provided by signs, post-dialysis weights on the dates documented NA on the legend/chart codes of meaning of NA.  On 12/7/2023 at 8:20 conducted with LPN clinical coordinator. residents were moning signs pre and post doweight. LPN #2 states not provided any treat R120's dialysis acceed gauze dressing was site was cared for by stated that the nursing for any changes or donotify the dialysis coobserved. She review documenting the interchange the access states that it was not accurately accessed. She review 11/1/2023-11/30/202 signs and weights she did not know whe TAR's and that therweights in the space	R documented NA on those end/chart codes failed to ag of NA.  I record for R120 failed to attion of care of the dialysis facility staff, pre-dialysis vital ital signs or post-dialysis listed above. The eTAR hose dates, the eTAR ailed to evidence the  S a.m., an interview was (licensed practical nurse) #2, LPN #2 stated that dialysis tored by obtaining their vital italysis and monitoring their ed that the facility staff did atment or dressing change to ss. She stated that the applied at dialysis and the the dialysis staff. She ag staff monitored the area rainage every shift and would onter or provider if any were wed R120's care plan ervention to check and ite dressing daily and stated ate and needed to be	F	598					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED  C 12/08/2023		
		495071	B. WING				
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 12/00/2020		
RIVERSIDE LIFELONG H & R WARWICK FOREST				1000 OLD DENBEIGH BOULEVARD NEWPORT NEWS, VA 23602			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREF		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPED DEFICIENCY)	D BE COMPLETION
F 698	Continued From page		F 698	3			
		e administrator, ASM #2, the d ASM #3, the chief nursing ware of the concern.					
F 699 SS=D	No further information Trauma Informed Ca CFR(s): 483.25(m)	n was obtained prior to exit. re	F 699	e e e e e e e e e e e e e e e e e e e	1/22/24		
	trauma survivors rece trauma-informed care professional standard for residents' experie order to eliminate or cause re-traumatizati This REQUIREMENT by: Based on resident in facility document revi review, it was determ failed to provide traus 60 residents in the sa The findings include: Resident #115 was a 4/26/23 with diagnos limited to: PTSD (pos CVA (cerebrovascula The most recent MDS assessment, a quarte ARD (assessment re coded the resident as the BIMS (brief interv	ure that residents who are eive culturally competent, in accordance with its of practice and accounting inces and preferences in mitigate triggers that may on of the resident.  To is not met as evidenced interview, staff interview, ew and clinical record inned that the facility staff ma informed care for one of ample Resident #115.		1. The social worker met with residents and she refused psychology/psychiatric services on 12/7/2023. She agreed to see the Chaplain on 12/12/2023 and particip spiritual programs.  2. The Director of Resident Services/designee will audit all resident who have a diagnosis of PTSD to er that they have been offered supporting services for trauma informed care.  3. Director of Resident Services/designee will educate the services clinical team on offering psychological/psychiatric services to residents with the diagnosis of PTSD documentation follow up regarding the informed care.  4. Director of Resident Services	eate in ents asure ve social othose D and		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I	2) MULTIPLE CONSTRUCTION BUILDING			(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER	RWICK FOREST		STREET ADDRESS, CITY, STATE, ZIP CODE  1000 OLD DENBEIGH BOULEVARD  NEWPORT NEWS, VA 23602			700/2023	
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F 699	coded the resident as assistance for bathin dressing, hygiene an I: Medical Diagnosis: Stress Disorder (PTS A review of the comp 8/10/23 revealed, "For potential for alteration history of trauma, dia INTERVENTIONS: If supportive care and sof safety, well-being Staff will use the app assessments to recomake referrals, as necare, as needed.".  A review of the facility Screen dated 4/30/2 READ: Sometimes the are unusually or espectraumatic. For examp fire *a physical or several physical physic	s requiring extensive g, bed mobility, transfer, d eating. A review of Section 16100. Post Traumatic 5D)-coded yes.  rehensive care plan dated DCUS: Resident has a in in wellbeing related to ignosis of PTSD. Provide resident with services to promote a sense and positive self-image. ropriate screening tools and gnize past trauma and will scessary. Consult pastoral  y's "Trauma Informed Care 3 revealed, "PTSD SCREEN things happen to people that secially frightening, horrible, or oble: *a serious accident or kual assault or abuse *an a war *seeing someone be ured *having a loved one die suicide. Have you ever I of event? Coded as No. If Please stop here. If yes, ions in the next section."	F	699	week for 8 weeks to ensure that those residents with diagnosis of PTSD have had support services offered for traum informed care. The results of the audi will be reported at the QAPI meeting for evaluation of compliance and ongoing monitoring for continuous improvement analysis.	e a t or		
	informed care from 5							

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ' '	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		495071	B. WING			C 1 <b>2/08/2023</b>		
	ROVIDER OR SUPPLIER	ARWICK FOREST		STREET ADDRESS, CITY, STATE, ZIP CODE  1000 OLD DENBEIGH BOULEVARD  NEWPORT NEWS, VA 23602	12/00/2023			
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F 699	Routine skilled inpi is a 69-year-old. fe with residual left he aphasia, left intertr (4/7/23), breast cal who presented to t debility secondary  An interview was company trauma or stress, Foothing to talk about.  An interview was company to talk about.  An interview was company to talk about.	age 79 d, "CHIEF COMPLAINT attent follow-up visit: Resident male with history of prior CVA emiparesis and expressive ochanteric fracture fixation neer, hypertension and PTSD he facility from hospital for to recent hospitalization."  onducted on 12/5/23 at 3:15 #115. When asked about Resident #115 stated, there is ut. I do not want to talk about onducted on 12/7/23 at 11:50 used practical nurse) #5. When specific interventions for are, LPN #5 stated, we monitor sychiatry consult, notify the e changes, minimize any s possible and keep them calm	F 69	9				
	PM with OSM (other director of social set trauma informed castated, for this resibehaviors, we would behaviors, for trigg When asked if ther would the diagnosistated, just because we would want behaved about the caregarding PTSD, C (interdisciplinary te	er staff member) #2, the ervices. When asked about are for Resident #115, OSM #2 dent, there are no triggers or ld be looking for any adverse ers to implement any care. The is a diagnosis of PTSD, is necessitate a plan? OSM #2 is there is a diagnosis, believe haviors and triggers. When are plan for Resident #115 oSM #2 stated, the IDT am) develops the care plan. It is responsible for psychosocial						

		I ' '		(X3) DATE SURVEY COMPLETED
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well-being, OSM #2 s responsible for psych residents.  On 12/7/23 at 4:45 P member) #1, the adm director of nursing an officer were made aw A review of the facility policy, revealed, "Statraining about trauma post-traumatic stress the healthcare setting will make referrals to needed for mental he health services may I means, including, but counseling or psycholout-patient services, groups, etc. The interedevelop a compreher addresses identified triggers in an effort to that will minimize restresident. Approaches	M, ASM (administrative staff ninistrator, ASM #2, the d ASM #3, the chief nursing rare of the findings.  It's "Trauma Informed Care"  Iff are provided in-service and it is impact on health, and disorder in the context of an attending practitioner as realth services. Mental provided in a variety of an ot limited to: In-person therapy services, Telehealth services, Support redisciplinary team will asive care plan that the raumatic events and/or a maintain an environment raumatization for the a will be person centered and	F 6	99	
Bedrails CFR(s): 483.25(n)(1) §483.25(n) Bed Rails The facility must atteralternatives prior to in a bed or side rail is u	-(4)  mpt to use appropriate a side or bed rail. If sed, the facility must ensure	F 7	00	1/22/24
	Continued From page well-being, OSM #2 s responsible for psych residents.  On 12/7/23 at 4:45 Pl member) #1, the adm director of nursing an officer were made aw A review of the facility policy, revealed, "Statraining about trauma post-traumatic stress the healthcare setting will make referrals to needed for mental he health services may be means, including, but counseling or psycho Out-patient services, groups, etc. The intedevelop a compreher addresses identified to that will minimize restresident. Approaches sensitive to the reside value."  No further information Bedrails CFR(s): 483.25(n) Bed Rails The facility must atternatives prior to in a bed or side rail is used.	ROVIDER OR SUPPLIER  E LIFELONG H & R WARWICK FOREST  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 80  well-being, OSM #2 stated, social services are responsible for psychosocial well being of residents.  On 12/7/23 at 4:45 PM, ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing and ASM #3, the chief nursing officer were made aware of the findings.  A review of the facility's "Trauma Informed Care" policy, revealed, "Staff are provided in-service training about trauma, its impact on health, and post-traumatic stress disorder in the context of the healthcare setting. The interdisciplinary team will make referrals to the attending practitioner as needed for mental health services. Mental health services may be provided in a variety of means, including, but not limited to: In-person counseling or psychotherapy services, Out-patient services, Telehealth services, Support groups, etc. The interdisciplinary team will develop a comprehensive care plan that addresses identified traumatic events and/or triggers in an effort to maintain an environment that will minimize re-traumatization for the resident. Approaches will be person centered and sensitive to the resident's culture, beliefs, and value."	ROVIDER OR SUPPLIER  E LIFELONG H & R WARWICK FOREST  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 80  well-being, OSM #2 stated, social services are responsible for psychosocial well being of residents.  On 12/7/23 at 4:45 PM, ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing and ASM #3, the chief nursing officer were made aware of the findings.  A review of the facility's "Trauma Informed Care" policy, revealed, "Staff are provided in-service training about trauma, its impact on health, and post-traumatic stress disorder in the context of the healthcare setting. The interdisciplinary team will make referrals to the attending practitioner as needed for mental health services. 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If a bed or side rail is used, the facility must ensure	ROWIDER OR SUPPLIER  ELIFELONG H & R WARWICK FOREST  SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REQUIATION OF LIST OF DEFICIENCY)  SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REQUIATION OF LIST OF DEFICIENCY)  Continued From page 80  well-being, OSM #2 stated, social services are responsible for psychosocial well being of residents.  On 12/7/23 at 4:45 PM, ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing and ASM #3, the chief nursing officer were made aware of the findings.  A review of the facility's "Trauma Informed Care" policy, revealed, "Staff are provided in-service training about traum, its impact on health, and post-traumatic stress disorder in the context of the healthcare setting. The interdisciplinary team will make referrals to the attending practitioner as needed for mental health services. 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F 700	elements.  §483.25(n)(1) Assess entrapment from bed §483.25(n)(2) Review bed rails with the respectative and on to installation.  §483.25(n)(3) Ensurare appropriate for the §483.25(n)(4) Follow recommendations are and maintaining bed This REQUIREMEN by:  Based on staff internand facility document facility staff failed requirements for thresurvey sample, Resigner #60.  The findings include  1. The facility staff failed consent for Resident #60.  Resident #49 was of half bed rails on 12/6 at 8:00 AM.  Resident #49 was at 12/17/21 with diagnormal staff and the same staff in the same staff in the survey sample, Resident #49 was of half bed rails on 12/6 at 8:00 AM.	s the resident for risk of drails prior to installation.  We the risks and benefits of sident or resident obtain informed consent prior  the that the bed's dimensions he resident's size and weight.  What the manufacturers' had specifications for installing rails.  This not met as evidenced wiew, clinical record review at review, it was determined at to implement bed rail the out of 60 residents in the dents # 49, Resident #58 and the dents # 49, Resident #58 and the dents # 49.  Deserved in bed with bilateral 5/23 at 7:30 AM and 12/7/23 demitted to the facility on the sist that included but were	F 70	<ol> <li>Resident #49, Resident #58 and Resident #60 had bed rail informed consents obtained on 12/7/23 by the Manager.</li> <li>Administrator/designee will audi residents with bed rails to ensure the signed consents are in place for eac resident.</li> <li>Clinical Educator /designee will educate admissions staff on the proof reviewing and signing a consent for admission for bed rails and as ne for other residents.</li> <li>Administrator / designee will aud records per week for 8 weeks to ens that there are informed consents for residents using bed rails. The results the audit will be reported at the QAP</li> </ol>	t t at h cess corm eded dit 4 ure all s of I
	not limited to: COPD pulmonary disease),	(chronic obstructive		meeting for evaluation of compliance ongoing monitoring for continuous	

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	ULTIPLE CONSTRUCTION  LDING			(X3) DATE SURVEY COMPLETED			
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F 700	(peripheral vascular  The most recent MD assessment, a quart ARD (assessment recoded the resident athe BIMS (brief interindicating the reside review of the MDS Scoded the resident assistance for bathir mobility, transfer, draindependent for locoloma Areview of the comparts of the compa	iovascular disease) and PVD disease).  S (minimum data set) erly assessment, with an eference date) of 11/28/23, as scoring a 15 out of 15 on view for mental status) score, in twas cognitively intact. A fection G-functional status is requiring extensive ag and supervision for bed essing, hygiene and eating; motion.  Orehensive care plan dated occus; Resident desires to eccive continued services. Provide services according to rt to enhance optimum is x2, limited assist x1:	F	700	improvement analysis.					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495071	B. WING	B. WING		C 12/08/2023	
NAME OF PROVIDER OR SUPPLIER  RIVERSIDE LIFELONG H & R WARWICK FOREST			1	STREET ADDRESS, CITY, STATE, ZIP CODE  000 OLD DENBEIGH BOULEVARD  NEWPORT NEWS, VA 23602	<u>  12/</u>	06/2023	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROPR DEFICIENCY)			(X5) COMPLETION DATE
F 700	Continued From page On 12/7/23 at 4:45 Pl member) #1, the adm director of nursing an officer were made aw A review of the facility Entrapment" policy, re alternatives have bee installation, the facility consent from the resi representative for the facility will maintain e sufficient information resident representative decision."  No further information  2.The facility staff fail consent for Resident Resident #58 was ob half bed rails on 12/5, 8:30 AM and 12/7/23  Resident #58 was ad 4/25/23 with diagnosi limited to: COPD (chr	M, ASM (administrative staff inistrator, ASM #2, the d ASM #3, the chief nursing are of the findings.  I's "Bed Rail / Side Rail evealed, "After appropriate in attempted and prior to y will obtain informed dent or the resident use of bed rails. The vidence that it has provided so that the resident or recould make an informed in was provided prior to exit.  Bed Rail / Side Rail evealed, "After appropriate in attempted and prior to y will obtain informed dent or the resident or recould make an informed in was provided prior to exit.  Bed to obtain informed #58.  Beerved in bed with bilateral #23 at 1:00 PM, 12/6/23 at		700	DEFICIENCY)	TE .	DATE
	The most recent MDS assessment, a quarte ARD (assessment recoded the resident as the BIMS (brief interv	6 (minimum data set) brly assessment, with an ference date) of 11/7/23, b scoring a 05 out of 15 on iew for mental status) score, t was severely cognitively					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495071	B. WING	B. WING		C 12/08/2023	
NAME OF PE	ROVIDER OR SUPPLIER	100011		_	STREET ADDRESS, CITY, STATE, ZIP CODE	121	06/2023
					1000 OLD DENBEIGH BOULEVARD		
RIVERSID	E LIFELONG H & R WAR	RWICK FOREST			NEWPORT NEWS, VA 23602		
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE
F 700	Continued From page	e 84	F	700			
	G-functional status co						
		ssistance for bathing, bed					
	mobility; limited assist	tance for transfers and					
	supervision for eating	J.					
	Δ review of the comp	rehensive care plan dated					
		OCUS: Resident desires to					
	·	ceive continued services.					
	INTERVENTIONS: P	Provide services according to					
	care plans in an effort						
		x2, total dependence x 2					
	transfers, extensive a dressing, toileting and	<del>_</del>					
	dressing, tolleting and	personal hygiene.					
	Bed Rail Risk evaluat	tion for Resident #58 was					
	·	here was no evidence of					
	consent obtained for l	bed rails for Resident #58.					
	An interview was con	ducted on 12/6/23 at 3:00					
		ed practical nurse) #4. When					
		onsent for the bedrails, LPN					
		bed safety/risks/benefits					
	evaluation. Not sure	who gets the consent.					
	An interview was con-	ducted on 12/7/23 at 8:00					
		administrator. ASM #1					
		e the consent for three					
	residents only this on	e.					
	On 12/7/22 at 4:45 DM	M ASM (administrative staff					
		M, ASM (administrative staff iinistrator, ASM #2, the					
		d ASM #3, the chief nursing					
	officer were made aw						
	No further information	n was provided prior to exit.					
	140 Iululei Illioillialioi	i was provided prior to exit.					
	3.The facility staff faile	ed to obtain informed					
	consent for Resident	#60.					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	PLE CONSTRUCTION  G	(X3	(X3) DATE SURVEY COMPLETED		
		495071	B. WING			C <b>12/08/2023</b>		
	ROVIDER OR SUPPLIER	ARWICK FOREST		STREET ADDRESS, CITY, STATE, ZIP CODE  1000 OLD DENBEIGH BOULEVARD  NEWPORT NEWS, VA 23602		12100/2020		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE		
F 700	half bed rails on 12 2:30 PM and 12/7/ Resident #60 was 1/15/21 with diagn- limited to: ESRD (e CVA (cerebrovasce hypertension.  The most recent M assessment, a qua ARD (assessment coded the resident the BIMS (brief inte indicating the resident for bathing, bed me hygiene and eating A review of the cor 5/30/23 revealed, ' remain in facility to INTERVENTIONS care plans in an ef well-being. Sidera dressing, toileting, and personal hygie transfers."  Bed Rail Risk eval completed 10/7/23 consent obtained for	observed in bed with bilateral 2/5/23 at 12:00 PM, 12/6/23 at 23 at 8:30 AM.  admitted to the facility on osis that included but were not end stage renal disease), DM, ular accident) and  ADS (minimum data set) arterly assessment, with an reference date) of 10/31/23, as scoring a 13 out of 15 on erview for mental status) score, lent was cognitively intact. A Section G-functional status as requiring limited assistance obility, transfer, dressing, d.  Imprehensive care plan dated are ceive continued services. Provide services according to fort to enhance optimum ils x2, limited assist x1: showers, incontinence care ene. Extensive assist x1:	F 70					
	PM with LPN (licer asked who obtains	nonducted on 12/6/23 at 3:00 ased practical nurse) #4. When consent for the bedrails, LPN are bed safety/risks/benefits						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED		
		495071	B. WING				08/ <b>2023</b>
	ROVIDER OR SUPPLIER  E LIFELONG H & R WA	RWICK FOREST	•	1	TREET ADDRESS, CITY, STATE, ZIP CODE 000 OLD DENBEIGH BOULEVARD IEWPORT NEWS, VA 23602		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 725 SS=D	An interview was cor AM with ASM #1, the stated, we do not har residents only this or On 12/7/23 at 4:45 Pmember) #1, the addirector of nursing ar officer were made as No further information Sufficient Nursing State CFR(s): 483.35(a) (1) §483.35(a) Sufficient The facility must have the appropriate comprovide nursing and resident safety and a practicable physical, well-being of each regressident assessment and considering the diagnoses of the facility accordance with the at §483.70(e).  §483.35(a)(1) The facility sufficient numbers types of personnel of nursing care to all regressident care plans:  (i) Except when waits this section, licensed	who gets the consent.  Inducted on 12/7/23 at 8:00 Is administrator. ASM #1 If we the consent for three ine.  If M, ASM (administrative staff ininistrator, ASM #2, the ind ASM #3, the chief nursing ware of the findings.  In was provided prior to exit.  In aff (2) Is Staff. It is sufficient nursing staff with petencies and skills sets to related services to assure intain or maintain the highest mental, and psychosocial isident, as determined by and individual plans of care number, acuity and lity's resident population in facility assessment required  It is considered to the following in a 24-hour basis to provide is sidents in accordance with including but not including		725			1/22/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MULT IDENTIFICATION NUMBER:  A. BUILDIN		PLE CONSTRUCTION  3	(X3) DATE SURVEY COMPLETED
		495071	B. WING	· · · · · · · · · · · · · · · · · · ·	C 12/08/2023
	ROVIDER OR SUPPLIER	ARWICK FOREST		STREET ADDRESS, CITY, STATE, ZIP CODE  1000 OLD DENBEIGH BOULEVARD  NEWPORT NEWS, VA 23602	,
(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 CORRECTIO  (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE COMPLETION
F 725	Continued From page \$483.35(a)(2) Excep	ge 87 ot when waived under	F 72	25	
	paragraph (e) of this designate a licensed nurse on each tour. This REQUIREMEN by: Based on resident is clinical record review, it was determined to ensure sufficient to ensure suffing to one of 60 residents. Resident #2.  The findings include For Resident #2 (R2 ensure sufficient CN (7:00 a.m. to 3:00 p adequate incontiner.  On the most recent annual assessment reference date) of 1 as scoring 14 out of interview for mental indicating the reside.  On the MDS assess with an ARD of 1/27 requiring extensive persons for toileting.  On 12/5/2023 at 3:4 conducted with R2. concerns with care is stated that there we	s section, the facility must d nurse to serve as a charge of duty.  IT is not met as evidenced interview, staff interview, and facility document mined that the facility staff icient CNA (certified nursing provide care and services for in the survey sample,  2), the facility staff failed to IAA staffing on the day shift interview.  MDS (minimum data set), an with an ARD (assessment 0/12/2023, R2 was assessed 15 on the BIMS (brief status) assessment, and was cognitively intact.		<ol> <li>Resident #2 received incontinent care on all three shifts on 12/6/2023, 12/7/2023, and 12/8/2023 by the clinical staff assigned to her.</li> <li>The Director of Nursing / design will review staffing daily to ensure sufficient CNA staffing is present to provide care and services to the residents.</li> <li>Administrator /designee will educlinical leaders and schedulers on acceptable staffing ratios per shift to ensure sufficient CNA staffing is present how to escalate staffing concerned. Administrator / designee will revistaffing 3 times weekly for 8 weeks to ensure appropriate CNA staff is present provide care and services to the residents. The results of the audit will reported at the QAPI meeting for evaluation of compliance and ongoin monitoring for continuous improvement analysis.</li> </ol>	ical nee  cate sent s. view o ent to I be

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	TIPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED	
		495071	B. WING _			C <b>12/08/2023</b>
	ROVIDER OR SUPPLIER  E LIFELONG H & R WA	ARWICK FOREST		STREET ADDRESS, CITY, STATE, ZIP CO 1000 OLD DENBEIGH BOULEVARD NEWPORT NEWS, VA 23602	•	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI) TAG	PROVIDER'S PLAN OF C  (EACH CORRECTIVE ACTIC  CROSS-REFERENCED TO TH  DEFICIENCY	ON SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 725	worked so hard.  Review of the facilit 3/18/2022 documer 2022, resident's rep (activities of daily live a timely manner and DON (director of assessment was constarted immediately investigation, there of not providing ADI Review of the as working the day shift of 56 residents.  On 12/7/2023 at 8:2 conducted with OSI staffing coordinator the Monticello unit with three nurses and two nurses and five and two nurses and five and two nurses and five and two nurses and cosm #4 stated that shortage and open contacted staff via a person to ask if states there where a lot of monetary incentives shifts.	d more help because they all  y synopsis of events dated nted in part, "On March 14, presentative alleged ADL ving) care was not provided in d reported to Administrator of nursing). A head-to-toe ompleted, and investigation rBased on a thorough is no evidence of willful intent L care to (name of R2)"  priced staffing sheet for the umented two CNA staff fit on 3/13/2022 with a census  20 a.m., an interview was M (other staff member) #4 (the ). OSM #4 stated she staffed which had a total of 60 beds, and six CNAs on the day shift, I two CNAs on the night shift. I two CNAs on the night shift. I two CNAs on the schedule, she email, phone, text and in iff were willing to work extra ted that for the dates that openings, she offered is for staff to work the extra	F7	725		
	conducted with OSI	:50 a.m., an interview was M #2, director of social officer. OSM #2 stated that ions and email				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  495071			(X2) MULT A. BUILDIN	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		495071	B. WING		,	C 12/08/2023		
	ROVIDER OR SUPPLIER	ARWICK FOREST		STREET ADDRESS, CITY, STATE, ZIP CODE 1000 OLD DENBEIGH BOULEVARD NEWPORT NEWS, VA 23602		12.700.2020		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF COR ( (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE		
F 725	Continued From particles correspondence with ADL care concerns that the former adm of nursing had concerns that the former adm of nursing had concerns after the concern.  On 12/7/2023 at 12 conducted with CNA were working on 3/5 She stated that she the first time she had only two CNAs. She with a male CNA arresidents who did not care of them. She stated the best that residents that were got the residents up meal trays and answer stated that there we unit and the two CN stated that she did rooms on the unit the seemed to take longer worked and the two CN stated that she did rooms on the unit the seemed to take longer worked and the two CN stated that she did rooms on the unit the seemed to take longer worked and the two CN stated that she did rooms on the unit the seemed to take longer worked and the two CN stated that she did rooms on the unit the seemed to take longer worked and the two CN stated that she did rooms on the unit the seemed to take longer worked and the two CN stated that she did rooms on the unit the seemed to take longer worked and the two CN stated that she did rooms on the unit the seemed to take longer worked and the two CN stated that she did rooms on the unit the seemed to take longer worked and the two CN stated that she did rooms on the unit the seemed to take longer worked and the two CN stated that she did rooms on the unit the seemed to take longer worked and the two CN stated that there were unit and the two CN stated that there were unit and the two CN stated that there were unit and the two CN stated that there were unit and the two CN stated that there were unit and the two CN stated that there were unit and the two CN stated that there were unit and the two CN stated that there were unit and the two CN stated that the two CN stated	,						
	who could make be rooms and take out provide any patient had residents that he while. She stated to 3:00 p.m. and R2 requesting to be che that she would come came back after he that she had passed	ds, answer call bells, tidy up the trash but they could not care. She stated that they had to be fed which took a hat she worked from 7:00 a.m. It did ring the call bell hanged and she had told them he back. She stated that she is r shift was over and told her did it to the next shift to make first resident to be changed.						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDIN		(X3) DATE SURVEY COMPLETED	
		495071	B. WING _		_	C <b>12/08/2023</b>
	ROVIDER OR SUPPLIER	RWICK FOREST		STREET ADDRESS, CITY, STA 1000 OLD DENBEIGH BOUL NEWPORT NEWS, VA 23	LEVARD	12/00/2020
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD B CED TO THE APPROPRIA EFICIENCY)	DATE
F 725	She stated that she is shift and the male Clanext CNA came in. not recall R2 getting resident should not it been changed.  On 12/7/2023 at 2:22 conducted with LPN LPN #8 stated that the that day but they did.  The administrator an incident no longer with the census, resident and the distribution of Staffing is adjusted to other resident needs document. Per diem needed to maintain a needed. Staffing lev day-to-day, shift-to-sfactors. We ensure CNAs who can work ensure residents reconstruction to the treatment, assessment to letting assistance, needs timely"  On 12/7/2023 at 4:36 staff member) #1, the director of nursing an officer were made as officer were made as staff member and the state of th	nad to leave at the end of her NA had stayed over until the CNA #6 stated that she did changed on her shift and the nave gone all day and not  2 p.m., an interview was (licensed practical nurse) #8. ney may have been working not recall the incident.  d DON at the time of the orked at the facility.  ent dated 3/14/2023 "Staff plan: Staffing is and is adjusted based on acuity, resident complexity, of residents in the building. The passed on the time of day and as described in this agency staff are used as appropriate staffing levels, as els are determined on a hift basis depending on those there are enough nurses and collaboratively as a team to eive their medications, ents, ADL care, showers, help during meals, and other  6 p.m., ASM (administrative end ASM #3, the chief nursing	F 7	25		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
495071			B. WING		C 12/08/2023
	ROVIDER OR SUPPLIER E LIFELONG H & R WA	RWICK FOREST		STREET ADDRESS, CITY, STATE, ZIP CODE 1000 OLD DENBEIGH BOULEVARD NEWPORT NEWS, VA 23602	, .=
(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 CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION
F 740 SS=D	provide the necessa services to attain or practicable physical, well-being, in accord assessment and plan encompasses a resimental well-being, w limited to, the prever and substance use of This REQUIREMENT by:  Based on resident in facility document reversive, it was determ failed to provide necestand services to attain practicable physical, well-being, in accord assessment and plan residents in the same The findings included The facility staff failed psychosocial interversive who had an admitting traumatic stress discussion MDS (mir with an ARD (assess 4/30/23, Section I: A post-traumatic stress	mealth services. receive and the facility must ry behavioral health care and maintain the highest mental, and psychosocial ance with the comprehensive n of care. Behavioral health dent's whole emotional and hich includes, but is not ntion and treatment of mental lisorders.  T is not met as evidenced  Interview, staff interview, iew and clinical record nined that the facility staff ressary behavioral health care n or maintain the highest mental, and psychosocial ance with the comprehensive n of care for one of 60 ple, Resident #115.  In d to assess and implement ntions for Resident #115, g diagnosis of PTSD (post order) and was coded on himum data set) assessment himment reference date) of ctive Diagnosis: I6100: In disorder- coded as present.	F 740	1. The provider ordered psychological/psychiatric services for resident #115 on 12/7/23. She was see by the Psych NP on 1/10/23. She agr to see the Chaplain on 12/12/2023 and participate in spiritual programs.  2. The Director of Resident Services/designee will audit all reside who have a diagnosis of PTSD to ensithat they have been offered supportives services for trauma informed care and that behaviors are being monitored.  3. Director of Resident Services/designee will educate the cliteam (social services and nursing) on offering psychological/psychiatric services to those residents with the diagnosis of PTSD, documentation and follow up regarding trauma informed care and monitoring of behaviors.  4. Director of Resident Services/	een eed ad ints sure e d inical vices of
	4/26/23 with diagnos	admitted to the facility on is that included but were not st-traumatic stress disorder),		designee will audit 4 resident records week for 8 weeks to ensure that those residents with diagnosis of PTSD hav	e

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495071	B. WING_		1	C 12/08/2023	
NAME OF P	ROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP C		2/06/2023	
				1000 OLD DENBEIGH BOULEVARD			
RIVERSID	E LIFELONG H & R WAF	RWICK FOREST		NEWPORT NEWS, VA 23602			
(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 (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 740	Continued From page	e 92	F 7	40			
	The most recent MDS assessment, a quarte ARD (assessment recoded the resident as the BIMS (brief intervindicating the resident review of the MDS Scoded the resident as assistance for bathing dressing, hygiene an I: Medical Diagnosis: Stress Disorder (PTS A review of the comp 8/10/23 revealed, "FC potential for alteration history of trauma, dia INTERVENTIONS: F supportive care and sof safety, well-being a Staff will use the app assessments to recognition."	r accident) and hemiplegia.  S (minimum data set) erly assessment, with an ference date) of 10/24/23, s scoring a 15 out of 15 on riew for mental status) score, at was cognitively intact. A fection G-functional status s requiring extensive g, bed mobility, transfer, d eating. A review of Section 16100. Post Traumatic SD)-coded yes.  rehensive care plan dated DCUS: Resident has a in in wellbeing related to gnosis of PTSD.		had support services offere informed care and monitori behaviors. The results of the reported at the QAPI meeting evaluation of compliance a monitoring for continuous in analysis.	ng of he audit will be ng for nd ongoing		
	Screen" dated 4/30/2 READ: Sometimes to are unusually or espetraumatic. For examplifire *a physical or severathquake or flood * killed or seriously injuthrough homicide or sexperienced this kind no, screen total = 0. I	y's "Trauma Informed Care 3 revealed, "PTSD SCREEN hings happen to people that ecially frightening, horrible, or ole: *a serious accident or kual assault or abuse *an a war *seeing someone be ured *having a loved one die suicide. Have you ever I of event? Coded as No. If Please stop here. If yes, ions in the next section."					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495071	B. WING	B. WING		C 12/08/2023	
NAME OF PR	ROVIDER OR SUPPLIER		1	5	STREET ADDRESS, CITY, STATE, ZIP CODE	1 12/	00/2023
RIVERSID	E LIFELONG H & R WAF	RWICK FOREST			1000 OLD DENBEIGH BOULEVARD NEWPORT NEWS, VA 23602		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		1	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD I TAG CROSS-REFERENCED TO THE APPROPR DEFICIENCY)			(X5) COMPLETION DATE
F 740	Continued From page	e 93	F	740			
		cian orders does not indicate It or orders to monitor					
	record) for Septembe	TAR (medication -treatment administration er 2023-December 6, 2023, monitoring of behaviors.					
	A review of the medical record does not reveal any social services follow up regarding trauma informed care from 5/1/23-12/6/23.						
	11:34 AM, revealed, "Routine skilled inpatic is a 69-year-old. fema with residual left hem aphasia, left intertrool (4/7/23), breast cance who presented to the	cians note dated 8/15/23 at  'CHIEF COMPLAINT ent follow-up visit: Resident ale with history of prior CVA iparesis and expressive hanteric fracture fixation er, hypertension and PTSD facility from hospital for recent hospitalization."					
	dated 8/21/23 revealed verbally responsive. For remain in her room in previous placement. Some readmitted to the facing following discharge. For made any significant admission. Resident's return home when shindependently. Residential with no noted medical No discharge plans as	She returned home and was lity less than a month Resident is not noted to have changes from previous so son will like for her to e is able to ambulate ent has diagnosis of PTSD titions. Resident is a DNR. There ervices notes to indicate					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTII	PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED	
		495071	B. WING		,	C 12/08/2023	
	ROVIDER OR SUPPLIER	VARWICK FOREST		STREET ADDRESS, CITY, STATE, ZIP CODE 1000 OLD DENBEIGH BOULEVARD NEWPORT NEWS, VA 23602	'		
(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 CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 740	Continued From pa	age 94	F 74	40			
	PM with Resident at trauma or stress, Foothing to talk about.  An interview was compared asked if there are strauma informed compared and comfortable.  An interview was compared and comfortable.  An interview was compared and comfortable.  An interview was compared and comfortable and comfortable are trauma informed compared asked, for this resident asked if there would the diagnosis stated, just because we would want behaviors, the compared asked about the corregarding PTSD, Compared to talk about the correct the talk about the talk about the correct the talk about the correct the talk about the t	conducted on 12/5/23 at 3:15 #115. When asked about Resident #115 stated, there is ut. I do not want to talk about  conducted on 12/7/23 at 11:50 nsed practical nurse) #5. When repectific interventions for are, LPN #5 stated, we monitor resychiatry consult, notify the re changes, minimize any respectively spossible and keep them calm  conducted on 12/7/23 at 4:15 restaff member) #2, the revices. When asked about rare for Resident #115, OSM #2 dent, there are no triggers or relid be looking for any adverse rers to implement any care. re is a diagnosis of PTSD, resis necessitate a plan? OSM #2 reste there is a diagnosis, believe reaviors and triggers. When replan for Resident #115 ream) develops the care plan.					
	When asked who i well-being, OSM # responsible for psy residents.  On 12/7/23 at 4:45 member) #1, the a director of nursing	s responsible for psychosocial 2 stated, social services are vchosocial well-being of PM, ASM (administrative staff dministrator, ASM #2, the and ASM #3, the chief nursing aware of the findings.					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495071	B. WING		1	C	
	ROVIDER OR SUPPLIER  E LIFELONG H & R WAF		B: Will C _	STREET ADDRESS, CITY, STATE, ZIP CODE  1000 OLD DENBEIGH BOULEVARD  NEWPORT NEWS, VA 23602	<u>  12/0</u>	08/2023	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION ( (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(X5) COMPLETION DATE	
F 740	policy, revealed, "Statraining about traumare post-traumatic stress the healthcare setting will make referrals to needed for mental he health services may be means, including, but counseling or psycho Out-patient services, groups, etc. The interest develop a comprehere addresses identified to triggers in an effort to that will minimize restresident. Approaches sensitive to the reside value."	r's "Trauma Informed Care"  ff are provided in-service , its impact on health, and disorder in the context of g. The interdisciplinary team the attending practitioner as alth services. Mental pe provided in a variety of anot limited to: In-person therapy services, Telehealth services, Support rdisciplinary team will asive care plan that traumatic events and/or maintain an environment	, F 7	40			
F 745 SS=D	S483.40(d) The facility medically-related social maintain the highest pand psychosocial well This REQUIREMENT by: Based on resident in facility document revireview, it was determined to provide medically.	y must provide ial services to attain or oracticable physical, mental I-being of each resident. is not met as evidenced terview, staff interview, ew and clinical record ined that the facility staff ically related social services is in the sample Resident	F 7	1. The provider ordered psychological/psychiatric services for resident #115 on 12/7/23. She was se by the Psych NP on 1/10/23. She agre to see the Chaplain on 12/12/2023 are participate in spiritual programs.  2. The Director of Resident	en eed	1/22/24	

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED	
		495071	B. WING _				08/2023	
NAME OF PI	ROVIDER OR SUPPLIER			ST	FREET ADDRESS, CITY, STATE, ZIP CODE			
DI (2001)				10	000 OLD DENBEIGH BOULEVARD			
RIVERSID	E LIFELONG H & R WAF	RWICK FOREST		N	EWPORT NEWS, VA 23602			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 745	Continued From page	e 96	F 7	'45				
	The findings include:				Services/designee will audit all residen	ts		
	J				who have a diagnosis of PTSD to ensu			
	For Resident #115, th	ne facility staff failed to			that they have been offered supportive			
	provide psychosocial	follow up following the			services for trauma informed care and			
		ed with a diagnosis of PTSD			that behaviors are being monitored.			
	(post-traumatic stress	s disorder).			<ol><li>Director of Resident</li></ol>			
					Services/designee will educate the clin	ical		
		dmitted to the facility on			team (social services and nursing) on			
		s that included but were not			offering psychological/psychiatric servi			
		t-traumatic stress disorder), r accident) and hemiplegia.			to those residents with the diagnosis of PTSD, documentation and follow up			
	CVA (cerebrovascula	i accident) and nemplegia.			regarding trauma informed care and			
	The most recent MDS	S (minimum data set)			monitoring of behaviors.			
		erly assessment, with an			Director of Resident Services /			
		ference date) of 10/24/23,			designee will audit 4 resident records p	er		
	,	s scoring a 15 out of 15 on			week for 8 weeks to ensure that those			
	the BIMS (brief interv	iew for mental status) score,			residents with diagnosis of PTSD have			
	indicating the residen	t was cognitively intact. A			had support services offered for trauma	3		
		ection G-functional status			informed care and monitoring of			
	coded the resident as	· ·			behaviors. The results of the audit will	be		
		g, bed mobility, transfer,			reported at the QAPI meeting for			
		d eating. A review of Section			evaluation of compliance and ongoing			
		I6100. Post Traumatic			monitoring for continuous improvemen	Į.		
	Stress Disorder (PTS	D)-coded yes.			analysis.			
	A review of the comp	rehensive care plan dated						
		OCUS: Resident has a						
		in wellbeing related to						
	history of trauma, dia	•						
	INTERVENTIONS: F	<u> </u>						
		services to promote a sense						
	of safety, well-being a	and positive self-image.						
		ropriate screening tools and						
		gnize past trauma and will						
		cessary. Consult pastoral						
	care, as needed.".							
	A mandanu af H f- ''''	de l'Trecone e Inferre e d'Orie						
	-	r's "Trauma Informed Care 3 revealed. "PTSD SCREEN						

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495071	B. WING		C 12/08/2023
	ROVIDER OR SUPPLIER	RWICK FOREST		STREET ADDRESS, CITY, STATE, ZIP CODE  1000 OLD DENBEIGH BOULEVARD  NEWPORT NEWS, VA 23602	12/00/2023
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	OULD BE COMPLETION
F 745	are unusually or esp traumatic. For exam fire *a physical or se earthquake or flood killed or seriously in through homicide or experienced this kin no, screen total = 0. please answer quest A review of the physical and psychiatry consideration.  A review of the MAF administration recorrecord) for Septemb does not reveal any A review of the med any social services informed care from the A review of the physical services informed care from the A review of the physical services informed care from the with residual left her aphasia, left intertro (4/7/23), breast can who presented to the debility secondary to A review of the quar dated 8/21/23 reveal verbally responsive.	things happen to people that recially frightening, horrible, or ple: *a serious accident or exual assault or abuse *an *a war *seeing someone be fured *having a loved one die suicide. Have you ever d of event? Coded as No. If Please stop here. If yes, tions in the next section."  A-TAR (medication detreatment administration er 2023-December 6, 2023, monitoring of behaviors.  Ical record does not reveal follow up regarding trauma	F 74	5	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	E CONSTRUCTION	COMPLETED
		495071	B. WING		C <b>12/08/2023</b>
	ROVIDER OR SUPPLIER  PE LIFELONG H & R W	ARWICK FOREST		STREET ADDRESS, CITY, STATE, ZIP CODE 1000 OLD DENBEIGH BOULEVARD NEWPORT NEWS, VA 23602	12.00.2020
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	O BE COMPLETION
F 745	readmitted to the fat following discharge made any significat admission. Resider return home when independently. Reswith no noted medi No discharge plans are no other social resident interviews.  An interview was concentrated trauma or stress, Rothing to talk about it.  An interview was concentrated and comformed casted if there are strauma informed casted, for this residual comfortable.  An interview was concentrated in the comfortable.  An interview was concentrated in the comfortable	acility less than a month a. Resident is not noted to have ant changes from previous at's son will like for her to ashe is able to ambulate acident has diagnosis of PTSD acations. Resident is a DNR. as are noted at this time." There aservices notes to indicate	F 745		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION  G	, ,	E SURVEY IPLETED
		495071	B. WING _		1:	C 2/08/2023
	ROVIDER OR SUPPLIER E LIFELONG H & R WA	RWICK FOREST	•	STREET ADDRESS, CITY, STATE, ZIP CODE  1000 OLD DENBEIGH BOULEVARD  NEWPORT NEWS, VA 23602		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 745	When asked who is well-being, OSM #2 responsible for psychresidents.  On 12/7/23 at 4:45 Fmember) #1, the adrifector of nursing an officer were made as A review of the facilit description reveals, Provides exposure to those services/progratient's quality of lift transition back to the for all discharge plar discharge notification applications, psychomonitoring, and asses psychosocial needs  No further information Pharmacy Srvcs/Pro CFR(s): 483.45(a)(b)  §483.45 Pharmacy ST The facility must prodrugs and biologicals them under an agree §483.70(g). The facility must prodrugs and biologicals them under an administration of the services of the servic	m) develops the care plan. responsible for psychosocial stated, social services are hosocial well-being of  PM, ASM (administrative staff ministrator, ASM #2, the hd ASM #3, the chief nursing ware of the findings.  Ry's social work job 'Essential Job Functions: ho, and an understanding of hams that can enhance the he and independence as they heir community. Responsible hining, care planning, hs, PASRR forms, Medicaid hactive monitoring, behavior hessment of the social and hof the patients."  In was provided prior to exit. hacedures/Pharmacist/Records ho(1)-(3)  Services hosocial services hosocial services hosocial and hor the patients."  Provided prior to exit. hacedures/Pharmacist/Records hosocial services hosocial services hosocial well-being of	F 7			1/22/24
		res. A facility must provide ices (including procedures				

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII		E CONSTRUCTION		LETED	
		495071	B. WING _				08/2023	
	ROVIDER OR SUPPLIER E LIFELONG H & R WA	RWICK FOREST	•	STREET ADDRESS, CITY, STATE, ZIP C 1000 OLD DENBEIGH BOULEVARD NEWPORT NEWS, VA 23602		•		
(X4) ID PREFIX TAG	(EACH DEFICIENC	(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH COR		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE		
F 755	Continued From pag	e 100 rate acquiring, receiving,	F 7	755				
	_	ninistering of all drugs and the needs of each resident.						
	, ,	Consultation. The facility in the services of a licensed						
	§483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility.							
		lishes a system of records of on of all controlled drugs in able an accurate						
	order and that an accis maintained and pe	mines that drug records are in count of all controlled drugs eriodically reconciled. T is not met as evidenced						
	Based on staff inter- and clinical record re the facility staff failed	on staff interview, facility document review nical record review, it was determined that lity staff failed to provide pharmacy s in a timely manner for one of 60 tts, Resident #49.			Resident # 49 received her Eliquis ordered on 12/7/2023; 12/8/2023; 12/9/2023 by the nurses assigned to h care.     Director of Nursing / designee will audit all residents on Eliquis as of Janu	er		
	The findings include:	:			1, 2024, to ensure all received the medication as ordered.	iai y		
	The facility staff failed to provide pharmacy services by administering medications as ordered, specifically ELIQUIS TAB 5MG (milligram), for Resident #49.				Clinical educator / designee will educate the clinical staff on the importance of administering medication as ordered and the process to follow for medications not available algorithm.			
		•			Director of Nursing / designee will audit 4 residents on Eliquis weekly time weeks to ensure the medication was administered as ordered. The results of			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED		
		495071	B. WING _				C <b>12/08/2023</b>		
NAME OF P	ROVIDER OR SUPPLIER			STREET AD	DDRESS, CITY, STATE, ZIP CODE		12/00/2020		
DIVEDOID	ELIEFI ONO ILO DIWAF	NATION FOREST		1000 OLD I	DENBEIGH BOULEVARD				
KIVEKSID	E LIFELONG H & R WAF	WICK FOREST		NEWPOR	RT NEWS, VA 23602				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE		
F 755	Continued From page	e 101	F 7	55		tion of compliance and g for continuous			
	(peripheral vascular of The most recent MDS assessment, a quarte ARD (assessment ref	,		meetii ongoi	udit will be reported at the QA ing for evaluation of compliant ing monitoring for continuous ovement analysis.				
	the BIMS (brief intervindicating the residen review of the MDS Secoded the resident as assistance for bathing	iew for mental status) score, t was cognitively intact. A ection G-functional status requiring extensive g and supervision for bed ssing, hygiene and eating;							
	5/22/23 revealed, "FC anticoagulant therapy fibrillation. INTERVE	r (Eliquis) related to Atrial NTIONS: Administer nedications as ordered by r side effects and							
	orders revealed, "ELI	cian orders dated 6/19/23 QUIS TAB 5MG (milligram), o times a day for Afib (atrial							
	PM with Resident #49	ducted on 12/5/23 at 3:40 9. Resident #49 stated, in ot give me my anticoagulant							
	administration record 5MG Give 1 tablet or was coded "9-other s	mber 2023 MAR (medication ) revealed, "ELIQUIS TAB ally two times a day for Afib, ee progress note" for PM and 11/13/23 at 8 AM.							

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI		ONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		495071	B. WING _			1	08/ <b>2023</b>
	ROVIDER OR SUPPLIER  E LIFELONG H & R WA	RWICK FOREST		100	EET ADDRESS, CITY, STATE, ZIP CODE  O OLD DENBEIGH BOULEVARD  WPORT NEWS, VA 23602	, , , ,	00/2020
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 755	9:14 AM, revealed "I tablet orally two time not given; Pharmacy notified; 11/13/23 at TAB 5MG Give 1 tab. Afib. Reorder."  An interview was cowith LPN (licensed pasked if medication obtaining the medication obtaining the medication obtaining the medication obtaining the medication as took. When asked medications, LPN #5 routine delivery and was reordered and sadministrations.  On 12/7/23 at 4:45 Fmember) #1, the addirector of nursing an officer were made as According to the faci and Receipt" policy, delivers medications schedule. Orders rebefore the designate on the Facility's regulation of the facility's regulation of the facility's regulation and the facility's regulation the facility of the facility's regulation the facility of	ress note dated 11/12/23 at ELIQUIS TAB 5MG Give 1 as a day for Afib. Medication of did not send. Pharmacy 9:30 AM revealed "ELIQUIS olet orally two times a day for anducted 12/7/23 at 12:05 PM aractical nurse) #5. When as not available with the as, what is the process for ations, LPN #5 stated, we cons from pharmacy and if we cock, we administer it from the the delivery process for a stated, they have a daily stat delivery. It looks like this still did not come in for three and ASM #3, the chief nursing ware of the findings.  Ility's "Medication Ordering which revealed, "Pharmacy according to an established ceived by the pharmacy dfax cut-off time will be sent allar scheduled delivery. The pharmacy after the fit time and required the same it to the pharmacy and	F	755			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION	(×	K3) DATE SURVEY COMPLETED
	495071	B. WING _			C <b>12/08/2023</b>
NAME OF PROVIDER OR SUPPLIER RIVERSIDE LIFELONG H & R			STREET ADDRESS, CITY, STATE, ZIP CODE 1000 OLD DENBEIGH BOULEVARD NEWPORT NEWS, VA 23602		12/00/2020
PREFIX (EACH DEFIC	RY STATEMENT OF DEFICIENCIES IENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CORF ( (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
\$483.45(c) Drug \$483.45(c)(1) The must be reviewed licensed pharmace \$483.45(c)(2) This of the resident's regularities to the facility's medical and these reports (i) Irregularities in drug that meets the drug that meets the drug that meets the drug this review separate, written attending physicial director and direct minimum, the resularity in the irregularity has be action has been the no change in the physician should the resident's meets drug regimen revelimited to, time from the irregularity has be action the irregularity has be action that the irregularity is medically the irregularity has be action that the irregularity has been that the irregularity has been the i	eview, Report Irregular, Act On ()(1)(2)(4)(5)  Regimen Review. e drug regimen of each resident of at least once a month by a cist.  Is review must include a review medical chart.  It is pharmacist must report any e attending physician and the director and director of nursing, a must be acted upon. Include, but are not limited to, any he criteria set forth in paragraph for an unnecessary drug. It is noted by the pharmacist of must be documented on a report that is sent to the an and the facility's medical etter of nursing and lists, at a ident's name, the relevant drug, by the pharmacist identified. In physician must document in the all record that the identified een reviewed and what, if any, aken to address it. If there is to the medication, the attending document his or her rationale in		756		1/22/24

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` '		CONSTRUCTION	(X3) DATE COMP	
		495071	B. WING			12/	08/2023
NAME OF PE	ROVIDER OR SUPPLIER		<del> </del>	STE	REET ADDRESS, CITY, STATE, ZIP CODE	1 12/	06/2023
	101.52.1 01.1 00.1 2.2.1				00 OLD DENBEIGH BOULEVARD		
RIVERSID	E LIFELONG H & R WAF	RWICK FOREST					
				INE	WPORT NEWS, VA 23602		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 756	Continued From page	e 104	F 7	'56			
	requires urgent action This REQUIREMENT by:	ifies an irregularity that n to protect the resident. is not met as evidenced cord review, staff interview			Resident #24 had the medication		
	and facility document that the facility staff fa pharmacy recommen implemented in a time residents reviewed for	review it was determined			regimen follow up review addressed or 6/21/23 and 8/24/2023 by the nurse practitioner. Resident #39 had the medication regimen follow up review addressed on 11/21/2023 and 11/29/20 by the nurse practitioner. Resident #41 had the medication regimen follow up review addressed on	)23	
	1. For Resident #24 (	R24), the facility staff failed nedication regimen review a timely manner.			<ul><li>10/25/2023.</li><li>2. Director of Nursing/ designee will review all follow up drug regimen review submitted since January 1, 2024 to</li></ul>		
	regimen reviews for F consultation report for report documented in currently on Olanzapi An A1c (Hemoglobin average blood sugar obtained 5/30/23, whithere are no orders for medications. Recommedications. Recommedications area for Physician/Probserved to be blank pharmacy report date the same request to medication. The area Response was observed. Attached to the consultation of the consultation of the same request to the same request to the same request to the same report.	r R24 dated 6/6/2023. The part, "Resident is ine 20mg (milligram) daily. A1C blood test to measure over the past 3 months) was ich resulted 9.3%. Currently,			ensure pharmacy reviews are acted up timely.  3. Administrator / designee will educa provider team on the importance of reviewing pharmacy recommendation timely and the process to follow.  4. Consultant Pharmacist / designee audit 4 drug regimen reviews monthly f8 months to ensure pharmacy recommendations are acted on timely. The results of the audit will be reported the QAPI meeting for evaluation of compliance and ongoing monitoring for continuous improvement analysis.	will or	

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION NG	()	X3) DATE COMP	
		495071	B. WING			12//	08/2023
	ROVIDER OR SUPPLIER  E LIFELONG H & R WAR	RWICK FOREST		STREET ADDRESS, CITY, STATE, ZIP CODE  1000 OLD DENBEIGH BOULEVARD  NEWPORT NEWS, VA 23602		121	50/2020
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		OULD BE	E	(X5) COMPLETION DATE
F 756	and sex of R24) LTC seen in hallway today to recommended GDI of diazepam and elev Diagnosis, Assessme mellitus type 2- likely medication, specifical addition of metformin from 500mg ER (exte and minimize GI (gas The physician orders "Metformin HCL ER Tablet Extended Rele (Metformin HCI) Give a day for DM2 (diaber Date: 08/24/2023. Sta The eMAR (electronic record) dated 8/1/202 the Metformin starting On 12/7/2023 at 2:53 conducted with ASM member) #2, the direct stated that the pharm medication reviews a recommendations via providers' nurse. ASI nurse shared the recomproviders and someting give their nurse order system and then sit depharmacy recommens stated the facility has last year. ASM #2 stadid not have any nurse stated that they nurse stated theyear. ASM #2 stadid not have any nurse stated theyear.	part, "Patient is a (age (long term care) resident of for recertification and due R (gradual dose reduction) rated blood glucose ent and Plan: Diabetes contributed to by lly depakote. Recommend and monitor. Will titrate up ended release) daily to try trointestinal) side effects"  for R24 documented in part, a (extended release) Oral case 24 Hour 1000 MG 2 tablet by mouth one time tes mellitus type 2). Order cart Date: 09/08/2023."  c medication administration 23-8/31/2023 documented g on 8/25/2023.  p.m., an interview was (administrative staff ctor of nursing. ASM #2 acist completed her monthly	F	756			

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION  G		OMPLETED
		495071	B. WING_			C <b>12/08/2023</b>
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE  1000 OLD DENBEIGH BOULEVARD  NEWPORT NEWS, VA 23602	I	12/06/2023
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 756	were gaps [periods recommendations were gaps [periods recommendations were gaps and policy, "I dated 5/16/2023 do medication regimen by a licensed Pharm state and local regulation state and local regulation and provided in the facility report any irregularior in a manner thresidentFor non-U facility and Attending recommendation(s) the needs of the resinext routine visit to a Attending Physician medical record"  On 1/26/2023 at 1:3 staff member) #1, the director of executation in the above concern.  No further information and the facility and Attending Physician medical record"  A teview of the monor regimen reviews for consultation report for report documented	ut got bogged down so there of time] when pharmacy vere not addressed.  Medication Regimen Review" cumented in part, "The of each resident is reviewed nacist according to Federal, lations as well as current e. The pharmacist must ties to the Attending sy's Medical Director and These reports must be acted nat meets the needs of the largent recommendations, the g Physician must address the in a timely manner that meets sident- but no later than their assess the resident- and the should document in the  17 p.m., ASM (administrative ne president/CEO, ASM #2, utive administration and ASM ursing were made aware of the largent recipiem in a timely manner.  (R39), the facility staff failed medication regimen review in a timely manner.	F 7:	56		

, ,	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED		
		495071	B. WING				08/2023
	ROVIDER OR SUPPLIER  E LIFELONG H & R WAF	RWICK FOREST		1000	ET ADDRESS, CITY, STATE, ZIP CODE OLD DENBEIGH BOULEVARD PORT NEWS, VA 23602		00.2020
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 756	nostril three times a coordered 4/24/2023. Fit be appropriate to readministration to BID for Physician/Prescribt to be blank.  Two additional month 10/13/2023 and 11/12 same request to redulpratropium Bromide Physician/Prescriber be blank on both reports was a copy of 11/21/2023 which doen nasal spray ordered to A review of the month regimen reviews for Foreport documented in currently has an ordeing daily. PMH (primal significant for Depres Please consider a graarea for Physician/Probserved to be blank. Two additional month 10/13/2023 and 11/12 same request to considered to be considered to the preports was a copy of dated 11/29/2023 whitmedication review an attempting a gradual	MCG/spray) 1 spray in each lay for vasomotor rhinitis. Recommendation(s): Would reduce the frequency of (twice a day)?" The area per Response was observed ally pharmacy reports dated al/2023 documented the ce the frequency of the masal spray. The area for Response was observed to orts. Attached to the three of a physician order dated cumented the Ipratropium wice a day.  In the part, " The resident of the part, " The resident of the reduction of the part, " The resident of the part, " The part, " The resident of the part, " The part, " The part, " The resident of the part, " The part,	F	756			

	OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		495071	B. WING _			C <b>12/08/2023</b>
	PROVIDER OR SUPPLIER  DE LIFELONG H & R WA	ARWICK FOREST		STREET ADDRESS, CITY, STATE, ZIP CODE 1000 OLD DENBEIGH BOULEVARD NEWPORT NEWS, VA 23602	•	12/00/2023
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR ( (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 756	"8/31/2022 Venlafa. tablet orally in the normal tablet orall tablet o	ine ER CAP 150MG Give 1 forming for depression"  53 p.m., an interview was M (administrative staff rector of nursing. ASM #2 macist completed her monthly and forwarded her ria email to ASM #2 and the SM #2 stated the providers' commendations with the etimes the providers would ers to put into the computer down later and complete the endation forms. ASM #2 as had a lot of providers in the estated for a while, the facility arse practitioners and the to handle all the pharmacy out got bogged down so there of time] when pharmacy were not addressed.  67 p.m., ASM (administrative the president/CEO, ASM #2, autive administration and ASM ursing were made aware of	F7	756		

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495071	B. WING				C 08/2023
	ROVIDER OR SUPPLIER  E LIFELONG H & R WAF	RWICK FOREST		1	TREET ADDRESS, CITY, STATE, ZIP CODE 000 OLD DENBEIGH BOULEVARD IEWPORT NEWS, VA 23602	, , ,	00/2020
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 756	order and to reduce a pantoprazole). Pharm the pharmacist to the physician/prescriber of 10/11/23 documented the following Prn (as OF MAG SUSP (susp (milligrams)/15ML (mas needed for Constip frequency of administ Recommendation(s): frequency for PRN us address the recommendation's order date "MILK OF MAG SUS ml orally every 24 hor Constipation." Pharm the pharmacist to the physician/prescriber of 10/11/23 documented History) includes GEF Reflux Disease). Cur 40mg Daily. Dose of form 40mg BID (twice Recommendation(s): consider further reductions and the physician or all physicia	clarify a milk of magnesia a PPI (proton pump inhibitor- macy recommendations from attending dated 8/17/23, 9/11/23 and d, "The resident is ordered needed) medication: MILK pension) 1200MG illiliters). Give 30 ml orally pation. There is no tration for this prn order. Please indicate a specific se." The physician did not endations until 10/25/23. A red 10/25/23 documented, P 1200MG/15ML- Give 30 curs as needed for macy recommendations from attending dated 8/17/23, 9/11/23 and d, "PMH (Past Medical RD (Gastroesophageal rently ordered Pantoprazole the Pantoprazole reduced e a day) to Daily on 1/4/2023. If appropriate, please ction to 20mg Daily before ician did not address the til 10/25/23. A physician's documented, "Pantoprazole relayed Release 20 MG- th one time a day for GERD."  m., an interview was (administrative staff ctor of nursing). ASM #2 t completes her monthly	F	756			

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION  G	(X3) DATE :	LETED
		495071	B. WING		12/0	) 08/2023
	ROVIDER OR SUPPLIER  E LIFELONG H & R WAI	RWICK FOREST		STREET ADDRESS, CITY, STATE, ZIP CODE  1000 OLD DENBEIGH BOULEVARD  NEWPORT NEWS, VA 23602	, .=.	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 756	nurse shares the recoproviders and sometimation their nurse orders to system then sit down pharmacy recommenstated the facility has last year. ASM #2 st did not have any nurse doctors were trying to recommendations but were gaps [periods or recommendations were commendations were commendations were gaps [periods or recommendations were gaps ]]	M #2 stated the providers' ommendations with the mes the providers will give put into the computer later and complete the dation forms. ASM #2 had a lot of providers in the ated for a while, the facility se practitioners and the o handle all the pharmacy t got bogged down so there f time] when pharmacy ere not addressed.	F 75	56		
F 758 SS=E	https://medlineplus.g tml Free from Unnec Psy CFR(s): 483.45(c)(3) §483.45(e) Psychotro §483.45(c)(3) A psychaffects brain activities processes and behave	flux disease. This ined from the website: by/druginfo/meds/a601246.h rchotropic Meds/PRN Use (e)(1)-(5)	F 75	58		1/22/24

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	COMPLETED	
		495071	B. WING		12/08/2023		
	ROVIDER OR SUPPLIER  E LIFELONG H & R WA	RWICK FOREST		STREET ADDRESS, CITY, STATE, ZIP CODE  1000 OLD DENBEIGH BOULEVARD  NEWPORT NEWS, VA 23602	,		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLÉ	TION	
F 758	sunless the medication specific condition as in the clinical record; \$483.45(e)(2) Residurgs receive graduate behavioral interventic contraindicated, in adrugs; \$483.45(e)(3) Residurgs receive graduate behavioral interventic contraindicated, in adrugs; \$483.45(e)(3) Residurgs receive graduate behavioral interventic contraindicated, in adrugs; \$483.45(e)(3) Residurgs that medication in the clinical record; \$483.45(e)(4) PRN care limited to 14 day \$483.45(e)(5), if the prescribing practition appropriate for the Peyond 14 days, he rationale in the residuridicate the duration \$483.45(e)(5) PRN care limited to 24 days, he rationale in the residuridicate the duration \$483.45(e)(5) PRN care limited to 25 drugs are 15 drugs ar	ensive assessment of a must ensure that ents who have not used are not given these drugs in is necessary to treat a diagnosed and documented ents who use psychotropic al dose reductions, and ons, unless clinically in effort to discontinue these ents do not receive entraunt to a PRN order on is necessary to treat a condition that is documented and enter the entered or provided in attending physician or the believes that it is RN order to be extended or she should document their ent's medical record and	F 75	8			

IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
495071	B. WING _		1	C 2/08/2023	
		STREET ADDRESS, CITY, STATE, ZIP COI	•	2/00/2023	
		1000 OLD DENBEIGH BOULEVARD			
VICK FOREST		NEWPORT NEWS, VA 23602			
MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
	F 7	58			
that medication.					
eview, it was determined ed to ensure that one of urvey sample, Resident cessary psychotropic  the facility staff failed to the diagnosis for the use of ed to ensure consistent of Trazodone and behavior monitoring, cts, and adverse reactions an antidepressant  record revealed a 19/13/23 for "Trazodone to 0.5 mg by mouth at the cord revealed a 19/13/23 for "Risperdal lligrams" (Risperidone) at bedtime for psychotic to reveal any orders for staff of Trazodone, including d symptoms of		an appropriate diagnosis for the provider. The order for Tre clarified by the provider to inconsistent monitoring for the include behaviors, effectiven effects and adverse reactions.  2. Director of Nursing / destaudit residents on antidepressantipsychotics for proper diagincluding behavior monitoring effectiveness, side effects ar reactions.  3. Clinical educator / designeducate the clinical staff on oproper diagnosis for antidepressantipsychotic medications armonitoring and documenting monitoring, effectiveness, side adverse reactions to a psychmedication.  4. Director of Resident Serdesignee will review 4 charts on antipsychotic or antidepressed medications weekly for 8 were validate diagnosis, behavior effectiveness, side effects ar reactions. The results of the reported at the QAPI meeting evaluation of compliance and	Trazadone by razadone was clude drug to less, side s. signee will sants and gnosis g, and adverse lessant and not on lessant and not on lessant and not on lessant effects and notropic lessant les antiers les antier		
	rement of Deficiencies MUST BE PRECEDED BY FULL CONTIFYING INFORMATION)  112  revaluates the resident for that medication. is not met as evidenced ew, clinical record review, eview, it was determined led to ensure that one of curvey sample, Resident exessary psychotropic  the facility staff failed to the diagnosis for the use of ed to ensure consistent of Trazodone and gobehavior monitoring, ects, and adverse reactions an antidepressant  record revealed a do 9/13/23 for "Trazodone for 0.5 mg by mouth at"  record revealed a do 9/13/23 for "Risperdal exe 0.5 mg by mouth at"  record revealed a do 9/13/23 for "Risperdal lligrams) (Risperidone) at bedtime for psychotic  reveal any orders for staff of Trazodone, including do symptoms of ess, side effects and lifor the use of Risperdal,	WICK FOREST  TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL CIDENTIFYING INFORMATION)  112  Tevaluates the resident for that medication. is not met as evidenced ew, clinical record review, eview, it was determined led to ensure that one of curvey sample, Resident ecessary psychotropic  the facility staff failed to the diagnosis for the use of ed to ensure consistent of Trazodone and gobehavior monitoring, ects, and adverse reactions dian antidepressant  Trecord revealed a dia 9/13/23 for "Trazodone ee 0.5 mg by mouth at "  Trecord revealed a dia 9/13/23 for "Risperdal lligrams) (Risperidone) at bedtime for psychotic ereveal any orders for staff of Trazodone, including disymptoms of ess, side effects and	VICK FOREST    STREET ADDRESS, CITY, STATE, ZIP CO	STREET ADDRESS, CITY, STATE, ZIP CODE  1000 OLD DENBEIGH BOULEVARD NEWPORT NEWS, VA 23602    PROVIDERS PLAN OF CORRECTION   PROVIDERS PLAN OF CORRECTION   PROFILE PLAN OF CORRECTION   CROSS-REFERENCED TO THE APPROPRIATE   DEFICIENCY	

	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: A. BUILDING			ATE SURVEY DMPLETED		
		495071	B. WING _		1	C 12/08/2023
	ROVIDER OR SUPPLIER	ARWICK FOREST		STREET ADDRESS, CITY, STATE, ZIP CODE 1000 OLD DENBEIGH BOULEVARD NEWPORT NEWS, VA 23602		12/06/2020
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 758	Continued From pag	ge 113 ns to an antipsychotic	F 7	58		
	medication.  A review of the MAF Record) and TAR (TRecord) for August was conducted. The use of Trazodone the symptoms of deprese effects and adverse that the required monthere was no line ite of Risperdal that income and adverse reaction required monitoring.  A review of the progrom consistent evidence the use of Trazodon symptoms of deprese effects and adverse notes also failed to that staff were monificated including behavior, and adverse reaction medication.  A review of the component dated 8/9/23 for psychotropic medication.  A review of the component dated 8/9/23 for psychotropic medication.  Psychotic Disturbant included an interver "Monitor/document/ladverse reactions of medications: unstead and the medications of the component dated and interver "Monitor/document/ladverse reactions of medications: unstead and the medications and the medications and the medications and the medications and the medication	R (Medication Administration Treatment Administration 2023 through December 2023 ere was no line item for the at included signs and ssion, effectiveness, side reactions for documenting onitoring was done. Also, em for monitoring for the use cluded behaviors, side effects are for documenting that the was done.  The staff were monitoring for e, including signs and esion, effectiveness, side reactions. The progress reveal consistent evidence toring the use of Risperdal, effectiveness, side effects, and to an antipsychotic effectiveness are plan included on "(Resident #134) uses ations (Trazodone and ons) r/t (related to) Disease dementia Severe with ces)." This care plan intion dated 5/1/23 for report PRN (as-needed) any				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII		DNSTRUCTION	(X3) DATE COMP	SURVEY LETED
		495071	B. WING _			1	08/ <b>2023</b>
	ROVIDER OR SUPPLIER  E LIFELONG H & R WA	RWICK FOREST		1000	EET ADDRESS, CITY, STATE, ZIP CODE OLD DENBEIGH BOULEVARD VPORT NEWS, VA 23602	,	00/2020
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 758	suicidal ideations, so diarrhea, fatigue, ins weight loss, muscle behavior symptoms  On 12/8/23 at 8:20 A conducted with LPN Nurse). When asked for behaviors, effecti adverse reactions, s given, the residents and if they are having there should be an odocumentation like a She stated that they assumed that if there then there wasn't and weight and the state of the sta	wing, dry mouth, depression, ocial isolation, blurred vision, omnia, loss of appetite, cramps nausea, vomiting, not usual to the person."  AM, an interview was #9 (Licensed Practical about monitoring residents veness, side effects and he stated that after meds are are monitored for side effects g behaviors. She said that	F	758			
	not an appropriate d probably written wro A policy for "psychot requested. The facil "Antipsychotic Grade documented, "che (diagnosis) for all res review targeted beha (related to) GDR; mo and ADRs (adverse interactionsensure Behavior Observed. revise the order if Be listed. This is necess document any reside	er psych" she stated that was iagnosis and that it was ing.  ropic meds - monitoring" was ity policy that was provided, ual Dose Reduction" eck/validate for appropriate dx sidents on antipsychotics; aviors for recommendation r/t ponitor for SE (side effects) drug reactions) or drug/drug exthere is an order for Nursing should be notified to enavior Observed is not sary in order for nursing to					

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED
		495071	B. WING		C 12/08/2023
	ROVIDER OR SUPPLIER  E LIFELONG H & R W.	ARWICK FOREST		STREET ADDRESS, CITY, STATE, ZIP CODE  1000 OLD DENBEIGH BOULEVARD  NEWPORT NEWS, VA 23602	12.00.2020
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION
F 758	Administrator and A were made aware of information was prosurvey.  (1) Trazodone is us Information obtained https://medlineplus.tml  (2) Risperdal is an all Information obtained https://medlineplus.tml  Nutritive Value/App CFR(s): 483.60(d)(f) §483.60(d) Food are Each resident received https://medlineplus.tml  Nutritive Value/App CFR(s): 483.60(d)(f) Secondary end at a secondary end at a temperature. This REQUIREMENT by:  Based on observation document review, it facility staff failed to manner from one of the survey of the surve	ative Staff Member) the ASM #2 the Director of Nursing of the findings. No further ovided by the end of the sed to treat depression. In addition of the defence of the sed to treat depression. In addition of the sed to treat depression of the sed	F 75	1. Food Service Director on 12/12/2 implemented a new procedure to stir on the steam table more frequently a keep it covered for longer periods. Theat on Demand system was reviewed.	food nd he ed
		e: 1 AM, tray line observation was M #9 (Other Staff Member) the		for proper functionality by Food Servi Director.  2. Residents receiving meal trays w interviewed by the Food Services Directors	vill be

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495071	B. WING _			1:	C 2/08/2023
NAME OF P	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE	1 12	100/2023
DIVEDOID		WA DIMION FORFOT		1	1000 OLD DENBEIGH BOULEVARD		
RIVERSID	E LIFELONG H & R W	VARWICK FOREST		١	NEWPORT NEWS, VA 23602		
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(X5) COMPLETION DATE
F 804	Continued From page	age 116	F 8	304			
		The temperatures were taken			/ designee to determine palatable of fo		
		ch meal. The following			3. Food Service Director / designee		
		e obtained for the main meal:			educate food and nutrition team memb	ers	
	Meatballs was 179	•			on methods to maintain food	_	
	Noodles was 176				temperatures on the steamtable and of		
	Mixed vegetables	soup was 167 degrees			the proper use of the Heat on Demand meal delivery system.	1	
		Soup was 107 degrees			Food Service Director / designee	will	
	On 12/6/23 at 12:4	17 PM the cart with the test tray			audit 4 tests trays weekly times 8 wee		
		Monticello unit. Staff started			for palatable temperatures of food. Fo		
	serving trays at 12			Service Director/ designee will intervie	w 4		
	residents were ser			residents weekly for 8 weeks for their			
		re obtained by OSM #9 as			satisfaction with the food □s palatabilit		
	follows:				and temperatures. The results of the a		
		degrees. This was a 57			will be reported at the QAPI meeting for		
	degree drop in tem	nperature. degrees. This was a 63 degree			evaluation of compliance and ongoing		
	drop in temperatur	-			monitoring for continuous improvemer analysis.	ıt	
		was 117 degrees. This was a			analysis.		
	66 degree drop in						
		soup was 128 degrees. This					
		Irop in temperature.					
	Two surveyors and	d OSM #9 tasted all items. It					
		e flavor was acceptable.					
		greed by all three that the					
		ed vegetables were only at					
	room temperature cold.	at best and the noodles were					
		'Organization and Leadership:					
		Services" documented,					
	"The goal is to p	e and nutritious meals that					
		e and numbus meals that hal needs and special dietary					
	needs of residents						
	On 12/6/23 at 5:15	5 PM at the end-of-day meeting,					
		rative Staff Member) the					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495071	B. WING				08/2023
	ROVIDER OR SUPPLIER	L		s 1	TREET ADDRESS, CITY, STATE, ZIP CODE  000 OLD DENBEIGH BOULEVARD	<u>  12/</u>	06/2023
					IEWPORT NEWS, VA 23602		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 804		M #2 the Director of Nursing the findings. No further	F	804			
	CFR(s): 483.60(i)(1)(2		F	812			1/22/24
	§483.60(i) Food safet The facility must -						
	state or local authoriti	ed satisfactory by federal, es.					
	. ,	ood items obtained directly subject to applicable State ulations.					
	facilities from using pr gardens, subject to co safe growing and food (iii) This provision doe	s not prohibit or prevent roduce grown in facility ompliance with applicable d-handling practices. es not preclude residents s not procured by the facility.					
		prepare, distribute and					
	by:	is not met as evidenced					
	document review, it w	n, staff interview and facility as determined that the tore food in a sanitary facility kitchens.			<ol> <li>Food Service Director discarded the box of garlic bread on 12/5/2023.</li> <li>Food Service Director / designee was complete an audit of all food stored under refrigeration to ensure that food is bein</li> </ol>	will der	
	The findings include:				stored in a sanitary manner.  3. Food Service Director/ designee w	/ill	
	conducted with OSM	AM a tour of the kitchen was #9 (Other Staff Member) the the walk-in refrigerator, a			educate food and nutrition team memb in proper storage and how to handle ite that are found improperly stored.		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495071	B. WING		C 12/08/2023
	ROVIDER OR SUPPLIER E LIFELONG H & R WA	RWICK FOREST		STREET ADDRESS, CITY, STATE, ZIP CODE  1000 OLD DENBEIGH BOULEVARD  NEWPORT NEWS, VA 23602	12/00/2020
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION
F 909 SS=E	bag open, exposing the refrigerator envirit should be sealed to The facility policy "Founfection Control, Founfection Control, Founfect	ras observed with the plastic the bread to the elements of comment. OSM #9 stated that to protect it.  Dod and Nutrition Services and Safety and Sanitation of this policy documented, ared in a manner to avoid the by drying out, freezer color"  PM at the end-of-day meeting, give Staff Member) the SM #2 the Director of Nursing the findings. No further yided by the end of the sees, and bed rails, if any, as intenance program to identify trapment. When bed rails used and purchased ared frame, the facility must rails, mattress, and bed seed frame, the facility must rails, mattress, and bed seed frame, the facility must rails, mattress, and bed seed frame, the facility must rails, mattress, and bed seed frame, the facility document review, it was the staff failed to evidence bed of 60 residents in the survey 49, Resident #58, Resident	F 90	4. Food Service Director / designed audit the food storage in the kitchen weekly times 8 weeks. The results of audit will be reported at the QAPI merfor evaluation of compliance and ong monitoring for continuous improveme analysis.	the eting oing int 1/22/24  1/22/24  nt staff will

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		LE CONSTRUCTION (X3) DATE SI COMPLE		
		495071	B. WING _			1	08/2023
	ROVIDER OR SUPPLIER  E LIFELONG H & R WAI	RWICK FOREST	•	10	TREET ADDRESS, CITY, STATE, ZIP CODE 000 OLD DENBEIGH BOULEVARD EWPORT NEWS, VA 23602		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 909	inspections for the use for Resident #49.  Resident #49 was obe half bed rails on 12/6 at 8:00 AM.  Resident #49 was ad 12/17/21 with diagnonot limited to: COPD pulmonary disease), (atherosclerotic cardi (peripheral vascular of the most recent MDS assessment, a quarte ARD (assessment recoded the resident as the BIMS (brief intervindicating the resident as assistance for bathin mobility, transfer, dreindependent for locol A review of the comp 7/3/23 revealed, "FO remain in facility to re INTERVENTIONS: For care plans in an effor well-being. Siderails dressing, toileting and	ded to perform bed rail se of positioning / assist bars asserved in bed with bilateral /23 at 7:30 AM and 12/7/23	FS	909	3. The Facilities Director / designee of the proper sequence/process of testing and documenting bed inspections. Recurring bed inspections will be scheduled in the automated work order management system and different unit the building will be scheduled quarterly 4. The Facilities Director / designee of audit 4 beds weekly for 8 weeks to ensure that proper bed rail safety inspections have been completed. The results of the audit will be reported at the QAPI meet for evaluation of compliance and ongoin monitoring for continuous improvement analysis.	r s of will sure he ting	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	MULTIPLE CONSTRUCTION ILDING		(X3) DATE SURVEY COMPLETED	
		495071	B. WING _			C <b>12/08/2023</b>	
NAME OF PROVIDER OR SUPPLIER  RIVERSIDE LIFELONG H & R WARWICK FOREST				STREET ADDRESS, CITY, STATE, ZIP COL 1000 OLD DENBEIGH BOULEVARD NEWPORT NEWS, VA 23602		12/00/2020	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CC ( (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 909	Log" and "Bed Safet inspections since 20 On 12/6/23 at 8:20 A maintenance staff pothe Chesapeake Un An interview was co AM with OSM (other maintenance staff.	ty's "Bed Safety Inspection by Inspection" revealed no bed 21.  AM, surveyor observed two erforming bed inspections on it.  Inducted on 12/6/23 at 8:25 at staff member) #11, the When asked what inspections	FS	009			
	not done the bed inscould not get into rewell we are doing them in the well are doing them in the well are director of nursing a officer were made and a separately from the model of bed in the validate the bed inspannually."  No further information	PM, ASM (administrative staff ministrator, ASM #2, the nd ASM #3, the chief nursing					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
		495071	B. WING _			C 12/08/2023	
NAME OF PROVIDER OR SUPPLIER  RIVERSIDE LIFELONG H & R WARWICK FOREST				STREET ADDRESS, CITY, STATE, ZIP CO 1000 OLD DENBEIGH BOULEVARD NEWPORT NEWS, VA 23602	DDE	12/00/2020	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C ( (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE	
F 909	half bed rails on 12/8:30 AM and 12/7/2 Resident #58 was a 4/25/23 with diagno limited to: COPD (cl disease), dysphagia The most recent ME assessment, a quar ARD (assessment roded the resident at the BIMS (brief interindicating the reside impaired. A review of G-functional status requiring extensive mobility; limited ass supervision for eating A review of the com 8/22/23 revealed, "Fremain in facility to in INTERVENTIONS: care plans in an efformal well-being. Siderail transfers, extensive dressing, toileting and "Bed Safe inspections since 20 On 12/6/23 at 8:20 maintenance staff p the Chesapeake University of the same and the company of the same and the company of the facil company of the faci	bserved in bed with bilateral 5/23 at 1:00 PM, 12/6/23 at 3 at 9:00 AM.  dmitted to the facility on sis that included but were not provide and acute respiratory failure.  OS (minimum data set) terly assessment, with an eference date) of 11/7/23, as scoring a 05 out of 15 on eview for mental status) score, and was severely cognitively of the MDS Section coded the resident as assistance for bathing, bed istance for transfers and effective continued services. Provide services according to port to enhance optimum as x2, total dependence x 2 assist x1: bed mobility, and personal hygiene."  Ty's "Bed Safety Inspection ty Inspection" revealed no bed 121.  AM, surveyor observed two erforming bed inspections on	FS	009			

	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
	495071	B. WING _			C   <b>2/08/2023</b>	
NAME OF PROVIDER OR SUPPLIER  RIVERSIDE LIFELONG H & R WARWICK FOREST			STREET ADDRESS, CITY, STATE, ZIP CODE  1000 OLD DENBEIGH BOULEVARD  NEWPORT NEWS, VA 23602		270072020	
(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION S	HOULD BE	(X5) COMPLETION DATE	
•		F 9	09			
maintenance staff. were being conduct not done the bed insecould not get into re We are doing them  On 12/7/23 at 4:45 member) #1, the addirector of nursing a officer were made at No further information  3. The facility staff from the form the fo	When asked what inspections ed, OSM #11 stated, we have spections since COVID. We sident rooms due to isolation. now.  PM, ASM (administrative staff ministrator, ASM #2, the and ASM #3, the chief nursing ware of the findings.  on was provided prior to exit.  ailed to perform bed rail use of positioning / assist bars  asserved in bed with bilateral 5/23 at 12:00 PM, 12/6/23 at 3 at 8:30 AM.  dmitted to the facility on sis that included but were not not stage renal disease), DM, far accident) and  DS (minimum data set) terly assessment, with an eference date) of 10/31/23, as scoring a 13 out of 15 on rview for mental status) score, ent was cognitively intact. A Section G-functional status as requiring limited assistance bility, transfer, dressing,					
A review of the com	prehensive care plan dated					
	SUMMARY SUMMARY SUMMARY SUMMARY SUMMARY SEACH DEFICIENT REGULATORY OF CONTINUED FROM PARTICIPATION OF THE METALLIAN SEACH DEFICIENT REGULATORY OF CONTINUED FOR THE METALLIAN SEACH DEFICIENT REGULATORY OF CONTINUED FOR THE METALLIAN SEACH DEFICIENT REGULATORY OF THE METALLIAN SEACH DEFICIENT SEACH DEFI	A95071  ROVIDER OR SUPPLIER  E LIFELONG H & R WARWICK FOREST  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 122  AM with OSM (other staff member) #11, the maintenance staff. When asked what inspections were being conducted, OSM #11 stated, we have not done the bed inspections since COVID. We could not get into resident rooms due to isolation. We are doing them now.  On 12/7/23 at 4:45 PM, ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing and ASM #3, the chief nursing officer were made aware of the findings.  No further information was provided prior to exit.  3. The facility staff failed to perform bed rail inspections for the use of positioning / assist bars for Resident #60.  Resident #60 was observed in bed with bilateral half bed rails on 12/5/23 at 12:00 PM, 12/6/23 at 2:30 PM and 12/7/23 at 8:30 AM.  Resident #60 was admitted to the facility on 1/15/21 with diagnosis that included but were not limited to: ESRD (end stage renal disease), DM, CVA (cerebrovascular accident) and	A BUILDIN B. WING	ROVIDER OR SUPPLIER  ELIFELONG H & R WARWICK FOREST  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEPICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LSC DENTIFYMS INFORMATION)  Continued From page 122  AM with OSM (other staff member) #11, the maintenance staff. When asked what inspections were being conducted, OSM #11 stated, we have not done the bed inspections since COVID. We could not get into resident rooms due to isolation. We are doing them now.  On 12/7/23 at 4:45 PM, ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing and ASM #3, the other funsing officer were made aware of the findings.  No further information was provided prior to exit.  3. The facility staff failed to perform bed rail inspections for the use of positioning / assist bars for Resident #60 was observed in bed with bilateral half bed rails on 12/5/23 at 12:00 PM, 12/6/23 at 2:30 PM and 12/7/23 at 8:30 AM.  Resident #60 was admitted to the facility on 1/15/21 with diagnosis that included but were not limited to: ESRD (end stage renal disease), DM, CVA (cerebrovascular accident) and hypertension.  The most recent MDS (minimum data set) assessment, a quarterly assessment, with an ARD (assessment reference date) of 103/1/23, coded the resident as scoring a 13 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident as requiring limited assistance for bathing, bed mobility, transfer, dressing, hygiene and eating.	A BUILDING A SUPPLIER  495071  BUNING TOO OLD DENBEIGH BOULEVARD NEWPORT NEWS, VA 23602  SUMMARY STATEMENT OF DEFICIENCIES EACH DEFICIENCIES (EACH DEFICIENCIES) (EACH DEFICIENCY)  Continued From page 122  AM with OSM (other staff member) #11, the maintenance staff. When asked what inspections were being conducted, OSM #11 stated, we have not done the bed inspections since COVID. We could not get into resident rooms due to isolation. We are doing them now.  On 12/7/23 at 4:45 PM, ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing and ASM #3, the chief nursing officer were made aware of the findings.  No further information was provided prior to exit.  3. The facility staff failed to perform bed rail inspections for the use of positioning / assist bars for Resident #60.  Resident #60 was admitted to the facility on 1/15/27 with diagnosis that included but were not limited to: ESRD (end stage renal disease), DM, CVA (cerebrovascular accident) and hypertension.  The most recent MDS (minimum data set) assessment, a quarterly assessment, with an ARD (assessment reference date) of 10/31/23, coded the resident as scoring a 13 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was cognitively intact. A review of the MDS Section G-functional status coded the resident as requiring limited assistance for bathing, bed mobility, transfer, dressing, hygiene and eating.	

· /		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ' '			(X3) DATE SURVEY COMPLETED	
		495071	B. WING_			C <b>12/08/2023</b>	
NAME OF PROVIDER OR SUPPLIER  RIVERSIDE LIFELONG H & R WARWICK FOREST				STREET ADDRESS, CITY, STATE, ZIP CODE  1000 OLD DENBEIGH BOULEVARD  NEWPORT NEWS, VA 23602		12/06/2023	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 909	remain in facility to INTERVENTIONS: care plans in an eff well-being. Siderai dressing, toileting, and personal hygie transfers."  A review of the faci Log" and "Bed Safe inspections since 2 On 12/6/23 at 8:20 maintenance staff proceeding the Chesapeake University of the Chesapeake University of the English of the bed in could not get into reweare doing them.  On 12/7/23 at 4:45 member) #1, the addirector of nursing officer were made at the for Resident #8.  Resident #8 was of	FOCUS: Resident desires to receive continued services. Provide services according to fort to enhance optimum its x2, limited assist x1: showers, incontinence care ine. Extensive assist x1:  lity's "Bed Safety Inspection ety Inspection" revealed no bed 021.  AM, surveyor observed two performing bed inspections on init.  onducted on 12/6/23 at 8:25 er staff member) #11, the When asked what inspections ted, OSM #11 stated, we have inspections since COVID. We esident rooms due to isolation. now.  PM, ASM (administrative staff diministrator, ASM #2, the and ASM #3, the chief nursing aware of the findings.  ion was provided prior to exit.  failed to perform bed rail use of positioning / assist bars	F9	09			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED		
		495071	B. WING		12/08/202	2
NAME OF PROVIDER OR SUPPLIER  RIVERSIDE LIFELONG H & R WARWICK FOREST				STREET ADDRESS, CITY, STATE, ZIP CODE  1000 OLD DENBEIGH BOULEVARD  NEWPORT NEWS, VA 23602	12/00/2023	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPL	ETION .
F 909	Continued From pag	e 124	F 90	09		
	4/12/13 with diagnos limited to: DM (diabe bladder and paraple The most recent MD assessment, a quart	mitted to the facility on his that included but were not hetes mellitus), neurogenic gia.  S (minimum data set) erly assessment, with an his eference date) of 10/17/23,				
	coded the resident a the BIMS (brief inter- indicating the resident review of the MDS S coded the resident a assistance for bathin	s scoring a 15 out of 15 on view for mental status) score, not was cognitively intact. A ection G-functional status is requiring extensive ig, bed mobility, transfer, and limited assistance for				
	1/30/23 revealed, "F remain in facility to re INTERVENTIONS: care plans in an effo well-being. Siderails extensive assist x1:	orehensive care plan dated OCUS: Resident desires to eceive continued services. Provide services according to rt to enhance optimum a x2, overbed trapeze, dressing, toileting and xtensive assist x1 showers re."				
		y's "Bed Safety Inspection y Inspection" revealed no bed 21.				
		M, surveyor observed two erforming bed inspections on t.				
	AM with OSM (other	nducted on 12/6/23 at 8:25 staff member) #11, the When asked what inspections				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495071	B. WING _			C 12/08/2023
NAME OF PROVIDER OR SUPPLIER  RIVERSIDE LIFELONG H & R WARWICK FOREST				STREET ADDRESS, CITY, STATE, ZIP CODE  1000 OLD DENBEIGH BOULEVARD  NEWPORT NEWS, VA 23602		12/00/2023
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CORR ( (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 909	were being conducted not done the bed insp could not get into resi We are doing them not not 12/7/23 at 4:45 Pl member) #1, the adm director of nursing an officer were made aw	d, OSM #11 stated, we have pections since COVID. We ident rooms due to isolation. ow.  M, ASM (administrative staff pinistrator, ASM #2, the d ASM #3, the chief nursing	FS			