STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495071	A. BUILDING _____ B. WING _____	C 12/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERSIDE LIFELONG H & R WARWICK FOREST	1000 OLD DENBEIGH BOULEVARD NEWPORT NEWS, VA 23602

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E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 12/5/2023 through 12/8/2023. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities.	E 000		
F 000	INITIAL COMMENTS 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, VA00059938-substantiated with deficiency, VA00051376-unsubstantiated without deficiency, VA00053003-substantiated with deficiency, VA00052472-substantiated without deficiency, VA00056165-substantiated with deficiency, VA00052962-substantiated with deficiency, VA00053514-substantiated with deficiency, VA00060038-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 000		
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable	F 558		1/22/24

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

Electronically Signed | 01/10/2024

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F 558	Continued From page 1 accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, clinical record review and facility document review, it was determined that the facility staff failed to ensure reasonable accommodation of needs for one of 60 residents in the survey sample, Resident #19. The findings include: For Resident #19 (R19), the facility staff failed to ensure their roommates personal belongings did not hinder their ability to leave the room if they chose. On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 9/14/2023, the resident scored 15 out of 15 on the BIMS (brief interview for mental status) assessment, indicating the resident was cognitively intact for making daily decisions. The assessment documented R19 being dependent on staff for bed to chair transfers, utilizing a manual wheelchair and dependent on staff to wheel at least 50 feet with two turns. On 12/5/2023 at 12:59 p.m., an interview was conducted with R19 in their room. R19 was observed in bed in their room on the right side of a semi-private room near the window. When asked about staff assisting them to get out of bed when they wanted to get up, R19 stated that they did not get out of bed often but liked to get up on	F 558	1. The Christmas tree was removed from room by maintenance on 12/8/23 so that resident #19 could move freely as desired. Resident #19 was asked 1/4/24 if they would like to attend PACE at her next scheduled session 1/10/24 and she agreed. Resident #19 attended her PACE seesion on 1/10/24. 2. Maintenance / designee will measure and evaluate all semiprivate rooms to ensure roommates personal belongings do not hinder their ability to leave the room. All residents who have appointments on 1/4/23 were asked to get up to attend, none-declined. 3. The Clinical Educator/designee will educate the clinical staff on notification to maintenance of rooms that hinder the ability of residents to leave the room freely. Education will also include notifying residents of appointments and assisting them out of bed to attend and how to handle refusals. 4. Maintenance/designee will audit 4 rooms per week x 8 weeks to ensure semiprivate rooms personal belongings do not hinder the ability of residents to leave the room. DON/designee will audit 5 residents per week x 8 weeks who have appointments and ensure they are assisted to get out of bed to attend. The results of the audit will be reported at the QAPI meeting for evaluation of	

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F 558	Continued From page 2 Wednesdays to go out of the facility to (Name of outside health program). R19 stated that they did not go every Wednesday but liked to go out when they felt up to it but the nursing staff had told them that they could not get their wheelchair past their roommate's Christmas tree to get them out of the room to go to the appointments so they had not gone recently. R19 stated that staff had to use a mechanical lift to get them up and had to have the wheelchair right by the bed and could not fit the chair past the end of the roommate's bed and the Christmas tree so she had not gotten out of bed recently. Observation of R19's roommates side of the room revealed an approximately 5 foot tall artificial Christmas tree at the foot of their bed with glass ornaments and tinsel with approximately 14 inches space between the end of the bed and the tree branches. When asked where their wheelchair was stored, R19 stated that the staff stored the wheelchair somewhere outside of the room and they were not exactly sure where. R19 stated that the tree had been up for at least two weeks and they had not gone to the appointment last Wednesday because the office was closed. R19 stated that they were hoping to be able to go on 12/6/2023. On 12/6/2023 at 3:50 p.m., an interview was conducted with R19 in their room in bed. R19 stated that staff did not offer to get them out of bed for the appointment that day and they had "forgotten about them." R19 stated that they would have gone if anyone had offered to get them out of bed and to the appointment. The comprehensive care plan for R19 documented in part, "(Name of R19) has an ADL (activities of daily living) self-care performance	F 558	compliance and ongoing monitoring for continuous improvement analysis.	

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F 558	Continued From page 3	F 558		

deficit r/t (related to): Amputation left aka (above the knee amputation)... Date Initiated: 09/27/2023. Revision on: 09/27/2023."

The progress notes for R19 documented in part,
- "11/15/2023 09:06 (9:06 a.m.) Note Text : (Name of staff) at (Name of outside health program) called an informed (Name of R19) refused to attend (Name of outside health program). (Name of staff) at (Name of outside health program) informed that (Name of R19) needed a new prescription for her Percocet tab 2.5 mg (milligram)-325 mg."
- "11/1/2023 11:45 (11:45 a.m.) Note Text : (Name of staff) at (Name of outside health program) informed (Name of R19) refused to attend (Name of outside health program). No reason given."
The clinical record failed to evidence documentation of any refusals to attend the program after 11/15/2023 or documentation of R19 attending the program.

On 12/7/2023 at 8:26 a.m., an interview was conducted with LPN (licensed practical nurse) #2, clinical coordinator. LPN #2 stated that R19 was followed by the provider at the (Name of outside health program) and refused to go often. She stated that she followed up with R19 every week and encouraged them to attend and participate. She stated that she did not speak with R19 on 12/6/2023 because she was not working on the unit that day. She stated that she was not aware of any issues getting R19 up and out of the room, that the wheelchair was stored in an alcove area behind the dining room. She stated that R19 used a manual wheelchair and required nursing staff to push them. She stated that since R19 had been refusing to go to (Name of outside health program), they had stopped coming to pick

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F 558	Continued From page 4	F 558		

them up every Wednesday and she would communicate with the DON (director of nursing) for the program when R19 planned to go ahead of time to set up the transportation. She stated that the medical provider from the program came to the facility quarterly to see R19 for re-certifications.

On 12/7/2023 at 9:06 a.m., a request was made to LPN #2 to observe them take R19's wheelchair into the room to the bedside. LPN #2 identified a manual bariatric wheelchair located in an alcove behind the dining area on the unit as R19's wheelchair. She pushed the wheelchair to R19's room and entered the doorway to the area where the foot of the roommate's bed and the Christmas tree were and stated that the wheelchair would not fit through the opening. She stated again that R19 always refused to go to (Name of outside health program) and to get out of bed and she felt that R19 may be using the Christmas tree as an excuse why they were not getting out of bed and the CNA would never leave them in the bed because of the tree. She stated that if R19 asked to get out of bed they would have to move the Christmas tree each time.

On 12/7/2023 at 9:10 a.m., an interview was conducted with CNA (certified nursing assistant) #5. CNA #5 stated that they did not offer for R19 to go out to (Name of outside health program) on 12/6/2023 and normally the resident would ask them to get out of bed when they wanted to go. She stated that R19 did not tell them that they wanted to go on 12/6/2023 so they had not gotten them up. When asked how the wheelchair would fit in and out of the room, CNA #5 stated that they would have to move the roommate's bed first. When asked what would be done if they had an

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F 558	Continued From page 5	F 558		

emergency and needed to evacuate, CNA #5 stated that it would be difficult.

On 12/7/2023 at 2:53 p.m., an interview was conducted with ASM (administrative staff member) #2, director of nursing. ASM #2 stated that R19 frequently refused to get out of bed and attend (Name of outside health program). She stated that the nursing staff had a schedule and they should ask R19 and offer for them to attend at least twice. She stated that R19 should not have to ask to attend, that R19 does not always refuse and the staff should be encouraging them to get out of bed and there should not be any barriers to get in and out of the room.

On 12/7/2023 at 1:57 p.m., an interview was conducted with OSM (other staff member) #3, facilities director. OSM #3 stated all residents should be able to get in and out of their rooms. He used a tape measure and measured R19's bariatric wheelchair identified by LPN #2 and stated that it was 30 inches wide. He measured the distance between R19's roommate's bed and the Christmas tree and stated that it was 17 inches and stated that the tree needed to be taken down.

The facility policy, "Resident Rights and Responsibilities" dated 6/20/2023 documented in part, "...The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents..."

On 12/7/2023 at 4:36 p.m., ASM #1, the administrator, ASM #2, the director of nursing, and ASM #3, the chief nursing officer were made

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F 558	Continued From page 6 aware of the above concern. No further information was presented prior to exit.	F 558		
F 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on review of facility's documentation and staff interview, it was determined that the facility	F 561	1. Resident # 154 was transferred out of bed to her motorized wheelchair	1/22/24

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F 561	Continued From page 7	F 561		

failed to promote and facilitate the resident's right to self-determination by promoting resident's choice in transferring to wheelchair for one of 60 residents in the survey sample, Resident #154.

The findings included:

Resident #154 was admitted to the facility on 3/1/22 with diagnosis that included but were not limited to: diabetes mellitus (DM), paraplegia and gangrene.

The most recent MDS (minimum data set) assessment, a quarterly assessment, with an ARD (assessment reference date) of 9/19/23, coded the resident as scoring a 15 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was not cognitively impaired. A review of the MDS Section G-functional status coded the resident as requiring extensive assistance for bed mobility, dressing and hygiene; supervision for eating and total dependence for transfers and bathing.

A review of the comprehensive care plan dated 5/22/23, which revealed, "FOCUS: Resident has paraplegia. INTERVENTIONS: Assist with ADLs and locomotion as required."

An interview was conducted with Resident #154 on 12/5/23 at 12:30 PM. Resident #154 stated, they do not transfer me to my wheelchair every day. In my motorized wheelchair, I can go to the activity room, dining room and just travel around.

An interview was conducted on 12/7/23 at 2:00 PM with LPN (licensed practical nurse) #7. When asked if a resident's choices are being honored if the resident is dependent on staff for transfers to

12/8/2023 by the clinical staff per her choice.
2. Social Services/ designee will interview residents on the unit who require assistance to transfer from the bed that are able to move around facility as to their preference when they would like to be up.
3. Clinical Educator / designee will educate facility staff on resident□s right to promote the resident□s choice in transferring them out of bed when they wish to.
4. Social Services / designee will audit 4 residents weekly to validate their choices are being met x 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.

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F 561	Continued From page 8 the wheelchair and is not transferred to the wheelchair daily, LPN #7 stated, no, the resident's choices are not being honored. 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. According to the facility's "Resident Rights and Responsibilities" policy, which revealed, "Self-Determination: The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to: The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, plan of care and other applicable provisions. The resident has the right to make choices about aspects of his or her life in the facility that are significant to the resident." No further information was provided prior to exit.	F 561		
F 622 SS=D	Transfer and Discharge Requirements CFR(s): 483.15(c)(1)(i)(ii)(2)(i)-(iii) §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- (i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B) The transfer or discharge is appropriate because the resident's health has improved	F 622		1/22/24

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F 622	Continued From page 9	F 622		

sufficiently so the resident no longer needs the services provided by the facility;
(C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident;
(D) The health of individuals in the facility would otherwise be endangered;
(E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or
(F) The facility ceases to operate.
(ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose.

§483.15(c)(2) Documentation.
When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is

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F 622	Continued From page 10 communicated to the receiving health care institution or provider. (i) Documentation in the resident's medical record must include: (A) The basis for the transfer per paragraph (c)(1)(i) of this section. (B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s). (ii) The documentation required by paragraph (c)(2)(i) of this section must be made by- (A) The resident's physician when transfer or discharge is necessary under paragraph (c) (1) (A) or (B) of this section; and (B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review and facility document review, it was determined the facility staff failed to provide evidence of	F 622	1. Required transfer discharge clinical documents were faxed to the ED by the Director of Nursing on 1/5/2024 for	

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RIVERSIDE LIFELONG H & R WARWICK FOREST	1000 OLD DENBEIGH BOULEVARD NEWPORT NEWS, VA 23602

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F 622	Continued From page 11 required resident information when a resident is transferred to the hospital, for one of 60 residents in the survey sample, Residents #49. The findings include: The facility staff failed to evidence provision of required resident information to a receiving facility at the time of discharge for Resident #49. Resident #49 was transferred to the hospital on 10/16/23 and 11/7/23. Resident #49 was admitted to the facility on 12/17/21 with diagnosis that included but were not limited to: COPD (chronic obstructive pulmonary disease), cellulitis, ASCVD (atherosclerotic cardiovascular disease) and PVD (peripheral vascular disease). The most recent MDS (minimum data set) assessment, a quarterly assessment, with an ARD (assessment reference date) of 11/28/23, coded the resident as scoring a 15 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 extensive assistance for bathing and supervision for bed mobility, transfer, dressing, hygiene and eating; independent for locomotion. A review of the comprehensive care plan dated 7/3/23 revealed, "FOCUS: Resident desires to remain in facility to receive continued services. INTERVENTIONS: Provide services according to care plans in an effort to enhance optimum well-being. Siderails x2, limited assist x1: dressing, toileting and personal hygiene. Extensive assist x1 showers and incontinence	F 622	resident #49. 2. Director of Nursing / designee will audit all residents that required transfer from the facility to the receiving facility on or after December 1, 2023, to ensure all required documentation were sent. 3. Clinical Educator / designee will educate the clinical team on the transfer discharge process to include what items to send out with the residents and use of the transfer/discharge checklist. 4. Director of Nursing / designee will audit 4 residents transfers per week x 8 weeks to ensure all required documentation were sent to the receiving facility to ensure safe and effective transition of care. The results of the audit will be reported at the QAPI meeting for evaluation of compliance and ongoing monitoring for continuous improvement analysis.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495071	A. BUILDING _____ B. WING _____	C 12/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERSIDE LIFELONG H & R WARWICK FOREST	1000 OLD DENBEIGH BOULEVARD NEWPORT NEWS, VA 23602

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F 622	Continued From page 12	F 622		

care."

There was no evidence of clinical documents sent with the resident to the hospital on 10/16/23 and 11/7/23.

A review of the progress note dated 10/16/23 at 5:09 PM, revealed, "Nursing observations, evaluation, and recommendations are: Resident bumped into a chair with her motorized wheelchair. A hematoma formed on RLE (right lower extremity). It was evaluated by in house Provider who wants patient to go to ED (emergency department) due to infected hematoma to RLE."

A review of the progress note dated 11/7/23 at 10:23 AM, revealed, "Today, nursing requested for patient to be seen for right leg nodule increased in size, firm to touch and painful. Patient is sitting up in wheelchair ready dressed for her eye appointment at 12 noon. patient stated right leg is infected and painful. discussed will transfer back to emergency room for evaluation and drain hematoma surgically since procedure cannot be done at the facility. Nursing made aware that patient can be sent out when she comes back from her eye appointment."

An interview was conducted on 12/6/23 at 3:00 PM with LPN (licensed practical nurse) #4. When asked for evidence of clinical documentation sent to the hospital for Resident #49, LPN #4 stated, we go through the transfer document list and send those documents, but we do not keep any documentation of that.

On 12/7/23 at 4:45 PM, ASM (administrative staff member) #1, the administrator, ASM #2, the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495071	A. BUILDING _____ B. WING _____	C 12/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERSIDE LIFELONG H & R WARWICK FOREST	1000 OLD DENBEIGH BOULEVARD NEWPORT NEWS, VA 23602

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F 622	Continued From page 13 director of nursing and ASM #3, the chief nursing officer were made aware of the findings. A review of the facilities "Transfer and Discharge" policy revealed, "Identify Information provided to the receiving provider which at a minimum will include: All information necessary to meet the resident's needs, which includes, but may not be limited to: Resident status, including baseline and current mental, behavioral, and functional status, reason for transfer, recent vital signs; Diagnoses and allergies; Medications (including when last received); and Most recent relevant labs, other diagnostic tests, and recent immunizations." No further information was provided prior to exit.	F 622		
F 623 SS=E	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and	F 623		1/22/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495071	A. BUILDING _____ B. WING _____	C 12/08/2023

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RIVERSIDE LIFELONG H & R WARWICK FOREST	1000 OLD DENBEIGH BOULEVARD NEWPORT NEWS, VA 23602

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F 623	Continued From page 14	F 623		

(c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged.
(ii) Notice must be made as soon as practicable before transfer or discharge when-
(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;
(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;
(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;
(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30 days.

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:
(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged;
(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495071	A. BUILDING _____ B. WING _____	C 12/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERSIDE LIFELONG H & R WARWICK FOREST	1000 OLD DENBEIGH BOULEVARD NEWPORT NEWS, VA 23602

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F 623	Continued From page 15 (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review and facility document review, it was determined the facility staff failed to provide evidence of	F 623	On 1/5/24 written notification was mailed by the Business Office Manager to the RP□s of Resident #49, Resident #58,	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495071	A. BUILDING _____ B. WING _____	C 12/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERSIDE LIFELONG H & R WARWICK FOREST	1000 OLD DENBEIGH BOULEVARD NEWPORT NEWS, VA 23602

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F 623	Continued From page 16 written RP (responsible party) notification was provided when four of 60 residents in the survey sample who were transferred to the hospital, Residents #49, Resident #58, Resident #8 and Resident #60. The findings include: 1. The facility staff failed to evidence provision of required written RP (responsible party) notification at the time of discharge for Resident #49. Resident #49 was transferred to the hospital on 10/16/23 and 11/7/23. Resident #49 was admitted to the facility on 12/17/21 with diagnosis that included but were not limited to: COPD (chronic obstructive pulmonary disease), cellulitis, ASCVD (atherosclerotic cardiovascular disease) and PVD (peripheral vascular disease). The most recent MDS (minimum data set) assessment, a quarterly assessment, with an ARD (assessment reference date) of 11/28/23, coded the resident as scoring a 15 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 extensive assistance for bathing and supervision for bed mobility, transfer, dressing, hygiene and eating; independent for locomotion. A review of the comprehensive care plan dated 7/3/23 revealed, "FOCUS: Resident desires to remain in facility to receive continued services. INTERVENTIONS: Provide services according to care plans in an effort to enhance optimum well-being. Siderails x2, limited assist x1:	F 623	Resident # 8, and Resident#60 that they were transferred to the hospital on their respective dates. 2. Business office manager / designee will audited all residents that required transfer or discharged from facility since December 1, 2023, to ensure that written notification was sent to the RP□s. 3. Director of Clinical Services educated the business office staff and the administrative staff on 12/7/2023 of the requirement to provide evidence of written RP notification of those residents who are transferred to the hospital. 4. Administrator / designee will audit 4 resident weekly x 8 weeks who were transferred to the hospital for completion of written RP notification. The results of the audit will be reported at the QAPI meeting for evaluation of compliance and ongoing monitoring for continuous improvement analysis.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495071	A. BUILDING _____ B. WING _____	C 12/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERSIDE LIFELONG H & R WARWICK FOREST	1000 OLD DENBEIGH BOULEVARD NEWPORT NEWS, VA 23602

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F 623	Continued From page 17	F 623		

dressing, toileting and personal hygiene. Extensive assist x1 showers and incontinence care."

There was no evidence of provision of required written RP notification when Resident #49 was sent to the hospital on 10/16/23 and 11/7/23.

A review of the progress note dated 10/16/23 at 5:09 PM, revealed, "Nursing observations, evaluation, and recommendations are: Resident bumped into a chair with her motorized wheelchair. A hematoma formed on RLE (right lower extremity). It was evaluated by in house Provider who wants patient to go to ED (emergency department) due to infected hematoma to RLE."

A review of the progress note dated 11/7/23 at 10:23 AM, revealed, "Today, nursing requested for patient to be seen for right leg nodule increased in size, firm to touch and painful. Patient is sitting up in wheelchair ready dressed for her eye appointment at 12 noon. patient stated right leg is infected and painful. discussed will transfer back to emergency room for evaluation and drain hematoma surgically since procedure cannot be done at the facility. Nursing made aware that patient can be sent out when she comes back from her eye appointment."

An interview was conducted on 12/6/23 at 3:00 PM with LPN (licensed practical nurse) #4. When asked for evidence of written RP notification, LPN #4 stated, we call the RP and document it, but we do not provide any written notification. I do not know who does this.

An interview was conducted on 12/6/23 at 3:10

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495071	A. BUILDING _____ B. WING _____	C 12/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERSIDE LIFELONG H & R WARWICK FOREST	1000 OLD DENBEIGH BOULEVARD NEWPORT NEWS, VA 23602

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F 623	Continued From page 18	F 623		

PM with OSM (other staff member) #1, the social worker. When asked for evidence of written RP notification, OSM #1 stated, we do not provide written notification. I do not know what the nurses do.

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 facilities "Transfer and Discharge" policy revealed, "Before a facility transfers or discharges a resident, the facility will notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand."

No further information was provided prior to exit.

2. The facility staff failed to evidence provision of required written RP notification at the time of discharge for Resident #58. Resident #58 was transferred to the hospital on 11/22/23.

Resident #58 was admitted to the facility on 4/25/23 with diagnosis that included but were not limited to: COPD (chronic obstructive pulmonary disease), dysphagia and acute respiratory failure.

The most recent MDS (minimum data set) assessment, a quarterly assessment, with an ARD (assessment reference date) of 11/7/23, coded the resident as scoring a 05 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was severely cognitively impaired. A review of the MDS Section G-functional status coded the resident as

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495071	A. BUILDING _____ B. WING _____	C 12/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 623	Continued From page 19	F 623		

requiring extensive assistance for bathing, bed mobility; limited assistance for transfers and supervision for eating.

A review of the comprehensive care plan dated 8/22/23 revealed, "FOCUS: Resident desires to remain in facility to receive continued services. INTERVENTIONS: Provide services according to care plans in an effort to enhance optimum well-being. Siderails x2, total dependence x 2 transfers, extensive assist x1: bed mobility, dressing, toileting and personal hygiene."

There was no evidence of provision of required written RP notification when Resident #58 was sent to the hospital on 11/22/23.

A review of the progress note dated 11/22/23 at 2:15 PM, revealed, "Patient was assessed by NP (nurse practitioner). NP ordered to send patient out via emergent, related to hypoxia with slight shortness of breath, oxygen saturation at 88% via 4 liters nasal cannula. Patient tested positive for COVID 11/21/23."

An interview was conducted on 12/6/23 at 3:00 PM with LPN (licensed practical nurse) #4. When asked for evidence of written RP notification, LPN #4 stated, we call the RP and document it, but we do not provide any written notification. I do not know who does this.

An interview was conducted on 12/6/23 at 3:10 PM with OSM (other staff member) #1, the social worker. When asked for evidence of written RP notification, OSM #1 stated, we do not provide written notification. I do not know what the nurses do.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495071	A. BUILDING _____ B. WING _____	C 12/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERSIDE LIFELONG H & R WARWICK FOREST	1000 OLD DENBEIGH BOULEVARD NEWPORT NEWS, VA 23602

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F 623	Continued From page 20	F 623		

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 evidence provision of required written RP notification at the time of discharge for Resident #8. Resident #8 was transferred to the hospital on 10/31/23.

Resident #8 was admitted to the facility on 4/12/13 with diagnosis that included but were not limited to: DM (diabetes mellitus), neurogenic bladder and paraplegia.

The most recent MDS (minimum data set) assessment, a quarterly assessment, with an ARD (assessment reference date) of 10/17/23, coded the resident as scoring a 15 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 extensive assistance for bathing, bed mobility, transfer, dressing, hygiene and limited assistance for eating.

A review of the comprehensive care plan dated 1/30/23 revealed, "FOCUS: Resident desires to remain in facility to receive continued services. INTERVENTIONS: Provide services according to care plans in an effort to enhance optimum well-being. Siderails x2, overbed trapeze, extensive assist x1: dressing, toileting and personal hygiene. Extensive assist x1 showers and incontinence care."
There was no evidence of provision of required

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495071	A. BUILDING _____ B. WING _____	C 12/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 623	Continued From page 21	F 623		

written RP notification when Resident #49 was sent to the hospital on 10/31/23.

A review of the progress note dated 10/31/23 at 9:56 AM, revealed, "Neurological Status Evaluation: Seizure Nursing observations, evaluation, and recommendations are: Primary Care Provider Feedback: physician was present in room during seizure activity, transport to ED."

An interview was conducted on 12/6/23 at 3:00 PM with LPN (licensed practical nurse) #4. When asked for evidence of written RP notification, LPN #4 stated, we call the RP and document it, but we do not provide any written notification. I do not know who does this.

An interview was conducted on 12/6/23 at 3:10 PM with OSM (other staff member) #1, the social worker. When asked for evidence of written RP notification, OSM #1 stated, we do not provide written notification. I do not know what the nurses do.

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.

4. The facility staff failed to evidence provision of required written RP (responsible party) notification at the time of discharge for Resident #60. Resident #60 was transferred to the hospital on 8/16/23.

Resident #60 was admitted to the facility on 1/15/21 with diagnosis that included but were not

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495071	A. BUILDING _____ B. WING _____	C 12/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 623	Continued From page 22	F 623		

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.

A review of the comprehensive care plan dated 5/30/23 revealed, "FOCUS: Resident desires to remain in facility to receive continued services. INTERVENTIONS: Provide services according to care plans in an effort to enhance optimum well-being. Siderails x2, limited assist x1: dressing, toileting, showers, incontinence care and personal hygiene. Extensive assist x1: transfers."

There was no evidence of provision of required written RP notification when Resident #60 was sent to the hospital on 8/16/23.

A review of the progress note dated 8/16/23 at 5:09 PM, revealed, "Resident was sent to the ER from dialysis due to
bleeding coming from his fistula site."

An interview was conducted on 12/6/23 at 3:00 PM with LPN (licensed practical nurse) #4. When asked for evidence of written RP notification, LPN #4 stated, we call the RP and document it, but we do not provide any written notification. I do not

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495071	A. BUILDING _____ B. WING _____	C 12/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERSIDE LIFELONG H & R WARWICK FOREST	1000 OLD DENBEIGH BOULEVARD NEWPORT NEWS, VA 23602

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F 623	Continued From page 23 know who does this. An interview was conducted on 12/6/23 at 3:10 PM with OSM (other staff member) #1, the social worker. When asked for evidence of written RP notification, OSM #1 stated, we do not provide written notification. I do not know what the nurses do. 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.	F 623		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on observations, staff interview, clinical record review and facility document review, it was determined the facility staff failed to provide an accurate MDS (minimum data set) assessment for two out of 60 residents in the survey sample, Resident #192 and Resident #129. The findings include: 1.The facility staff failed to complete an accurate MDS (minimum data set), a discharge assessment for Resident #192. Resident #192 was sampled during the closed record review for transfer to hospital.	F 641	1. Resident #192 MDS was corrected, re- submitted, and accepted on 12/7/2023. Resident #129 MDS assessment was corrected, re-submitted, and accepted 12/7/2023 by the Senior MDS Coordinator. 2. Senior MDS Coordinator / designee will audit discharge assessments and assessments requiring the use of restraints from 11/1/2023 □ 1/4/2024 to validate accuracy of the assessment. All MDSs ARD 1/1/23- 12/15/23 section P were validated for accuracy on 12/15/23. 3. Director of Clinical Reimbursement / designee will educate the MDS	1/22/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495071	A. BUILDING _____ B. WING _____	C 12/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 641	Continued From page 24 Resident #192 was admitted to the facility on 10/3/23 with diagnosis that included but were not limited to: COPD (chronic obstructive pulmonary disease), chronic bronchitis and acute kidney failure. The most recent MDS (minimum data set) assessment, a Medicare 5-day assessment, with an ARD (assessment reference date) of 10/8/23, coded the resident as scoring a 15 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was cognitively intact. A review of Section A: Identification Information: A2105. Discharge Status, 04. Short term general hospital (acute care)." A review of the comprehensive care plan dated 10/5/23 revealed, "FOCUS: The resident is independent for meeting emotional, intellectual, physical, and social needs. INTERVENTIONS: Resident will maintain involvement in cognitive stimulation, social activities at her leisure as she is willing and able to tolerate through review date." A review of the nursing progress note dated 10/8/23 at 11:49 AM revealed, "Resident left facility against medical advice with daughters. Original copy of AMA form with patient's signature is in her chart. On call provider made aware." A review of the facility's "Against Medical Advice (AMA form)", reveals Resident #192 signed form on 10-8-23. An interview was conducted on 12/7/23 at 1:48 PM with RN (registered nurse) #2, the MDS coordinator. When asked to review the discharge	F 641	coordinators on the importance of accuracy on MDS assessments as it relates to transferring to the hospital/discharge assessments and those regarding the use of restraints. 4. Senior MDS Coordinator / designee will audit 4 residents weekly x 8 weeks to ensure they are coded accurately as transfer and those assessments regarding the use of restraints. The results of the audit will be reported at the QAPI meeting for evaluation of compliance and ongoing monitoring for continuous improvement analysis.	

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F 641	Continued From page 25	F 641		

information on Resident #192, RN #2 stated, yes, it documents that she went the hospital, let me check, no she did not go to the hospital, so it must be a coding error. When asked what standard is followed for completing the MDS, RN #2 stated, we follow the RAI.

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.

According to the RAI (resident assessment instrument) MDS Section A2100 OBRA Discharge Assessment: "Steps for Assessment: Review the medical record including the discharge plan and discharge orders for documentation of discharge location. Coding Instructions: Select the 2-digit code that corresponds to the resident's discharge status. Code 01, community (private home/apt., board/care, assisted living, group home): if discharge location is a private home, apartment, board and care, assisted living facility, or group home. Code 02, another nursing home or swing bed: if discharge location is an institution (or a distinct part of an institution) that is primarily engaged in providing skilled nursing care and related services for residents who require medical or nursing care or rehabilitation services for injured, disabled, or sick persons. Includes swing beds. Code 03, acute hospital: if discharge location is an institution that is engaged in providing, by or under the supervision of physicians for inpatients, diagnostic services, therapeutic services for medical diagnosis, and the treatment and care of injured, disabled, or sick persons."

No further information was provided prior to exit.

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	495071	A. BUILDING _____ B. WING _____	C 12/08/2023

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F 641	Continued From page 26	F 641		

2. For Resident #129 (R129), the facility staff failed to maintain an accurate MDS (minimum data set) assessment regarding the use of restraints.

On the most recent MDS assessment, a quarterly assessment, with an ARD (assessment reference date) of 9/7/2023, R129 was coded as using a trunk restraint less than daily in bed.

On 12/6/2023 at 11:08 a.m., an observation was made of R129 in bed in their room, no trunk restraint was observed. Additional observations on 12/6/2023 at 2:48 p.m., 12/7/2023 at 8:22 a.m. and 12/7/2023 at 3:12 p.m. of R129 in bed revealed no trunk restraint in place.

Review of R129's clinical record failed to evidence documentation of trunk restraint usage.

On 12/7/2023 at 8:26 a.m., an interview was conducted with LPN (licensed practical nurse) #2, clinical coordinator. LPN #2 stated that she worked with R129 and she was not aware of any restraint usage.

On 12/7/2023 at approximately 8:15 a.m., an interview was conducted with RN (registered nurse) #2, MDS coordinator. RN #2 stated that they followed the RAI (resident assessment instrument) manual when completing the MDS assessments. RN #2 stated that the facility was restraint free and would need to review R129's MDS to determine why it was coded for restraint usage.

On 12/7/2023 at 9:19 a.m., RN #2 stated that she had reviewed the quarterly MDS with the ARD of

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	495071	A. BUILDING _____ B. WING _____	C 12/08/2023

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F 641	Continued From page 27 9/7/2023 and the trunk restraint coding was an error. She stated that R129 had not utilized any restraints. She stated that she had corrected the MDS and resubmitted it. According to the RAI Manual, Version 1.16, dated October 2018, section P0100 documented in the steps for assessment, "1. Review the resident's medical record (e.g., physician orders, nurses' notes, nursing assistant documentation) to determine if physical restraints were used during the 7-day look-back period..." On 12/7/2023 at 4:36 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing and ASM #3, the chief nurse officer were made aware of the concern. No further information was provided prior to exit.	F 641		
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders.	F 655		1/22/24

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F 655	Continued From page 28 (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, the facility staff failed to develop a complete baseline care plan for one of 60 residents in the survey sample, Resident #347. The findings include: For Resident #347 (R347), the facility staff failed to develop a baseline care plan for dialysis care.	F 655	1. The Baseline care plan for resident # 347 was updated for dialysis care on 12/7/2023 by the Unit Manager. 2. All residents admitted since 1/1/24 will have their baseline care plan audited to include initial goals based on admission orders and all services provided to the resident by the DON/designee. 3. Clinical educator / designee will educate the clinical team members on the baseline care plan for each resident that	

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	495071	A. BUILDING _____ B. WING _____	C 12/08/2023

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F 655	Continued From page 29 R347 was admitted to the facility on 11/25/23. A review of R347's clinical record revealed a physician's order for dialysis every Monday, Wednesday and Friday. R347's baseline care plan with an admission date of 11/25/23 only documented the resident was at risk for weight fluctuations due to dialysis; this was documented in the dietary section of the care plan. The care plan failed to document any information regarding R347's dialysis care. On 12/6/23 at approximately 3:30 p.m., an interview was conducted with LPN (licensed practical nurse) #5. LPN #5 stated the purpose of the baseline care plan is to show the plan of care for the patient while they are at the facility. LPN #5 stated dialysis care should be documented on the baseline care plan, so it's included in the plan of care. On 12/6/23 at 5:10 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern. The facility policy titled, "Baseline Care Plan Policy" documented, "To provide guidelines for development and implementation of a Baseline Care plan within 48 hours of admission for each resident that includes information needed to effectively provide person-centered care prior to development of the comprehensive care plan."	F 655	includes development within 48 hours of admission and provides person centered care of the resident and all services provided to meet their needs. 4. DON / designee will audit 4 baseline care plans per week to ensure they were implemented timely are person centered and all services provided are included to meet their needs. The results of the audit will be reported at the QAPI meeting for evaluation of compliance and ongoing monitoring for continuous improvement analysis.	
F 656 SS=E	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered	F 656		1/22/24

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F 656	Continued From page 30	F 656		

care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -
(i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and
(ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).
(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.
(iv)In consultation with the resident and the resident's representative(s)-
(A) The resident's goals for admission and desired outcomes.
(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.
(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.
§483.21(b)(3) The services provided or arranged

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	495071	A. BUILDING _____ B. WING _____	C 12/08/2023

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F 656	Continued From page 31 by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, facility document review, and clinical record review, the facility staff failed to develop and/or implement the care plan for seven of 60 residents in the survey sample, Residents #59, #70, #49, #115, #60, #23, and #134. The findings include: 1. For Resident #59 (R59), the facility staff failed to develop a care plan for the resident's ADL (activities of daily living) needs. On R59's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 10/10/23, R59 was coded as having no cognitive impairment for making daily decisions, having scored 15 out of 15 on the BIMS (brief interview for mental status). On 12/6/23 at 10:23 a.m., R59 was observed sitting up in bed. He stated he received assistance from the facility staff for his daily needs, including dressing, bathing, and personal hygiene. A review of R59's comprehensive care plan dated 12/1/22 revealed no information related to the assistance the resident requires for ADL performance. On 12/7/23 at 8:19 a.m., RN (registered nurse) #2, the MDS coordinator, was interviewed. She stated the MDS staff open up the comprehensive	F 656	1. Resident # 59 ADL care plan was developed and implemented on 12/7/2023 by nursing leadership. Resident # 70 discharged from facility 12/6/2023. Resident # 49 care plan for medication administration was reviewed on 12/7/2023 by the Unit Manager all medications were administered as ordered on 12/8/2023 by nurse assigned to the resident□s care. Resident # 60 care plan was updated by 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 dialysis 12/7/2023 requesting return of documents. ADON called and educated both dialysis centers on the importance of returning dialysis communications timely. Resident # 115 care plan was updated by nursing leadership on 12/7/23 to include PTSD. On 12/12/2023 Social Services met with resident # 115 who declined supportive services including licensed clinical social worker but agreed to see the chaplain for spiritual services. Resident # 23 pain care plan was updated by the Unit Manager on 12/7/23.. On 12/6/2023 resident was evaluated by the nurse assigned to her care for pain and received pain medications as ordered and it was effective. Resident # 134 care plan was updated by	

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F 656	Continued From page 32 care plan as soon as possible after a resident is admitted. She stated she interviews the resident, interviews staff members, reviews the information from the hospital, and looks at the diagnosis list, physician's orders, and assessments from the facility staff to formulate the comprehensive care plan. After reviewing R59's care plan, she stated she did not see his ADL assistance anywhere on the document. She stated his ADL assistance should have been included on the care plan. On 12/07/23 at 4:33 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, and ASM #3, the chief nursing officer, were informed of these concerns. A review of the facility policy, "Comprehensive Care Planning," revealed, in part: "The facility must work with the resident and their representative, if applicable, to understand and meet the resident's preferences, choices, and goals while they are at the facility...The facility must establish, document and implement the care and services to be provided to each resident to assist in attaining or maintaining his or her highest practicable quality of life. A comprehensive care plan must be developed and implemented no later than day 21 of the resident's admission to the facility...The facility must develop care plans that describe the resident's medical, nursing, physical, mental, and psychosocial needs and preferences and how the facility will assist in meeting these needs and preferences. Care plans must include person-specific, measurable objectives and timeframes in order to evaluate the resident's progress toward their goal(s)." No further information was provided prior to exit.	F 656	nursing leadership for monitoring for the use of psychotropic medications to include Trazadone monitoring for signs and symptoms of depression, effectiveness, side effects and adverse reactions was corrected on 12/8/2023. IDT reviewed comprehensive care plan 1/4/2024. 2. Director of Clinical Reimbursement / designee will review LTC resident comprehensive care plans in the following areas: ADL care, anticoagulants, PTSD, dialysis, pain, and psychoactive medication. 3. Director of Clinical Reimbursement / designee will educate IDT on the process for development and implementation of comprehensive care plans and updates for ADL care, anticoagulants, medication administration, PTSD, dialysis, pain, and psychoactive medication. 4. Director of Nursing / designee will audit 4 comprehensive care plans 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.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495071	A. BUILDING _____ B. WING _____	C 12/08/2023

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F 656	Continued From page 33	F 656		

2. For Resident #70 (R70), the facility staff failed to develop a care plan for the resident's use of an anticoagulant.

A review of R70's physician's orders December 2023 MAR (medication administration record) revealed R70 was receiving Eliquis, and anticoagulant, every day.

A review of R70's care plan dated 9/11/23 failed to reveal any information related to the resident's receiving an anticoagulant.

On 12/7/23 at 8:19 a.m., RN (registered nurse) #2, the MDS coordinator, was interviewed. She stated the MDS staff open up the comprehensive care plan as soon as possible after a resident is admitted. She stated she interviews the resident, interviews staff members, reviews the information from the hospital, and looks at the diagnosis list, physician's orders, and assessments from the facility staff to formulate the comprehensive care plan. After reviewing R70's care plan, she stated she did not see the resident's anticoagulant anywhere on the document. She stated the anticoagulant should be included in the care plan.

On 12/07/23 at 4:33 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, and ASM #3, the chief nursing officer, were informed of these concerns.

No further information was provided prior to exit.

3. The facility staff failed to implement the comprehensive care plan for medications as

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	495071	A. BUILDING _____ B. WING _____	C 12/08/2023

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RIVERSIDE LIFELONG H & R WARWICK FOREST	1000 OLD DENBEIGH BOULEVARD NEWPORT NEWS, VA 23602

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F 656	Continued From page 34	F 656		

ordered for Resident #49.

Resident #49 was admitted to the facility on 12/17/21 with diagnosis that included but were not limited to: COPD (chronic obstructive pulmonary disease), cellulitis, ASCVD (atherosclerotic cardiovascular disease) and PVD (peripheral vascular disease).

The most recent MDS (minimum data set) assessment, a quarterly assessment, with an ARD (assessment reference date) of 11/28/23, coded the resident as scoring a 15 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 extensive assistance for bathing and supervision for bed mobility, transfer, dressing, hygiene and eating; independent for locomotion.

A review of the comprehensive care plan dated 5/22/23 revealed, "FOCUS: Resident is prescribed fluoxetine for diagnosis of major depressive disorder. Resident is on anticoagulant therapy (Eliquis) related to Atrial fibrillation. INTERVENTIONS: Administer medications as ordered by provider. Monitor for side effects and effectiveness. Administer ANTICOAGULANT medications as ordered by physician. Monitor for side effects and effectiveness Q-SHIFT."

A review of the physician orders dated 12/4/22, revealed "Fluoxetine CAP 40MG (milligram) Give 1 capsule orally one time a day for Depression; and 6/19/23 orders revealed, "ELIQUIS TAB 5MG (milligram), Give 1 tablet orally two times a day for Afib (atrial fibrillation)".

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495071	A. BUILDING _____ B. WING _____	C 12/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 656	Continued From page 35	F 656		

An interview was conducted on 12/5/23 at 3:40 PM with Resident #49. Resident #49 stated, in November, they did not give me my anticoagulant and my antidepressant for several shift.

A review of the November 2023 MAR (medication administration record) revealed, "ELIQUIS TAB 5MG Give 1 tablet orally two times a day for Afib, was coded "9-other see progress note" for 11/12/23 8 AM and 9 PM and 11/13/23 at 8 AM; and Fluoxetine 40 mg give 1 capsule orally one time a day for depression was coded "9-other see progress note" for 11/13/23 8 AM.

A review of the progress note dated 11/12/23 at 9:14 AM, revealed "ELIQUIS TAB 5MG Give 1 tablet orally two times a day for Afib. Medication not given; Pharmacy did not send. Pharmacy notified; 11/13/23 at 9:30 AM revealed "ELIQUIS TAB 5MG Give 1 tablet orally two times a day for Afib. Reorder; 11/13/23 at 9:31 AM revealed "Fluoxetine CAP 40MG Give 1 capsule orally one time a day for Depression. Reorder."

An interview was conducted 12/7/23 at 12:05 PM with LPN (licensed practical nurse) #5. When asked if the care plan reveals to administer medications as ordered and there is no evidence of the administration, is the care plan implemented, LPN #5 stated, no, it is not being followed.

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 656	Continued From page 36	F 656		

4. The facility staff failed to implement the comprehensive care plan for dialysis care as ordered for Resident #60.

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 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.

A review of the comprehensive care plan dated 11/7/23 revealed, "FOCUS: Resident needs dialysis (hemodialysis) HD three days a week on Monday, Wednesday and Friday related to renal failure. INTERVENTIONS: Monitor/document/report as needed for signs/symptoms of renal insufficiency: changes in level of consciousness, changes in skin turgor, oral mucosa, changes in heart and lung sounds." Revised interventions dated 12/7/23 revealed, "Monitor dialysis access site left arm every shift for bleeding or signs/symptoms of infection. If observed, notify provider and document."

A review of the physician orders dated 9/24/23, revealed, "DIALYSIS - Attends Dialysis on Monday-Wednesday-Friday for dialysis time at

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495071	A. BUILDING _____ B. WING _____	C 12/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERSIDE LIFELONG H & R WARWICK FOREST	1000 OLD DENBEIGH BOULEVARD NEWPORT NEWS, VA 23602

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F 656	Continued From page 37	F 656		

0515. Assess fistula for bruit and thrill every shift. NOTIFY PROVIDER immediately if not present. Every shift for fistula." Discontinue date of orders 10/5/23. Resident continued to go to dialysis Monday-Wednesday-Friday.

A review of Resident #60's dialysis communication book revealed, missing documentation 34 out of 41 dialysis appointments. September 2023: 9/1, 9/6, 9/11, 9/18, 9/20, 9/22, 9/27; October 2023: 10/2, 10/6, 10/9, 10/11, 10/13, 10/16, 10/18, 10/20, 10/23, 10/25, 10/27, 10/30; November: 11/1, 11/3, 11/6, 11/8, 11/10, 11/13, 11/15, 11/17, 11/20, 11/22, 11/24, 11/27, 11/29 and December: 12/1 and 12/4.

A review of Resident #60's TAR (treatment administration record) for October, November and to December 6, 2023, for a total of 61-day shifts, 61-evening shifts and 61-night shift.

Resident #60 was either sleeping or unavailable for interview.

An interview was conducted 12/7/23 at 12:05 PM with LPN (licensed practical nurse) #5. When asked if the care plan reveals to assess the bruit and thrill and there is no evidence of the assessment, is the care plan implemented, LPN #5 stated, no, it is not being followed.

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495071	A. BUILDING _____ B. WING _____	C 12/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERSIDE LIFELONG H & R WARWICK FOREST	1000 OLD DENBEIGH BOULEVARD NEWPORT NEWS, VA 23602

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F 656	Continued From page 38	F 656		

5. The facility staff failed to implement the comprehensive care plan for dialysis care as ordered for Resident #115.

Resident #115 was admitted to the facility on 4/26/23 with diagnosis that included but were not limited to: PTSD (post-traumatic stress disorder), CVA (cerebrovascular accident) and hemiplegia.

The most recent MDS (minimum data set) assessment, a quarterly assessment, with an ARD (assessment reference date) of 10/24/23, coded the resident as scoring a 15 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 extensive assistance for bathing, bed mobility, transfer, dressing, hygiene and eating. A review of Section I: Medical Diagnosis: I6100. Post Traumatic Stress Disorder (PTSD)-coded yes.

A review of the comprehensive care plan dated 8/10/23 revealed, "FOCUS: Resident has a potential for alteration in wellbeing related to history of trauma, diagnosis of PTSD. INTERVENTIONS: Provide resident with supportive care and services to promote a sense of safety, well-being and positive self-image. Staff will use the appropriate screening tools and assessments to recognize past trauma and will make referrals, as necessary. Consult pastoral care, as needed."

An interview was conducted on 12/5/23 at 3:15 PM with Resident #115. When asked about trauma or stress, Resident #115 stated, there is nothing to talk about. I do not want to talk about it.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495071	A. BUILDING _____ B. WING _____	C 12/08/2023

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RIVERSIDE LIFELONG H & R WARWICK FOREST	1000 OLD DENBEIGH BOULEVARD NEWPORT NEWS, VA 23602

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F 656	Continued From page 39 An interview was conducted 12/7/23 at 12:05 PM with LPN (licensed practical nurse) #5. When asked if the care plan reveals to provide interventions related to PTSD and there is no evidence of any interventions, is the care plan implemented, LPN #5 stated, no, it is not being followed. 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. 6. For Resident #23 (R23), the facility staff failed to implement the resident's comprehensive care plan for pain. On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 11/14/23, the resident scored 15 out of 15 on the BIMS (brief interview for mental status), indicating the resident was cognitively intact for making daily decisions. A review of R23's clinical record revealed a physician's order dated 3/15/23 for acetaminophen (Tylenol) 325 milligrams- give 650 milligrams by mouth every six hours as needed for pain. R23's comprehensive care plan dated 8/29/23 documented, "(R23) is at risk for pain r/t (related to) a history of polio, UC (ulcerative colitis). Anticipate the resident's need for pain relief and respond immediately to any complaint of pain..."	F 656		

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	495071	A. BUILDING _____ B. WING _____	C 12/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERSIDE LIFELONG H & R WARWICK FOREST	1000 OLD DENBEIGH BOULEVARD NEWPORT NEWS, VA 23602

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F 656	Continued From page 40 On 12/5/23 at 4:16 p.m., R23 was lying in bed. The resident stated her right leg was hurting and the facility staff had not done anything for her pain. A note signed by the nurse practitioner on 12/5/23 documented, "Seen today in bed resting. She is alert and following commands. She denies any fevers or chills. She complains of right leg pain and requests for pian [sic] medicine, discussed will ask nurse to medicate..." Further review of R23's clinical record failed to reveal acetaminophen was administered to the resident and failed to reveal non-pharmacological interventions were offered to the resident. On 12/6/23 at 8:29 a.m., R23 was lying in bed. The resident stated the staff still had not done anything to treat her leg pain. On 12/6/23 at 2:43 p.m., an interview was conducted with LPN (licensed practical nurse) #4 (the nurse who cared for R23 on 12/5/23 when the nurse practitioner wrote the note). LPN #4 stated the purpose of the care plan is to know how to care for the resident. LPN #4 stated nurses implement the care plan by checking physician's orders and she was not sure if she could see residents' care plans in the computer system. LPN #4 stated that on 12/5/23, she was not aware of R23's right leg pain, and the nurse practitioner never reported the pain to her or asked her to medicate the resident. On 12/6/23 at 5:10 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern.	F 656		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495071	A. BUILDING _____ B. WING _____	C 12/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 656	Continued From page 41	F 656		

7. For Resident #134 the facility staff failed to follow the comprehensive care plan for monitoring for the use of psychotropic medications.

A review of the clinical record revealed a physician's order dated 9/13/23 for "Trazodone (1) Oral Tablet 50 MG, Give 0.5 mg by mouth at bedtime for per psych."

A review of the clinical record revealed a physician's order dated 9/13/23 for "Risperdal (2) Oral Tablet 0.5 MG (milligrams) (Risperidone) Give 1 tablet by mouth at bedtime for psychotic disturbance."

Further review failed to reveal any orders for staff monitoring for the use of Trazodone, including monitoring for signs and symptoms of depression, effectiveness, side effects and adverse reactions; and for the use of Risperdal, including behavior, effectiveness, side effects, and adverse reactions to an antipsychotic medication.

A review of the MAR (Medication Administration Record) and TAR (Treatment Administration Record) for August 2023 through December 2023 was conducted. There was no line item for the use of Trazodone that included signs and symptoms of depression, effectiveness, side effects and adverse reactions for documenting that the required monitoring was done. Also, there was no line item for monitoring for the use of Risperdal that included behaviors, side effects

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495071	A. BUILDING _____ B. WING _____	C 12/08/2023

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F 656	Continued From page 42	F 656		

and adverse reactions for documenting that the required monitoring was done.

A review of the progress notes failed to reveal consistent evidence that staff were monitoring for the use of Trazodone, including signs and symptoms of depression, effectiveness, side effects and adverse reactions. The progress notes also failed to reveal consistent evidence that staff were monitoring the use of Risperdal, including behavior, effectiveness, side effects, and adverse reactions to an antipsychotic medication.

A review of the comprehensive care plan included one dated 8/9/23 for "(Resident #134) uses psychotropic medications (Trazodone and Risperdal) medications) r/t (related to) Disease process (Vascular Dementia Severe with Psychotic Disturbances)." This care plan included an intervention dated 5/1/23 for "Monitor/document/report PRN (as-needed) any adverse reactions of PSYCHOTROPIC medications: unsteady gait, tardive dyskinesia, EPS (Extrapyramidal symptoms) (shuffling gait, rigid muscles, shaking), frequent falls, refusal to eat, difficulty swallowing, dry mouth, depression, suicidal ideations, social isolation, blurred vision, diarrhea, fatigue, insomnia, loss of appetite, weight loss, muscle cramps nausea, vomiting, behavior symptoms not usual to the person."

On 12/6/23 at 4:31 p.m., an interview was conducted with RN (Registered Nurse) #1. RN #1 stated the purpose of the care plan is that, "It tells the story of the resident. It's how we communicate residents' individual needs."

On 12/8/23 at 8:20 AM, an interview was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495071	A. BUILDING _____ B. WING _____	C 12/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 656	Continued From page 43 conducted with LPN #9 (Licensed Practical Nurse). When asked if the care plan included to monitor and document, and there isn't consistent documentation of monitoring then was the care plan being followed, she stated that she believed it was being followed if they chart by exception any noted behaviors. She stated it would be more efficient if there was an order to check off for monitoring. The facility policy, "Care Planning" documented, "...Each resident will have a person-centered comprehensive care plan developed and implemented to meet his or her preferences and goals, and address the resident's medical, physical, mental and psychosocial needs." On 12/7/23 at 4:50 PM at the end-of-day meeting, ASM #1 (Administrative Staff Member) the Administrator and ASM #2 the Director of Nursing were made aware of the findings. No further information was provided by the end of the survey. (1) Trazodone is used to treat depression. Information obtained from https://medlineplus.gov/druginfo/meds/a681038.html (2) Risperdal is an antipsychotic. Information obtained from https://medlineplus.gov/druginfo/meds/a694015.html	F 656		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must	F 657		1/22/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495071	A. BUILDING _____ B. WING _____	C 12/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERSIDE LIFELONG H & R WARWICK FOREST	1000 OLD DENBEIGH BOULEVARD NEWPORT NEWS, VA 23602

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F 657	Continued From page 44 be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, clinical record review and facility document review, it was determined the facility staff failed to review and revise the care plans for three of 60 residents in the survey sample, Resident #24, Resident #120 and Resident #145. The findings include: 1. For Resident #24 (R24), the facility staff failed to review and revise the comprehensive care plan after a fall on 10/27/2023.	F 657	1. Resident # 24 care plan was updated on 12/7/23 by nursing leadership to include fall and interventions for fall that occurred on 10/27/23. Resident # 120 care plan was updated by nursing leadership to include ordered dialysis catheter care on 12/6/2023. Resident # 145 care plan was updated by nursing leadership to include diagnosis of shingles on 12/7/23. 2. Director of Nursing / designee will audit comprehensive care plans for	

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	495071	A. BUILDING _____ B. WING _____	C 12/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERSIDE LIFELONG H & R WARWICK FOREST	1000 OLD DENBEIGH BOULEVARD NEWPORT NEWS, VA 23602

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F 657	Continued From page 45 On the most recent MDS (minimum data set) assessment, a quarterly assessment with an ARD (assessment reference date) of 10/5/2023, the resident scored 3 of 15 on the BIMS (brief interview for mental status) assessment, indicating the resident was severely impaired for making daily decisions. Section J documented no falls. Observations of R24 conducted during the dates of the survey revealed R24 in their wheelchair in the day area of the unit or participating in activities. The comprehensive care plan for R24 documented in part, "(Name of R24) is High risk for falls r/t (related to) Gait/balance problems, Incontinence, Psychoactive drug use and history of falls. Date Initiated: 10/21/2022. Revision on: 05/10/2023." The comprehensive care plan failed to evidence a review and/or revision after the fall on 10/27/2023. The progress notes for R24 documented in part, - "10/27/2023 09:03 (9:03 a.m.) Was called to Residents room around 0350 (3:50 a.m.) by the CNA (certified nursing assistant) whom stated the resident is on the floor. Proceeded to residents room and observed his legs on the floor. Left arm on the mattress with his head resting in his elbow. Right arm was wedged between the mattress and the rail on the bed. Resident showed no sign of distress. When asked how he got on the floor he stated he didn't know. Freed his arm and lowered him to the floor with the CNA and other nurse on shift. A quick assessment of him was done. He showed no bruises or any new areas on his body. He was put back into bed	F 657	residents who have fallen, are on dialysis or have a new diagnosis for accuracy. 3. Clinical Educator/ designee will educate the IDT team on process for care plan 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.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495071	A. BUILDING _____ B. WING _____	C 12/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERSIDE LIFELONG H & R WARWICK FOREST	1000 OLD DENBEIGH BOULEVARD NEWPORT NEWS, VA 23602

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F 657	Continued From page 46	F 657		

using the hoyer lift. Residents vitals were taken, Neuro (neurological) checks started as it was an unwitnessed fall..." The progress notes failed to evidence a review and/or revision of the care plan after the fall on 10/27/2023.

The Fall investigation for R24 for the 10/27/2023 fall failed to evidence a review of the comprehensive care plan. The investigation was completed by LPN (licensed practical nurse) #2, clinical coordinator.

On 12/7/2023 at 8:26 a.m., an interview was conducted with LPN #2, clinical coordinator. LPN #2 stated that the purpose of the care plan was to show any interventions that needed to be in place for the resident and update the family of the care provided. She stated that the care plan was reviewed and revised by her, the MDS staff, nursing staff and the interdisciplinary team when there were changes in condition or new treatments or medications. She stated that the care plan was reviewed and revised as needed after a fall by the leadership team during the fall investigation.

On 12/7/2023 at 9:19 a.m., an interview was conducted with RN (registered nurse) #2, MDS coordinator. RN #2 stated that daily updates to the care plan were done by the nursing staff, nurse manager or the assistant director of nursing. She stated that she would expect the care plan to be reviewed and/or revised after a fall.

The facility policy, "Comprehensive Care Planning" dated 7/1/2023 documented in part, "...8. In between quarterly care plan review periods, the resident's care plan will continue to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495071	A. BUILDING _____ B. WING _____	C 12/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 47	F 657		

be revised and updated with changes that occur to the resident's status, risk factors, orders, interventions, etc. in order to keep the plan of care current..."

On 12/7/2023 at 4:36 p.m., 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 concern.

No further information was obtained prior to exit.

2. For Resident #120 (R120), the facility staff failed to review and revise the comprehensive care plan regarding care of a dialysis catheter.

On the most recent MDS (minimum data set) assessment, a quarterly assessment with an ARD (assessment reference date) of 11/23/2023, the resident scored 15 of 15 on the BIMS (brief interview for mental status) assessment, indicating the resident was cognitively intact for making daily decisions. Section O documented R120 receiving dialysis services.

On 12/5/2023 at 2:49 p.m., an interview was conducted with R120 in their room. R120 stated that they went to dialysis outside of the facility three days a week. A dialysis access catheter was observed to R120's chest on the left side. The catheter site was observed to be covered with a gauze dressing that was not dated. When asked about catheter care and dressing changes, R120 stated that the facility staff did not care for the catheter or change the dressings. R120 stated that the dialysis staff cared for the catheter and changed the dressings on dialysis days.

The comprehensive care plan for R120

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495071	A. BUILDING _____ B. WING _____	C 12/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 657	Continued From page 48	F 657		

documented in part, "(Name of R120) requires hemo-dialysis [sic] r/t (related to) end stage renal failure. Date Initiated: 10/20/2022. Revision on: 07/18/2023." Under "Interventions" it documented in part, "Check and change dressing daily at access site. Document. Date Initiated: 10/20/2022..."

Review of the clinical record for R120 failed to evidence documentation of care of the dialysis catheter provided by facility staff.

On 12/7/2023 at 8:26 a.m., an interview was conducted with LPN (licensed practical nurse) #2, clinical coordinator. LPN #2 stated that the purpose of the care plan was to show any interventions that needed to be in place for the resident and update the family of the care provided. She stated that the care plan was reviewed and revised by her, the MDS staff, nursing staff and the interdisciplinary team when there were changes in condition or new treatments or medications. She stated that the facility staff did not provided any treatment or dressing change to R120's dialysis access. She stated that the gauze dressing was applied at dialysis and the site was cared for by the dialysis staff. She stated that the nursing staff monitored the area for any changes or drainage and would notify the dialysis center or provider if any were observed. She reviewed R120's care plan documenting the intervention to check and change the access site dressing daily and stated that it was not accurate and needed to be revised.

On 12/7/2023 at 4:36 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing and ASM #3, the chief nursing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495071	A. BUILDING _____ B. WING _____	C 12/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERSIDE LIFELONG H & R WARWICK FOREST	1000 OLD DENBEIGH BOULEVARD NEWPORT NEWS, VA 23602

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F 657	Continued From page 49 officer were made aware of the concern. No further information was obtained prior to exit. 3. For Resident #145, the facility staff failed to revise the comprehensive care plan to address the presence and treatment of shingles. A physician's order dated 11/9/23 documented, "Valacyclovir Oral Tablet 1 (one) GM. Give 1 tablet by mouth three times a day for zoster form 7 Days." A review of the clinical record revealed a social worker care plan meeting note dated 11/8/23 that documented, "....Resident/Family Requests or Concerns? resident husband express observe wife skin changes on left arm: redness blister like and want provider to see her. All requests been flag to the provider...." A physician progress note dated 11/9/23 documented, "... resident seen today for reported rash on right wrist which 1st (first) appeared yesterday. Subjective experience of rash unable to be determined due to patient's chronic degenerative neurologic condition.....Right wrist shows linear streaky macular erythema with a few vesicular lesions on right distal forearm....Shingles....recommend isolation x7 (times seven) days and valacyclovir 3 times a day for 7 days. Isolation precautions can be removed once lesions are crusted over or 7 days whichever is sooner. Recommend rash be	F 657		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495071	A. BUILDING _____ B. WING _____	C 12/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERSIDE LIFELONG H & R WARWICK FOREST	1000 OLD DENBEIGH BOULEVARD NEWPORT NEWS, VA 23602

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F 657	Continued From page 50	F 657		

covered when possible, since patient is unable to be relied upon not to touch the area...."

A nurse's note dated 11/9/23 documented, " Resident placed in room and place on contact precautions for shingles per M.D. (Medical Doctor) Small blister-like areas noted on right wrist."

A nurse's note dated 11/10/23 documented, "Resident in bed....Right wrist continues to have small redden blister like area. Resident remains on contact precautions for shingles. Resident on po (oral) Valtrex tab 1Gm (gram), day 1 of 7...."

A review of the comprehensive care plan revealed one dated 12/6/22 for "(Resident #145) has the potential for actual impairment to skin integrity r/t (related to) fragile skin, incontinence and decreased mobility." This care plan included an intervention dated 12/6/22 for "Monitor/document location, size and treatment of skin injury. Report abnormalities, failure to heal, s/sx (signs and symptoms) of infection, maceration etc. to MD."

Further review failed to reveal any evidence of the presence and treatment of shingles being added to the comprehensive care plan.

On 12/8/23 at 8:20 AM, an interview was conducted with LPN #9 (Licensed Practical Nurse). She stated that if the resident has a change in condition, the care plan should be updated to address it. When asked if a resident developed a rash of shingles, should that be on the care plan, she stated the care plan should be updated to reflect that and the treatment, and also updated to include the new diagnosis if this

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495071	A. BUILDING _____ B. WING _____	C 12/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERSIDE LIFELONG H & R WARWICK FOREST	1000 OLD DENBEIGH BOULEVARD NEWPORT NEWS, VA 23602

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F 657	Continued From page 51 was the first time the resident developed shingles. The facility policy, "Care Planning" documented, "...In between quarterly care plan review periods, the resident's care plan will continue to be revised and updated with changes that occur to the resident's status, risk factors, orders, interventions, etc. in order to keep the plan of care current." On 12/7/23 at 4:50 PM at the end-of-day meeting, ASM #1 (Administrative Staff Member) the Administrator and ASM #2 the Director of Nursing were made aware of the findings. No further information was provided by the end of the survey. (1) Valacyclovir is used to treat herpes zoster (shingles) and genital herpes. Information obtained from https://medlineplus.gov/druginfo/meds/a695010.html	F 657		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review and facility document review, it was determined the facility staff failed to meet professional standards for one of 60 residents, Resident #49.	F 658	1. Resident # 49 medication administration record was reviewed on 12/8/2023 by Director of Nursing and all medication were administered as ordered on 12/8/2023.	1/22/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495071	A. BUILDING _____ B. WING _____	C 12/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERSIDE LIFELONG H & R WARWICK FOREST	1000 OLD DENBEIGH BOULEVARD NEWPORT NEWS, VA 23602

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F 658	Continued From page 52 The findings include: The facility staff failed to meet professional standards by administering medications as ordered, specifically Fluoxetine CAP 40MG (milligram), for Resident #49. Resident #49 was admitted to the facility on 12/17/21 with diagnosis that included but were not limited to: COPD (chronic obstructive pulmonary disease), cellulitis, ASCVD (atherosclerotic cardiovascular disease) and PVD (peripheral vascular disease). The most recent MDS (minimum data set) assessment, a quarterly assessment, with an ARD (assessment reference date) of 11/28/23, coded the resident as scoring a 15 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 extensive assistance for bathing and supervision for bed mobility, transfer, dressing, hygiene and eating; independent for locomotion. A review of the comprehensive care plan dated 5/22/23 revealed, "FOCUS: Resident is prescribed fluoxetine for diagnosis of major depressive disorder. INTERVENTIONS: Administer medications as ordered by provider. Monitor for side effects and effectiveness." A review of the physician orders dated 12/4/22, revealed "Fluoxetine CAP 40MG (milligram) Give 1 capsule orally one time a day for Depression". An interview was conducted on 12/5/23 at 3:40 PM with Resident #49. Resident #49 stated, in	F 658	2. Director of Nursing /Designee will audit MARS of residents on antidepressants since January 1, 2024, to ensure they were administered as ordered. 3. Clinical Educator / designee will educate licensed nursing staff on the medication administration process ensuring medications are administered as ordered. 4. Director of Nursing / designee will audit 4 residents on antidepressant medication weekly for 8 weeks to ensure they were given as ordered. The results of the audit will be reported at the QAPI meeting for evaluation of compliance and ongoing monitoring for continuous improvement analysis.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495071	A. BUILDING _____ B. WING _____	C 12/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERSIDE LIFELONG H & R WARWICK FOREST	1000 OLD DENBEIGH BOULEVARD NEWPORT NEWS, VA 23602

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F 658	Continued From page 53 November, they did not give me my antidepressant and I worry if I do not take it daily. A review of the November 2023 MAR (medication administration record) revealed, "Fluoxetine 40 mg give 1 capsule orally one time a day for depression was coded "9-other see progress note" for 11/13/23 8 AM." A review of the progress note dated 11/13/23 at 9:31 AM, revealed "Fluoxetine CAP 40MG Give 1 capsule orally one time a day for Depression. Reorder." A review of the facility's "MedBank Medication Listing" identified "Fluoxetine 10 mg tablet with a par level of eight (8). An interview was conducted 12/7/23 at 12:05 PM with LPN (licensed practical nurse) #5. When asked if the medication was not in the resident's medication and was in the drug stock, should the medication have been administered from the drug stock, LPN #5 stated, yes, it should have been administered if we had it in the drug stock. 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. According to the facility's "Medication Administration Policy" which revealed, "Medications will be administered in accordance with regulatory guidelines, infection control and clinical practice standards." No further information was provided prior to exit.	F 658		
F 676 SS=E	Activities Daily Living (ADLs)/Mntn Abilities	F 676		1/22/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495071	A. BUILDING _____ B. WING _____	C 12/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERSIDE LIFELONG H & R WARWICK FOREST	1000 OLD DENBEIGH BOULEVARD NEWPORT NEWS, VA 23602

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F 676	Continued From page 54 CFR(s): 483.24(a)(1)(b)(1)-(5)(i)-(iii) §483.24(a) Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility must provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. This includes the facility ensuring that: §483.24(a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section ... §483.24(b) Activities of daily living. The facility must provide care and services in accordance with paragraph (a) for the following activities of daily living: §483.24(b)(1) Hygiene -bathing, dressing, grooming, and oral care, §483.24(b)(2) Mobility-transfer and ambulation, including walking, §483.24(b)(3) Elimination-toileting, §483.24(b)(4) Dining-eating, including meals and snacks, §483.24(b)(5) Communication, including (i) Speech, (ii) Language, (iii) Other functional communication systems.	F 676		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495071	A. BUILDING _____ B. WING _____	C 12/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERSIDE LIFELONG H & R WARWICK FOREST	1000 OLD DENBEIGH BOULEVARD NEWPORT NEWS, VA 23602

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F 676	Continued From page 55 This REQUIREMENT is not met as evidenced by: Based on resident and staff interview, clinical record review and facility document review, it was determined the facility staff failed to provide evidence of providing ADLs (activities of daily living) care to maintain abilities for two of 60 residents, Resident #49 and Resident #8. 1.The findings include: The facility staff failed to provide evidence of bathing and showers for Resident #49. Resident #49 was admitted to the facility on 12/17/21 with diagnosis that included but were not limited to: COPD (chronic obstructive pulmonary disease), cellulitis, ASCVD (atherosclerotic cardiovascular disease) and PVD (peripheral vascular disease). The most recent MDS (minimum data set) assessment, a quarterly assessment, with an ARD (assessment reference date) of 11/28/23, coded the resident as scoring a 15 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 extensive assistance for bathing and supervision for bed mobility, transfer, dressing, hygiene and eating; independent for locomotion. A review of the comprehensive care plan dated 7/3/23 revealed, "FOCUS: Resident desires to remain in facility to receive continued services. INTERVENTIONS: Provide services according to care plans in an effort to enhance optimum well-being. Siderails x2, limited assist x1:	F 676	1. Resident # 49 received full bed baths on 12/6/2023, 12/7/2023, and a shower on 12/8/2023 by clinical staff assigned to her care. Resident # 8 received a shower on 12/8/2023 and has documented personal hygiene on 12/6/23, 12/7/23 and 12/8/23 by clinical staff assigned to her care 2. Director of Nursing / designee will audit residents personal hygiene /grooming and bathing and shower records from January 1, 2024, to ensure residents were provided and documented personal hygiene, grooming, bathing, and showers. 3. Clinical educator / designee will educate clinical team members on the importance of accurate documentation of personal hygiene /grooming and bathing and showers. 4. Director of Nursing / designee will audit 4 residents care records for hygiene /grooming and bathing and showers per week 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.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495071	A. BUILDING _____ B. WING _____	C 12/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERSIDE LIFELONG H & R WARWICK FOREST	1000 OLD DENBEIGH BOULEVARD NEWPORT NEWS, VA 23602

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F 676	Continued From page 56	F 676		

dressing, toileting and personal hygiene. Extensive assist x1 showers and incontinence care."

A review of October 2023 shower ADL documentation revealed that three of eight days are missing: 10/11, 10/14 and 10/18.

A review of November 2023 shower ADL documentation revealed that five of nine days are missing: 11/1, 11/8, 11/15, 11/18 and11/22.

An interview was conducted on 12/7/23 at 12:30 PM with CNA (certified nursing assistant) #2. When asked where bathing and showers are documented, CNA #2 stated, we document our showers in PCC (Point Click Care) there is no book. When asked what it indicates if there are blanks in the documentation, CNA #2 stated, the bathing and showers were not done. When asked what it indicates if NA is documented, CNA #2 stated, that is not applicable, that does not make any sense.

An interview was conducted on 12/7/23 at 4:00 PM with CNA #3. When asked where showers are documented, CNA #3 stated, they are documented in PCC. When asked what it indicates if there are blanks in the documentation, CNA #3 stated, it means that the showers were not done.

An interview was conducted on 12/8/23 at 8:15 AM with CNA #4. When asked the frequency of showers and where they are documented, CNA #4 stated, they are twice a week and are documented in PCC. When asked what it indicates if there are blanks in the documentation, CNA #4 stated, it was not done.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495071	A. BUILDING _____ B. WING _____	C 12/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 676	Continued From page 57	F 676		

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 "Routine Care and Activities of Daily Living" policy revealed, " Provision of care and services will be based on a comprehensive assessment and consistent with resident needs and choices. Documentation of routine care and activities of daily living will be documented in the EMR (electronic medical record) touchscreen and will align with definitions in the state's RAI (Resident Assessment Instrument) manual. Residents who are unable to carry out activities of daily living will receive the necessary services to maintain and maximize their functional abilities."

No further information was provided prior to exit.

2. The findings include:

The facility staff failed to provide evidence of bathing and showers for Resident #8.

Resident #8 was admitted to the facility on 4/12/13 with diagnosis that included but were not limited to: DM (diabetes mellitus), neurogenic bladder and paraplegia.

The most recent MDS (minimum data set) assessment, a quarterly assessment, with an ARD (assessment reference date) of 10/17/23, coded the resident as scoring a 15 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495071	A. BUILDING _____ B. WING _____	C 12/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERSIDE LIFELONG H & R WARWICK FOREST	1000 OLD DENBEIGH BOULEVARD NEWPORT NEWS, VA 23602

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F 676	Continued From page 58	F 676		

coded the resident as requiring extensive assistance for bathing, bed mobility, transfer, dressing, hygiene and limited assistance for eating.

A review of the comprehensive care plan dated 1/30/23 revealed, "FOCUS: Resident desires to remain in facility to receive continued services. INTERVENTIONS: Provide services according to care plans in an effort to enhance optimum well-being. Siderails x2, overbed trapeze, extensive assist x1: dressing, toileting and personal hygiene. Extensive assist x1 showers and incontinence care."

A review of September 2023 shower ADL documentation revealed that six of eight days are missing: 9/6, 9/13, 9/16, 9/20, 9/23 and 9/27; personal hygiene/grooming documentation revealed that five of 30 days are missing: 9/2, 9/4, 9/8, 9/23, and 9/25.

A review of October 2023 shower ADL documentation revealed that five of nine days are missing: 10/6, 10/10, 10/17, 10/27 and 10/31; personal hygiene/grooming documentation revealed that six of 31 days are missing: 10/6, 10/10, 10/17, 10/26, 10/27 and 10/31.

A review of November 2023 shower ADL documentation revealed that one of seven days are missing: 11/17; personal hygiene/grooming documentation revealed that five of 24 days are missing: 11/12, 11/14, 11/17, 11/19 and 11/25.

An interview was conducted on 12/7/23 at 12:30 PM with CNA (certified nursing assistant) #2. When asked where bathing and showers are documented, CNA #2 stated, we document our

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495071	A. BUILDING _____ B. WING _____	C 12/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 676	Continued From page 59 showers in PCC (Point Click Care) there is no book. When asked what it indicates if there are blanks in the documentation, CNA #2 stated, the bathing and showers were not done. When asked what it indicates if NA is documented, CNA #2 stated, that is not applicable, that does not make any sense. An interview was conducted on 12/7/23 at 4:00 PM with CNA #3. When asked where showers are documented, CNA #3 stated, they are documented in PCC. When asked what it indicates if there are blanks in the documentation, CNA #3 stated, it means that the showers were not done. An interview was conducted on 12/8/23 at 8:15 AM with CNA #4. When asked the frequency of showers and where they are documented, CNA #4 stated, they are twice a week and are documented in PCC. When asked what it indicates if there are blanks in the documentation, CNA #4 stated, it was not done. 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.	F 676		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced	F 677		1/22/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495071	A. BUILDING _____ B. WING _____	C 12/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 677	Continued From page 60 by: Based on resident interview, staff interview, clinical record review and facility document review, it was determined that the facility staff failed to provide ADL (activities of daily living) care to a dependent resident to one of 60 residents in the survey sample, Resident #2. The findings include: For Resident #2 (R2), the facility staff failed to provide incontinence care on the day shift (7:00 a.m. to 3:00 p.m.) of 3/13/2022. On the most recent MDS (minimum data set), an annual assessment with an ARD (assessment reference date) of 10/12/2023, R2 was assessed as scoring 14 out of 15 on the BIMS (brief interview for mental status) assessment, indicating the resident was cognitively intact. The assessment documented R2 requiring substantial/maximal assistance with toileting and being always incontinent of bowel and bladder. On the MDS assessment, a quarterly assessment with an ARD of 1/27/2022, R2 was assessed as requiring extensive assistance from two or more persons for toileting. Section H documented R2 being always incontinent of bowel and bladder. On 12/5/2023 at 3:44 p.m., an interview was conducted with R2. R2 stated that they had no concerns with care received at the facility. R2 stated that there were times when they waited to be cleaned up after incontinence episodes and felt that they needed more help because they all worked so hard. The comprehensive care plan for R2 documented	F 677	1. Resident # 2 received incontinence care on all three shifts on 12/6/2023, 12/7/2023, and 12/8/2023 by clinical staff assigned to her care. 2. Director of Nursing /designee will audit incontinent resident care records from January 1, 2024, to ensure incontinence care was provided and documentation was completed. 3. Clinical educator or designee will educate clinical team members on the importance of providing and accurate documentation of incontinence care. 4. Director of Nursing / designee will audit incontinence care was provided for 4 residents per week 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.	

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	495071	A. BUILDING _____ B. WING _____	C 12/08/2023

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F 677	Continued From page 61	F 677		

in part, "(Name of R2) has bowel and bladder incontinence. Date Initiated: 11/10/2022. Revision on: 12/06/2023."

Review of the facility synopsis of events dated 3/18/2022 documented in part, "...On March 14, 2022, resident's representative alleged ADL (activities of daily living) care was not provided in a timely manner and reported to Administrator and DON (director of nursing). A head-to-toe assessment was completed, and investigation started immediately...Investigation: On March 14, 2022, daughters of resident (Name of R2) alleged that resident was not provided ADL care in a timely manner on the day shift of March 13, 2022. A head-to-toe assessment was completed and there was no evidence of skin breakdown or injury noted... Based on a thorough investigation, there is no evidence of willful intent of not providing ADL care to (name of R2)..." The document contained follow up visits to R2, conducted by the social services staff, interviews with four other residents on the unit, written statements from staff and education to the staff.

On 12/7/2023 at 10:50 a.m., an interview was conducted with OSM (other staff member) #2, director of social services, grievance officer. OSM #2 stated that they had conversations and email correspondence with R2's family regarding the ADL care concerns on 3/13/2022. She stated that the former administrator and director of nursing had conducted an investigation and had a follow up conference call with the family after the concern. She stated that she did not recall the final investigation findings because usually the director of nursing and administrator take over any care concerns after the concern was filed.

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F 677	Continued From page 62	F 677		

On 12/7/2023 at 12:44 p.m., an interview was conducted with CNA (certified nursing assistant) #6. CNA #6 stated that they were working on 3/13/2022 on the Monticello unit. She stated that she was a new CNA and it was the first time she had ever worked the unit with only two CNAs. She stated that she was working with a male CNA and she had to take the female residents who did not want male CNAs taking care of them and that R2 was one of those residents. She stated that the male CNA no longer worked at the facility. She stated that she did the best that she could do with the residents that were assigned to her that day, got the residents up that had to be up, passed the meal trays and answered the call bells. She stated that there were about 58 residents on the unit and the two CNAs split the unit in half. She stated that they did have a hospitality aide on the floor who could make beds, answer call bells, tidy up rooms and take out the trash but they could not provide any hands-on patient care. She stated that she worked from 7:00 a.m. to 3:00 p.m. and R2 did ring the call bell requesting to be changed and she had told them that she would come back. She stated that she came back after her shift was over and told R2 that she had passed it to the next shift to make sure they were the first resident to be changed. She stated that she had to leave at the end of her shift and the male CNA had stayed over until the next CNA came in. CNA #6 stated that she did not recall R2 getting changed on her shift and the resident should not have gone all day and not been changed.

On 12/7/2023 at 2:22 p.m., an interview was conducted with LPN (licensed practical nurse) #8. LPN #8 stated that they may have been working

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F 677	Continued From page 63 that day but they did not recall the incident. The administrator and DON at the time of the incident no longer worked at the facility. The facility policy "Routine Care and Activities of Daily Living" dated 3/31/2023 documented in part, "...Residents who are unable to carry out activities of daily living will receive the necessary services to maintain and maximize their functional abilities. Procedure: The facility will provide care and services, to include: 1. Hygiene- bathing, dressing, grooming, and oral care. 2. Mobility- transfer and ambulation, including walking. 3. Elimination- toileting..." On 12/7/2023 at 4:36 p.m., 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 concern. No further information was provided prior to exit.	F 677		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an	F 690		1/22/24

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F 690	Continued From page 64 indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, facility document review and clinical record review, the facility staff failed to provide care and services for a urinary catheter for one of 60 residents in the survey sample, Resident #23. The findings include: For Resident #23 (R23), the facility staff failed to obtain physician's orders and provide care per manufacturer's instructions for the resident's external urinary catheter. On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 11/14/23, the resident scored	F 690	1. Resident #23 orders for an external urinary catheter device was updated on 12/6/2023 by the unit Manger. The care plan was updated on 12/7/2023 by the Unit Manager. 2. Director of Nursing / designee with audit all residents with external urinary catheter devices for appropriate orders and care plans. 3. Clinical educator / designee will educate clinical staff on the importance of orders for external urinary catheter devices and their care. 4. Director of nursing / designee will audit 4 residents with external urinary catheters weekly for 8 weeks to validate	

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F 690	Continued From page 65 15 out of 15 on the BIMS (brief interview for mental status), indicating the resident was cognitively intact for making daily decisions. On 12/5/23 at 4:16 p.m., R23 was observed lying in bed. The resident's external urinary catheter canister was observed in a box on the floor beside the bed. R23 stated the staff changes the catheter wick every day and changes the canister, "every so often." A review of R23's clinical record failed to reveal any physician's orders for R23's external urinary catheter. Further review of R23's clinical record failed to reveal any instructions for care of the external urinary catheter. On 12/6/23 at 4:31 p.m., an interview was conducted with RN (registered nurse) #1, regarding care of R23's external urinary catheter. RN #1 stated the facility has provided training to some nurses regarding R23's external urinary catheter and there is a report between nurses. RN #1 stated the report between nurses is an opportunity for nurses to ask questions but there should be orders in the chart for care and management of the external urinary catheter. On 12/6/23 at 5:10 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern. The facility did not have a policy regarding female external urinary catheters. The external urinary catheter manufacturer's instructions documented the following, "The PureWick System (Trademark) is an innovative option to managing urinary incontinence. It includes the PureWick (Trademark) Female	F 690	orders are present and care is being provided as ordered. The results of the audit will be reported at the QAPI meeting for evaluation of compliance and ongoing monitoring for continuous improvement analysis.	

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F 690	Continued From page 66 External Catheter and the PureWick (Trademark) Urine Collection System. The System works outside the body to draw urine away, helping keep skin dry. The PureWick (Trademark) Urine Collection System 2000cc (mL) canister should be emptied before volume reaches 1800cc (mL), or as needed. Is the PureWick (Trademark) Female External Catheter reusable? No. The wick should be replaced at least every 8 to 12 hours or sooner if soiled with feces or blood. Skin should be assessed to see if it's been compromised, and perineal care should be performed prior to placement of a new wick. The canister and tubing should be replaced every 60 days, or sooner if you see signs of degradation." This information was obtained from the website: https://www.purewickathome.com/faq.html.	F 690		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, facility document review and clinical record review, the facility staff failed to provide respiratory care and services for one of 60	F 695	1. The mouthpiece for resident # 344□s nebulizer was discarded by the unit Manager , and a new nebulizer mouthpiece was obtained and was stored	1/22/24

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F 695	Continued From page 67 residents in the survey sample, Resident #344. The findings include: For Resident #344 (R344), the facility staff failed to store a nebulizer (1) mouthpiece in a sanitary manner. R344's admission minimum data set assessment was not complete. A clinical admission form dated 11/27/23 documented R344 was alert and oriented times three. A review of R344's clinical record revealed a physician's order dated 11/27/23 for ipratropium-albuterol inhalation solution (2) 0.5-2.5 three milligrams/three milliliters- three milligrams inhale orally four times a day for chronic obstructive pulmonary disease. On 12/5/23 at 12:23 p.m., R344 was observed sitting in a wheelchair in the bedroom. The resident's nebulizer mouthpiece was uncovered and sitting on the nebulizer machine. R344 stated the staff had never provided anything to cover the nebulizer mouthpiece. On 12/6/23 at 4:10 p.m., the nebulizer mouthpiece remained uncover and sitting on the nebulizer machine. On 12/6/23 at 2:43 p.m., an interview was conducted with LPN (licensed practical nurse) #4. LPN #4 stated a nebulizer mouthpiece should be stored in a clear plastic bag to prevent contamination. On 12/6/23 at 5:10 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern. The facility policy titled, "Infection Control:	F 695	in a sanitary manner on 12/5/2023. 2. Director of Nursing /designee will audit all residents with nebulizers to ensure that all mouth pieces are stored in a sanitary manner. 3. Clinical educator/ designee will educate all clinical staff on the proper storage of nebulizer mouth pieces and equipment in a sanitary manner. 4. Director of Nursing /designee will audit 4 residents weekly for 8 weeks for proper storage of respiratory mouthpieces. The results of the audit will be reported at the QAPI meeting for evaluation of compliance and ongoing monitoring for continuous improvement analysis.	

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F 695	Continued From page 68 Respiratory Therapy" documented, "Medication Nebulizer/Continuous Aerosol: 3. Rinse container with normal saline after completion of therapy. Store in plastic wrapper, making sure mouthpiece is covered." References: (1) "A nebulizer is a small machine that turns liquid medicine into a mist that can be easily inhaled." This information was obtained from the website: https://medlineplus.gov/ency/patientinstructions/000006.htm (2) Ipratropium-albuterol inhalation solution is used to treat chronic obstructive pulmonary disease. This information was obtained from the website: https://medlineplus.gov/ency/patientinstructions/000006.htm	F 695		
F 697 SS=D	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, facility document review and clinical record review, the facility staff failed to implement a complete pain management program for one of 60 residents in the survey sample, Resident #23. The findings include:	F 697	1. On 12/6/2023 resident #23 was evaluated for pain by the nurse and resident was medicated as ordered and effective. 2. Residents who have as needed pain medications ordered will be interviewed by the Director of Nursing / designee to	1/22/24

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F 697	Continued From page 69 For Resident #23 (R23), the facility staff failed to treat the resident's reported right leg pain on 12/5/23. On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 11/14/23, the resident scored 15 out of 15 on the BIMS (brief interview for mental status), indicating the resident was cognitively intact for making daily decisions. A review of R23's clinical record revealed a physician's order dated 3/15/23 for acetaminophen (Tylenol) 325 milligrams- give 650 milligrams by mouth every six hours as needed for pain. On 12/5/23 at 4:16 p.m., R23 was lying in bed. The resident stated her right leg was hurting and the facility staff had not done anything for her pain. A note signed by the nurse practitioner on 12/5/23 documented, "Seen today in bed resting. She is alert and following commands. She denies any fevers or chills. She complains of right leg pain and requests for pian [sic] medicine, discussed will ask nurse to medicate..." Further review of R23's clinical record failed to reveal acetaminophen was administered to the resident and failed to reveal non-pharmacological interventions were offered to the resident. On 12/6/23 at 8:29 a.m., R23 was lying in bed. The resident stated the staff still had not done anything to treat her leg pain. On 12/6/23 at 2:43 p.m., an interview was conducted with LPN (licensed practical nurse) #4 (the nurse who cared for R23 on 12/5/23 when the nurse practitioner wrote the note). LPN #4	F 697	ensure pain is managed appropriately. 3. Clinical educator / designee will educate clinical team members on response to resident verbalization of pain and implementation of pain management program per providers orders. 4. Director of Nursing / designee will audit 4 residents per week for 8 weeks on as needed pain medication for presence of pain and appropriateness of responses to the pain. The results of the audit will be reported at the QAPI meeting for evaluation of compliance and ongoing monitoring for continuous improvement analysis.	

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F 697	Continued From page 70 stated that on 12/5/23, she was not aware of R23's right leg pain and the nurse practitioner never reported the pain to her or asked her to medicate the resident. On 12/6/23 at 5:10 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern. The facility policy titled, "Pain Assessment and Management" documented, "When a resident expresses pain/discomfort, treatment and/or intervention will be provided per physician order and/or the comprehensive care plan."	F 697		
F 698 SS=E	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, clinical record review and facility document review, it was determined that the facility staff failed to provide dialysis care and services to three of nine facility dialysis residents; Residents #72, #60, and #120. The findings include: 1. For Resident #72, the facility staff failed to include pre-dialysis vital signs on the communication sheet from the facility to the	F 698	1. Resident #72 was discharged from the facility on 12/6/23. Resident #60 orders and care plan were reviewed and updated by nursing leadership on 12/6/23. Resident #120 care plan was updated by leadership to reflect current orders for dialysis site care on 12/6/23. 2. All residents receiving dialysis services as if January 1, 2024, will be reviewed by the Director of Nursing / designee to ensure pre □ post dialysis	1/22/24

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F 698	Continued From page 71 dialysis center on four of nine dialysis visits. Resident #72 was admitted to the facility on 11/14/23 and discharged on 12/6/23. The resident had nine dialysis visits during her stay. A review of the clinical record revealed a physician's order dated 11/14/23 documented, "DIALYSIS - Attends Dialysis (address of dialysis center) every day shift every Mon (Monday), Wed (Wednesday), Fri (Friday)." A review of the dialysis communication sheets revealed that four of the nine times the resident had dialysis while at the facility, the sheets were missing the vital signs from the facility to the dialysis center: On 11/17/23, the vital signs that were written were crossed off with "error" documented. There was no new set written in. On 11/29/23, 12/4/23 and 12/6/23, there were no vital signs documented on the communication sheet from the facility to the dialysis center. The area was left blank. On 12/8/23 at 8:20 AM, an interview was conducted with LPN #9 (Licensed Practical Nurse). She stated that the communication sheets should be filled out each time the resident goes to dialysis. She stated that there is also a form in the electronic health record system that can be filled out after dialysis. She stated that if the form to dialysis was not filled in then the facility is not providing efficient communication to the dialysis center. A policy regarding dialysis care and services was requested. None was provided. Instead, the facility referred the survey team to an external source for information the survey team did not	F 698	vital signs, weights, dialysis care and communication sheets are being provided. 3. Clinical educator / designee will educate facility clinical team members on obtaining pre - post-dialysis weights, vital signs, dialysis care and use of appropriate documentation tools to communicate with the dialysis centers when residents receive dialysis services. 4. Director of Nursing / designee will audit 4 residents per week for 8 weeks to ensure that pre and post vital signs, weights, dialysis care and communication sheets/book are being completed. The results of the audit will be reported at the QAPI meeting for evaluation of compliance and ongoing monitoring for continuous improvement analysis.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495071	A. BUILDING _____ B. WING _____	C 12/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 698	Continued From page 72	F 698		

have access to.

On 12/7/23 at 4:50 PM at the end-of-day meeting, ASM #1 (Administrative Staff Member) the Administrator and ASM #2 the Director of Nursing were made aware of the findings. No further information was provided by the end of the survey.

2. For Resident #60, the facility failed to provide dialysis communication from the facility to the dialysis center.

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 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.

A review of the comprehensive care plan dated 11/7/23 revealed, "FOCUS: Resident needs dialysis (hemodialysis) HD three days a week on Monday, Wednesday and Friday related to renal failure. INTERVENTIONS: Monitor/document/report as needed for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495071	A. BUILDING _____ B. WING _____	C 12/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 698	Continued From page 73	F 698		

signs/symptoms of renal insufficiency: changes in level of consciousness, changes in skin turgor, oral mucosa, changes in heart and lung sounds." Revised interventions dated 12/7/23 revealed, "Monitor dialysis access site left arm every shift for bleeding or signs/symptoms of infection. If observed, notify provider and document."

A review of the physician orders dated 9/24/23, revealed, "DIALYSIS - Attends Dialysis on Monday-Wednesday-Friday for dialysis time at 0515. Assess fistula for bruit and thrill every shift. NOTIFY PROVIDER immediately if not present. Every shift for fistula." Discontinue date of orders 10/5/23. Resident continued to go to dialysis Monday-Wednesday-Friday.

A review of Resident #60's dialysis communication book revealed, missing documentation 34 out of 41 dialysis appointments. September 2023: 9/1, 9/6, 9/11, 9/18, 9/20, 9/22, 9/27; October 2023: 10/2, 10/6, 10/9, 10/11, 10/13, 10/16, 10/18, 10/20, 10/23, 10/25, 10/27, 10/30; November: 11/1, 11/3, 11/6, 11/8, 11/10, 11/13, 11/15, 11/17, 11/20, 11/22, 11/24, 11/27, 11/29 and December: 12/1 and 12/4.

A review of Resident #60's TAR (treatment administration record) for October, November and to December 6, 2023, for a total of 61-day shifts, 61-evening shifts and 61-night shift.

Resident #60 was either sleeping or unavailable for interview.

An interview was conducted 12/7/23 at 12:05 PM with LPN (licensed practical nurse) #5. When asked the process for sending a resident to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495071	A. BUILDING _____ B. WING _____	C 12/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 698	Continued From page 74	F 698		

dialysis, LPN #5 stated, there is paperwork we complete and send to the dialysis center, with updated resident information. When asked what care is provided for a dialysis resident, LPN #5 stated, we monitor their fistula site for bleeding, bruit and thrill. When asked where this is documented, LPN #5 stated, it is on the TAR.

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.

According to the facility, they follow "Elsevier Clinical Skills" for dialysis care. No further information was provided.

No further information was provided prior to exit.
3. For Resident #120 (R120), the facility staff failed to evidence complete dialysis care and services.

On the most recent MDS (minimum data set) assessment, a quarterly assessment with an ARD (assessment reference date) of 11/23/2023, the resident scored 15 of 15 on the BIMS (brief interview for mental status) assessment, indicating the resident was cognitively intact for making daily decisions. Section O documented R120 receiving dialysis services.

On 12/5/2023 at 2:49 p.m., an interview was conducted with R120 in their room. R120 stated that they went to dialysis outside of the facility three days a week on Mondays, Wednesdays and Fridays. R120 stated that the dialysis staff cared for the dialysis access that they had on the left side of their chest and the facility staff "don't mess with it." R120 stated that the facility staff

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495071	A. BUILDING _____ B. WING _____	C 12/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 698	Continued From page 75	F 698		

did not assess them or check vital signs when they returned from dialysis. R120 stated that the dialysis center had recently changed their dialysis time and they had switched from early morning to after breakfast.

The comprehensive care plan for R120 documented in part, "(Name of R120) requires hemo-dialysis [sic] r/t (related to) end stage renal failure. Date Initiated: 10/20/2022. Revision on: 07/18/2023." Under "Interventions" it documented in part, "Check and change dressing daily at access site. Document. Date Initiated: 10/20/2022..."

The physician orders for R120 documented in part,
- "10/12/2023 Record Post-dialysis vitals every evening shift every Mon, Wed, Fri."
- "10/12/2023 Record Post-dialysis weight every evening shift every
Mon, Wed, Fri."
- "10/12/2023 Take Pre-dialysis vitals every day shift every Mon, Wed, Fri."

The eTAR (electronic treatment administration record) for R120 dated 11/1/2023-11/30/2023 failed to evidence pre-dialysis vital signs on 11/6/2023 and 11/15/2023 and post-dialysis vital signs on 11/3/2023, 11/13/2023, 11/20/2023 and 11/27/2023. It further failed to evidence post-dialysis weight on 11/3/2023, 11/10/2023, 11/13/2023, 11/20/2023, 11/22/2023 and 11/27/2023.

The eTAR for R120 dated 12/1/2023-12/31/2023 failed to evidence post- dialysis vital signs on 12/1/2023 and 12/4/2023. It further failed to evidence post-dialysis weight on 12/1/2023 and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495071	A. BUILDING _____ B. WING _____	C 12/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERSIDE LIFELONG H & R WARWICK FOREST	1000 OLD DENBEIGH BOULEVARD NEWPORT NEWS, VA 23602

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F 698	Continued From page 76	F 698		

12/4/2023. The eTAR documented NA on those dates, the eTAR legend/chart codes failed to evidence the meaning of NA.

Review of the clinical record for R120 failed to evidence documentation of care of the dialysis catheter provided by facility staff, pre-dialysis vital signs, post-dialysis vital signs or post-dialysis weights on the dates listed above. The eTAR documented NA on those dates, the eTAR legend/chart codes failed to evidence the meaning of NA.

On 12/7/2023 at 8:26 a.m., an interview was conducted with LPN (licensed practical nurse) #2, clinical coordinator. LPN #2 stated that dialysis residents were monitored by obtaining their vital signs pre and post dialysis and monitoring their weight. LPN #2 stated that the facility staff did not provided any treatment or dressing change to R120's dialysis access. She stated that the gauze dressing was applied at dialysis and the site was cared for by the dialysis staff. She stated that the nursing staff monitored the area for any changes or drainage every shift and would notify the dialysis center or provider if any were observed. She reviewed R120's care plan documenting the intervention to check and change the access site dressing daily and stated that it was not accurate and needed to be revised. She reviewed the eTAR dated 11/1/2023-11/30/2023 and stated that the vital signs and weights should be documented on the eTAR or in the clinical record. She stated that she did not know what the "NA" meant on the eTAR's and that there should be vital signs and weights in the spaces where the "NA" was.

On 12/7/2023 at 4:36 p.m., ASM (administrative

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495071	A. BUILDING _____ B. WING _____	C 12/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERSIDE LIFELONG H & R WARWICK FOREST	1000 OLD DENBEIGH BOULEVARD NEWPORT NEWS, VA 23602

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F 698	Continued From page 77 staff member) #1, the administrator, ASM #2, the director of nursing and ASM #3, the chief nursing officer were made aware of the concern. No further information was obtained prior to exit.	F 698		
F 699 SS=D	Trauma Informed Care CFR(s): 483.25(m) §483.25(m) Trauma-informed care The facility must ensure that residents who are trauma survivors receive culturally competent, trauma-informed care in accordance with professional standards of practice and accounting for residents' experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization of the resident. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, facility document review and clinical record review, it was determined that the facility staff failed to provide trauma informed care for one of 60 residents in the sample Resident #115. The findings include: Resident #115 was admitted to the facility on 4/26/23 with diagnosis that included but were not limited to: PTSD (post-traumatic stress disorder), CVA (cerebrovascular accident) and hemiplegia. The most recent MDS (minimum data set) assessment, a quarterly assessment, with an ARD (assessment reference date) of 10/24/23, coded the resident as scoring a 15 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	F 699	1. The social worker met with resident # 115 and she refused psychology/psychiatric services on 12/7/2023. She agreed to see the Chaplain on 12/12/2023 and participate in spiritual programs. 2. The Director of Resident Services/designee will audit all residents who have a diagnosis of PTSD to ensure that they have been offered supportive services for trauma informed care. 3. Director of Resident Services/designee will educate the social services clinical team on offering psychological/psychiatric services to those residents with the diagnosis of PTSD and documentation follow up regarding trauma informed care. 4. Director of Resident Services /designee will audit 4 resident records per	1/22/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495071	A. BUILDING _____ B. WING _____	C 12/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERSIDE LIFELONG H & R WARWICK FOREST	1000 OLD DENBEIGH BOULEVARD NEWPORT NEWS, VA 23602

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F 699	Continued From page 78 coded the resident as requiring extensive assistance for bathing, bed mobility, transfer, dressing, hygiene and eating. A review of Section I: Medical Diagnosis: I6100. Post Traumatic Stress Disorder (PTSD)-coded yes. A review of the comprehensive care plan dated 8/10/23 revealed, "FOCUS: Resident has a potential for alteration in wellbeing related to history of trauma, diagnosis of PTSD. INTERVENTIONS: Provide resident with supportive care and services to promote a sense of safety, well-being and positive self-image. Staff will use the appropriate screening tools and assessments to recognize past trauma and will make referrals, as necessary. Consult pastoral care, as needed.". A review of the facility's "Trauma Informed Care Screen" dated 4/30/23 revealed, "PTSD SCREEN READ: Sometimes things happen to people that are unusually or especially frightening, horrible, or traumatic. For example: *a serious accident or fire *a physical or sexual assault or abuse *an earthquake or flood *a war *seeing someone be killed or seriously injured *having a loved one die through homicide or suicide. Have you ever experienced this kind of event? Coded as No. If no, screen total = 0. Please stop here. If yes, please answer questions in the next section." A review of the physician orders does not indicate any psychiatry consult. 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. A review of the physicians note dated 8/15/23 at	F 699	week for 8 weeks to ensure that those residents with diagnosis of PTSD have had support services offered for trauma informed care. The results of the audit will be reported at the QAPI meeting for evaluation of compliance and ongoing monitoring for continuous improvement analysis.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495071	A. BUILDING _____ B. WING _____	C 12/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 699	Continued From page 79	F 699		

11:34 AM, revealed, "CHIEF COMPLAINT Routine skilled inpatient follow-up visit: Resident is a 69-year-old. female with history of prior CVA with residual left hemiparesis and expressive aphasia, left intertrochanteric fracture fixation (4/7/23), breast cancer, hypertension and PTSD who presented to the facility from hospital for debility secondary to recent hospitalization."

An interview was conducted on 12/5/23 at 3:15 PM with Resident #115. When asked about trauma or stress, Resident #115 stated, there is nothing to talk about. I do not want to talk about it.

An interview was conducted on 12/7/23 at 11:50 AM with LPN (licensed practical nurse) #5. When asked if there are specific interventions for trauma informed care, LPN #5 stated, we monitor behaviors, get a psychiatry consult, notify the provider if there are changes, minimize any triggers as much as possible and keep them calm and comfortable.

An interview was conducted on 12/7/23 at 4:15 PM with OSM (other staff member) #2, the director of social services. When asked about trauma informed care for Resident #115, OSM #2 stated, for this resident, there are no triggers or behaviors, we would be looking for any adverse behaviors, for triggers to implement any care. When asked if there is a diagnosis of PTSD, would the diagnosis necessitate a plan? OSM #2 stated, just because there is a diagnosis, believe we would want behaviors and triggers. When asked about the care plan for Resident #115 regarding PTSD, OSM #2 stated, the IDT (interdisciplinary team) develops the care plan. When asked who is responsible for psychosocial

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495071	A. BUILDING _____ B. WING _____	C 12/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 699	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." No further information was provided prior to exit.	F 699		
F 700 SS=D	Bedrails CFR(s): 483.25(n)(1)-(4) §483.25(n) Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed	F 700		1/22/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495071	A. BUILDING _____ B. WING _____	C 12/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 700	Continued From page 81 rails, including but not limited to the following elements. §483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation. §483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. §483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. §483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review and facility document review, it was determined the facility staff failed to implement bed rail requirements for three out of 60 residents in the survey sample, Residents # 49, Resident #58 and Resident #60. The findings include: 1.The facility staff failed to obtain informed consent for Resident #49. Resident #49 was observed in bed with bilateral half bed rails on 12/6/23 at 7:30 AM and 12/7/23 at 8:00 AM. Resident #49 was admitted to the facility on 12/17/21 with diagnosis that included but were not limited to: COPD (chronic obstructive pulmonary disease), cellulitis, ASCVD	F 700	1. Resident #49, Resident #58 and Resident #60 had bed rail informed consents obtained on 12/7/23 by the Unit Manager. 2. Administrator/designee will audit residents with bed rails to ensure that signed consents are in place for each resident. 3. Clinical Educator /designee will educate admissions staff on the process of reviewing and signing a consent form on admission for bed rails and as needed for other residents. 4. Administrator / designee will audit 4 records per week for 8 weeks to ensure that there are informed consents for all residents using bed rails. The results of the audit will be reported at the QAPI meeting for evaluation of compliance and ongoing monitoring for continuous	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495071	A. BUILDING _____ B. WING _____	C 12/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 700	Continued From page 82 (atherosclerotic cardiovascular disease) and PVD (peripheral vascular disease). The most recent MDS (minimum data set) assessment, a quarterly assessment, with an ARD (assessment reference date) of 11/28/23, coded the resident as scoring a 15 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 extensive assistance for bathing and supervision for bed mobility, transfer, dressing, hygiene and eating; independent for locomotion. A review of the comprehensive care plan dated 7/3/23 revealed, "FOCUS: Resident desires to remain in facility to receive continued services. INTERVENTIONS: Provide services according to care plans in an effort to enhance optimum well-being. Siderails x2, limited assist x1: dressing, toileting and personal hygiene. Extensive assist x1 showers and incontinence care." Bed Rail Risk evaluation for Resident #49 was completed on 8/30/23. There was no evidence of consent obtained for bed rails for Resident #49. An interview was conducted on 12/6/23 at 3:00 PM with LPN (licensed practical nurse) #4. When asked who obtains consent for the bedrails, LPN #4 stated, we do the bed safety/risks/benefits evaluation. Not sure who gets the consent. An interview was conducted on 12/7/23 at 8:00 AM with ASM #1, the administrator. ASM #1 stated, we do not have the consent for three residents only this one.	F 700	improvement analysis.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495071	A. BUILDING _____ B. WING _____	C 12/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 700	Continued From page 83	F 700		

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 "Bed Rail / Side Rail Entrapment" policy, revealed, "After appropriate alternatives have been attempted and prior to installation, the facility will obtain informed consent from the resident or the resident representative for the use of bed rails. The facility will maintain evidence that it has provided sufficient information so that the resident or resident representative could make an informed decision."

No further information was provided prior to exit.

2.The facility staff failed to obtain informed consent for Resident #58.

Resident #58 was observed in bed with bilateral half bed rails on 12/5/23 at 1:00 PM, 12/6/23 at 8:30 AM and 12/7/23 at 9:00 AM.

Resident #58 was admitted to the facility on 4/25/23 with diagnosis that included but were not limited to: COPD (chronic obstructive pulmonary disease), dysphagia and acute respiratory failure.

The most recent MDS (minimum data set) assessment, a quarterly assessment, with an ARD (assessment reference date) of 11/7/23, coded the resident as scoring a 05 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was severely cognitively impaired. A review of the MDS Section

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495071	A. BUILDING _____ B. WING _____	C 12/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 700	Continued From page 84	F 700		

G-functional status coded the resident as requiring extensive assistance for bathing, bed mobility; limited assistance for transfers and supervision for eating.

A review of the comprehensive care plan dated 8/22/23 revealed, "FOCUS: Resident desires to remain in facility to receive continued services. INTERVENTIONS: Provide services according to care plans in an effort to enhance optimum well-being. Siderails x2, total dependence x 2 transfers, extensive assist x1: bed mobility, dressing, toileting and personal hygiene."

Bed Rail Risk evaluation for Resident #58 was completed 11/7/23. There was no evidence of consent obtained for bed rails for Resident #58.

An interview was conducted on 12/6/23 at 3:00 PM with LPN (licensed practical nurse) #4. When asked who obtains consent for the bedrails, LPN #4 stated, we do the bed safety/risks/benefits evaluation. Not sure who gets the consent.

An interview was conducted on 12/7/23 at 8:00 AM with ASM #1, the administrator. ASM #1 stated, we do not have the consent for three residents only this one.

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 obtain informed consent for Resident #60.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495071	A. BUILDING _____ B. WING _____	C 12/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 700	Continued From page 85	F 700		

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 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.

A review of the comprehensive care plan dated 5/30/23 revealed, "FOCUS: Resident desires to remain in facility to receive continued services. INTERVENTIONS: Provide services according to care plans in an effort to enhance optimum well-being. Siderails x2, limited assist x1: dressing, toileting, showers, incontinence care and personal hygiene. Extensive assist x1: transfers."

Bed Rail Risk evaluation for Resident #60 was completed 10/7/23. There was no evidence of consent obtained for bed rails for Resident #60.

An interview was conducted on 12/6/23 at 3:00 PM with LPN (licensed practical nurse) #4. When asked who obtains consent for the bedrails, LPN #4 stated, we do the bed safety/risks/benefits

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495071	A. BUILDING _____ B. WING _____	C 12/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 700	Continued From page 86 evaluation. Not sure who gets the consent. An interview was conducted on 12/7/23 at 8:00 AM with ASM #1, the administrator. ASM #1 stated, we do not have the consent for three residents only this one. 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.	F 700		
F 725 SS=D	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides.	F 725		1/22/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495071	A. BUILDING _____ B. WING _____	C 12/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERSIDE LIFELONG H & R WARWICK FOREST	1000 OLD DENBEIGH BOULEVARD NEWPORT NEWS, VA 23602

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F 725	Continued From page 87 §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, clinical record review and facility document review, it was determined that the facility staff failed to ensure sufficient CNA (certified nursing assistant) staffing to provide care and services for one of 60 residents in the survey sample, Resident #2. The findings include: For Resident #2 (R2), the facility staff failed to ensure sufficient CNA staffing on the day shift (7:00 a.m. to 3:00 p.m.) of 3/13/2022 to provide adequate incontinence care. On the most recent MDS (minimum data set), an annual assessment with an ARD (assessment reference date) of 10/12/2023, R2 was assessed as scoring 14 out of 15 on the BIMS (brief interview for mental status) assessment, indicating the resident was cognitively intact. On the MDS assessment, a quarterly assessment with an ARD of 1/27/2022, R2 was assessed as requiring extensive assistance from two or more persons for toileting. On 12/5/2023 at 3:44 p.m., an interview was conducted with R2. R2 stated that they had no concerns with care received at the facility. R2 stated that there were times when they waited to be cleaned up after incontinence episodes and	F 725	1. Resident #2 received incontinence care on all three shifts on 12/6/2023, 12/7/2023, and 12/8/2023 by the clinical staff assigned to her. 2. The Director of Nursing / designee will review staffing daily to ensure sufficient CNA staffing is present to provide care and services to the residents. 3. Administrator /designee will educate clinical leaders and schedulers on acceptable staffing ratios per shift to ensure sufficient CNA staffing is present and how to escalate staffing concerns. 4. Administrator / designee will review staffing 3 times weekly for 8 weeks to ensure appropriate CNA staff is present to provide care and services to the residents. The results of the audit will be reported at the QAPI meeting for evaluation of compliance and ongoing monitoring for continuous improvement analysis.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495071	A. BUILDING _____ B. WING _____	C 12/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERSIDE LIFELONG H & R WARWICK FOREST	1000 OLD DENBEIGH BOULEVARD NEWPORT NEWS, VA 23602

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F 725	Continued From page 88	F 725		

felt that they needed more help because they all worked so hard.

Review of the facility synopsis of events dated 3/18/2022 documented in part, "...On March 14, 2022, resident's representative alleged ADL (activities of daily living) care was not provided in a timely manner and reported to Administrator and DON (director of nursing). A head-to-toe assessment was completed, and investigation started immediately...Based on a thorough investigation, there is no evidence of willful intent of not providing ADL care to (name of R2)..."

Review of the as worked staffing sheet for the Monticello unit documented two CNA staff working the day shift on 3/13/2022 with a census of 56 residents.

On 12/7/2023 at 8:20 a.m., an interview was conducted with OSM (other staff member) #4 (the staffing coordinator). OSM #4 stated she staffed the Monticello unit which had a total of 60 beds, with three nurses and six CNAs on the day shift, two nurses and five CNAs on the evening shift, and two nurses and two CNAs on the night shift. OSM #4 stated that when there was a staffing shortage and open spaces on the schedule, she contacted staff via email, phone, text and in person to ask if staff were willing to work extra shifts. OSM #4 stated that for the dates that there where a lot of openings, she offered monetary incentives for staff to work the extra shifts.

On 12/7/2023 at 10:50 a.m., an interview was conducted with OSM #2, director of social services, grievance officer. OSM #2 stated that they had conversations and email

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495071	A. BUILDING _____ B. WING _____	C 12/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 725	Continued From page 89	F 725		

correspondence with R2's family regarding the ADL care concerns on 3/13/2022. She stated that the former administrator and former director of nursing had conducted an investigation and had a follow up conference call with the family after the concern.

On 12/7/2023 at 12:44 p.m., an interview was conducted with CNA #6. CNA #6 stated that they were working on 3/13/2022 on the Monticello unit. She stated that she was a new CNA and it was the first time she had ever worked the unit with only two CNAs. She stated that she was working with a male CNA and she had to take the female residents who did not want male CNAs taking care of them. She stated that R2 was one of those residents. She stated that the male CNA no longer worked at the facility. She stated that she did the best that she could do with the residents that were assigned to her that day and got the residents up that had to be up, passed the meal trays and answered the call bells. She stated that there were about 58 residents on the unit and the two CNAs split the unit in half. She stated that she did not remember any empty rooms on the unit that day and everything seemed to take longer than usual. She stated that they did have a hospitality aide on the floor who could make beds, answer call bells, tidy up rooms and take out the trash but they could not provide any patient care. She stated that they had residents that had to be fed which took a while. She stated that she worked from 7:00 a.m. to 3:00 p.m. and R2 did ring the call bell requesting to be changed and she had told them that she would come back. She stated that she came back after her shift was over and told her that she had passed it to the next shift to make sure they were the first resident to be changed.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495071	A. BUILDING _____ B. WING _____	C 12/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 725	Continued From page 90	F 725		

She stated that she had to leave at the end of her shift and the male CNA had stayed over until the next CNA came in. CNA #6 stated that she did not recall R2 getting changed on her shift and the resident should not have gone all day and not been changed.

On 12/7/2023 at 2:22 p.m., an interview was conducted with LPN (licensed practical nurse) #8. LPN #8 stated that they may have been working that day but they did not recall the incident.

The administrator and DON at the time of the incident no longer worked at the facility.

The facility assessment dated 3/14/2023 documented in part, "...Staff plan: Staffing is determined by a ratio and is adjusted based on the census, resident acuity, resident complexity, and the distribution of residents in the building. Staffing is adjusted based on the time of day and other resident needs as described in this document. Per diem agency staff are used as needed to maintain appropriate staffing levels, as needed. Staffing levels are determined on a day-to-day, shift-to-shift basis depending on those factors. We ensure there are enough nurses and CNAs who can work collaboratively as a team to ensure residents receive their medications, treatment, assessments, ADL care, showers, toileting assistance, help during meals, and other needs timely..."

On 12/7/2023 at 4:36 p.m., 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 concern.

No further information was provided prior to exit.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495071	A. BUILDING _____ B. WING _____	C 12/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 740 SS=D	Behavioral Health Services CFR(s): 483.40 §483.40 Behavioral health services. Each resident must receive and the facility must provide the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Behavioral health encompasses a resident's whole emotional and mental well-being, which includes, but is not limited to, the prevention and treatment of mental and substance use disorders. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, facility document review and clinical record review, it was determined that the facility staff failed to provide necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care for one of 60 residents in the sample, Resident #115. The findings include: The facility staff failed to assess and implement psychosocial interventions for Resident #115, who had an admitting diagnosis of PTSD (post traumatic stress disorder) and was coded on admission MDS (minimum data set) assessment with an ARD (assessment reference date) of 4/30/23, Section I: Active Diagnosis: I6100: post-traumatic stress disorder- coded as present. Resident #115 was admitted to the facility on 4/26/23 with diagnosis that included but were not limited to: PTSD (post-traumatic stress disorder),	F 740	1. The provider ordered psychological/psychiatric services for resident #115 on 12/7/23. She was seen by the Psych NP on 1/10/23. She agreed to see the Chaplain on 12/12/2023 and participate in spiritual programs. 2. The Director of Resident Services/designee will audit all residents who have a diagnosis of PTSD to ensure that they have been offered supportive services for trauma informed care and that behaviors are being monitored. 3. Director of Resident Services/designee will educate the clinical team (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/ designee will audit 4 resident records per week for 8 weeks to ensure that those residents with diagnosis of PTSD have	1/22/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495071	A. BUILDING _____ B. WING _____	C 12/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 740	Continued From page 92 CVA (cerebrovascular accident) and hemiplegia. The most recent MDS (minimum data set) assessment, a quarterly assessment, with an ARD (assessment reference date) of 10/24/23, coded the resident as scoring a 15 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 extensive assistance for bathing, bed mobility, transfer, dressing, hygiene and eating. A review of Section I: Medical Diagnosis: I6100. Post Traumatic Stress Disorder (PTSD)-coded yes. A review of the comprehensive care plan dated 8/10/23 revealed, "FOCUS: Resident has a potential for alteration in wellbeing related to history of trauma, diagnosis of PTSD. INTERVENTIONS: Provide resident with supportive care and services to promote a sense of safety, well-being and positive self-image. Staff will use the appropriate screening tools and assessments to recognize past trauma and will make referrals, as necessary. Consult pastoral care, as needed.". A review of the facility's "Trauma Informed Care Screen" dated 4/30/23 revealed, "PTSD SCREEN READ: Sometimes things happen to people that are unusually or especially frightening, horrible, or traumatic. For example: *a serious accident or fire *a physical or sexual assault or abuse *an earthquake or flood *a war *seeing someone be killed or seriously injured *having a loved one die through homicide or suicide. Have you ever experienced this kind of event? Coded as No. If no, screen total = 0. Please stop here. If yes, please answer questions in the next section."	F 740	had support services offered for trauma informed care and monitoring of behaviors. The results of the audit will be reported at the QAPI meeting for evaluation of compliance and ongoing monitoring for continuous improvement analysis.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495071	A. BUILDING _____ B. WING _____	C 12/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 740	Continued From page 93	F 740		

A review of the physician orders does not indicate any psychiatry consult or orders to monitor behavior.

A review of the MAR-TAR (medication administration record-treatment administration record) for September 2023-December 6, 2023, does not reveal any 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.

A review of the physicians note dated 8/15/23 at 11:34 AM, revealed, "CHIEF COMPLAINT Routine skilled inpatient follow-up visit: Resident is a 69-year-old. female with history of prior CVA with residual left hemiparesis and expressive aphasia, left intertrochanteric fracture fixation (4/7/23), breast cancer, hypertension and PTSD who presented to the facility from hospital for debility secondary to recent hospitalization."

A review of the quarterly social services screening dated 8/21/23 revealed, "Resident is alert and verbally responsive. Resident is noted to prefer to remain in her room in bed. Resident was a previous placement. She returned home and was readmitted to the facility less than a month following discharge. Resident is not noted to have made any significant changes from previous admission. Resident's son will like for her to return home when she is able to ambulate independently. Resident has diagnosis of PTSD with no noted medications. Resident is a DNR. No discharge plans are noted at this time." There are no other social services notes to indicate resident interviews regarding PTSD.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495071	A. BUILDING _____ B. WING _____	C 12/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERSIDE LIFELONG H & R WARWICK FOREST	1000 OLD DENBEIGH BOULEVARD NEWPORT NEWS, VA 23602

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F 740	Continued From page 94	F 740		

An interview was conducted on 12/5/23 at 3:15 PM with Resident #115. When asked about trauma or stress, Resident #115 stated, there is nothing to talk about. I do not want to talk about it.

An interview was conducted on 12/7/23 at 11:50 AM with LPN (licensed practical nurse) #5. When asked if there are specific interventions for trauma informed care, LPN #5 stated, we monitor behaviors, get a psychiatry consult, notify the provider if there are changes, minimize any triggers as much as possible and keep them calm and comfortable.

An interview was conducted on 12/7/23 at 4:15 PM with OSM (other staff member) #2, the director of social services. When asked about trauma informed care for Resident #115, OSM #2 stated, for this resident, there are no triggers or behaviors, we would be looking for any adverse behaviors, for triggers to implement any care. When asked if there is a diagnosis of PTSD, would the diagnosis necessitate a plan? OSM #2 stated, just because there is a diagnosis, believe we would want behaviors and triggers. When asked about the care plan for Resident #115 regarding PTSD, OSM #2 stated, the IDT (interdisciplinary team) develops the care plan. When asked who is responsible for psychosocial 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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495071	A. BUILDING _____ B. WING _____	C 12/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 740	Continued From page 95 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." No further information was provided prior to exit.	F 740		
F 745 SS=D	Provision of Medically Related Social Service CFR(s): 483.40(d) §483.40(d) The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, facility document review and clinical record review, it was determined that the facility staff failed to provide medically related social services for one of 60 residents in the sample Resident #115.	F 745	1. The provider ordered psychological/psychiatric services for resident #115 on 12/7/23. She was seen by the Psych NP on 1/10/23. She agreed to see the Chaplain on 12/12/2023 and participate in spiritual programs. 2. The Director of Resident	1/22/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495071	A. BUILDING _____ B. WING _____	C 12/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERSIDE LIFELONG H & R WARWICK FOREST	1000 OLD DENBEIGH BOULEVARD NEWPORT NEWS, VA 23602

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F 745	Continued From page 96 The findings include: For Resident #115, the facility staff failed to provide psychosocial follow up following the resident being admitted with a diagnosis of PTSD (post-traumatic stress disorder). Resident #115 was admitted to the facility on 4/26/23 with diagnosis that included but were not limited to: PTSD (post-traumatic stress disorder), CVA (cerebrovascular accident) and hemiplegia. The most recent MDS (minimum data set) assessment, a quarterly assessment, with an ARD (assessment reference date) of 10/24/23, coded the resident as scoring a 15 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 extensive assistance for bathing, bed mobility, transfer, dressing, hygiene and eating. A review of Section I: Medical Diagnosis: I6100. Post Traumatic Stress Disorder (PTSD)-coded yes. A review of the comprehensive care plan dated 8/10/23 revealed, "FOCUS: Resident has a potential for alteration in wellbeing related to history of trauma, diagnosis of PTSD. INTERVENTIONS: Provide resident with supportive care and services to promote a sense of safety, well-being and positive self-image. Staff will use the appropriate screening tools and assessments to recognize past trauma and will make referrals, as necessary. Consult pastoral care, as needed.". A review of the facility's "Trauma Informed Care Screen" dated 4/30/23 revealed, "PTSD SCREEN	F 745	Services/designee will audit all residents who have a diagnosis of PTSD to ensure that they have been offered supportive services for trauma informed care and that behaviors are being monitored. 3. Director of Resident Services/designee will educate the clinical team (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 / designee will audit 4 resident records per week for 8 weeks to ensure that those residents with diagnosis of PTSD have had support services offered for trauma informed care and monitoring of behaviors. The results of the audit will be reported at the QAPI meeting for evaluation of compliance and ongoing monitoring for continuous improvement analysis.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495071	A. BUILDING _____ B. WING _____	C 12/08/2023

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RIVERSIDE LIFELONG H & R WARWICK FOREST	1000 OLD DENBEIGH BOULEVARD NEWPORT NEWS, VA 23602

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F 745	Continued From page 97	F 745		

READ: Sometimes things happen to people that are unusually or especially frightening, horrible, or traumatic. For example: *a serious accident or fire *a physical or sexual assault or abuse *an earthquake or flood *a war *seeing someone be killed or seriously injured *having a loved one die through homicide or suicide. Have you ever experienced this kind of event? Coded as No. If no, screen total = 0. Please stop here. If yes, please answer questions in the next section."

A review of the physician orders does not indicate any psychiatry consult or orders to monitor behavior.

A review of the MAR-TAR (medication administration record-treatment administration record) for September 2023-December 6, 2023, does not reveal any 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.

A review of the physicians note dated 8/15/23 at 11:34 AM, revealed, "CHIEF COMPLAINT Routine skilled inpatient follow-up visit: Resident is a 69-year-old. female with history of prior CVA with residual left hemiparesis and expressive aphasia, left intertrochanteric fracture fixation (4/7/23), breast cancer, hypertension and PTSD who presented to the facility from hospital for debility secondary to recent hospitalization."

A review of the quarterly social services screening dated 8/21/23 revealed, "Resident is alert and verbally responsive. Resident is noted to prefer to remain in her room in bed. Resident was a previous placement. She returned home and was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495071	A. BUILDING _____ B. WING _____	C 12/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERSIDE LIFELONG H & R WARWICK FOREST	1000 OLD DENBEIGH BOULEVARD NEWPORT NEWS, VA 23602

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F 745	Continued From page 98	F 745		

readmitted to the facility less than a month following discharge. Resident is not noted to have made any significant changes from previous admission. Resident's son will like for her to return home when she is able to ambulate independently. Resident has diagnosis of PTSD with no noted medications. Resident is a DNR. No discharge plans are noted at this time." There are no other social services notes to indicate resident interviews regarding PTSD.

An interview was conducted on 12/5/23 at 3:15 PM with Resident #115. When asked about trauma or stress, Resident #115 stated, there is nothing to talk about. I do not want to talk about it.

An interview was conducted on 12/7/23 at 11:50 AM with LPN (licensed practical nurse) #5. When asked if there are specific interventions for trauma informed care, LPN #5 stated, we monitor behaviors, get a psychiatry consult, notify the provider if there are changes, minimize any triggers as much as possible and keep them calm and comfortable.

An interview was conducted on 12/7/23 at 4:15 PM with OSM (other staff member) #2, the director of social services. When asked about trauma informed care for Resident #115, OSM #2 stated, for this resident, there are no triggers or behaviors, we would be looking for any adverse behaviors, for triggers to implement any care. When asked if there is a diagnosis of PTSD, would the diagnosis necessitate a plan? OSM #2 stated, just because there is a diagnosis, believe we would want behaviors and triggers.
When asked about the care plan for Resident #115 regarding PTSD, OSM #2 stated, the IDT

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495071	A. BUILDING _____ B. WING _____	C 12/08/2023

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RIVERSIDE LIFELONG H & R WARWICK FOREST	1000 OLD DENBEIGH BOULEVARD NEWPORT NEWS, VA 23602

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F 745	Continued From page 99 (interdisciplinary team) develops the care plan. When asked who is responsible for psychosocial 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 social work job description reveals, "Essential Job Functions: Provides exposure to, and an understanding of those services/programs that can enhance the patient's quality of life and independence as they transition back to their community. Responsible for all discharge planning, care planning, discharge notifications, PASRR forms, Medicaid applications, psychoactive monitoring, behavior monitoring, and assessment of the social and psychosocial needs of the patients." No further information was provided prior to exit.	F 745		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures	F 755		1/22/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495071	A. BUILDING _____ B. WING _____	C 12/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 755	Continued From page 100 that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, it was determined that the facility staff failed to provide pharmacy services in a timely manner for one of 60 residents, Resident #49. The findings include: The facility staff failed to provide pharmacy services by administering medications as ordered, specifically ELIQUIS TAB 5MG (milligram), for Resident #49. Resident #49 was admitted to the facility on 12/17/21 with diagnosis that included but were not limited to: COPD (chronic obstructive pulmonary disease), cellulitis, ASCVD	F 755	1. Resident # 49 received her Eliquis as ordered on 12/7/2023; 12/8/2023; 12/9/2023 by the nurses assigned to her care. 2. Director of Nursing / designee will audit all residents on Eliquis as of January 1, 2024, to ensure all received the medication as ordered. 3. Clinical educator / designee will educate the clinical staff on the importance of administering medications as ordered and the process to follow for medications not available algorithm. 4. Director of Nursing / designee will audit 4 residents on Eliquis weekly times 8 weeks to ensure the medication was administered as ordered. The results of	

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	495071	A. BUILDING _____ B. WING _____	C 12/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERSIDE LIFELONG H & R WARWICK FOREST	1000 OLD DENBEIGH BOULEVARD NEWPORT NEWS, VA 23602

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F 755	Continued From page 101	F 755		

(atherosclerotic cardiovascular disease) and PVD (peripheral vascular disease).

The most recent MDS (minimum data set) assessment, a quarterly assessment, with an ARD (assessment reference date) of 11/28/23, coded the resident as scoring a 15 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 extensive assistance for bathing and supervision for bed mobility, transfer, dressing, hygiene and eating; independent for locomotion.

A review of the comprehensive care plan dated 5/22/23 revealed, "FOCUS: Resident is on anticoagulant therapy (Eliquis) related to Atrial fibrillation. INTERVENTIONS: Administer ANTICOAGULANT medications as ordered by physician. Monitor for side effects and effectiveness Q-SHIFT."

A review of the physician orders dated 6/19/23 orders revealed, "ELIQUIS TAB 5MG (milligram), Give 1 tablet orally two times a day for Afib (atrial fibrillation)".

An interview was conducted on 12/5/23 at 3:40 PM with Resident #49. Resident #49 stated, in November, they did not give me my anticoagulant for several shifts.

A review of the November 2023 MAR (medication administration record) revealed, "ELIQUIS TAB 5MG Give 1 tablet orally two times a day for Afib, was coded "9-other see progress note" for 11/12/23 8 AM and 9 PM and 11/13/23 at 8 AM.

the audit will be reported at the QAPI meeting for evaluation of compliance and ongoing monitoring for continuous improvement analysis.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495071	A. BUILDING _____ B. WING _____	C 12/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERSIDE LIFELONG H & R WARWICK FOREST	1000 OLD DENBEIGH BOULEVARD NEWPORT NEWS, VA 23602

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F 755	Continued From page 102	F 755		

A review of the progress note dated 11/12/23 at 9:14 AM, revealed "ELIQUIS TAB 5MG Give 1 tablet orally two times a day for Afib. Medication not given; Pharmacy did not send. Pharmacy notified; 11/13/23 at 9:30 AM revealed "ELIQUIS TAB 5MG Give 1 tablet orally two times a day for Afib. Reorder."

An interview was conducted 12/7/23 at 12:05 PM with LPN (licensed practical nurse) #5. When asked if medication is not available with the residents' medications, what is the process for obtaining the medications, LPN #5 stated, we reorder the medications from pharmacy and if we have it in the drug stock, we administer it from the stock. When asked the delivery process for medications, LPN #5 stated, they have a daily routine delivery and stat delivery. It looks like this was reordered and still did not come in for three administrations.

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.

According to the facility's "Medication Ordering and Receipt" policy, which revealed, "Pharmacy delivers medications according to an established schedule. Orders received by the pharmacy before the designated fax cut-off time will be sent on the Facility's regular scheduled delivery. Orders received by the pharmacy after the designated fax cut-off time and required the same night, must be called to the pharmacy and requested for same day delivery."

No further information was provided prior to exit.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495071	A. BUILDING _____ B. WING _____	C 12/08/2023

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F 756	Continued From page 103	F 756		
F 756 SS=E	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take	F 756		1/22/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495071	A. BUILDING _____ B. WING _____	C 12/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 756	Continued From page 104 when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff interview and facility document review it was determined that the facility staff failed to ensure that pharmacy recommendations were reviewed and implemented in a timely manner for three of five residents reviewed for unnecessary medications, Resident #24, Resident #39 and Resident #41. The findings include: 1. For Resident #24 (R24), the facility staff failed to act on pharmacy medication regimen review recommendations in a timely manner. A review of the monthly pharmacy medication regimen reviews for R24 documented a consultation report for R24 dated 6/6/2023. The report documented in part, "...Resident is currently on Olanzapine 20mg (milligram) daily. An A1c (Hemoglobin A1C blood test to measure average blood sugar over the past 3 months) was obtained 5/30/23, which resulted 9.3%. Currently, there are no orders for any antidiabetic medications. Recommendation(s): At this time, would it be appropriate to consider evaluation for potential initiation of an antidiabetic agent?" The area for Physician/Prescriber response was observed to be blank. An additional monthly pharmacy report dated 7/11/2023 documented the same request to consider an antidiabetic medication. The area for Physician/Prescriber Response was observed to be blank on the report. Attached to the consultation report was a medical recertification provider note dated 8/24/2023	F 756	1. Resident #24 had the medication regimen follow up review addressed on 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 11/29/2023 by the nurse practitioner. Resident #41 had the medication regimen follow up review addressed on 10/25/2023. 2. Director of Nursing/ designee will review all follow up drug regimen reviews submitted since January 1, 2024 to ensure pharmacy reviews are acted upon timely. 3. Administrator / designee will educate provider team on the importance of reviewing pharmacy recommendation timely and the process to follow. 4. Consultant Pharmacist / designee will audit 4 drug regimen reviews monthly for 8 months to ensure pharmacy recommendations are acted on timely. The results of the audit will be reported at the QAPI meeting for evaluation of compliance and ongoing monitoring for continuous improvement analysis.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495071	A. BUILDING _____ B. WING _____	C 12/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 756	Continued From page 105	F 756		

which documented in part, "...Patient is a (age and sex of R24) LTC (long term care) resident seen in hallway today for recertification and due to recommended GDR (gradual dose reduction) of diazepam and elevated blood glucose... Diagnosis, Assessment and Plan: Diabetes mellitus type 2- likely contributed to by medication, specifically depakote. Recommend addition of metformin and monitor. Will titrate up from 500mg ER (extended release) daily to try and minimize GI (gastrointestinal) side effects..."

The physician orders for R24 documented in part, "...Metformin HCL ER (extended release) Oral Tablet Extended Release 24 Hour 1000 MG (Metformin HCl) Give 2 tablet by mouth one time a day for DM2 (diabetes mellitus type 2). Order Date: 08/24/2023. Start Date: 09/08/2023."

The eMAR (electronic medication administration record) dated 8/1/2023-8/31/2023 documented the Metformin starting on 8/25/2023.

On 12/7/2023 at 2:53 p.m., an interview was conducted with ASM (administrative staff member) #2, the director of nursing. ASM #2 stated that the pharmacist completed her monthly medication reviews and forwarded her recommendations via email to ASM #2 and the providers' nurse. ASM #2 stated the providers' nurse shared the recommendations with the providers and sometimes the providers would give their nurse orders to put into the computer system and then sit down later and complete the pharmacy recommendation forms. ASM #2 stated the facility has had a lot of providers in the last year. ASM #2 stated for a while, the facility did not have any nurse practitioners and the doctors were trying to handle all the pharmacy

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495071	A. BUILDING _____ B. WING _____	C 12/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERSIDE LIFELONG H & R WARWICK FOREST	1000 OLD DENBEIGH BOULEVARD NEWPORT NEWS, VA 23602

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F 756	Continued From page 106	F 756		

recommendations but got bogged down so there were gaps [periods of time] when pharmacy recommendations were not addressed.

The facility policy, "Medication Regimen Review" dated 5/16/2023 documented in part, "...The medication regimen of each resident is reviewed by a licensed Pharmacist according to Federal, state and local regulations as well as current standards of practice. The pharmacist must report any irregularities to the Attending Physician, the facility's Medical Director and Director of Nursing. These reports must be acted upon in a manner that meets the needs of the resident...For non-Urgent recommendations, the facility and Attending Physician must address the recommendation(s) in a timely manner that meets the needs of the resident- but no later than their next routine visit to assess the resident- and the Attending Physician should document in the medical record..."

On 1/26/2023 at 1:37 p.m., ASM (administrative staff member) #1, the president/CEO, ASM #2, the director of executive administration and ASM #3, the director of nursing were made aware of the above concern.

No further information was provided prior to exit.

2. For Resident #39 (R39), the facility staff failed to act on pharmacy medication regimen review recommendations in a timely manner.

A review of the monthly pharmacy medication regimen reviews for R39 documented a consultation report for R39 dated 9/12/2023. The report documented in part, "...The resident has an order for Ipratropium Bromide Nasal Soln

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495071	A. BUILDING _____ B. WING _____	C 12/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 756	Continued From page 107	F 756		

(solution) 0.06% (42 MCG/spray) 1 spray in each nostril three times a day for vasomotor rhinitis. Ordered 4/24/2023. Recommendation(s): Would it be appropriate to reduce the frequency of administration to BID (twice a day)?..." The area for Physician/Prescriber Response was observed to be blank.
Two additional monthly pharmacy reports dated 10/13/2023 and 11/14/2023 documented the same request to reduce the frequency of the Ipratropium Bromide nasal spray. The area for Physician/Prescriber Response was observed to be blank on both reports. Attached to the three reports was a copy of a physician order dated 11/21/2023 which documented the Ipratropium nasal spray ordered twice a day.

A review of the monthly pharmacy medication regimen reviews for R39 documented a consultation report for R39 dated 9/12/2023. The report documented in part, "...The resident currently has an order for Venlafaxine Hcl Er 150 mg daily. PMH (primary medical history) is significant for Depression. Recommendation(s): Please consider a gradual dose reduction..." The area for Physician/Prescriber Response was observed to be blank.
Two additional monthly pharmacy reports dated 10/13/2023 and 11/14/2023 documented the same request to consider a gradual dose reduction of the Venlafaxine. The area for Physician/Prescriber Response was observed to be blank on both reports. Attached to the three reports was a copy of a psychiatric consultation dated 11/29/2023 which documented a medication review and clinical rationale for not attempting a gradual dose reduction at that time.

The physician orders for R39 documented in part,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495071	A. BUILDING _____ B. WING _____	C 12/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERSIDE LIFELONG H & R WARWICK FOREST	1000 OLD DENBEIGH BOULEVARD NEWPORT NEWS, VA 23602

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F 756	Continued From page 108	F 756		

"8/31/2022 Venlafaxine ER CAP 150MG Give 1 tablet orally in the morning for depression..."

On 12/7/2023 at 2:53 p.m., an interview was conducted with ASM (administrative staff member) #2, the director of nursing. ASM #2 stated that the pharmacist completed her monthly medication reviews and forwarded her recommendations via email to ASM #2 and the providers' nurse. ASM #2 stated the providers' nurse shared the recommendations with the providers and sometimes the providers would give their nurse orders to put into the computer system and then sit down later and complete the pharmacy recommendation forms. ASM #2 stated the facility has had a lot of providers in the last year. ASM #2 stated for a while, the facility did not have any nurse practitioners and the doctors were trying to handle all the pharmacy recommendations but got bogged down so there were gaps [periods of time] when pharmacy recommendations were not addressed.

On 1/26/2023 at 1:37 p.m., ASM (administrative staff member) #1, the president/CEO, ASM #2, the director of executive administration and ASM #3, the director of nursing were made aware of the above concern.

No further information was provided prior to exit.

3. For Resident #41 (R41), the facility staff failed to act on pharmacy recommendations regarding milk of magnesia (1) and pantoprazole (2) in a timely manner.

A review of R41's clinical record revealed a medication regimen review completed by the pharmacist on 8/17/23 that documented

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495071	A. BUILDING _____ B. WING _____	C 12/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERSIDE LIFELONG H & R WARWICK FOREST	1000 OLD DENBEIGH BOULEVARD NEWPORT NEWS, VA 23602

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F 756	Continued From page 109	F 756		

recommendations to clarify a milk of magnesia order and to reduce a PPI (proton pump inhibitor-pantoprazole). Pharmacy recommendations from the pharmacist to the attending physician/prescriber dated 8/17/23, 9/11/23 and 10/11/23 documented, "The resident is ordered the following Prn (as needed) medication: MILK OF MAG SUSP (suspension) 1200MG (milligrams)/15ML (milliliters). Give 30 ml orally as needed for Constipation. There is no frequency of administration for this prn order. Recommendation(s): Please indicate a specific frequency for PRN use." The physician did not address the recommendations until 10/25/23. A physician's order dated 10/25/23 documented, "MILK OF MAG SUSP 1200MG/15ML- Give 30 ml orally every 24 hours as needed for Constipation." Pharmacy recommendations from the pharmacist to the attending physician/prescriber dated 8/17/23, 9/11/23 and 10/11/23 documented, "PMH (Past Medical History) includes GERD (Gastroesophageal Reflux Disease). Currently ordered Pantoprazole 40mg Daily. Dose of the Pantoprazole reduced form 40mg BID (twice a day) to Daily on 1/4/2023. Recommendation(s): If appropriate, please consider further reduction to 20mg Daily before breakfast." The physician did not address the recommendations until 10/25/23. A physician's order dated 10/25/23 documented, "Pantoprazole Sodium Oral Tablet Delayed Release 20 MG- Give 1 tablet by mouth one time a day for GERD."

On 12/7/23 at 2:53 p.m., an interview was conducted with ASM (administrative staff member) #2 (the director of nursing). ASM #2 stated the pharmacist completes her monthly medication reviews and forwards her recommendations via email to ASM #2 and the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495071	A. BUILDING _____ B. WING _____	C 12/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERSIDE LIFELONG H & R WARWICK FOREST	1000 OLD DENBEIGH BOULEVARD NEWPORT NEWS, VA 23602

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F 756	Continued From page 110 providers' nurse. ASM #2 stated the providers' nurse shares the recommendations with the providers and sometimes the providers will give their nurse orders to put into the computer system then sit down later and complete the pharmacy recommendation forms. ASM #2 stated the facility has had a lot of providers in the last year. ASM #2 stated for a while, the facility did not have any nurse practitioners and the doctors were trying to handle all the pharmacy recommendations but got bogged down so there were gaps [periods of time] when pharmacy recommendations were not addressed. On 12/7/23 at 4:55 p.m., ASM #1 (the administrator) and ASM #2 were made aware of the above concern. References: (1) Milk of magnesia is used to treat constipation. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a601073.html (2) Pantoprazole is used to treat gastroesophageal reflux disease. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a601246.html	F 756		
F 758 SS=E	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories:	F 758		1/22/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495071	A. BUILDING _____ B. WING _____	C 12/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERSIDE LIFELONG H & R WARWICK FOREST	1000 OLD DENBEIGH BOULEVARD NEWPORT NEWS, VA 23602

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F 758	Continued From page 111 (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or	F 758		

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	495071	A. BUILDING _____ B. WING _____	C 12/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 758	Continued From page 112 prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, and facility document review, it was determined that the facility staff failed to ensure that one of sixty residents in the survey sample, Resident #134, was free of unnecessary psychotropic medications. The findings include: 1. For Resident #134 the facility staff failed to evidence an appropriate diagnosis for the use of Trazodone (1), and failed to ensure consistent monitoring for the use of Trazodone and Risperdal (2), including behavior monitoring, effectiveness, side effects, and adverse reactions to an antipsychotic and an antidepressant medication. A review of the clinical record revealed a physician's order dated 9/13/23 for "Trazodone Oral Tablet 50 MG, Give 0.5 mg by mouth at bedtime for per psych." A review of the clinical record revealed a physician's order dated 9/13/23 for "Risperdal Oral Tablet 0.5 MG (milligrams) (Risperidone) Give 1 tablet by mouth at bedtime for psychotic disturbance." Further review failed to reveal any orders for staff monitoring for the use of Trazodone, including monitoring for signs and symptoms of depression, effectiveness, side effects and adverse reactions; and for the use of Risperdal, including behavior, effectiveness, side effects,	F 758	1. Resident # 134 on 12/11/23 obtained an appropriate diagnosis for Trazadone by the provider. The order for Trazadone was clarified by the provider to include consistent monitoring for the drug to include behaviors, effectiveness, side effects and adverse reactions. 2. Director of Nursing / designee will audit residents on antidepressants and antipsychotics for proper diagnosis including behavior monitoring, effectiveness, side effects and adverse reactions. 3. Clinical educator / designee will educate the clinical staff on obtaining proper diagnosis for antidepressant and antipsychotic medications and on monitoring and documenting behavior monitoring, effectiveness, side effects and adverse reactions to a psychotropic medication. 4. Director of Resident Services / designee will review 4 charts of residents on antipsychotic or antidepressant medications weekly for 8 weeks to validate diagnosis, behavior monitoring, effectiveness, side effects and adverse reactions. The results of the audit will be reported at the QAPI meeting for evaluation of compliance and ongoing monitoring for continuous improvement analysis.	

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	495071	A. BUILDING _____ B. WING _____	C 12/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERSIDE LIFELONG H & R WARWICK FOREST	1000 OLD DENBEIGH BOULEVARD NEWPORT NEWS, VA 23602

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F 758	Continued From page 113	F 758		

and adverse reactions to an antipsychotic medication.

A review of the MAR (Medication Administration Record) and TAR (Treatment Administration Record) for August 2023 through December 2023 was conducted. There was no line item for the use of Trazodone that included signs and symptoms of depression, effectiveness, side effects and adverse reactions for documenting that the required monitoring was done. Also, there was no line item for monitoring for the use of Risperdal that included behaviors, side effects and adverse reactions for documenting that the required monitoring was done.

A review of the progress notes failed to reveal consistent evidence that staff were monitoring for the use of Trazodone, including signs and symptoms of depression, effectiveness, side effects and adverse reactions. The progress notes also failed to reveal consistent evidence that staff were monitoring the use of Risperdal, including behavior, effectiveness, side effects, and adverse reactions to an antipsychotic medication.

A review of the comprehensive care plan included one dated 8/9/23 for "(Resident #134) uses psychotropic medications (Trazodone and Risperdal) medications) r/t (related to) Disease process (Vascular Dementia Severe with Psychotic Disturbances)." This care plan included an intervention dated 5/1/23 for "Monitor/document/report PRN (as-needed) any adverse reactions of PSYCHOTROPIC medications: unsteady gait, tardive dyskinesia, EPS (Extrapyramidal symptoms) (shuffling gait, rigid muscles, shaking), frequent falls, refusal to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495071	A. BUILDING _____ B. WING _____	C 12/08/2023

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RIVERSIDE LIFELONG H & R WARWICK FOREST	1000 OLD DENBEIGH BOULEVARD NEWPORT NEWS, VA 23602

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F 758	Continued From page 114	F 758		

eat, difficulty swallowing, dry mouth, depression, suicidal ideations, social isolation, blurred vision, diarrhea, fatigue, insomnia, loss of appetite, weight loss, muscle cramps nausea, vomiting, behavior symptoms not usual to the person."

On 12/8/23 at 8:20 AM, an interview was conducted with LPN #9 (Licensed Practical Nurse). When asked about monitoring residents for behaviors, effectiveness, side effects and adverse reactions, she stated that after meds are given, the residents are monitored for side effects and if they are having behaviors. She said that there should be an order for follow up documentation like a check off, but it isn't there. She stated that they chart by exception, so it is assumed that if there isn't anything documented then there wasn't any issues. She stated that it would be more efficient if there was a check off. When asked about the diagnosis for the Trazodone being "per psych" she stated that was not an appropriate diagnosis and that it was probably written wrong.

A policy for "psychotropic meds - monitoring" was requested. The facility policy that was provided, "Antipsychotic Gradual Dose Reduction" documented, "....check/validate for appropriate dx (diagnosis) for all residents on antipsychotics; review targeted behaviors for recommendation r/t (related to) GDR; monitor for SE (side effects) and ADRs (adverse drug reactions) or drug/drug interactions....ensure there is an order for Behavior Observed. Nursing should be notified to revise the order if Behavior Observed is not listed. This is necessary in order for nursing to document any resident behaviors...."

On 12/7/23 at 4:50 PM at the end-of-day meeting,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495071	A. BUILDING _____ B. WING _____	C 12/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERSIDE LIFELONG H & R WARWICK FOREST	1000 OLD DENBEIGH BOULEVARD NEWPORT NEWS, VA 23602

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F 758	Continued From page 115 ASM #1 (Administrative Staff Member) the Administrator and ASM #2 the Director of Nursing were made aware of the findings. No further information was provided by the end of the survey. (1) Trazodone is used to treat depression. Information obtained from https://medlineplus.gov/druginfo/meds/a681038.html (2) Risperdal is an antipsychotic. Information obtained from https://medlineplus.gov/druginfo/meds/a694015.html	F 758		
F 804 SS=E	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and facility document review, it was determined that the facility staff failed to serve food in a palatable manner from one of one facility kitchens. The findings include: On 12/6/23 at 11:21 AM, tray line observation was conducted with OSM #9 (Other Staff Member) the	F 804	1. Food Service Director on 12/12/23 implemented a new procedure to stir food on the steam table more frequently and keep it covered for longer periods. The Heat on Demand system was reviewed for proper functionality by Food Service Director. 2. Residents receiving meal trays will be interviewed by the Food Services Director	1/22/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495071	A. BUILDING _____ B. WING _____	C 12/08/2023

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F 804	Continued From page 116 Dietary Manager. The temperatures were taken of the tray line lunch meal. The following temperatures were obtained for the main meal: Meatballs was 179 degrees Noodles was 176 degrees Mixed vegetables was 183 degrees Florentine tomato soup was 167 degrees On 12/6/23 at 12:47 PM the cart with the test tray was taken to the Monticello unit. Staff started serving trays at 12:53 PM. At 1:11 PM after all residents were served, temperatures for the test tray food items were obtained by OSM #9 as follows: Meatballs was 121 degrees. This was a 57 degree drop in temperature. Noodles was 113 degrees. This was a 63 degree drop in temperature. Mixed vegetables was 117 degrees. This was a 66 degree drop in temperature. Florentine tomato soup was 128 degrees. This was a 39 degree drop in temperature. Two surveyors and OSM #9 tasted all items. It was agreed that the flavor was acceptable. However, it was agreed by all three that the meatballs and mixed vegetables were only at room temperature at best and the noodles were cold. The facility policy "Organization and Leadership: Food and Nutrition Services" documented, "....The goal is to provide palatable, well-balanced, safe and nutritious meals that meets the nutritional needs and special dietary needs of residents and patient...." On 12/6/23 at 5:15 PM at the end-of-day meeting, ASM #1 (Administrative Staff Member) the	F 804	/ designee to determine palatable of food 3. Food Service Director / designee will educate food and nutrition team members on methods to maintain food temperatures on the steamtable and on the proper use of the Heat on Demand meal delivery system. 4. Food Service Director / designee will audit 4 tests trays weekly times 8 weeks for palatable temperatures of food. Food Service Director/ designee will interview 4 residents weekly for 8 weeks for their satisfaction with the food□s palatability and temperatures. The results of the audit will be reported at the QAPI meeting for evaluation of compliance and ongoing monitoring for continuous improvement analysis.	

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	495071	A. BUILDING _____ B. WING _____	C 12/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERSIDE LIFELONG H & R WARWICK FOREST	1000 OLD DENBEIGH BOULEVARD NEWPORT NEWS, VA 23602

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F 804	Continued From page 117 Administrator and ASM #2 the Director of Nursing were made aware of the findings. No further information was provided by the end of the survey.	F 804		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and facility document review, it was determined that the facility staff failed to store food in a sanitary manner in one of one facility kitchens. The findings include: On 12/5/23 at 11:10 AM a tour of the kitchen was conducted with OSM #9 (Other Staff Member) the Dietary Manager. In the walk-in refrigerator, a	F 812	1. Food Service Director discarded the box of garlic bread on 12/5/2023. 2. Food Service Director / designee will complete an audit of all food stored under refrigeration to ensure that food is being stored in a sanitary manner. 3. Food Service Director/ designee will educate food and nutrition team members in proper storage and how to handle items that are found improperly stored.	1/22/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495071	A. BUILDING _____ B. WING _____	C 12/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERSIDE LIFELONG H & R WARWICK FOREST	1000 OLD DENBEIGH BOULEVARD NEWPORT NEWS, VA 23602

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F 812	Continued From page 118 box of garlic bread was observed with the plastic bag open, exposing the bread to the elements of the refrigerator environment. OSM #9 stated that it should be sealed to protect it. The facility policy "Food and Nutrition Services Infection Control, Food Safety and Sanitation Policy" was reviewed. This policy documented, "...J. Food will be stored in a manner to avoid deterioration in quality by drying out, freezer burning or change in color...." On 12/6/23 at 5:15 PM at the end-of-day meeting, ASM #1 (Administrative Staff Member) the Administrator and ASM #2 the Director of Nursing were made aware of the findings. No further information was provided by the end of the survey.	F 812	4. Food Service Director / designee will audit the food storage in the kitchen weekly times 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.	
F 909 SS=E	Resident Bed CFR(s): 483.90(d)(3) §483.90(d)(3) Conduct Regular inspection of all bed frames, mattresses, and bed rails, if any, as part of a regular maintenance program to identify areas of possible entrapment. When bed rails and mattresses are used and purchased separately from the bed frame, the facility must ensure that the bed rails, mattress, and bed frame are compatible. This REQUIREMENT is not met as evidenced by: Based on observations, staff interview, clinical record review and facility document review, it was determined the facility staff failed to evidence bed inspections for four of 60 residents in the survey sample, Residents # 49, Resident #58, Resident #60 and Resident #8.	F 909	Resident #49, Resident #58, Resident #60, and Resident # 8 beds were inspected by the facility maintenance staff on 12/6/23. 2. The Facilities Director /designee will audit all beds in the facility for a current bed rail safety inspection.	1/22/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495071	A. BUILDING _____ B. WING _____	C 12/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERSIDE LIFELONG H & R WARWICK FOREST	1000 OLD DENBEIGH BOULEVARD NEWPORT NEWS, VA 23602

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F 909	Continued From page 119 The findings include: 1.The facility staff failed to perform bed rail inspections for the use of positioning / assist bars for Resident #49. Resident #49 was observed in bed with bilateral half bed rails on 12/6/23 at 7:30 AM and 12/7/23 at 8:00 AM. Resident #49 was admitted to the facility on 12/17/21 with diagnosis that included but were not limited to: COPD (chronic obstructive pulmonary disease), cellulitis, ASCVD (atherosclerotic cardiovascular disease) and PVD (peripheral vascular disease). The most recent MDS (minimum data set) assessment, a quarterly assessment, with an ARD (assessment reference date) of 11/28/23, coded the resident as scoring a 15 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 extensive assistance for bathing and supervision for bed mobility, transfer, dressing, hygiene and eating; independent for locomotion. A review of the comprehensive care plan dated 7/3/23 revealed, "FOCUS: Resident desires to remain in facility to receive continued services. INTERVENTIONS: Provide services according to care plans in an effort to enhance optimum well-being. Siderails x2, limited assist x1: dressing, toileting and personal hygiene. Extensive assist x1 showers and incontinence care."	F 909	3. The Facilities Director / designee will educate the facilities team members on 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 units of the building will be scheduled quarterly. 4. The Facilities Director / designee will 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 meeting for evaluation of compliance and ongoing monitoring for continuous improvement analysis.	

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	495071	A. BUILDING _____ B. WING _____	C 12/08/2023

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F 909	Continued From page 120	F 909		

A review of the facility's "Bed Safety Inspection Log" and "Bed Safety Inspection" revealed no bed inspections since 2021.

On 12/6/23 at 8:20 AM, surveyor observed two maintenance staff performing bed inspections on the Chesapeake Unit.

An interview was conducted on 12/6/23 at 8:25 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.

A review of the facility's "Bed Rail / Side Rail Entrapment" policy, revealed, "Before bed rails are installed, the facility will check with the manufacturer(s) to make sure the bed rails, mattress, and bed frame are compatible, since most bed rails and mattresses are purchased separately from the bed frame. Prior to using any model of bed in the facility, designated staff will validate the bed inspection has been completed annually."

No further information was provided prior to exit.

2.The facility staff failed to perform bed rail inspections for the use of positioning / assist bars for Resident #58.

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F 909	Continued From page 121	F 909		

Resident #58 was observed in bed with bilateral half bed rails on 12/5/23 at 1:00 PM, 12/6/23 at 8:30 AM and 12/7/23 at 9:00 AM.

Resident #58 was admitted to the facility on 4/25/23 with diagnosis that included but were not limited to: COPD (chronic obstructive pulmonary disease), dysphagia and acute respiratory failure.

The most recent MDS (minimum data set) assessment, a quarterly assessment, with an ARD (assessment reference date) of 11/7/23, coded the resident as scoring a 05 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was severely cognitively impaired. A review of the MDS Section G-functional status coded the resident as requiring extensive assistance for bathing, bed mobility; limited assistance for transfers and supervision for eating.

A review of the comprehensive care plan dated 8/22/23 revealed, "FOCUS: Resident desires to remain in facility to receive continued services. INTERVENTIONS: Provide services according to care plans in an effort to enhance optimum well-being. Siderails x2, total dependence x 2 transfers, extensive assist x1: bed mobility, dressing, toileting and personal hygiene."

A review of the facility's "Bed Safety Inspection Log" and "Bed Safety Inspection" revealed no bed inspections since 2021.

On 12/6/23 at 8:20 AM, surveyor observed two maintenance staff performing bed inspections on the Chesapeake Unit.

An interview was conducted on 12/6/23 at 8:25

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F 909	Continued From page 122	F 909		

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 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.

A review of the comprehensive care plan dated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 909	Continued From page 123	F 909		

5/30/23 revealed, "FOCUS: Resident desires to remain in facility to receive continued services. INTERVENTIONS: Provide services according to care plans in an effort to enhance optimum well-being. Siderails x2, limited assist x1: dressing, toileting, showers, incontinence care and personal hygiene. Extensive assist x1: transfers."

A review of the facility's "Bed Safety Inspection Log" and "Bed Safety Inspection" revealed no bed inspections since 2021.

On 12/6/23 at 8:20 AM, surveyor observed two maintenance staff performing bed inspections on the Chesapeake Unit.

An interview was conducted on 12/6/23 at 8:25 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.

4. The facility staff failed to perform bed rail inspections for the use of positioning / assist bars for Resident #8.

Resident #8 was observed in bed with bilateral half bed rails on 12/5/23 at 12:10 PM, 12/6/23 at 8:30 AM and 12/7/23 at 8:20 AM.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 909	Continued From page 124	F 909		

Resident #8 was admitted to the facility on 4/12/13 with diagnosis that included but were not limited to: DM (diabetes mellitus), neurogenic bladder and paraplegia.

The most recent MDS (minimum data set) assessment, a quarterly assessment, with an ARD (assessment reference date) of 10/17/23, coded the resident as scoring a 15 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 extensive assistance for bathing, bed mobility, transfer, dressing, hygiene and limited assistance for eating.

A review of the comprehensive care plan dated 1/30/23 revealed, "FOCUS: Resident desires to remain in facility to receive continued services. INTERVENTIONS: Provide services according to care plans in an effort to enhance optimum well-being. Siderails x2, overbed trapeze, extensive assist x1: dressing, toileting and personal hygiene. Extensive assist x1 showers and incontinence care."

A review of the facility's "Bed Safety Inspection Log" and "Bed Safety Inspection" revealed no bed inspections since 2021.

On 12/6/23 at 8:20 AM, surveyor observed two maintenance staff performing bed inspections on the Chesapeake Unit.

An interview was conducted on 12/6/23 at 8:25 AM with OSM (other staff member) #11, the maintenance staff. When asked what inspections

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F 909	Continued From page 125 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.	F 909		