STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495204	A. BUILDING _____ B. WING _____	C 03/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLD DOMINION REHABILITATION AND NURSING	4 RIDGEWOOD PARKWAY 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
E 000	Initial Comments The unannounced Standard Medicaid/Medicare survey was conducted on 02/28/22 through 03/03/22. Corrections are required for compliance with the Emergency Preparedness requirements and with 42 CFR 483 Federal Long Term Care requirements.	E 000		
E 006 SS=C	Plan Based on All Hazards Risk Assessment CFR(s): 483.73(a)(1)-(2) §403.748(a)(1)-(2), §416.54(a)(1)-(2), §418.113(a)(1)-(2), §441.184(a)(1)-(2), §460.84(a)(1)-(2), §482.15(a)(1)-(2), §483.73(a)(1)-(2), §483.475(a)(1)-(2), §484.102(a)(1)-(2), §485.68(a)(1)-(2), §485.625(a)(1)-(2), §485.727(a)(1)-(2), §485.920(a)(1)-(2), §486.360(a)(1)-(2), §491.12(a)(1)-(2), §494.62(a)(1)-(2) [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following:] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach.* (2) Include strategies for addressing emergency events identified by the risk assessment. * [For Hospices at §418.113(a):] Emergency Plan. The Hospice must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk	E 006		4/15/22

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

Electronically Signed | 04/04/2022

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495204	A. BUILDING _____ B. WING _____	C 03/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLD DOMINION REHABILITATION AND NURSING	4 RIDGEWOOD PARKWAY 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
E 006	Continued From page 1 assessment, utilizing an all-hazards approach. (2) Include strategies for addressing emergency events identified by the risk assessment, including the management of the consequences of power failures, natural disasters, and other emergencies that would affect the hospice's ability to provide care. *[For LTC facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing residents. (2) Include strategies for addressing emergency events identified by the risk assessment. *[For ICF/IIDs at §483.475(a):] Emergency Plan. The ICF/IID must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing clients. (2) Include strategies for addressing emergency events identified by the risk assessment. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility staff failed to have documentation of the facility's updated Emergency Preparedness Plan. The findings included:	E 006	Staff failed to have documentation of the facility's Emergency Preparedness Plan. 1.Emergency Preparedness Manual was reviewed and updated on	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495204	A. BUILDING _____ B. WING _____	C 03/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLD DOMINION REHABILITATION AND NURSING	4 RIDGEWOOD PARKWAY 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
E 006	Continued From page 2 During an interview on 03/02/22 at 10:00 A.M. with the Maintenance Director and the Regional Nurse Consultant, the Maintenance Director was asked for documentation of the facility's community based risk assessments that will assist the facility in addressing the needs of their patients. The Maintenance Director and the Regional Nurse Consultant, stated the facility had not conducted a risk assessment of it's emergency preparedness plan. The documentation presented indicated the Emergency Preparedness Plan had not been updated since 10/9/20. The Plan included the name of a different facility.	E 006	3/22/2022. 2) All residents are at risk when the facility's emergency preparedness plan is not reviewed and updated. 3) Staff will be educated on the facility's Emergency Preparedness Plan. Emergency preparedness manuals will be updated and made available in the administrative office and each nurse's station by 4/4/2022. 4) Administrator or designee will review facility's Emergency Preparedness Plan. Emergency Preparedness Plan will be reviewed quarterly X 2 at QAPI committee for oversight for any recommended changes and/or updates.	
E 007 SS=C	EP Program Patient Population CFR(s): 483.73(a)(3) §403.748(a)(3), §416.54(a)(3), §418.113(a)(3), §441.184(a)(3), §460.84(a)(3), §482.15(a)(3), §483.73(a)(3), §483.475(a)(3), §484.102(a)(3), §485.68(a)(3), §485.625(a)(3), §485.727(a)(3), §485.920(a)(3), §491.12(a)(3), §494.62(a)(3). [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following:] (3) Address [patient/client] population, including, but not limited to, persons at-risk; the type of services the [facility] has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession plans.**	E 007		4/15/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495204	A. BUILDING _____ B. WING _____	C 03/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLD DOMINION REHABILITATION AND NURSING	4 RIDGEWOOD PARKWAY 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
E 007	Continued From page 3 *[For LTC facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do all of the following: (3) Address resident population, including, but not limited to, persons at-risk; the type of services the LTC facility has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession plans. *NOTE: ["Persons at risk" does not apply to: ASC, hospice, PACE, HHA, CORF, CMCH, RHC/FQHC, or ESRD facilities.] This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility staff failed to have documentation of the facility's patient population and services the facility would be able to provide during an emergency. The findings included: During an interview on 03/02/22 at 10:05 A.M. with the Maintenance Director and the Regional Nurse Consultant, the Maintenance Director was asked for documentation of the facility's patient population and services the facility would be able to provide during an emergency. The Maintenance Director and the Regional Nurse Consultant, stated the facility had not conducted a patient population assessment nor had they reviewed what services would be provided during an emergency. The documentation presented indicated the Emergency Preparedness Plan had not been	E 007	1. The facility risk assessment of patient population was updated and added to the emergency operations plan on 3/22/2022. 2. All residents are at risk when the facilitys emergency plan is not reviewed and updated 3. Staff will be educated on the facility's Emergency Preparedness Plan to include assessing and identifying at risk populations. Emergency preparedness manuals will be updated and made available in the administrative office and each nurses station by 4/4/2022. 4. Director of Nursing or designee will review patient populations in facility risk assessment and present to QAPI quarterly X two to ensure facility at risk populations are identified and included in EOP.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495204	A. BUILDING _____ B. WING _____	C 03/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLD DOMINION REHABILITATION AND NURSING	4 RIDGEWOOD PARKWAY 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
E 007	Continued From page 4 updated since 10/9/20. The Plan included the name of a different facility.	E 007		
E 013 SS=C	Development of EP Policies and Procedures CFR(s): 483.73(b) §403.748(b), §416.54(b), §418.113(b), §441.184(b), §460.84(b), §482.15(b), §483.73(b), §483.475(b), §484.102(b), §485.68(b), §485.625(b), §485.727(b), §485.920(b), §486.360(b), §491.12(b), §494.62(b). (b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years. *[For LTC facilities at §483.73(b):] Policies and procedures. The LTC facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. *Additional Requirements for PACE and ESRD Facilities: *[For PACE at §460.84(b):] Policies and procedures. The PACE organization must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk	E 013		4/15/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495204	A. BUILDING _____ B. WING _____	C 03/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLD DOMINION REHABILITATION AND NURSING	4 RIDGEWOOD PARKWAY 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
E 013	Continued From page 5 assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must address management of medical and nonmedical emergencies, including, but not limited to: Fire; equipment, power, or water failure; care-related emergencies; and natural disasters likely to threaten the health or safety of the participants, staff, or the public. The policies and procedures must be reviewed and updated at least every 2 years. *[For ESRD Facilities at §494.62(b):] Policies and procedures. The dialysis facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years. These emergencies include, but are not limited to, fire, equipment or power failures, care-related emergencies, water supply interruption, and natural disasters likely to occur in the facility's geographic area. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility staff failed to have documentation of the facility's Emergency Preparedness Plan policy and procedures had been updated on an annual basis. The findings included: During an interview on 03/02/22 at 10:12 A.M. with the Maintenance Director and the Regional Nurse Consultant, the Maintenance Director was	E 013	1.Emergency operations Policies and Procedures were reviewed and updated on 3/22/2022. 2) All residents are at risk when emergency policies and procedures are not reviewed and updated. 3) Staff will be educated on facilitys Emergency Preparedness plan. Emergency preparedness manuals will be updated and made available in	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495204	A. BUILDING _____ B. WING _____	C 03/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLD DOMINION REHABILITATION AND NURSING	4 RIDGEWOOD PARKWAY 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
E 013	Continued From page 6 asked for documentation of the facility's Emergency Preparedness updated policy and procedures. The Maintenance Director and the Regional Nurse Consultant, stated the facility had not updated the Emergency Preparedness Plan policy and procedures. The documentation presented indicated the Emergency Preparedness Plan had not been updated since 10/9/20. The Plan included the name of a different facility.	E 013	the administrative office and each nurses station by 4/4/2022. 4) Administrator or designee will review facilitys Emergency Policies and Procedures. Emergency Policies and Procedures will be reviewed quarterly X 2 at QAPI committee for oversight for any recommended changes.	
E 015 SS=C	Subsistence Needs for Staff and Patients CFR(s): 483.73(b)(1) §403.748(b)(1), §418.113(b)(6)(iii), §441.184(b)(1), §460.84(b)(1), §482.15(b)(1), §483.73(b)(1), §483.475(b)(1), §485.625(b)(1) [(b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following: (1) The provision of subsistence needs for staff and patients whether they evacuate or shelter in place, include, but are not limited to the following: (i) Food, water, medical and pharmaceutical supplies (ii) Alternate sources of energy to maintain the following: (A) Temperatures to protect patient health and	E 015		4/15/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495204	A. BUILDING _____ B. WING _____	C 03/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLD DOMINION REHABILITATION AND NURSING	4 RIDGEWOOD PARKWAY 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
E 015	Continued From page 7 safety and for the safe and sanitary storage of provisions. (B) Emergency lighting. (C) Fire detection, extinguishing, and alarm systems. (D) Sewage and waste disposal. *[For Inpatient Hospice at §418.113(b)(6)(iii):] Policies and procedures. (6) The following are additional requirements for hospice-operated inpatient care facilities only. The policies and procedures must address the following: (iii) The provision of subsistence needs for hospice employees and patients, whether they evacuate or shelter in place, include, but are not limited to the following: (A) Food, water, medical, and pharmaceutical supplies. (B) Alternate sources of energy to maintain the following: (1) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions. (2) Emergency lighting. (3) Fire detection, extinguishing, and alarm systems. (C) Sewage and waste disposal. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility staff failed to have documentation of the facility's updated Emergency Preparedness Plan included policies and procedures to ensure adequate energy sources as well as provide for sewage and waste disposal. The findings included:	E 015	1.Policies and procedures for emergency lighting, fire detection, extinguishing, alarm system and sewage and waste disposal updated in the EP binder on 3/22/2022. 2) All residents are at risk when the emergency plan for sustenance needs is not reviewed and updated. 3) Maintenance Director was educated on	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495204	A. BUILDING _____ B. WING _____	C 03/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLD DOMINION REHABILITATION AND NURSING	4 RIDGEWOOD PARKWAY 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
E 015	Continued From page 8 During an interview on 03/02/22 at 10:23 A.M. with the Maintenance Director and the Regional Nurse Consultant, the Maintenance Director was asked for documentation of the facility's policies and procedures to ensure adequate energy sources were maintained during an emergency as well as provide for sewage and waste disposal. The Maintenance Director and the Regional Nurse Consultant, stated the facility had not developed policies and procedures to ensure alternate energy sources as well as sewage and waste disposal. The documentation presented indicated the Emergency Preparedness Plan had not been updated since 10/9/20. The Plan included the name of a different facility.	E 015	3/22/22 re: accommodation for sustenance needs as a part of a comprehensive emergency preparedness plan. Emergency preparedness manuals will be updated and made available in the administrative office and each nurses station by 4/4/2022. 4. Maintenance Director or designee will review accommodations for sustenance needs and update QAPI team quarterly x two quarters. Administrator or designee to discuss change with interdisciplinary team at following QAPI.	
E 018 SS=C	Procedures for Tracking of Staff and Patients CFR(s): 483.73(b)(2) §403.748(b)(2), §416.54(b)(1), §418.113(b)(6)(ii) and (v), §441.184(b)(2), §460.84(b)(2), §482.15(b)(2), §483.73(b)(2), §483.475(b)(2), §485.625(b)(2), §485.920(b)(1), §486.360(b)(1), §494.62(b)(1). [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following:]	E 018		4/15/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495204	A. BUILDING _____ B. WING _____	C 03/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLD DOMINION REHABILITATION AND NURSING	4 RIDGEWOOD PARKWAY 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
E 018	Continued From page 9	E 018		

[(2) or (1)] A system to track the location of on-duty staff and sheltered patients in the [facility's] care during an emergency. If on-duty staff and sheltered patients are relocated during the emergency, the [facility] must document the specific name and location of the receiving facility or other location.

*[For PRTFs at §441.184(b), LTC at §483.73(b), ICF/IIDs at §483.475(b), PACE at §460.84(b):] Policies and procedures. (2) A system to track the location of on-duty staff and sheltered residents in the [PRTF's, LTC, ICF/IID or PACE] care during and after an emergency. If on-duty staff and sheltered residents are relocated during the emergency, the [PRTF's, LTC, ICF/IID or PACE] must document the specific name and location of the receiving facility or other location.

*[For Inpatient Hospice at §418.113(b)(6):] Policies and procedures.
(ii) Safe evacuation from the hospice, which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s) and primary and alternate means of communication with external sources of assistance.
(v) A system to track the location of hospice employees' on-duty and sheltered patients in the hospice's care during an emergency. If the on-duty employees or sheltered patients are relocated during the emergency, the hospice must document the specific name and location of the receiving facility or other location.

*[For CMHCs at §485.920(b):] Policies and procedures. (2) Safe evacuation from the CMHC,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495204	A. BUILDING _____ B. WING _____	C 03/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLD DOMINION REHABILITATION AND NURSING	4 RIDGEWOOD PARKWAY 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
E 018	Continued From page 10 which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s); and primary and alternate means of communication with external sources of assistance. *[For OPOs at § 486.360(b):] Policies and procedures. (2) A system of medical documentation that preserves potential and actual donor information, protects confidentiality of potential and actual donor information, and secures and maintains the availability of records. *[For ESRD at § 494.62(b):] Policies and procedures. (2) Safe evacuation from the dialysis facility, which includes staff responsibilities, and needs of the patients. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility staff failed to have documentation of the facility's updated Emergency Preparedness Plan included policies and procedures to ensure the tracking system used to document the location of patients and staff were a part of the Emergency Preparedness Plan. The findings included: During an interview on 03/02/22 at 10:32 A.M. with the Maintenance Director and the Regional Nurse Consultant, the Maintenance Director was asked for documentation of the facility's policies and procedures to ensure staff and resident locations could be tracked during an emergency. The Maintenance Director and the Regional Nurse Consultant, stated the facility had not	E 018	1.Tracking system for tracking on duty staff and sheltered patients who may be relocated during an emergency was updated in EP binder. 2. All residents that may be relocated during an emergency have the potential to be affected. 3. Staff in all departments will be educated on facilitys Emergency Preparedness plan to include tracking staff and sheltered patients in an evacuation scenario. Emergency preparedness manuals will be updated and made available in the administrative office and each nurses station by 4/4/2022. 4. Business office manager/Hr Manger will review system for tracking staff and sheltered patients and review at	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495204	A. BUILDING _____ B. WING _____	C 03/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLD DOMINION REHABILITATION AND NURSING	4 RIDGEWOOD PARKWAY 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
E 018	Continued From page 11 updated policies and procedures to ensure the facility's tracking system for Residents and staff were a part of the emergency preparedness plan. The documentation presented indicated the Emergency Preparedness Plan had not been updated since 10/9/20. The Plan included the name of a different facility.	E 018	quarterly QAPI meeting x two quarters.	
E 020 SS=C	Policies for Evac. and Primary/Alt. Comm. CFR(s): 483.73(b)(3) §403.748(b)(3), §416.54(b)(2), §418.113(b)(6)(ii), §441.184(b)(3), §460.84(b)(3), §482.15(b)(3), §483.73(b)(3), §483.475(b)(3), §485.68(b)(1), §485.625(b)(3), §485.727(b)(1), §485.920(b)(2), §491.12(b)(1), §494.62(b)(2) [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following:] [(3) or (1), (2), (6)] Safe evacuation from the [facility], which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s); and primary and alternate means of communication with external sources of assistance. *[For RNHCIs at §403.748(b)(3) and ASCs at	E 020		4/15/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495204	A. BUILDING _____ B. WING _____	C 03/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLD DOMINION REHABILITATION AND NURSING	4 RIDGEWOOD PARKWAY 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
E 020	Continued From page 12 §416.54(b)(2):] Safe evacuation from the [RNHCI or ASC] which includes the following: (i) Consideration of care needs of evacuees. (ii) Staff responsibilities. (iii) Transportation. (iv) Identification of evacuation location(s). (v) Primary and alternate means of communication with external sources of assistance. * [For CORFs at §485.68(b)(1), Clinics, Rehabilitation Agencies, OPT/Speech at §485.727(b)(1), and ESRD Facilities at §494.62(b)(2):] Safe evacuation from the [CORF; Clinics, Rehabilitation Agencies, and Public Health Agencies as Providers of Outpatient Physical Therapy and Speech-Language Pathology Services; and ESRD Facilities], which includes staff responsibilities, and needs of the patients. * [For RHCs/FQHCs at §491.12(b)(1):] Safe evacuation from the RHC/FQHC, which includes appropriate placement of exit signs; staff responsibilities and needs of the patients. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility staff failed to have documentation of the facility's updated Emergency Preparedness Plan included policies and procedures to ensure the safe evacuation from the facility. The findings included: During an interview on 03/02/22 at 10:41 A.M. with the Maintenance Director and the Regional Nurse Consultant, the Maintenance Director was	E 020	1.Policies and procedures for safe evacuation, transportation, identification of evacuation locations and alternate means of communication with external resources and staff responsibilities have been updated in EP binder on 3-22-22. 2. All residents that may be relocated during an emergency have the potential to be affected. 3. Staff in all departments will be educated	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495204	A. BUILDING _____ B. WING _____	C 03/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLD DOMINION REHABILITATION AND NURSING	4 RIDGEWOOD PARKWAY 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
E 020	Continued From page 13 asked for documentation of the facilities policies and procedures to ensure safe evacuation from the facility. The Maintenance Director and the Regional Nurse Consultant, stated the facility had not updated policies and procedures to ensure the facility's safe evacuation from the facility. tracking system for Residents and staff were a part of the emergency preparedness plan. The documentation presented indicated the Emergency Preparedness Plan had not been updated since 1/30/20. The Plan included the name of a different facility.	E 020	on facilitys Emergency Preparedness plan to include policies for resident evacuation and communication. Emergency preparedness manuals will be updated and made available in the administrative office and each nurses station by 4/4/2022. 4. Maintenance Director or designee will monitor and update when applicable evacuation policies and procedures, and review quarterly with QAPI team for two quarters	
E 022 SS=C	Policies/Procedures for Sheltering in Place CFR(s): 483.73(b)(4) §403.748(b)(4), §416.54(b)(3), §418.113(b)(6)(i), §441.184(b)(4), §460.84(b)(5), §482.15(b)(4), §483.73(b)(4), §483.475(b)(4), §485.68(b)(2), §485.625(b)(4), §485.727(b)(2), §485.920(b)(3), §491.12(b)(2), §494.62(b)(3). (b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following:] [(4) or (2),(3),(5),(6)] A means to shelter in place for patients, staff, and volunteers who remain in	E 022		4/15/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495204	A. BUILDING _____ B. WING _____	C 03/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLD DOMINION REHABILITATION AND NURSING	4 RIDGEWOOD PARKWAY 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
E 022	Continued From page 14 the [facility]. *[For Inpatient Hospices at §418.113(b):] Policies and procedures. (6) The following are additional requirements for hospice-operated inpatient care facilities only. The policies and procedures must address the following: (i) A means to shelter in place for patients, hospice employees who remain in the hospice. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility staff failed to have documentation of the facility's updated Emergency Preparedness Plan included policies and procedures to shelter in place for patients, staff and volunteers. The findings included: During an interview on 03/02/22 at 10:48 A.M. with the Maintenance Director and the Regional Nurse Consultant, the Maintenance Director was asked for documentation of the facility's policies and procedures to ensure sheltering in place for the patients, staff and volunteers. The Maintenance Director and the Regional Nurse Consultant, stated the facility had not updated policies and procedures to ensure the facility's sheltering in place for residents, staff and volunteers. The documentation presented indicated the Emergency Preparedness Plan had not been updated since 1/30/20. The Plan included the name of a different facility.	E 022	1. Policies and procedures for sheltering in place have been updated and placed in EP binder. 2. All residents that may be relocated during an emergency have the potential to be affected. 3. Maintenance Director or designee will educate staff on sheltering in place and will ensure that the policy will be included in the EP binder and updated, as necessary. 4. Maintenance Director or designee will monitor and update when applicable sheltering in place policies and procedures, the EP binder weekly for 3 weeks, and monthly for six months. Administrator or designee to discuss change with interdisciplinary team at following QAPI.	
E 023 SS=C	Policies/Procedures for Medical Documentation	E 023		4/15/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495204	A. BUILDING _____ B. WING _____	C 03/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLD DOMINION REHABILITATION AND NURSING	4 RIDGEWOOD PARKWAY 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
E 023	Continued From page 15 CFR(s): 483.73(b)(5) §403.748(b)(5), §416.54(b)(4), §418.113(b)(3), §441.184(b)(5), §460.84(b)(6), §482.15(b)(5), §483.73(b)(5), §483.475(b)(5), §484.102(b)(4), §485.68(b)(3), §485.625(b)(5), §485.727(b)(3), §485.920(b)(4), §486.360(b)(2), §491.12(b)(3), §494.62(b)(4). [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following:] [(5) or (3),(4),(6)] A system of medical documentation that preserves patient information, protects confidentiality of patient information, and secures and maintains availability of records. *[For RNHCIs at §403.748(b):] Policies and procedures. (5) A system of care documentation that does the following: (i) Preserves patient information. (ii) Protects confidentiality of patient information. (iii) Secures and maintains the availability of records. *[For OPOs at §486.360(b):] Policies and procedures. (2) A system of medical documentation that preserves potential and actual	E 023		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495204	A. BUILDING _____ B. WING _____	C 03/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLD DOMINION REHABILITATION AND NURSING	4 RIDGEWOOD PARKWAY 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
E 023	Continued From page 16 donor information, protects confidentiality of potential and actual donor information, and secures and maintains the availability of records. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility staff failed to have documentation of the facility's updated Emergency Preparedness Plan included policies and procedures to ensure patient information was preserved and confidentiality of patient information was protected. The findings included: During an interview on 03/02/22 at 10:53 A.M. with the Maintenance Director and the Regional Nurse Consultant, the Maintenance Director was asked for documentation of the facility's policies and procedures to ensure patient information was preserved and confidentiality of patient information was protected. The Maintenance Director and the Regional Nurse Consultant, stated the facility had not updated policies and procedures to ensure patient information was preserved and confidentiality of patient information was protected. The documentation presented indicated the Emergency Preparedness Plan had not been updated since 1/30/20. The Plan included the name of a different facility.	E 023	1. Policies and procedures for the preservation and protection of patient information, as well as the availability of patient records, have been updated in the EP binder. 2. Any residents who may evacuate during an emergency have the potential to be affected. 3. Administrator (or assigned person) to discuss changes with interdisciplinary team at March QAPI meeting. 4. SDC/designee to educate staff on evacuation policies and procedures, that pertain to the preservation and availability of resident information during an evacuation, as well as how to maintain the availability of resident records. Maintenance Director (or assigned person) will monitor and update when applicable policies and procedures pertaining to the presentation and protection of patient information during an evacuation, as well as the availability of resident records monthly for 6 months.	
E 024 SS=C	Policies/Procedures-Volunteers and Staffing CFR(s): 483.73(b)(6)	E 024		4/15/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495204	A. BUILDING _____ B. WING _____	C 03/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLD DOMINION REHABILITATION AND NURSING	4 RIDGEWOOD PARKWAY 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
E 024	Continued From page 17	E 024		

§403.748(b)(6), §416.54(b)(5), §418.113(b)(4), §441.184(b)(6), §460.84(b)(7), §482.15(b)(6), §483.73(b)(6), §483.475(b)(6), §484.102(b)(5), §485.68(b)(4), §485.625(b)(6), §485.727(b)(4), §485.920(b)(5), §491.12(b)(4), §494.62(b)(5).

[(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following:]

(6) [or (4), (5), or (7) as noted above] The use of volunteers in an emergency or other emergency staffing strategies, including the process and role for integration of State and Federally designated health care professionals to address surge needs during an emergency.

*[For RNHCIs at §403.748(b):] Policies and procedures. (6) The use of volunteers in an emergency and other emergency staffing strategies to address surge needs during an emergency.

*[For Hospice at §418.113(b):] Policies and procedures. (4) The use of hospice employees in an emergency and other emergency staffing strategies, including the process and role for integration of State and Federally designated health care professionals to address surge

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495204	A. BUILDING _____ B. WING _____	C 03/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLD DOMINION REHABILITATION AND NURSING	4 RIDGEWOOD PARKWAY 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
E 024	Continued From page 18 needs during an emergency. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility staff failed to have documentation of the facility's updated Emergency Preparedness Plan included policies and procedures to ensure the use of volunteers and other staffing strategies are in the emergency preparedness plan. The findings included: During an interview on 03/02/22 at 10:58 A.M. with the Maintenance Director and the Regional Nurse Consultant, the Maintenance Director was asked for documentation of the facility's policies and procedures to ensure the use of volunteers and other staffing strategies are in the emergency preparedness plan. The Maintenance Director and the Regional Nurse Consultant, stated the facility had not updated policies and procedures to ensure patient information was preserved and confidentiality of patient information was protected. The documentation presented indicated the Emergency Preparedness Plan had not been updated since 1/30/20. The Plan included the name of a different facility.	E 024	1. Policies and procedures for use of volunteers and facility staffing during an emergency have been updated and placed in EP binder on what date. 2. All residents that may be relocated during an emergency have the potential to be affected. 3. Staff and facility volunteers will be educated on the facilitys Emergency Preparedness Plan to include the staffing plan and use of volunteers during an emergency. Emergency preparedness manuals will be updated and made available in the administrative office and each nurse□s station by 4/4/2022. 4. Administrator or designee will review facilitys Emergency Preparedness Plan. Emergency Preparedness Plan will be reviewed quarterly X 2 at QAPI committee for oversight for any recommended changes and/or updates.	
E 025 SS=C	Arrangement with Other Facilities CFR(s): 483.73(b)(7) §403.748(b)(7), §418.113(b)(5), §441.184(b)(7), §460.84(b)(8), §482.15(b)(7), §483.73(b)(7), §483.475(b)(7), §485.625(b)(7), §485.920(b)(6), §494.62(b)(6).	E 025		4/15/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495204	A. BUILDING _____ B. WING _____	C 03/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLD DOMINION REHABILITATION AND NURSING	4 RIDGEWOOD PARKWAY 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
E 025	Continued From page 19	E 025		

[(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following:]

*[For Hospices at §418.113(b), PRFTs at §441.184,(b) Hospitals at §482.15(b), and LTC Facilities at §483.73(b):] Policies and procedures. (7) [or (5)] The development of arrangements with other [facilities] [and] other providers to receive patients in the event of limitations or cessation of operations to maintain the continuity of services to facility patients.

*[For PACE at §460.84(b), ICF/IIDs at §483.475(b), CAHs at §486.625(b), CMHCs at §485.920(b) and ESRD Facilities at §494.62(b):] Policies and procedures. (7) [or (6), (8)] The development of arrangements with other [facilities] [or] other providers to receive patients in the event of limitations or cessation of operations to maintain the continuity of services to facility patients.

*[For RNHCIs at §403.748(b):] Policies and procedures. (7) The development of arrangements with other RNHCIs and other providers to receive patients in the event of limitations or cessation of operations to maintain the continuity of non-medical services to RNHCI

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495204	A. BUILDING _____ B. WING _____	C 03/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLD DOMINION REHABILITATION AND NURSING	4 RIDGEWOOD PARKWAY 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
E 025	Continued From page 20 patients. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility staff failed to have documentation of the facility's updated Emergency Preparedness Plan included agreements and arrangements with other facility's for the receiving of patients during an emergency. The findings included: During an interview on 03/02/22 at 11:03 A.M. with the Maintenance Director and the Regional Nurse Consultant, the Maintenance Director was asked for documentation of the facility agreements and arrangements for receiving patients in the event of an emergency. The Maintenance Director and the Regional Nurse Consultant, stated the facility did not have agreements and arrangements with other facility's for the receiving of patients during an emergency and ensure patient information was preserved and confidentiality of patient information was protected. The documentation presented indicated the Emergency Preparedness Plan had not been updated since 1/30/20. The Plan included the name of a different facility.	E 025	1. The emergency operations plan was updated to include arrangements with other facilities for resident evacuation during and emergency and was placed in the EOP on 03/22/2022. 2. All residents that may be relocated during an emergency have the potential to be affected. 3. Staff will be educated on the facility's Emergency Preparedness Plan to include arrangements for resident transfer to other facilities during an emergency. Emergency preparedness manuals will be updated and made available in the administrative office and each nurses station by 4/4/2022. 4. Administrator or designee will review facility's Emergency Preparedness Plan. Emergency Preparedness Plan will be reviewed quarterly X 2 at QAPI committee for oversight for any recommended changes and/or updates	
E 026 SS=C	Roles Under a Waiver Declared by Secretary CFR(s): 483.73(b)(8) §403.748(b)(8), §416.54(b)(6), §418.113(b)(6)(C)(iv), §441.184(b)(8), §460.84(b)(9), §482.15(b)(8), §483.73(b)(8), §483.475(b)(8), §485.625(b)(8), §485.920(b)(7), §494.62(b)(7).	E 026		4/15/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495204	A. BUILDING _____ B. WING _____	C 03/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLD DOMINION REHABILITATION AND NURSING	4 RIDGEWOOD PARKWAY 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
E 026	Continued From page 21 [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following:] (8) [(6), (6)(C)(iv), (7), or (9)] The role of the [facility] under a waiver declared by the Secretary, in accordance with section 1135 of the Act, in the provision of care and treatment at an alternate care site identified by emergency management officials. *[For RNHCIs at §403.748(b):] Policies and procedures. (8) The role of the RNHCI under a waiver declared by the Secretary, in accordance with section 1135 of Act, in the provision of care at an alternative care site identified by emergency management officials. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility staff failed to have documentation of the facility's updated Emergency Preparedness Plan included policies and procedures to ensure the role of the facility in providing care and treatment at alternate care sites.. The findings included: During an interview on 03/02/22 at 11:13 A.M. with the Maintenance Director and the Regional	E 026	1. Documentation describing the facility's role in providing care at an alternate care site has been updated in the EP binder. 2. Any residents who may evacuate during an emergency have the potential to be affected. 3. Administrator (or assigned person) to discuss changes with interdisciplinary team at March QAPI meeting. SDC to educate staff on facility role in providing care at an alternate care site,	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495204	A. BUILDING _____ B. WING _____	C 03/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLD DOMINION REHABILITATION AND NURSING	4 RIDGEWOOD PARKWAY 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
E 026	Continued From page 22 Nurse Consultant, the Maintenance Director was asked for documentation of the facility's policies and procedures to ensure the role of the facility in providing care and treatment at alternate care sites. The Maintenance Director and the Regional Nurse Consultant, stated the facility had not updated policies and procedures to ensure the role of the facility staff in providing care and treatment at alternate care sites. The documentation presented indicated the Emergency Preparedness Plan had not been updated since 1/30/20. The Plan included the name of a different facility.	E 026	when evacuated. 4. Maintenance Director (or assigned person) will monitor and update when applicable policies and procedures pertaining to the facility's role in providing care at an alternate care site when evacuated, monthly for 6 months.	
E 030 SS=C	Names and Contact Information CFR(s): 483.73(c)(1) §403.748(c)(1), §416.54(c)(1), §418.113(c)(1), §441.184(c)(1), §460.84(c)(1), §482.15(c)(1), §483.73(c)(1), §483.475(c)(1), §484.102(c)(1), §485.68(c)(1), §485.625(c)(1), §485.727(c)(1), §485.920(c)(1), §486.360(c)(1), §491.12(c)(1), §494.62(c)(1). [(c) The [facility must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years [annually for LTC facilities]. The communication plan must include all of the following:] (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement.	E 030		4/15/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495204	A. BUILDING _____ B. WING _____	C 03/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLD DOMINION REHABILITATION AND NURSING	4 RIDGEWOOD PARKWAY 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
E 030	Continued From page 23 (iii) Patients' physicians (iv) Other [facilities]. (v) Volunteers. *[For Hospitals at §482.15(c) and CAHs at §485.625(c)] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians (iv) Other [hospitals and CAHs]. (v) Volunteers. *[For RNHCIs at §403.748(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Next of kin, guardian, or custodian. (iv) Other RNHCIs. (v) Volunteers. *[For ASCs at §416.45(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians. (iv) Volunteers. *[For Hospices at §418.113(c):] The communication plan must include all of the following:	E 030		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495204	A. BUILDING _____ B. WING _____	C 03/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLD DOMINION REHABILITATION AND NURSING	4 RIDGEWOOD PARKWAY 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
E 030	Continued From page 24 (1) Names and contact information for the following: (i) Hospice employees. (ii) Entities providing services under arrangement. (iii) Patients' physicians. (iv) Other hospices. *[For HHAs at §484.102(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians. (iv) Volunteers. *[For OPOs at §486.360(c):] The communication plan must include all of the following: (2) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Volunteers. (iv) Other OPOs. (v) Transplant and donor hospitals in the OPO's Donation Service Area (DSA). This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility staff failed to have documentation of the facility's updated Emergency Preparedness Communication Plan has been updated as necessary on an annual basis. The findings included: During an interview on 03/02/22 at 11:22 A.M. with the Maintenance Director and the Regional Nurse Consultant, the Maintenance Director were	E 030	1. Names of all staff members and contact information have been updated in the EP binder. Information regarding entities providing services during an emergency updated in the EP. 2. All residents in an emergency have the potential to be affected. 3.Administrator will discuss change with interdisciplinary team at following QAPI meeting. 4. Business office manager/HR or	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495204	A. BUILDING _____ B. WING _____	C 03/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLD DOMINION REHABILITATION AND NURSING	4 RIDGEWOOD PARKWAY 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
E 030	Continued From page 25 asked for documentation of the annual updated Emergency Preparedness Communication Plan. The Maintenance Director and the Regional Nurse Consultant, stated the facility had not updated Emergency Preparedness Communication Plan. The documentation presented indicated the Emergency Preparedness Plan had not been updated since 1/30/20. The Plan included the name of a different facility.	E 030	designee will monitor and update when applicable, staff member and contact list information, weekly for four weeks and monthly for two months. Maintenance director or designee will monitor and update when applicable policies and procedures regarding the facility□s role in providing care at an alternate care site when evacuated.	
E 031 SS=C	Emergency Officials Contact Information CFR(s): 483.73(c)(2) §403.748(c)(2), §416.54(c)(2), §418.113(c)(2), §441.184(c)(2), §460.84(c)(2), §482.15(c)(2), §483.73(c)(2), §483.475(c)(2), §484.102(c)(2), §485.68(c)(2), §485.625(c)(2), §485.727(c)(2), §485.920(c)(2), §486.360(c)(2), §491.12(c)(2), §494.62(c)(2). [(c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years [annually for LTC facilities]. The communication plan must include all of the following: (2) Contact information for the following: (i) Federal, State, tribal, regional, and local emergency preparedness staff. (ii) Other sources of assistance. *[For LTC Facilities at §483.73(c):] (2) Contact information for the following:	E 031		4/15/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495204	A. BUILDING _____ B. WING _____	C 03/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLD DOMINION REHABILITATION AND NURSING	4 RIDGEWOOD PARKWAY 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
E 031	Continued From page 26 (i) Federal, State, tribal, regional, and local emergency preparedness staff. (ii) The State Licensing and Certification Agency. (iii) The Office of the State Long-Term Care Ombudsman. (iv) Other sources of assistance. *[For ICF/IIDs at §483.475(c):] (2) Contact information for the following: (i) Federal, State, tribal, regional, and local emergency preparedness staff. (ii) Other sources of assistance. (iii) The State Licensing and Certification Agency. (iv) The State Protection and Advocacy Agency. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility staff failed to have documentation of the facility's updated Emergency Preparedness Communication Plan which included all facility contact information and Emergency Officials. The findings included: During an interview on 03/02/22 at 11:26 A.M. with the Maintenance Director and the Regional Nurse Consultant, the Maintenance Director was asked for documentation of the annual updated Emergency Preparedness Communication Plan which included Emergency Officials and facility contact information. The Maintenance Director and the Regional Nurse Consultant, stated the facility had not updated Emergency Preparedness Communication Plan to include Emergency Officials and facility contact information.	E 031	1.Policies and procedures pertaining to emergency official contacts have been updated in EP binder. 2. All residents that may be relocated during an emergency have the potential to be affected. 3. Administrator or designee to discuss change with interdisciplinary team at following QAPI meeting. 4. Maintenance Director or designee will monitor and update when applicable state and federal emergency official contacts in the EP binder weekly for 3 weeks, and monthly for six months.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495204	A. BUILDING _____ B. WING _____	C 03/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLD DOMINION REHABILITATION AND NURSING	4 RIDGEWOOD PARKWAY 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
E 031	Continued From page 27 The documentation presented indicated the Emergency Preparedness Plan had not been updated since 1/30/20. The Plan included the name of a different facility.	E 031		
E 032 SS=C	Primary/Alternate Means for Communication CFR(s): 483.73(c)(3) §403.748(c)(3), §416.54(c)(3), §418.113(c)(3), §441.184(c)(3), §460.84(c)(3), §482.15(c)(3), §483.73(c)(3), §483.475(c)(3), §484.102(c)(3), §485.68(c)(3), §485.625(c)(3), §485.727(c)(3), §485.920(c)(3), §486.360(c)(3), §491.12(c)(3), §494.62(c)(3). [(c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years [annually for LTC facilities]. The communication plan must include all of the following: (3) Primary and alternate means for communicating with the following: (i) [Facility] staff. (ii) Federal, State, tribal, regional, and local emergency management agencies. *[For ICF/IIDs at §483.475(c):] (3) Primary and alternate means for communicating with the ICF/IID's staff, Federal, State, tribal, regional, and local emergency management agencies. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility staff failed to have documentation of the facility's updated Emergency Preparedness Communication Plan has been updated as	E 032	1. An Emergency Preparedness Communication Plan , which includes alternate means of communication in an emergency, has been updated in the EP	4/15/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495204	A. BUILDING _____ B. WING _____	C 03/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLD DOMINION REHABILITATION AND NURSING	4 RIDGEWOOD PARKWAY 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
E 032	Continued From page 28 necessary on an annual basis to include the primary and alternate means of communicating with facility staff, Federal, state and local emergency management agencies . The findings included: During an interview on 03/02/22 at 11:32 A.M. with the Maintenance Director and the Regional Nurse Consultant, the Maintenance Director was asked for documentation of the annual updated Emergency Preparedness Communication Plan. The Maintenance Director and the Regional Nurse Consultant, stated the facility had not updated Emergency Preparedness Communication Plan to include the primary and alternate means of communicating with facility staff, Federal, state, and local emergency management agencies. The documentation presented indicated the Emergency Preparedness Plan had not been updated since 1/30/20. The Plan included the name of a different facility.	E 032	binder. 2. Any residents in an emergency have the potential to be affected. 3. Administrator (or assigned person) to discuss change with interdisciplinary team at March QAPI meeting. 4. Maintenance Director will monitor and update when applicable the Emergency Preparedness Communication Plan, weekly for 4 weeks and monthly for months.	
E 033 SS=C	Methods for Sharing Information CFR(s): 483.73(c)(4)-(6) §403.748(c)(4)-(6), §416.54(c)(4)-(6), §418.113(c)(4)-(6), §441.184(c)(4)-(6), §460.84(c)(4)-(6), §441.184(c)(4)-(6), §460.84(c)(4)-(6), §482.15(c)(4)-(6), §483.73(c)(4)-(6), §483.475(c)(4)-(6), §484.102(c)(4)-(5), §485.68(c)(4), §485.625(c)(4)-(6), §485.727(c)(4), §485.920(c)(4)-(6), §491.12(c)(4), §494.62(c)(4)-(6). [(c) The [facility] must develop and maintain an	E 033		4/15/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495204	A. BUILDING _____ B. WING _____	C 03/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLD DOMINION REHABILITATION AND NURSING	4 RIDGEWOOD PARKWAY 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
E 033	Continued From page 29 emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years [annually for LTC facilities]. The communication plan must include all of the following: (4) A method for sharing information and medical documentation for patients under the [facility's] care, as necessary, with other health providers to maintain the continuity of care. (5) A means, in the event of an evacuation, to release patient information as permitted under 45 CFR 164.510(b)(1)(ii). [This provision is not required for HHAs under §484.102(c), CORFs under §485.68(c)] (6) [(4) or (5)]A means of providing information about the general condition and location of patients under the [facility's] care as permitted under 45 CFR 164.510(b)(4). *[For RNHCIs at §403.748(c):] (4) A method for sharing information and care documentation for patients under the RNHCI's care, as necessary, with care providers to maintain the continuity of care, based on the written election statement made by the patient or his or her legal representative. *[For RHCs/FQHCs at §491.12(c):] (4) A means of providing information about the general condition and location of patients under the facility's care as permitted under 45 CFR 164.510(b)(4). This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the	E 033	1. A communication plan, including a	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495204	A. BUILDING _____ B. WING _____	C 03/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLD DOMINION REHABILITATION AND NURSING	4 RIDGEWOOD PARKWAY 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
E 033	Continued From page 30 facility staff failed to have documentation of the facility's policies and procedures that address the means the facility will release patient information.. The findings included: During an interview on 03/02/22 at 11:26 A.M. with the Maintenance Director and the Regional Nurse Consultant, the Maintenance Director was asked for documentation of the Emergency Preparedness Communication Plan to release patient information . The Maintenance Director and the Regional Nurse Consultant, stated the facility had not updated policies and procedures of the Emergency Preparedness Communication Plan to release patient information. The documentation presented indicated the Emergency Preparedness Plan had not been updated since 1/30/20. The Plan included the name of a different facility.	E 033	method for sharing information and medical documentation to maintain continuity of care, which has been updated in the EP binder. 2. Any residents in an emergency have the potential to be affected. 3. Administrator (or designee) to discuss change with interdisciplinary team at March QAPI meeting. 4. Maintenance Director will monitor and update when applicable the Communication Plan, weekly for 4 weeks and monthly for 2 months.	
E 034 SS=C	Information on Occupancy/Needs CFR(s): 483.73(c)(7) §403.748(c)(7), §416.54(c)(7), §418.113(c)(7) §441.184(c)(7), §482.15(c)(7), §460.84(c)(7), §483.73(c)(7), §483.475(c)(7), §484.102(c)(6), §485.68(c)(5), §485.68(c)(5), §485.727(c)(5), §485.625(c)(7), §485.920(c)(7), §491.12(c)(5), §494.62(c)(7). [(c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every	E 034		4/15/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495204	A. BUILDING _____ B. WING _____	C 03/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLD DOMINION REHABILITATION AND NURSING	4 RIDGEWOOD PARKWAY 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
E 034	Continued From page 31 2 years [annually for LTC facilities]. The communication plan must include all of the following: (7) [(5) or (6)] A means of providing information about the [facility's] occupancy, needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee. *[For ASCs at 416.54(c)]: (7) A means of providing information about the ASC's needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee. *[For Inpatient Hospice at §418.113(c):] (7) A means of providing information about the hospice's inpatient occupancy, needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility staff failed to have documentation of the facility's communication plan which provides a means of sharing information about the facility's occupancy.. The findings included: During an interview on 03/02/22 at 11:30 A.M. with the Maintenance Director and the Regional Nurse Consultant, the Maintenance Director was asked for documentation of the Emergency Preparedness Communication Plan to provide a means of sharing information about the facility's occupancy.	E 034	1. Documentation about facility□s occupancy needs and its ability to provide assistance has been updated in the EP binder. 2. Any residents in an emergency have the potential to be affected. 3. Administrator (or designee) to discuss change with interdisciplinary team at March QAPI meeting. 4. Maintenance Director will monitor and updated when applicable the documentation on facility occupancy needs, and the ability to provide assistance, weekly for 4 weeks, and monthly for 6 months.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495204	A. BUILDING _____ B. WING _____	C 03/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLD DOMINION REHABILITATION AND NURSING	4 RIDGEWOOD PARKWAY 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
E 034	Continued From page 32 The Maintenance Director and the Regional Nurse Consultant, stated the facility had not updated policies and procedures of the Emergency Preparedness Communication Plan to share information about the facility's occupancy. The documentation presented indicated the Emergency Preparedness Plan had not been updated since 1/30/20. The Plan included the name of a different facility.	E 034		
E 035 SS=C	LTC and ICF/IID Sharing Plan with Patients CFR(s): 483.73(c)(8) §483.73(c)(8); §483.475(c)(8) *[For LTC Facilities at §483.73(c):] [(c) The LTC facility must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually. The communication plan must include all of the following:] *[For ICF/IIDs at §483.475(c):] [(c) The ICF/IID must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years. The communication plan must include all of the following:] (8) A method for sharing information from the emergency plan, that the facility has determined is appropriate, with residents [or clients] and their families or representatives. This REQUIREMENT is not met as evidenced	E 035		4/15/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495204	A. BUILDING _____ B. WING _____	C 03/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLD DOMINION REHABILITATION AND NURSING	4 RIDGEWOOD PARKWAY 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
E 035	Continued From page 33 by: Based on record review and staff interview, the facility staff failed to have documentation of the facility's communication plan which provides a means of sharing information with residents and family's. The findings included: During an interview on 03/02/22 at 11:33 A.M. with the Maintenance Director and the Regional Nurse Consultant, the Maintenance Director was asked for documentation of the Emergency Preparedness Communication Plan to provide a means of sharing information about the facility's Emergency Preparedness Plan with residents and family's. The Maintenance Director and the Regional Nurse Consultant, stated the facility had not updated policies and procedures of the Emergency Preparedness Communication Plan to include sharing information about the facility's Emergency Preparedness Plan with residents and family's. The documentation presented indicated the Emergency Preparedness Plan had not been updated since 1/30/20. The Plan included the name of a different facility.	E 035	1. Policies and procedures sharing plans with patients have been updated and placed in EP binder. 2. All residents that may be relocated during an emergency have the potential to be affected. 3. Resident and responsible parties with receive documentation on emergency preparedness by 4/8/2022 4. Social Services Director or designee will update when applicable, residents and responsible or any updates the emergency preparedness and will discuss and the following QAPI.	
E 036 SS=C	EP Training and Testing CFR(s): 483.73(d) §403.748(d), §416.54(d), §418.113(d), §441.184(d), §460.84(d), §482.15(d), §483.73(d), §483.475(d), §484.102(d), §485.68(d), §485.625(d), §485.727(d), §485.920(d), §486.360(d), §491.12(d), §494.62(d).	E 036		4/15/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495204	A. BUILDING _____ B. WING _____	C 03/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLD DOMINION REHABILITATION AND NURSING	4 RIDGEWOOD PARKWAY 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
E 036	Continued From page 34 *[For RNCHIs at §403.748, ASCs at §416.54, Hospice at §418.113, PRTFs at §441.184, PACE at §460.84, Hospitals at §482.15, HHAs at §484.102, CORFs at §485.68, CAHs at §486.625, "Organizations" under 485.727, CMHCs at §485.920, OPOs at §486.360, and RHC/FHQs at §491.12:] (d) Training and testing. The [facility] must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years. *[For LTC facilities at §483.73(d):] (d) Training and testing. The LTC facility must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually. *[For ICF/IIDs at §483.475(d):] Training and testing. The ICF/IID must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at	E 036		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495204	A. BUILDING _____ B. WING _____	C 03/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLD DOMINION REHABILITATION AND NURSING	4 RIDGEWOOD PARKWAY 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
E 036	Continued From page 35 paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years. The ICF/IID must meet the requirements for evacuation drills and training at §483.470(i). *[For ESRD Facilities at §494.62(d):] Training, testing, and orientation. The dialysis facility must develop and maintain an emergency preparedness training, testing and patient orientation program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training, testing and orientation program must be evaluated and updated at every 2 years. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility staff failed to have documentation of the facility's written training and testing program. The findings included: During an interview on 03/02/22 at 11:35 A.M. with the Maintenance Director and the Regional Nurse Consultant, the Maintenance Director was asked for documentation of the Emergency Preparedness Plan written training and testing program. The Maintenance Director and the Regional Nurse Consultant, stated the facility had not implemented a written training and testing program. The documentation presented indicated the	E 036	1. Emergency Preparedness Training and Testing Program Review was updated in the EP binder. 2. Any residents in the emergency have the potential t be affected. 3. Administrator (or designee) to discuss change with interdisciplinary team at March QAPI meeting. 4. Maintenance Director will monitor and update when applicable the Emergency Preparedness Training and Testing Program, weekly for 4 weeks and monthly for 2 months.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495204	A. BUILDING _____ B. WING _____	C 03/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLD DOMINION REHABILITATION AND NURSING	4 RIDGEWOOD PARKWAY 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
E 036	Continued From page 36 Emergency Preparedness Plan written training and testing program had not been updated and implemented since 2019.	E 036		
E 037 SS=C	EP Training Program CFR(s): 483.73(d)(1) §403.748(d)(1), §416.54(d)(1), §418.113(d)(1), §441.184(d)(1), §460.84(d)(1), §482.15(d)(1), §483.73(d)(1), §483.475(d)(1), §484.102(d)(1), §485.68(d)(1), §485.625(d)(1), §485.727(d)(1), §485.920(d)(1), §486.360(d)(1), §491.12(d)(1). *[For RNCHIs at §403.748, ASCs at §416.54, Hospitals at §482.15, ICF/IIDs at §483.475, HHAs at §484.102, "Organizations" under §485.727, OPOs at §486.360, RHC/FQHCs at §491.12:] (1) Training program. The [facility] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the [facility] must conduct training on the updated policies and procedures. *[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing	E 037		4/15/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495204	A. BUILDING _____ B. WING _____	C 03/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLD DOMINION REHABILITATION AND NURSING	4 RIDGEWOOD PARKWAY 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
E 037	Continued From page 37	E 037		

hospice employees, and individuals providing services under arrangement, consistent with their expected roles.
(ii) Demonstrate staff knowledge of emergency procedures.
(iii) Provide emergency preparedness training at least every 2 years.
(iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the procedures necessary to protect patients and others.
(v) Maintain documentation of all emergency preparedness training.
(vi) If the emergency preparedness policies and procedures are significantly updated, the hospice must conduct training on the updated policies and procedures.

*[For PRTFs at §441.184(d):] (1) Training program. The PRTF must do all of the following:
(i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.
(ii) After initial training, provide emergency preparedness training every 2 years.
(iii) Demonstrate staff knowledge of emergency procedures.
(iv) Maintain documentation of all emergency preparedness training.
(v) If the emergency preparedness policies and procedures are significantly updated, the PRTF must conduct training on the updated policies and procedures.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495204	A. BUILDING _____ B. WING _____	C 03/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLD DOMINION REHABILITATION AND NURSING	4 RIDGEWOOD PARKWAY 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
E 037	Continued From page 38	E 037		

*[For PACE at §460.84(d):] (1) The PACE organization must do all of the following:
(i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, contractors, participants, and volunteers, consistent with their expected roles.
(ii) Provide emergency preparedness training at least every 2 years.
(iii) Demonstrate staff knowledge of emergency procedures, including informing participants of what to do, where to go, and whom to contact in case of an emergency.
(iv) Maintain documentation of all training.
(v) If the emergency preparedness policies and procedures are significantly updated, the PACE must conduct training on the updated policies and procedures.

*[For LTC Facilities at §483.73(d):] (1) Training Program. The LTC facility must do all of the following:
(i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected role.
(ii) Provide emergency preparedness training at least annually.
(iii) Maintain documentation of all emergency preparedness training.
(iv) Demonstrate staff knowledge of emergency procedures.

*[For CORFs at §485.68(d):](1) Training. The CORF must do all of the following:
(i) Provide initial training in emergency preparedness policies and procedures to all new

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495204	A. BUILDING _____ B. WING _____	C 03/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLD DOMINION REHABILITATION AND NURSING	4 RIDGEWOOD PARKWAY 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
E 037	Continued From page 39	E 037		

and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.
(ii) Provide emergency preparedness training at least every 2 years.
(iii) Maintain documentation of the training.
(iv) Demonstrate staff knowledge of emergency procedures. All new personnel must be oriented and assigned specific responsibilities regarding the CORF's emergency plan within 2 weeks of their first workday. The training program must include instruction in the location and use of alarm systems and signals and firefighting equipment.
(v) If the emergency preparedness policies and procedures are significantly updated, the CORF must conduct training on the updated policies and procedures.

*[For CAHs at §485.625(d):] (1) Training program. The CAH must do all of the following:
(i) Initial training in emergency preparedness policies and procedures, including prompt reporting and extinguishing of fires, protection, and where necessary, evacuation of patients, personnel, and guests, fire prevention, and cooperation with firefighting and disaster authorities, to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.
(ii) Provide emergency preparedness training at least every 2 years.
(iii) Maintain documentation of the training.
(iv) Demonstrate staff knowledge of emergency procedures.
(v) If the emergency preparedness policies and procedures are significantly updated, the CAH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495204	A. BUILDING _____ B. WING _____	C 03/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLD DOMINION REHABILITATION AND NURSING	4 RIDGEWOOD PARKWAY 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
E 037	Continued From page 40 must conduct training on the updated policies and procedures. *[For CMHCs at §485.920(d):] (1) Training. The CMHC must provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least every 2 years. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility staff failed to have documentation of the facility's staff receiving annual emergency preparedness training. The findings included: During an interview on 03/02/22 at 11:37 A.M. with the Maintenance Director and the Regional Nurse Consultant, the Maintenance Director was asked for documentation of the staff Emergency Preparedness annual training and testing. The Maintenance Director and the Regional Nurse Consultant, stated the facility had not implemented annual training and testing. The documentation presented indicated the Emergency Preparedness Plan written training and testing program had not been updated and implemented since 2019.	E 037	1. Documentation of Emergency Preparedness Training has been updated in the EP binder. 2. Any residents have the potential to be affected. 3. Administrator (or designee) to discuss change with interdisciplinary team at March QAPI meeting. SDC (or designee) to provide Emergency Preparedness Training. 4. Maintenance Director (or designee) will monitor and update when applicable documentation of Emergency Preparedness Training in the EP binder weekly for 3 weeks, and monthly for 2 months.	
E 039 SS=C	EP Testing Requirements	E 039		4/15/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495204	A. BUILDING _____ B. WING _____	C 03/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLD DOMINION REHABILITATION AND NURSING	4 RIDGEWOOD PARKWAY 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
E 039	Continued From page 41 CFR(s): 483.73(d)(2) §416.54(d)(2), §418.113(d)(2), §441.184(d)(2), §460.84(d)(2), §482.15(d)(2), §483.73(d)(2), §483.475(d)(2), §484.102(d)(2), §485.68(d)(2), §485.625(d)(2), §485.727(d)(2), §485.920(d)(2), §491.12(d)(2), §494.62(d)(2). *[For ASCs at §416.54, CORFs at §485.68, OPO, "Organizations" under §485.727, CMHCs at §485.920, RHCs/FQHCs at §491.12, and ESRD Facilities at §494.62]: (2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following: (i) Participate in a full-scale exercise that is community-based every 2 years; or (A) When a community-based exercise is not accessible, conduct a facility-based functional exercise every 2 years; or (B) If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required community-based or individual, facility-based functional exercise following the onset of the actual event. (ii) Conduct an additional exercise at least every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based functional exercise; or (B) A mock disaster drill; or	E 039		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495204	A. BUILDING _____ B. WING _____	C 03/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLD DOMINION REHABILITATION AND NURSING	4 RIDGEWOOD PARKWAY 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
E 039	Continued From page 42	E 039		

(C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.
(iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed.

*[For Hospices at 418.113(d):]
(2) Testing for hospices that provide care in the patient's home. The hospice must conduct exercises to test the emergency plan at least annually. The hospice must do the following:
(i) Participate in a full-scale exercise that is community based every 2 years; or
(A) When a community based exercise is not accessible, conduct an individual facility based functional exercise every 2 years; or
(B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospital is exempt from engaging in its next required full scale community-based exercise or individual facility-based functional exercise following the onset of the emergency event.
(ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following:
(A) A second full-scale exercise that is community-based or a facility based functional exercise; or
(B) A mock disaster drill; or
(C) A tabletop exercise or workshop that is led by

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495204	A. BUILDING _____ B. WING _____	C 03/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLD DOMINION REHABILITATION AND NURSING	4 RIDGEWOOD PARKWAY 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
E 039	Continued From page 43	E 039		

a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.

(3) Testing for hospices that provide inpatient care directly. The hospice must conduct exercises to test the emergency plan twice per year. The hospice must do the following:
(i) Participate in an annual full-scale exercise that is community-based; or
(A) When a community-based exercise is not accessible, conduct an annual individual facility-based functional exercise; or
(B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospice is exempt from engaging in its next required full-scale community based or facility-based functional exercise following the onset of the emergency event.
(ii) Conduct an additional annual exercise that may include, but is not limited to the following:
(A) A second full-scale exercise that is community-based or a facility based functional exercise; or
(B) A mock disaster drill; or
(C) A tabletop exercise or workshop led by a facilitator that includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.
(iii) Analyze the hospice's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the hospice's emergency plan, as needed.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495204	A. BUILDING _____ B. WING _____	C 03/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLD DOMINION REHABILITATION AND NURSING	4 RIDGEWOOD PARKWAY 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
E 039	Continued From page 44 *[For PRFTs at §441.184(d), Hospitals at §482.15(d), CAHs at §485.625(d):] (2) Testing. The [PRTF, Hospital, CAH] must conduct exercises to test the emergency plan twice per year. The [PRTF, Hospital, CAH] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the [PRTF, Hospital, CAH] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an [additional] annual exercise or and that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the [facility's] emergency plan, as needed.	E 039		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495204	A. BUILDING _____ B. WING _____	C 03/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLD DOMINION REHABILITATION AND NURSING	4 RIDGEWOOD PARKWAY 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
E 039	Continued From page 45 *[For PACE at §460.84(d):] (2) Testing. The PACE organization must conduct exercises to test the emergency plan at least annually. The PACE organization must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the PACE experiences an actual natural or man-made emergency that requires activation of the emergency plan, the PACE is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the PACE's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the PACE's emergency plan, as needed. *[For LTC Facilities at §483.73(d):]	E 039		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495204	A. BUILDING _____ B. WING _____	C 03/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLD DOMINION REHABILITATION AND NURSING	4 RIDGEWOOD PARKWAY 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
E 039	Continued From page 46 (2) The [LTC facility] must conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The [LTC facility, ICF/IID] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise. (B) If the [LTC facility] facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required a full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [LTC facility] facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [LTC facility] facility's emergency plan, as needed. *[For ICF/IIDs at §483.475(d)]: (2) Testing. The ICF/IID must conduct exercises to test the emergency plan at least twice per year. The ICF/IID must do the following:	E 039		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495204	A. BUILDING _____ B. WING _____	C 03/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLD DOMINION REHABILITATION AND NURSING	4 RIDGEWOOD PARKWAY 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
E 039	Continued From page 47 (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or. (B) If the ICF/IID experiences an actual natural or man-made emergency that requires activation of the emergency plan, the ICF/IID is exempt from engaging in its next required full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the ICF/IID's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IID's emergency plan, as needed. *[For HHAs at §484.102] (d)(2) Testing. The HHA must conduct exercises to test the emergency plan at least annually. The HHA must do the following: (i) Participate in a full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise every 2 years;	E 039		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495204	A. BUILDING _____ B. WING _____	C 03/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLD DOMINION REHABILITATION AND NURSING	4 RIDGEWOOD PARKWAY 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
E 039	Continued From page 48	E 039		

or.

(B) If the HHA experiences an actual natural or man-made emergency that requires activation of the emergency plan, the HHA is exempt from engaging in its next required full-scale community-based or individual, facility based functional exercise following the onset of the emergency event.

(ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following:

(A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or

(B) A mock disaster drill; or

(C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.

(iii) Analyze the HHA's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the HHA's emergency plan, as needed.

*[For OPOs at §486.360]

(d)(2) Testing. The OPO must conduct exercises to test the emergency plan. The OPO must do the following:

(i) Conduct a paper-based, tabletop exercise or workshop at least annually. A tabletop exercise is led by a facilitator and includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495204	A. BUILDING _____ B. WING _____	C 03/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLD DOMINION REHABILITATION AND NURSING	4 RIDGEWOOD PARKWAY 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
E 039	Continued From page 49 statements, directed messages, or prepared questions designed to challenge an emergency plan. If the OPO experiences an actual natural or man-made emergency that requires activation of the emergency plan, the OPO is exempt from engaging in its next required testing exercise following the onset of the emergency event. (ii) Analyze the OPO's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed. *[RNCHIs at §403.748]: (d)(2) Testing. The RNHCI must conduct exercises to test the emergency plan. The RNHCI must do the following: (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (ii) Analyze the RNHCI's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the RNHCI's emergency plan, as needed. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility staff failed to have documentation of an annual full scale community based emergency exercise. The findings included: During an interview on 03/02/22 at 11:39 A.M. with the Maintenance Director and the Regional Nurse Consultant, the Maintenance Director was	E 039	1. Documentation of EP Testing Requirements has been updated in the EP binder. 2. All residents have potential to be affected. 3. Administrator or designee to discuss change with interdisciplinary team at following QAPI meeting. Interdisciplinary team to analyze results of emergency preparedness exercise.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495204	A. BUILDING _____ B. WING _____	C 03/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLD DOMINION REHABILITATION AND NURSING	4 RIDGEWOOD PARKWAY 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
E 039	Continued From page 50 asked for documentation of the facility's annual community based Emergency Preparedness exercise. The Maintenance Director and the Regional Nurse Consultant, stated the facility had not conducted nor participated in a community based emergency exercise. The documentation presented indicated the community Emergency Preparedness exercise was last updated on 10/2020.	E 039	4. Maintenance Director or designee will monitor and update when applicable documentation of EP testing requirements in the EP binder weekly for 3 weeks, and monthly for six months.	
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 02/28/22 through 03/03/22. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. Five complaints were investigated during the survey: VA00053939-Substantiated (Sub) without deficiency; VA00050348-Sub without deficiency; VA00051001-Sub without deficiency; VA00049040-Sub without deficiency; VA00051577-Sub with deficiency. The census in this 115 certified bed facility was 65 at the time of the survey. The survey sample consisted of 35 current and closed resident/record reviews.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and	F 550		4/15/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495204	A. BUILDING _____ B. WING _____	C 03/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLD DOMINION REHABILITATION AND NURSING	4 RIDGEWOOD PARKWAY 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 550	Continued From page 51	F 550		

access to persons and services inside and outside the facility, including those specified in this section.

§483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident.

§483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source.

§483.10(b) Exercise of Rights.
The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.

§483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.

§483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart.
This REQUIREMENT is not met as evidenced by:
Based on observation, resident interview and

1) No immediate correction can be

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495204	A. BUILDING _____ B. WING _____	C 03/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLD DOMINION REHABILITATION AND NURSING	4 RIDGEWOOD PARKWAY 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 550	Continued From page 52 staff interview, the facility's staff failed to ensure 1 resident was treated with dignity and respect while receiving wound care. For 1 of 35 Residents (Resident #22), in the survey sample. The findings included: Resident #22 was originally admitted to the facility on 11/21/2020 after an acute care hospital stay and readmitted on 12/29/21. The current diagnoses included; Type 2 Diabetes Mellitus with Diabetic Chronic Kidney Disease and Pressure Ulcer of the Sacral Region. The quarterly-5 day, Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 12/17/2021 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 15 out of a possible 15. This indicated Resident #22 cognitive abilities for daily decision making were intact. In section"G"(Physical functioning) the resident was coded as requiring extensive assistance of two persons with bed mobility. Extensive assistance of one person physical assist with dressing, eating and personal hygiene. Requiring total dependence od one person with toilet use and bathing. In section "M" (M0100. Determination of Pressure Ulcer/Injury Risk) the resident was coded as having one stage 4 pressure ulcer on admission. The care plan date 12/11/21 reads: FOCUS: I am at risk for skin breakdown r/t decreased mobility. Resident refuses to be turned and repositioning. Resident refused baths and hygiene care at times. The Goals: The resident will have intact	F 550	completed for this area. 2) All residents who receive wound care treatment are at risk. 3) Nursing facility and agency staff members were educated resident rights including wound care dressing changes on 3-17-2022 4) DON or designee will audit 10% of wound care treatment procedures for 8 weeks to ensure labeling of wound care dressing occurs prior to applying it on resident. 5) Results of these audits will be reported to the QAPI committee for oversight and any recommended changes.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495204	A. BUILDING _____ B. WING _____	C 03/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLD DOMINION REHABILITATION AND NURSING	4 RIDGEWOOD PARKWAY 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 550	Continued From page 53 skin, free of redness, blisters or discoloration by/through review date. Interventions: Monitor/document/report to MD PRN (as needed) changes in skin status: appearance, color, wound healing, s/sx (signs/symptoms) of infection. Preventive skin care: Apply Baza to Sacrum every shift and prn every shift. The resident needs assistance to turn/reposition frequently while in bed, more often as needed or requested. The TAR (Treatment Administration Record) reads: Sacral ulcer: cleanse with dermal wound cleanser. place iodosorb gel inside wound bed. Cover with foam dressing. change m-w-f and prn if it comes off every day shift every Mon, Wed, Fri -Start Date 01/19/2022 7:00 AM. On 03/02/22 at approximately 11:19 AM., RN (Registered Nurse) #2 was observed labeling a wound dressing after placing the dressing on Resident #22's sacrum. On 03/03/22 at approximately, 11:45 AM., RN #2 was approached concerning the above wound care. She stated, "I shouldn't have written on the dressing after it was placed on the resident because I could have punctured the dressing contaminating her wound." The above findings were shared with the Administrator and Director of Nursing on 3/03/2022 at approximately 9:00 PM. No comments were voiced.	F 550		
F 557 SS=D	Respect, Dignity/Right to have Prsnl Property CFR(s): 483.10(e)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect	F 557		4/15/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495204	A. BUILDING _____ B. WING _____	C 03/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLD DOMINION REHABILITATION AND NURSING	4 RIDGEWOOD PARKWAY 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 557	Continued From page 54 and dignity, including: §483.10(e)(2) The right to retain and use personal possessions, including furnishings, and clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other residents. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview and staff interview and during the course of a complaint investigation, the facility's staff failed to ensure privacy while providing wound care for 1 of 35 residents (Resident #31) in the survey sample. The findings included: Resident #31 was originally admitted to the facility 08/16/19 after an acute care hospital stay. The resident has never been discharged from the facility. The current diagnoses included; Infection and Inflammatory Reaction due to other internal joint prosthesis and Osteoarthritis, Right Knee. The quarterly revision, Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 12/23/2021 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 15 out of a possible 15. This indicated Resident #31 cognitive abilities for daily decision making were intact. In section"G"(Physical functioning) the resident was coded as requiring extensive assistance of two persons with bed mobility, dressing and locomotion on the unit. Requires total dependence of two person with transfers. Requires total dependence of one person with	F 557	1) Resident #31 was informed of her rights on 3-31-22. 2) Residents receiving wound care are at risk of being exposed for treatment and not receiving privacy. 3) Staff education was provided on resident rights, to include dignity and privacy during care on 3-17-22. 4) The SW or designee will review 10% of residents receiving wound care weekly x 8 weeks for any concerns with dignity or privacy. Results of these audits will be reported to the QAPI committee for oversight and any recommended changes.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495204	A. BUILDING _____ B. WING _____	C 03/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLD DOMINION REHABILITATION AND NURSING	4 RIDGEWOOD PARKWAY 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 557	Continued From page 55	F 557		

personal hygiene and bathing. Independent with eating, set-up help only.

In section "M" (M1040. Other Ulcers, Wounds and Skin Problems) Coded resident as having surgical wounds requiring wound care.

The TAR (Treatment Administration Record) reads: Left superior and inferior knee wounds: pack loosely with gauze that is moistened with 0.125% dakins. cover with DSD (Dressing). change DAILY every day shift -Start Date 02/08/2022 7:00 AM.

The Care Plan dated: 12/23/21 reads: FOCUS: The resident has a chronic Lt knee wound. GOAL: The resident will have no complications r/t Lt (left) knee wound through the review date. INTERVENTIONS: Encourage good nutrition and hydration in order to promote healthier skin.
LEFT KNEE: Cleanse area with ns (normal saline), apply Aquacel AG, apply dry dressing every other day and prn (as needed) for Wound drainage.

On 03/01/22 at approximately 2:10 PM surveyor noticed a saturated dressing in the facility hallway. Shortly, thereafter LPN (Licensed Practical Nurse) #5 was noticed picking the dressing up. She stated, "I'm gonna replace the dressing." It fell off Resident #31's leg. A wound care observation was made after receiving the resident's permission. Throughout wound care the resident's door remained opened as well as the privacy curtain. When the LPN stated that she was done with the wound care she was asked to turn around and look towards the door by the surveyor. The surveyor ask LPN #5 what should have been done before performing the wound

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495204	A. BUILDING _____ B. WING _____	C 03/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLD DOMINION REHABILITATION AND NURSING	4 RIDGEWOOD PARKWAY 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 557	Continued From page 56 care. She stated, "I should have closed the door to provide dignity and privacy." The above findings were shared with the Administrator and Director of Nursing on 3/03/2022 at approximately 9:00 PM. No comments were voiced.	F 557		
F 567 SS=D	Protection/Management of Personal Funds CFR(s): 483.10(f)(10(i)(ii) §483.10(f)(10) The resident has a right to manage his or her financial affairs. This includes the right to know, in advance, what charges a facility may impose against a resident's personal funds. (i) The facility must not require residents to deposit their personal funds with the facility. If a resident chooses to deposit personal funds with the facility, upon written authorization of a resident, the facility must act as a fiduciary of the resident's funds and hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in this section. (ii) Deposit of Funds. (A) In general: Except as set out in paragraph (f)(l0)(ii)(B) of this section, the facility must deposit any residents' personal funds in excess of $100 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain a resident's personal funds that do not exceed $100 in a non-interest bearing account, interest-bearing account, or petty cash fund. (B) Residents whose care is funded by Medicaid:	F 567		4/15/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495204	A. BUILDING _____ B. WING _____	C 03/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLD DOMINION REHABILITATION AND NURSING	4 RIDGEWOOD PARKWAY 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 567	Continued From page 57 The facility must deposit the residents' personal funds in excess of $50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain personal funds that do not exceed $50 in a noninterest bearing account, interest-bearing account, or petty cash fund. This REQUIREMENT is not met as evidenced by: Based on a resident personal funds review, resident interview, staff interview and facility document review the facility staff failed to ensure that 1 resident out of 35 residents, (Resident #14) in the survey sample was afforded the right to manage their personal funds. The findings included; Resident #14 was originally admitted to the facility 08/28/2020 and readmitted 02/15/2021 after an acute care hospital stay. The resident has never been discharged from the facility. The current diagnoses included; Acute Kidney Failure, Unspecified and Essential Hypertension. The quarterly, Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 02/16/2022 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 14 out of a possible 15. This indicated Resident #14 cognitive abilities for daily decision making were intact. On 03/01/22 at approximately 11:36 AM., during the initial tour Resident #14 was asked by the surveyor if she had any concerns. She stated, "I	F 567	1) Resident #14 was informed of personal funds availability daily (to include weekends) during hours of 1pm □ 430pm at front desk in facility lobby on 4-1-22. 2) All residents with personal funds within nursing facility are at risk of not having daily access to personal funds. 3) Residents/RPs have received information regarding the schedule and location for residents to obtain their personal funds on 4-8-22. 4) The Administrator or designee will inquire with 4 residents weekly x 8 weeks for any concerns with obtaining personal funds. Results of these audits will be reported to the QAPI committee for oversight and any recommended changes.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495204	A. BUILDING _____ B. WING _____	C 03/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLD DOMINION REHABILITATION AND NURSING	4 RIDGEWOOD PARKWAY 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 567	Continued From page 58	F 567		

get $30 a month but haven't receive my money in 4 months

On 03/03/22 at approximately 2:46 PM., an interview was conducted with OSM (Other Staff Member) #1, Social Worker #1, concerning resident #14 personal funds. She stated, "When the BOM (Business Office Manager) left in October. She left only $200 in petty cash. Residents have to ask for their money. BOM left the end of October. When the other company took over in December I was still trying to help out. They didn't have a bank for resident funds. Now we deal with a bank. A corporate staff member is still listed on the bank of bank account. I deposited a $50,000.00 check into the account last week. Some residents have a high amount in their account. Resident #14 has $700 but room and board has not been taken out. The previous company AX GLOBAL SOLUTIONS has to transfer the funds from the Atlantic Union Bank to Metropolitan Bank. We deposit resident's room and board into the Metropolitan bank."

On 03/03/22 at approximately 5:44 PM an interview was conducted with OSM (Other Staff Member) #1 concerning the above issues. She stated, on nights and weekends we don't have anyone to give out money. Monday through Thursday from 8:30 AM-5:00 PM are our hours. We have to get straight about weekends including Fridays. I'm not here on Fridays and don't have access to the safe Resident #14 account was reviewed with OSM #1. It showed a balance of $701.18 with a transfer of $30.00 into resident's account for spending.

The above findings were shared with the Administrator and Director of Nursing on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495204	A. BUILDING _____ B. WING _____	C 03/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLD DOMINION REHABILITATION AND NURSING	4 RIDGEWOOD PARKWAY 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 567	Continued From page 59 3/03/2022 at approximately 9:00 PM. No comments were voiced.	F 567		
F 568 SS=D	Accounting and Records of Personal Funds CFR(s): 483.10(f)(10)(iii) §483.10(f)(10)(iii) Accounting and Records. (A) The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf. (B) The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident. (C)The individual financial record must be available to the resident through quarterly statements and upon request. This REQUIREMENT is not met as evidenced by: Based on a resident personal funds review, resident interview, staff interview and facility document review the facility staff failed to ensure that 1 resident out of 35 residents (Resident #14) in the survey sample was afforded the right to manage their personal funds. The findings included; Resident #14 was originally admitted to the facility 08/28/2020 and readmitted 02/15/2021 after an acute care hospital stay. The resident has never been discharged from the facility. The current diagnoses included; Acute Kidney Failure, Unspecified and Essential Hypertension. The quarterly, Minimum Data Set (MDS) assessment with an assessment reference date	F 568	1) Resident #14 was informed of personal funds availability daily (to include weekends) during hours of 1pm □ 430pm at front desk in facility lobby on 4-1-22. 2) All residents with personal funds within nursing facility are at risk of not having access to personal funds daily. 3) Residents/RPs have received information regarding the schedule and location for residents to obtain their personal funds on 4-8-22. 4) The Administrator or designee will inquire with 4 residents weekly x 8 weeks for any concerns with obtaining personal funds. Results of these audits will be reported to the QAPI committee for	4/15/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495204	A. BUILDING _____ B. WING _____	C 03/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLD DOMINION REHABILITATION AND NURSING	4 RIDGEWOOD PARKWAY 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 568	Continued From page 60 (ARD) of 02/16/2022 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 14 out of a possible 15. This indicated Resident #14 cognitive abilities for daily decision making were intact. On 03/01/22 at approximately 11:36 AM., during the initial tour Resident #14 was asked by the surveyor if she had any concerns. She stated, "I get $30 a month but haven't receive my money in 4 months. I don't receive quarterly statements either." On 03/03/22 at approximately 2:46 PM., an interview was conducted with OSM (Other Staff Member) #1, Social Worker #1, concerning resident #14 quarterly statements. She stated, When the BOM (Business Office Manager) left in October. She left only $200 in petty cash. Residents have to ask for their money. BOM left the end of October. When the other company took over in December I was still trying to help out. They didn't have a bank for resident funds. Now we deal with a bank. A corporate staff member is still listed on the bank account. Resident's should receive their quarterly statements, but they had no money in their accounts until last week. I will email the finance people about the quarterly statements at AX Global Solutions)." The above findings were shared with the Administrator and Director of Nursing on 3/03/2022 at approximately 9:00 PM. No comments were voiced.	F 568	oversight and any recommended changes.	
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v)	F 578		4/15/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495204	A. BUILDING _____ B. WING _____	C 03/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLD DOMINION REHABILITATION AND NURSING	4 RIDGEWOOD PARKWAY 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 578	Continued From page 61	F 578		

§483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495204	A. BUILDING _____ B. WING _____	C 03/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLD DOMINION REHABILITATION AND NURSING	4 RIDGEWOOD PARKWAY 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 578	Continued From page 62 appropriate time. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interviews, clinical record reviews and facility documentation review, the facility staff failed to ensure 2 of 35 residents in the survey sample, (Resident #55 and #3) were given the opportunity to formulate an advance directive. The findings included: The facility staff failed to ensure Resident #55 was given the opportunity to formulate an Advance Directive. Resident #55 was originally admitted to the nursing facility on 09/01/20. Diagnosis for Resident #55 included but not limited to Chronic Obstructive Pulmonary Disease (COPD). The current Minimum Data Set (MDS) a quarterly assessment with an Assessment Reference Date (ARD) of 02/09/22 coded the resident with a 15 of a total possible score of 15 on the Brief Interview for Mental Status (BIMS), indicating no cognitive impairment. Review of the clinical record revealed that there was no advance directive for Resident #55. Review of Resident #55's Physician Order Sheet (POS) for March 2022 revealed the following order: Full Code (starting on 09/01/20). On 03/01/22 at approximately 12:16 p.m., an interview was conducted with Resident #55 who stated, "I do not remember anyone here at this facility ever speaking to me about an advance directive.	F 578	1) Resident #55 was offered and completed an Advanced Directive on 3-2-22. Resident #3 was offered and completed an Advanced Directive on 3-21-22. 2) All residents are at risk if their wishes for end-of-life care are not followed. A 100% audit was conducted to see if any other residents would like to develop an Advanced Directive. 3) The SW was educated on elements of F578 and contents of the SW assessment to include formulation of an Advanced Directive on 3-31-22. 4) The SW will audit 100% new admits weekly X 8 weeks to assure residents have been offered an opportunity to develop an Advanced Directive. Results of this audit will be presented to the QAPI committee for additional oversight and recommendations.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495204	A. BUILDING _____ B. WING _____	C 03/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLD DOMINION REHABILITATION AND NURSING	4 RIDGEWOOD PARKWAY 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 578	Continued From page 63	F 578		

An interview was conducted with the Social Worker #1 on 03/02/22 at approximately 12:17 p.m. The Social Worker said there was a tab in Point Click Care (PCC) titled Social History where the Advance Directive were stored but that tab is no longer there. She said under the social history tab is where we discussed if the resident had interest or not to have an advance directive. When asked if there were evidence that a discussion was ever had with Resident #55 if he was given the opportunity to formulate an advance directive, she replied, "No."

On 03/02/22 at approximately 4:10 p.m., the surveyor was given a document titled: Virginia Advance Medical Directive. The document was signed by Resident #55 and the Social Worker on 03/02/22. The document contained the following information: I donate my organs, eyes and tissues for use of transplantation, therapy, research and education.

A briefing was held with the Administrator, Director of Nursing and Cooperate support on 03/03/22 at approximately 3:00 p.m., who stated, "An Advance Directive should have been discussed upon admission with Resident #55 by the Social Worker who should have document the conversation regarding the advance directive in the resident's clinical record.

Definitions:
-COPD is a chronic inflammatory lung disease that causes obstructed airflow from the lungs. Symptoms include breathing difficulty, cough, mucus (sputum) production and wheezing (https://www.mayoclinic.org/diseases-conditions/copd/symptoms-causes).

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495204	A. BUILDING _____ B. WING _____	C 03/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLD DOMINION REHABILITATION AND NURSING	4 RIDGEWOOD PARKWAY 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 578	Continued From page 64	F 578		

2. The facility staff failed to ensure Resident #3 was given the opportunity to formulate an Advance Directive upon admission.

Resident #3 was originally admitted on 7/23/19 and readmitted on 11/29/2021 with diagnoses to include but not limited to Left Hemiparesis, Bipolar Disorder and Muscle Weakness.

Resident #3's most recent Minimum Data Set (MDS) was a quarterly assessment with an Assessment Reference Date (ARD) of 12/2/21. The Brief Interview for Mental Status (BIMS) was coded as 15 out of a possible 15, indicating the resident was cognitively intact and capable of daily decision making.

Resident #3's medical record was reviewed and there was no advance directive document located.

Resident #3's current comprehensive care plan was review and is documented in part, as follows:

Focus: My Code Status is: FULL CODE
Date Initiated: 7/31/2019

Resident #3's current Physician Orders were reviewed and are documented in part, as follows:

Full Code. Order Status: Active Order Date: 8/3/21

On 3/2/22 at 12:55 p.m. an interview was conducted with Resident #3. Resident #3 was asked if the facility had ever asked him if he had an advance directive or wanted help making one. Resident #3 stated, "I don't have an advance directive and nobody has every asked me if I

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495204	A. BUILDING _____ B. WING _____	C 03/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLD DOMINION REHABILITATION AND NURSING	4 RIDGEWOOD PARKWAY 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 578	Continued From page 65	F 578		

wanted to make one. They just asked if I wanted CPR (cardiopulmonary resuscitation)."

On 3/3/22 at 3:24 p.m. an interview was conducted with the facility Social Worker #2 regarding Resident #3's Advance Directive. The Social Worker #2 stated, "We don't have an advance directive for Name (Resident #3). He was admitted in 2019, so that should have been done upon admission and he wasn't asked. There is no advance directive in his medical record. On admission if the resident has an advance directive we ask for the document and upload it into the medical record. If the resident doesn't have one, we ask them if we can help them formulate one upon admission. I wasn't told until this week that the advance directive need to be done on admission."

The facility policy titled "Advance Directives" last revised 10/1/21 was reviewed and is documented in part, as follows:

Policy: It is the policy of this facility to support and facilitate a resident's right to request, refuse and/or discontinue medical or surgical treatment and to formulate an advance directive.

Policy Explanation and Compliance Guidelines:
1. On admission, the facility will determine if the resident has executed an advance directive, and if not determine whether the resident would like to formulate an advance directive.

On 3/3/22 at 4:30 p.m. a pre-exit debriefing was held with the Administrator, the Director of Nursing and the Regional Director of Clinical Services were the above findings were shared. The Administrator was asked what are the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495204	A. BUILDING _____ B. WING _____	C 03/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLD DOMINION REHABILITATION AND NURSING	4 RIDGEWOOD PARKWAY 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 578	Continued From page 66 expectations in regards to advance directives. The Administrator stated, "My expectation is that Social Services will find out if the resident has an advance directive and if they don't they will offer to formulate one upon admission and document the conservation" Prior to exit no further information was provided.	F 578		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any,	F 580		4/15/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495204	A. BUILDING _____ B. WING _____	C 03/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLD DOMINION REHABILITATION AND NURSING	4 RIDGEWOOD PARKWAY 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 580	Continued From page 67 when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review; the facility staff failed to ensure the physician and resident representative were informed the medication (Zyprexa) was not decreased from 5 mg to 2.5 mg as ordered for 1 of 35 residents (Resident #30), and the facility staff failed to notify the resident representative and physician of a change in condition in a timely manner for 1 of 35 residents (Resident #316), in the survey sample. The Findings Included: 1. The facility staff failed to notify the physician/Nurse Practitioner (NP) and Resident Representative (RR) that Resident #30's psychotropic medication (Zyprexa 5 mg) was not	F 580	1) The physician was notified of a recommendation for a gradual dose reduction of an antipsychotic medication that was not initiated on resident #30 on 3-25-22. No immediate correction can be initiated on resident #316 regarding condition status change since she is discharged. 2) All residents have the potential to be affected if changes are not reported timely to the physician. 3) Direct care staff were educated on 3-17-22 regarding the requirement to notify the MD when changes occur, including examples of changes. The policy on Notification of Changes was reviewed and updated on 3-10-2022 to	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495204	A. BUILDING _____ B. WING _____	C 03/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLD DOMINION REHABILITATION AND NURSING	4 RIDGEWOOD PARKWAY 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 580	Continued From page 68 decreased to 2.5 mg as recommended by the (NP) on 01/20/22. Resident #30 received 41 extra doses of the psychotropic medication Zyprexa. Resident #30 was admitted to the facility on 08/23/17. Diagnosis for Resident #30 included but not limited to Dementia with behavioral disturbance. Resident #30's Minimum Data Set (MDS), a quarterly Assessment Reference Date (ARD) of 12/23/21 scored a 99 indicating short and long term memory problems and with severe cognitive impairment - never/rarely made decisions. The MDS coded Resident #30 requiring total dependence of two with transfer, total dependence of one with dressing, eating, toilet use, personal hygiene and bathing and extensive assistance of one with bed mobility for Activities of Daily Living (ADL) care. Resident #30's comprehensive care plan documented with a revision date of 05/12/21 identified Resident #30 is on an antipsychotic medication (Zyprexa) related to dementia with behaviors. The goal set for the resident by the staff is to remain free of drug related complications or cognitive/behavioral impairment. Some of the interventions/approaches the staff would use to accomplish this goal is to administer medication as ordered (monitor/document for side effects and effectiveness) and consult with pharmacy, MD to consider dose reduction when clinically appropriate. On 01/20/22, a progress note entered by (NP) #1 revealed the following information: "Resident #30 is being seen today for follow up gradual dose	F 580	include additional examples of clinical changes that require MD notification. 4) The DON or designee will conduct 3 chart reviews weekly X 8 weeks to assure changes have been communicated to physician. Results of these audits will be presented to the QAPI committee for additional oversight and recommendations.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495204	A. BUILDING _____ B. WING _____	C 03/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLD DOMINION REHABILITATION AND NURSING	4 RIDGEWOOD PARKWAY 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 580	Continued From page 69	F 580		

reduction (GDR). Resident #30 is seen in her room in no distress. The nurse does not report any agitation, anxiety, insomnia, depression or psychotic process and has been tolerating her (GDR) without any worsening of symptoms. Resident is currently taking Zyprexa 2.5 mg in the morning and 5 mg at bedtime. The recommendation is to decrease Zyprexa to 2.5 mg in the evening."

The physician Order Sheet (POS) for March 2022 included the following order:
Zyprexa 5 mg tablet by mouth daily in the evening at 6:00 p.m., for agitation.

1. Review of January 2022 Medication Administration Record (MAR) revealed Zyprexa 5 mg was administered 01/21/22 - 01/31/22.

2. Review of February 2022 Medication Administration Record (MAR) revealed Zyprexa 5 mg was administered 02/01/22 - 02/28/22.

3. Review of March 2022 Medication Administration Record (MAR) revealed Zyprexa 5 mg was administered 03/01/22 - 03/03/22.

Review of Resident #30's clinical record did not indicate that the physician/NP or Resident #30's representative were notified the medication Zyprexa 5 mg was not decreased to 2.5 mg every evening as recommended by the (NP) on 01/20/22.

A briefing was held with the Administrator, Director of Nursing and Corporate support on 03/03/22 at approximately 3:00 p.m. A copy of the (NP's) progress note dated 01/20/22 and the Resident #30's MAR's from 01/22 - 03/22 were

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495204	A. BUILDING _____ B. WING _____	C 03/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLD DOMINION REHABILITATION AND NURSING	4 RIDGEWOOD PARKWAY 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 580	Continued From page 70	F 580		

reviewed with the Administration team.

The administration team reviewed the provided documents and the resident's clinical note for the notification to physician/Nurse Practitioner (NP) and Resident Representative (RR) but was unable to locate documentation the physician/Nurse Practitioner (NP) and Resident Representative (RR) were notified about the above findings.

Definitions:
-Zyprexa is used to treat the symptoms of schizophrenia (a mental illness that causes disturbed or unusual thinking, loss of interest in life, and strong or inappropriate emotions) (https://medlineplus.gov/drug).

-Dementia with behavioral disturbances is frequently the most challenging manifestations of dementia and are exhibited in almost all people with dementia (https://www.ncbi.nlm.nih.gov/pubmed/22644311) .

2. Resident #316 was admitted to the facility on 1/27/20 and discharged on 9/28/21 to an acute care facility. Diagnosis for Resident #316 included but not limited to COVID-19 and Difficulty in walking.

Quarterly-5 day, Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 9/01/21 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 10 out of a possible 15. This indicated Resident #316 cognitive abilities for daily decision making were moderately impaired.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495204	A. BUILDING _____ B. WING _____	C 03/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLD DOMINION REHABILITATION AND NURSING	4 RIDGEWOOD PARKWAY 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 580	Continued From page 71	F 580		

In section"G"(Physical functioning) the resident was coded as requiring extensive assistance of two persons with bed mobility and toilet use. Requiring extensive assistance of one person with dressing, personal hygiene and eating. Requiring limited assistance of one person with transfers. Requires total dependence with bathing.

The care plan dated 8/26/21 reads: Focus: The resident has an ADL (Activity of Daily Living) Self Care Performance Deficit r/t debility. Goal: The resident will maintain current level of function in ADL scores through the review date. Intervention: BATHING: The resident requires total help of 1 staff participation with bathing.

The care plan dated 8/26/21 reads: Focus: The resident has bladder incontinence r/t debility, impaired vision. Goals: The resident will remain free from skin breakdown due to incontinence and brief use through the review date. Interventions: Ensure the resident has unobstructed path to the bathroom. Monitor/document for s/sx UTI: pain, burning, blood tinged urine, cloudiness, no output, deepening of urine color, increased pulse,increased temp, Urinary frequency, foul smelling urine, fever, chills, altered mental status, change in behavior, change in eating patterns. Resident is able to call with incontinent episodes. Staff to assist to wash, rinse and dry perineum. Change clothing PRN (as needed) after incontinence episodes.

A review of the facility einteract change in condition (CIC) assessment reads: Altered Mental status since this morning. The report shows that vital signs are stable but resident

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495204	A. BUILDING _____ B. WING _____	C 03/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLD DOMINION REHABILITATION AND NURSING	4 RIDGEWOOD PARKWAY 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 580	Continued From page 72	F 580		

appears unresponsive. Clinician and family member not notified until midnight of CIC.

A review of progress notes reveal: On 9/28/2021 at 3:58 PM., Pt (Patient) would not take her medication this morning at 9:00 AM., Asked the Aide if she ate breakfast and they advised me no. Pt would not wake up and would groan when asked a question. O2 (Oxygen) was not on pt, was replaced. Vitals stable. Pt did the same thing last week and by noon pt was responsive. Went back in there and still not responsive. Took vitals again and still stable. Advised the DON (Director of Nursing) of the change of condition to see what the next steps should be and she advised me that the NP (Nurse Practitioner) would be in to let her know. This was at noon.

A review of progress notes on 9/28/2021 at 4:00 AM., reads: Late Entry: Pt left via stretcher with 911 at 4:00 PM. Order was given by the NP (Nurse Practitioner) to send her out for AMS (Altered Mental Status). Pt left and daughter got her purse.

A review of the e-interact transfer assessment dated 9/28/21 reads: Mental and Mobility status: Not alert. ambulates by wheelchair. Emergency contact notified of transfer. Report called in on 9/28/21 at 12 Midnight.

A review of the Hospital admission notes read: Resident #316 admitted to the ER (Emergency Room) with stroke like symptoms. Patient last known normal was 8:00 AM., this morning. Patient is able to move her right sided extremities but flaccid on her left side. The nursing home states she's less responsive today. Physical Exam: Decrease Responsiveness. Does not

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495204	A. BUILDING _____ B. WING _____	C 03/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLD DOMINION REHABILITATION AND NURSING	4 RIDGEWOOD PARKWAY 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 580	Continued From page 73 open eyes on command. Findings: acute subacute infarct involving the frontal lobe. Date of Death was 10/13/21. Acute cause of death was CVA (Cerebral Vascular Accident). On 3/03/22 at approximately, 11:50 AM., an interview was conducted with RN (Registered Nurse) #1 concerning the above allegations. She stated, "I interacted with the family often. I wasn't working here when she was sent out to the hospital. On 3/01/22 at approximately 12:15 PM an interview was conducted with LPN (Licensed Practical Nurse) #5 concerning the above allegations. She stated, " Resident #316 was very mild spoken, likes to participate in activities. She required more assistance because she came off the COVID-19 unit. She was also legally blind. I float throughout the building. She went to the hospital for a change in condition. " Interviews were attempted throughout the survey but staff either denied knowing Resident #316 or stated that they were agency staff and just started working in the facility. The above findings were shared with the Administrator and Director of Nursing on 3/03/2022 at approximately 9:00 PM. No comments were voiced.	F 580		
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including	F 584		4/15/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495204	A. BUILDING _____ B. WING _____	C 03/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLD DOMINION REHABILITATION AND NURSING	4 RIDGEWOOD PARKWAY 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 584	Continued From page 74 but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, and staff interview the	F 584	1) The maintenance staff member fixed	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495204	A. BUILDING _____ B. WING _____	C 03/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLD DOMINION REHABILITATION AND NURSING	4 RIDGEWOOD PARKWAY 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 584	Continued From page 75 facility staff failed to ensure resident rooms were maintained in a safe comfortable and homelike environment. The findings included: Observations made on 03/03/22 at 10:43 a.m. with the Administrator and Maintenance Director, indicated in room 19 bed -A a hole was observed in the wall at the head of the bed. The hole was estimated to be 8 inches wide and 14 inches long. The hole was observed to go through the wall. In room 19 bed -B, the wall was noted to have scrapes and paint chips. In room 35 the ceiling titles in front of the bathroom were observed to have water stains and black mold like substance. In room 55 bed A wall socket covering was noted to have exposed electrical outlets. The ceiling title was observed to be not affixed at the back exit door of the Bernadine Unit were rooms 52 through 58 are located. In room 56 the window blinds were observed to be bent, the walls were observed to have scraps and paint chips. The heat and air unit vent covering was observed to be missing. In room 58 the walls were observed to have scraps and paint chips. The sink left corner laminate covering was observed to have a large 3 inch by 4 inch broken area. In the hallway of the Bernadine Unit in front of room 58 the floor tiles were observed to have a 3 inch by 2 inch broken title area. During observation of the outside loading area on 3/2/22 at 1:45 P.M., the outside area was observed to have 17 pallets cluttered in various areas of the loading area and next to the trash	F 584	hole in wall, patched paint on wall after removing paint chips, removed and replaced ceiling tiles, replaced bent window blind, replaced missing heat/air vent cover on 3-11-22. Repair of kitchen laminate and broken floor tiles completed 4-1-22. Over-flowing garbage removed on 3-4-22. 2) Dir Maintenance will perform walking rounds on 100% of facility (indoor and outdoor) and communicate environment needs to administrator. 3) Dir Maintenance was educated on ensuring facility was clean and in good repair on 3-3-2022. 4) 100% grounds audit on facility indoors and outdoors for 6 weeks. Results of audit will be forwarded to QAPI for oversight and any additional recommendations.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495204	A. BUILDING _____ B. WING _____	C 03/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLD DOMINION REHABILITATION AND NURSING	4 RIDGEWOOD PARKWAY 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 584	Continued From page 76 dumpsters. The outside loading areas was observed to have tree leaves, paper, and debris. Three wheelchairs in disrepair were observed in the area. A food loading cart with wheels missing was observed to be in the loading area. Two closed fenced areas measuring approximately five feet wide, five feet long and six feet high were observed to have over flowing soiled Bio-hazard bags. The bags numbered over a hundred. During an interview at 10: 55 a.m. on 3/3/22 with the Administrator she stated, the Bio-Hazard bags should have been picked up at the beginning of the week. During an interview with the Administrator she stated the facility did not have an environmental policy and that the Maintenance Director would take care of the areas as soon as possible.	F 584		
F 607 SS=E	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(3) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by:	F 607		4/15/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495204	A. BUILDING _____ B. WING _____	C 03/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLD DOMINION REHABILITATION AND NURSING	4 RIDGEWOOD PARKWAY 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 607	Continued From page 77 Based on review of facility documents, staff interview and the facility's policy; the facility staff failed to implement their abuse policy regarding the screening of employees for 25 of 25 employee records reviewed. The findings included: On 3/1/22, a list of twenty-five employee names was provided to the Administrator to obtain information regarding their attestation/sworn statement, reference checks and obtaining a criminal background check and certification/licensure if applicable. Review of twenty-five employee records revealed the following; The facility staff failed to obtain a criminal background check within 30 days of hire for twenty-three Employees. The Criminal background check request for the twenty-three employees were obtained on 3/2/22 from the Central Criminal Records Exchange of the Virginia State Police. One of the employee criminal background check provided wasn't for an employee of the facility. It was for a person with a similar name. The facility staff failed to verify that the certification of four Certified Nursing Assistants was active and in good standing and to the facility staff failed verify professional license for one Physical Therapist Assistant, one Occupational Therapist, two Certified Occupational Assistant, two Licensed Practical Nurse (LPN) and three Registered Nurse was active and in good standing prior to allowing them to provide resident care within the facility. One of the LPN license	F 607	1) Background checks were completed on all active employees at facility by 4-15-22. 2) All residents are at risk from this deficient practice. 100% employee background check audit completed by BOM on 3-31-22 with any employees found without background check completed. 3) BOM was educated on ensuring background checks are completed on all new employees within 30 days of hire or rehire on 3-31-22. 4) Administrator or designee will complete audits on new hire background checks weekly for 8 weeks and ensure any deficient practice is corrected. Results of audit will be forwarded to QAPI for oversight and any additional recommendations.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495204	A. BUILDING _____ B. WING _____	C 03/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLD DOMINION REHABILITATION AND NURSING	4 RIDGEWOOD PARKWAY 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 607	Continued From page 78	F 607		

verification provided wasn't for the facility employee; it was for a person with a similar name.

Review of the facility's policy titled, Abuse, Neglect and Exploitation with a revision date of 10/1/2, read; it is the policy of this facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property. Component I was screening and read as follows: Potential employees will be screened for a history of abuse, neglect, exploitation, or misappropriation of resident property.
1. Background, reference, and credentials' checks shall be conducted on potential employees, contracted temporary staff, students affiliated with academic institutions, volunteers, and consultants.
2. Screenings may be conducted by the facility itself, third-party agency, or academic institution.
3. The facility will maintain documentation of proof that the screening occurred.

An interview was conducted with the Administrator on 3/3/22 at approximately 7:10 p.m., because she stated there was no Human Resource personnel. The Administrator stated she and the previous Business Office Manager were told they would be given log-in information for the new hires and to conduct other Human Resource duties but it never happened therefore; the documents provided were all they had and it didn't include all screening documents for each facility employee. The facility staff only obtained

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495204	A. BUILDING _____ B. WING _____	C 03/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLD DOMINION REHABILITATION AND NURSING	4 RIDGEWOOD PARKWAY 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 607	Continued From page 79 certification/professional license verification and a criminal background check for the individual requested by the survey team, no others. On 3/3/22 at approximately 9:00 p.m., the above findings were shared with the Administrator, Director of Nursing and Corporate Consultant. An opportunity was offered to the facility's staff to present additional information but no additional information was provided and no concerns were voiced.	F 607		
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 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	F 622		4/15/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495204	A. BUILDING _____ B. WING _____	C 03/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLD DOMINION REHABILITATION AND NURSING	4 RIDGEWOOD PARKWAY 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 622	Continued From page 80	F 622		

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 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-

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495204	A. BUILDING _____ B. WING _____	C 03/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLD DOMINION REHABILITATION AND NURSING	4 RIDGEWOOD PARKWAY 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 622	Continued From page 81 (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 interviews, clinical record review and facility documentation review the facility staff failed to ensure Comprehensive Care Plan Goals were sent upon transfer to the hospital for 1 out of 35 residents in the survey sample, Resident #3. The facility staff failed to ensure Resident #3's Comprehensive Care Plan Goals were sent upon transfer to the hospital on 11/25/21. The findings included: Resident #3 was originally admitted on 7/23/19 and readmitted on 11/29/2021 with diagnoses to include but not limited to Left Hemiparesis, Bipolar Disorder and Muscle Weakness.	F 622	1) Residents #3 care plan was reviewed and given to him on 4-1-22. 2) All residents are at risk of this deficient practice. Facility will review past 14 days resident discharges to hospital and provide any missing paperwork. 3) Facility educated Licensed staff (LPN/RN) including agency on appropriate discharge summary paperwork requirements and process 3-31-22. 4) Director of Nursing/designee will audit 100% all discharges weekly x 8 weeks for appropriate discharge paperwork. Results of these audits will be presented to the QAPI committee for additional oversight and recommendations.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495204	A. BUILDING _____ B. WING _____	C 03/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLD DOMINION REHABILITATION AND NURSING	4 RIDGEWOOD PARKWAY 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 622	Continued From page 82	F 622		

Resident #3's most recent Minimum Data Set (MDS) was a quarterly assessment with an Assessment Reference Date (ARD) of 12/2/21. The Brief Interview for Mental Status (BIMS) was coded as 15 out of a possible 15, indicating the resident was cognitively intact and capable of daily decision making.

Resident #3's Clinical Census was reviewed and revealed the resident was discharged on 11/25/21.

Resident #3's Progress Notes were reviewed and are documented in part, as follows:

11/25/2021 20:42 (9:42 p.m.) Health Status Note: Resident complained to staff of tightness in chest, w(with)/pain and it being hard to breathe. V/s(vital signs) 158/97 P(pulse): 70 R(respirations):24,sp02(oxygen saturation) 93% on RA(room air),O2(oxygen) applied at 2 liters up to 96%. Resident states tightness is worst notified on call MD(medical doctor), Sent resident (Name) hospital ED(emergency department)via 911. Interim DON(director of nursing) and RP(responsible party) notified of resident status.

There was no documentation in Resident #3's clinical record to indicated that the resident's comprehensive care plan goals were sent upon transfer from the facility to the hospital on 11/25/21.

On 3/3/22 at 2:16 p.m. an interview was conducted with Licensed Practical Nurse (LPN) #2 regarding the documentation that was sent with him upon transfer to the hospital on 11/25/21. LPN #2 stated, "I do not see where I

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495204	A. BUILDING _____ B. WING _____	C 03/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLD DOMINION REHABILITATION AND NURSING	4 RIDGEWOOD PARKWAY 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 622	Continued From page 83	F 622		

charted what I sent with him. I usually send the facesheet, the history and physical, the labs, the physician orders and the bedhold notice." LPN #2 was asked if the comprehensive care plan goals were sent. LPN #2 stated, "I never send the care plan with them."

On 3/3/22 at 3:30 p.m. an interview was conducted with the Director of Nursing regarding the what documentation is to be send with residents upon discharge to the hospital. The Director of Nursing stated, "The nurse is to send the facesheet, advance directives, physician orders, any labs, the bedhold notice and the care plan when a resident goes out to the hospital."

The facility policy titled "Transfer and Discharge" dated 10/5/21 was reviewed and is documented in part, as follows:

7. Emergency Transfers/Discharges-imitated by the facility for medical reasons, or for the immediate safety and welfare of a resident (nursing responsibilities unless otherwise specified).
d. Complete and send with the resident (or provide as soon as practicable) a Transfer Form which documents:
viii. Comprehensive care plan goals.

On 3/3/22 at 4:30 p.m. a pre-exit debriefing was held with the Administrator, the Director of Nursing and the Regional Director of Clinical Services were the above findings were shared. The Regional Director of Clinical Services stated, "The expectation is that the transferring nurse is to send the bedhold notice and the care plan with the resident upon transfer to the hospital."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495204	A. BUILDING _____ B. WING _____	C 03/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLD DOMINION REHABILITATION AND NURSING	4 RIDGEWOOD PARKWAY 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 622	Continued From page 84 Prior to exit no further information was provided.	F 622		
F 625 SS=D	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on staff interviews, clinical record review and facility documentation review the facility staff failed to ensure a Bedhold notice was sent upon transfer to the hospital for 1 out of 35 residents in	F 625	1) The Bed Hold policy was reviewed with resident #3 on 3-31-22. 2) All residents are at risk of this deficient practice. Facility reviewed all discharges	4/15/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495204	A. BUILDING _____ B. WING _____	C 03/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLD DOMINION REHABILITATION AND NURSING	4 RIDGEWOOD PARKWAY 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 625	Continued From page 85 the survey sample, Resident #3. The facility staff failed to ensure Resident #3's Bedhold notice was sent upon transfer to the hospital on 11/25/21. The findings included: Resident #3 was originally admitted on 7/23/19 and readmitted on 11/29/2021 with diagnoses to include but not limited to Left Hemiparesis, Bipolar Disorder and Muscle Weakness. Resident #3's most recent Minimum Data Set (MDS) was a quarterly assessment with an Assessment Reference Date (ARD) of 12/2/21. The Brief Interview for Mental Status (BIMS) was coded as 15 out of a possible 15, indicating the resident was cognitively intact and capable of daily decision making. Resident #3's Clinical Census was reviewed and revealed the resident was discharged on 11/25/21. Resident #3's Progress Notes were reviewed and are documented in part, as follows: 11/25/2021 20:42 (9:42 p.m.) Health Status Note: Resident complained to staff of tightness in chest, w(with)/pain and it being hard to breathe. V/s(vital signs) 158/97 P(pulse): 70 R(respirations):24,sp02(oxygen saturation) 93% on RA(room air),O2(oxygen) applied at 2 liters up to 96%. Resident states tightness is worst notified on call MD(medical doctor), Sent resident (Name) hospital ED(emergency department)via 911. Interim DON(director of nursing) and RP(responsible party) notified of resident status.	F 625	in past 14 days to ensure bed hold policy was provided to resident or resident responsible party. Any identified discrepancies were corrected immediately. 3) Facility educated Licensed staff (LPN/RN) including agency on appropriate discharge summary paperwork requirements and process 3-31-22. 4) Director of Nursing/designee will audit 100% all discharges weekly x 8 weeks for appropriate discharge paperwork. Results of these audits will be presented to the QAPI committee for additional oversight and recommendations.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495204	A. BUILDING _____ B. WING _____	C 03/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLD DOMINION REHABILITATION AND NURSING	4 RIDGEWOOD PARKWAY 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 625	Continued From page 86	F 625		

There was no documentation in Resident #3's clinical record to indicated a bedhold notice was sent upon transfer from the facility to the hospital on 11/25/21.

On 3/3/22 at 2:16 p.m. an interview was conducted with Licensed Practical Nurse (LPN) #2 regarding the documentation that was sent with him upon transfer to the hospital on 11/25/21. LPN #2 stated, "I do not see where I charted what I sent with him. I usually send the facesheet, the history and physical, the labs, the physician orders and the bedhold notice." LPN #2 was asked if the bedhold notice was sent. LPN #2 stated, "I don't remember if I did or not."

On 3/3/22 at 3:30 p.m. an interview was conducted with the Director of Nursing regarding the what documentation is to be send with residents upon discharge to the hospital. The Director of Nursing stated, "The nurse is to send the facesheet, advance directives, physician orders, any labs, the bedhold notice and the care plan when a resident goes out to the hospital."

The facility policy titled "Transfer and Discharge" dated 10/5/21 was reviewed and is documented in part, as follows:

7. Emergency Transfers/Discharges-imitated by the facility for medical reasons, or for the immediate safety and welfare of a resident (nursing responsibilities unless otherwise specified).
i. Provide a notice of the resident's bedhold policy to the resident and representative at the time of transfer, as possible, but no later than 24 hours of the transfer.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495204	A. BUILDING _____ B. WING _____	C 03/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLD DOMINION REHABILITATION AND NURSING	4 RIDGEWOOD PARKWAY 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 625	Continued From page 87 On 3/3/22 at 4:30 p.m. a pre-exit debriefing was held with the Administrator, the Director of Nursing and the Regional Director of Clinical Services were the above findings were shared. The Regional Director of Clinical Services stated, "The expectation is that the transferring nurse is to send the bedhold notice and the care plan with the resident upon transfer to the hospital." Prior to exit no further information was provided.	F 625		
F 645 SS=D	PASARR Screening for MD & ID CFR(s): 483.20(k)(1)-(3) §483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability. §483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission, (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services; or (ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission- (A) That, because of the physical and mental	F 645		4/15/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495204	A. BUILDING _____ B. WING _____	C 03/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLD DOMINION REHABILITATION AND NURSING	4 RIDGEWOOD PARKWAY 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 645	Continued From page 88	F 645		

condition of the individual, the individual requires the level of services provided by a nursing facility; and
(B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability.

§483.20(k)(2) Exceptions. For purposes of this section-
(i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital.
(ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual-
(A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital,
(B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and
(C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services.

§483.20(k)(3) Definition. For purposes of this section-
(i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1).
(ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495204	A. BUILDING _____ B. WING _____	C 03/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLD DOMINION REHABILITATION AND NURSING	4 RIDGEWOOD PARKWAY 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 645	Continued From page 89 or is a person with a related condition as described in 435.1010 of this chapter. This REQUIREMENT is not met as evidenced by: Based on observations, clinical record review, and staff interviews the facility staff failed to ensure that a Level I Preadmission Screening and Resident Review (PASARR) was conducted prior to admission or within 30 days of admission to the nursing facility for 1 of 35 residents in the survey sample, Resident #3. The facility staff failed to ensure a Level I Preadmission Screening and Resident Review (PASARR) was conducted prior to admission or within 30 days of Resident #3's admission to the facility on 7/23/19. The finding included: Resident #3 was originally admitted on 7/23/19 and readmitted on 11/29/2021 with diagnoses to include but not limited to Left Hemiparesis, Bipolar Disorder and Muscle Weakness. Resident #3's most recent Minimum Data Set (MDS) was a quarterly assessment with an Assessment Reference Date (ARD) of 12/2/21. The Brief Interview for Mental Status (BIMS) was coded as 15 out of a possible 15, indicating the resident was cognitively intact and capable of daily decision making. Upon review of the clinical record a PASARR for Resident #3 could not be located and was requested from the facility. On 3/2/22 at 2:30 p.m. the Social Worker provided the surveyor with a Level I PASARR for	F 645	1) A PASSR was completed for resident #3 on 3-2-22. No additional services were recommended. 2) All residents are at risk if a PASSR is not completed, and services are indicated. A 100% review was done to assure all residents had a level 1 screening. No additional services were indicated. 3) The SW was education on PASSR screening and the elements of F645 on 3-31-22. 4) The Admissions Director/Designee will audit all new admissions x 8 weeks to assure Level 1 PASSR□s have been completed. Those found without PASSAR will be corrected immediately. Results of these audits will be presented to the QAPI committee for additional oversight and recommendations.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495204	A. BUILDING _____ B. WING _____	C 03/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLD DOMINION REHABILITATION AND NURSING	4 RIDGEWOOD PARKWAY 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 645	Continued From page 90 Resident #3 that was completed on 3/2/22 indicating a Level II PASARR was not required. On 3/3/22 at 1:00 p.m. an interview was conducted with the Social Worker regarding Resident #3's PASARR and if she was able to locate it. The Social Worker stated, "No, it wasn't done as part of his UAI (uniform assessment instrument) from the hospital, so we did it yesterday. I evaluated him yesterday and he does not require a level II PASARR. His (Resident #3's) Level I PASARR should be done upon admission or before." The Regional Director of Clinical Services was unable to locate a facility policy for Level I PASARR requirements in the facility.. On 3/3/22 at 4:30 p.m. a pre-exit debriefing was held with the Administrator, the Director of Nursing and the Regional Director of Clinical Services were the above findings were shared. The Administrator was asked what are the expectations for Level I PASARRs" in the facility. The Administrator stated, "My expectation is that they are done prior to admission and if not then they are done upon admission by the social worker." Prior to exit no further information was provided.	F 645		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and	F 656		4/15/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495204	A. BUILDING _____ B. WING _____	C 03/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLD DOMINION REHABILITATION AND NURSING	4 RIDGEWOOD PARKWAY 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 656	Continued From page 91 §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. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview and clinical record review the facility	F 656	1) Care plan for resident #55 was updated on 3-3-22 to reflect current use of	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495204	A. BUILDING _____ B. WING _____	C 03/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLD DOMINION REHABILITATION AND NURSING	4 RIDGEWOOD PARKWAY 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 656	Continued From page 92 staff failed to include anticoagulation in the comprehensive care plan, for 1 of 35 resident (Resident #55), in the survey sample. The findings included: The facility staff failed to develop a care plan for Resident #55 who was receiving an anticoagulation medication (Xarelto). Resident #55 was originally admitted to the nursing facility on 09/18/19. Diagnosis for included but not limited to Atrial Fibrillation (A-Fib). The current Minimum Data Set (MDS) a quarterly assessment with an Assessment Reference Date (ARD) of 02/09/22 coded the resident with a 15 of a total possible score of 15 on the Brief Interview for Mental Status (BIMS), indicating no cognitive impairment. The residents MDS was coded for the usage of anticoagulant. The section N on the MDS under medications read as follows: Indicate the number of DAYS the resident receiving the medication during the last 7 days, the MDS was coded for receiving an anticoagulant for 7 days. The resident had a Physician order dated 09/02/20: Xarelto 10 mg tablet - give 1 tablet by mouth daily in the evening for Atrial Fibrillation. The review of Resident 55's comprehensive care plan did not include a care plan for the use of an anticoagulant. An interview was conducted with the MDS Coordinator on 03/03/22 at approximately 10:19 a.m. The MDS Coordinator was asked if there should have been an anticoagulant care plan for Resident #55 who was taking an anticoagulation medication (Xarelto), she replied, "Yes, there	F 656	an anticoagulant medication. 2) All residents are at risk from this deficient practice. 3) The Comprehensive Care Plan policy was reviewed. No changes were necessary. Education provided to licensed professional staff as well as MDS staff on 3-17-22 regarding elements of a comprehensive care plan. 4) The MDS nurse will audit 10% of resident care plans weekly x 4 weeks, then 10% for 8 weeks to assure medication management is care planned as necessary. Results of these audits will be presented to the QAPI committee for additional oversight and recommendations.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495204	A. BUILDING _____ B. WING _____	C 03/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLD DOMINION REHABILITATION AND NURSING	4 RIDGEWOOD PARKWAY 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 656	Continued From page 93	F 656		

should have been an anticoagulant care plan."

An anticoagulant care plan was given to the surveyor that was created on 03/03/22 at approximately 5:51 p.m., but only created after it was requested by the surveyor. The review of the anticoagulation care plan included but not limited to following information: The resident is on anticoagulant therapy related to A-Fib. The goal set for the resident by the staff is to remain free from discomfort or adverse reactions related to anticoagulant use. Some of the interventions/approaches the staff would use to accomplish this goal is to administer anticoagulant medication as ordered by the physician, monitor for side effects and effectiveness every shift, monitor/document/report adverse reactions of anticoagulant therapy: blood tinged or red blood in urine, black tarry stools, dark for bright red blood in stools, sudden severe headaches, nausea vomiting, diarrhea, muscle joint pain, lethargy, bruising, blurred vision, shortness of breath, loss of appetite, sudden changes in mental status, significant or sudden changes in vital signs.

A briefing was held with the Administrator, Director of Nursing and Corporate support on 03/03/22 at approximately 3:00 p.m., who stated, "Resident #55 should have had an anticoagulant care plan."

Definitions:

-Atrial Fibrillation is the most common type of arrhythmia. An arrhythmia is a problem with the rate or rhythm of the heartbeat. During an arrhythmia, the heart can beat too fast, too slow,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495204	A. BUILDING _____ B. WING _____	C 03/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLD DOMINION REHABILITATION AND NURSING	4 RIDGEWOOD PARKWAY 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 656	Continued From page 94 or with an irregular rhythm. (Source: www.Nhlbl.nih.gov). -If you have atrial fibrillation (a condition in which the heart beats irregularly, increasing the chance of clots forming in the body, and possibly causing strokes) and are taking Xarelto to help prevent strokes or serious blood clots, you are at a higher risk of having a stroke after you stop taking this medication (medlineplus.gov).	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 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	F 657		4/15/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495204	A. BUILDING _____ B. WING _____	C 03/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLD DOMINION REHABILITATION AND NURSING	4 RIDGEWOOD PARKWAY 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 95 comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observations, resident interviews, staff interviews, and clinical record review, the facility staff failed to review and revise the care plan after the resident's dentures were broken for 1 of 35 residents (Resident #65) in the survey sample. The findings included: Resident #65 was originally admitted on 12/01/17 and readmitted on 11/08/21 after an acute hospital stay. The current diagnoses include; chronic kidney Disease, osteoporosis, and diabetes. The significant change Minimum Data Set (MDS) assessment with an assessment reference date (ARD) 2/9/22 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 15 out of a possible 15. This indicated Resident #65 cognitive abilities for daily decision making were intact. In section "G" (Physical Functioning), the resident was coded as requiring total care of two people with bed mobility, total care of one person with toileting, personal hygiene and bathing, and extensive assistance of one person with eating. At section L0200 (Dental) the resident was coded for no mouth or facial pain, discomfort or difficulty with chewing. On 3/1/22 at approximately 12:00 p.m., an interview was conducted with Resident #65. The resident stated she removed her dentures one night in December 2020, dropped them and they broke. The resident stated it was her fault and later the Certified Nursing Assistant (CNA) came	F 657	1) Care plan for resident #55 was updated on 3-3-22 to reflect current use of an anticoagulant medication. 2) All residents are at risk from this deficient practice. 3) The Comprehensive Care Plan policy was reviewed. No changes were necessary. Education provided to licensed professional staff as well as MDS staff on 3-17-22 regarding elements of a comprehensive care plan. 4) The MDS nurse will audit 10% of resident care plans weekly x 4 weeks, then 10% for 8 weeks to assure medication management is care planned as necessary. Results of these audits will be presented to the QAPI committee for additional oversight and recommendations.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495204	A. BUILDING _____ B. WING _____	C 03/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLD DOMINION REHABILITATION AND NURSING	4 RIDGEWOOD PARKWAY 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 96	F 657		

in picked her dentures up and put them in the bedside table drawer where they have been ever since. Resident #65 stated she has difficulty eating a lot of foods without her dentures and she can't eat the sausages that frequently serve her.

Review of Resident #65 most recent nutrition assessment dated 2/14/22 read; Does the resident use/have dentures? No.

Review of the current care plan dated 11/10/2021 revealed; a problem which read; The resident has an ADL Self Care Performance Deficit related to dementia and impaired mobility, paraplegia, femur fracture. A goal which read; The resident will maintain current level of function in ADL scores through the review 5/10/2022. An intervention read; Ensure dentures are available and provide oral care as needed.

On 3/1/22 at 2:55 p.m., Social Worker #1 was interviewed regarding resident #65's broken dentures. Social Worker #1 stated dental appointments are made when a concern is brought to their attention and Resident #65 wasn't on their list for any appointments.

An interview was conducted with the MDS Coordinator on 3/3/22 at approximately 5:00 p.m. The MDS Coordinator stated the care plan should have been updated to reflect the broken dentures.

On 3/3/22 at approximately 9:00 p.m., the above findings were shared with the Administrator, Director of Nursing and Corporate Consultant. An opportunity was offered to the facility's staff to present additional information but no additional information was provided and no concerns were

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495204	A. BUILDING _____ B. WING _____	C 03/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLD DOMINION REHABILITATION AND NURSING	4 RIDGEWOOD PARKWAY 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 97 voiced.	F 657		
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 by: Based on observation, resident interview, staff interview, clinical record review, and review of facility documents, the facility's staff failed to ensure a resident who is unable to carry out activities of daily living receives the necessary services to maintain grooming, and personal hygiene for 2 of 35 residents (Resident #31 and #14), in the survey sample. The findings included: 1.Resident #14 was originally admitted to the facility 08/28/2020 and readmitted 02/15/2021 after an acute care hospital stay. The resident has never been discharged from the facility. The current diagnoses included; Acute Kidney Failure, Unspecified and Essential Hypertension. The quarterly, Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 02/16/2022 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 14 out of a possible 15. This indicated Resident #14 cognitive abilities for daily decision making were intact. In section"G"(Physical functioning) the resident was coded as requiring extensive assistance of	F 677	1) Residents # 31 and #14 received showers on 3-7-22. Their preference for shower schedules were confirmed and care planned on 4-1-22. 2) All residents are at risk if shower/bathing schedules are not provided. 3) Direct care staff were educated on 3-17-22 regarding hygiene and are needs for the residents and current shower schedule. 4) The DON or designee will interview 5 residents weekly x 8 weeks to ensure hygiene is being provided as needed. Results of these audits will be presented to the QAPI committee for additional oversight and recommendations.	4/15/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495204	A. BUILDING _____ B. WING _____	C 03/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLD DOMINION REHABILITATION AND NURSING	4 RIDGEWOOD PARKWAY 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 98	F 677		

two persons with bed mobility and personal hygiene. Requires total dependence of one person with dressing and bathing. Requires total dependence of two persons with toilet use. Requires independence one personal assist with eating.
The Care Plan dated on 2/16/22 reads: Focus: The resident has an ADL Self Care Performance Deficit r/t Activity Intolerance. Goals: The resident will improve current level of function in ADL (Activities of Daily Living) scores through the review date. Interventions: BATHING: The resident requires total assist of 1 staff participation with bathing.

A review of the shower schedule for Resident #14 shows that showers should be given on Tuesday and Friday.

A review of the ADL (Activities of Daily Living) shower sheet reveal that Resident #14 did not receive any showers for the month of February 2022 and did not receive any showers during the duration of the survey for the month of March 3/01/22-3/03/22.

On 03/01/22 at approximately 11:15 AM., during the initial tour Resident #14 was asked by the surveyor if she had shower or bathing concerns. She stated, "I get bed baths every 4 days. I would love to have them daily or every other day. Tuesdays and Fridays are shampoo days and shower days. I didn't know I could take a shower but I don't want to be put in a shower chair. My hair feels greasy.

On 03/03/22 at approximately 3:12 PM., an interview was conducted with Resident #14. She expressed that she would like to take showers. "It

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495204	A. BUILDING _____ B. WING _____	C 03/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLD DOMINION REHABILITATION AND NURSING	4 RIDGEWOOD PARKWAY 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 99	F 677		

makes me feel itchy not getting a shower." "I feel like I should be scratching to get the dirt off of me after getting a bed bath. I feel bad knowing I haven't had one for so long. Before I came in here I took a shower and washed my hair every other day. They washed my hair two days ago. It was a week and half before that."

On 3/01/22 at approximately 1:00 Pm an interview was conducted with CNA (Certified Nurse's Aide) #3 concerning showers. She stated, "I have about 19 or 20 Residents to care for. There's no way I can give showers. I was able to give only one shower today. We haven't been able to give many showers since the pandemic started."

2. Resident #31 was originally admitted to the facility 08/16/19 after an acute care hospital stay. The resident has never been discharged from the facility. The current diagnoses included; Infection and Inflammatory Reaction due to other internal joint prosthesis and Osteoarthritis, Right Knee.

The quarterly revision, Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 12/23/2021 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 15 out of a possible 15. This indicated Resident #31 cognitive abilities for daily decision making were intact.

In section"G"(Physical functioning) the resident was coded as requiring extensive assistance of two persons with bed mobility, dressing and locomotion on the unit. Requires total dependence of two person with transfers. Requires total dependence of one person with personal hygiene and bathing. Independent with

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495204	A. BUILDING _____ B. WING _____	C 03/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLD DOMINION REHABILITATION AND NURSING	4 RIDGEWOOD PARKWAY 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 100 eating, set-up help only. The Care Plan dated: 12/23/21 reads: Focus: The resident has an ADL Self Care Performance Deficit r/t impaired mobility. Goals: The resident will improve current level of function in ADL scores through the review date. Interventions: BATHING: The resident requires physical help of 1 staff participation with bathing. A review of the shower schedule for Resident #31 shows that showers should be given on Monday and Thursday. A review of the ADL (Activities of Daily Living) shower sheet reveal that Resident #31 only received one shower since 2/07/22. She did not receive any showers during the duration of the survey for the month of March 3/01/22-3/03/22. On 03/03/22 at approximately, 3:50 PM., an interview was conducted with Resident #31 concerning showers. She stated, "It's been months since I showered. I feel nasty because I haven't had a shower in months. I was rubbing my arm and I saw grayness and dirt. I really need a shower. There's odor in the creases of my skin." The above findings were shared with the Administrator and Director of Nursing on 3/03/2022 at approximately 9:00 PM. No comments were voiced.	F 677		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a	F 688		4/15/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495204	A. BUILDING _____ B. WING _____	C 03/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLD DOMINION REHABILITATION AND NURSING	4 RIDGEWOOD PARKWAY 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 688	Continued From page 101 resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observations, family interviews, staff interviews, and clinical record review, the facility staff failed to ensure a resident with limited range of motion of the left arm received application of the left arm splint as ordered to prevent further decrease in range of motion for 1 of 35 residents, (Resident #13), in the survey sample. The findings included: Resident #13 was originally admitted to the facility 7/15/19 and readmitted 2/25/22 after an acute care hospital stay. The resident has never been discharged from the facility. The current diagnoses included; stroke with left hemiparesis, aphasia and dysphagia. The quarterly Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 12/16/21 coded the resident as not having the ability to complete the Brief Interview	F 688	1) The left arm splint was applied to resident #13 on 3-31-22. 2) All residents requiring splinting are at risk if not applied. All residents with splint orders have been evaluated by therapy for continued use. 3) Direct care staff were educated on 3-17-22 regarding splinting needs of residents. 4) The DON or designee will observe 3 residents weekly x 8 weeks to ensure splints are being applied as ordered. Results of these audits will be presented to the QAPI committee for additional oversight and recommendations.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495204	A. BUILDING _____ B. WING _____	C 03/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLD DOMINION REHABILITATION AND NURSING	4 RIDGEWOOD PARKWAY 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 688	Continued From page 102	F 688		

for Mental Status (BIMS). The staff interview was coded for long and short term memory problems as well as moderately impaired for daily decision making. In section "G" (Physical functioning) the resident was coded as requiring total care of two people with bed mobility, personal hygiene and bathing, total care of one person with dressing, eating, and toileting.

On 3/1/22 at approximately 11:25 a.m., an interview was conducted with Resident #13's husband. The husband stated because of lack of Certified Nursing Assistants (CNA) his wife doesn't receive care as she should. He stated the CNA may come in about 10:00 a.m. and clean his wife up in the bed and the CNA returned at approximately 2:30 p.m., or before their shift ends and check and turn her. He further stated on the evening shift she gets care approximately once during the shift, depending on how many staff members are on duty. Resident #13's husband also stated he thinks that the toes to his wife's right foot resulted in surgical removal because she wears socks and the socks weren't removed daily for monitoring of and bathing. He stated no one knew there was a problem with her right toes until one day (2/16/22) blood was observed on the resident's right sock and upon removal of the sock the condition of her foot was recognized. The husband also stated her left arm splint is over there on the table and hasn't been put on her for months.

Resident #13 was observed in bed lying on her back with her head facing right. She was dressed in a hospital gown and bilateral arms were down to her side. The resident wasn't responsive to talk and the splint was observed on the table as the husband stated.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495204	A. BUILDING _____ B. WING _____	C 03/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLD DOMINION REHABILITATION AND NURSING	4 RIDGEWOOD PARKWAY 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 688	Continued From page 103	F 688		

On 3/2/22 at approximately 11:15 a.m., the resident was again observed in bed unresponsive but with her eyes open. The left arm splint remained on the table.

Splints are ordered to prevent or reduce contracture and contribute to hand function.

Review of the clinical record revealed an order dated 12/21/19 which read; left hand splint to be applied after AM care and remove at dinner time.

Review of the care plan revealed a problem dated 7/17/2019, which read; The resident has an Activities of Daily Living (ADL) Self Care Performance Deficit related to activity intolerance, impaired mobility. The goal read; The resident will improve current level of function in ADL scores through the review date and the Intervention red; Left hand splint to be applied after AM care and remove at dinner time.

An interview was conducted with Registered Nurse (RN) #2 on 3/2/22 at approximately 3:05 p.m. RN#2 stated she hadn't applied or verified that Resident #13's splint left arm was in place because it's something the CNA does after morning care but she signs it off on the administration record. RN #2 made an observation of Resident #13 and stated the splint wasn't in place and she would find out additional information regarding application of the splint.

RN #2 was unaware if the resident had experienced decreased range of motion to the left hand/arm as a result of not wearing the splint.

On 3/3/22 at approximately 9:00 p.m., the above

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495204	A. BUILDING _____ B. WING _____	C 03/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLD DOMINION REHABILITATION AND NURSING	4 RIDGEWOOD PARKWAY 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 688	Continued From page 104 findings were shared with the Administrator, Director of Nursing and Corporate Consultant. The Director of Nursing stated we don't have enough staff to perform all care therefore we have to prioritize care, The DON further stated sometimes she is the CNA and she does what she can but care not rendered shouldn't be documented as performed.	F 688		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on clinical record reviews, staff and resident interviews and during the course of a complaint investigation, the facility staff failed to ensure 1 of 35 residents (Resident #316), in the survey sample was free of accident hazards. Activities of daily Living (ADL) assistance was not provided for a resident that was care planned to have the assistance of one person while bathing/showering which placed the resident at risk for falls. This is a closed record resident. The findings included: Resident #316 was admitted to the facility on 1/27/20 and discharged on 9/28/21 to an acute care facility. Diagnosis for Resident #316 included but not limited to COVID-19 and	F 689	1) No immediate correction can be initiated on resident #316 regarding assessment and care planning of ADL assistance needed since she is discharged. 2) All residents are at risk for Falls if ADL assessments are not completed and care planned accurately. 100% residents were assessed for ADL level and care planned appropriately. 3) LPN/RN staff were educated on 4-1-22 regarding ADL assessment and care plan accuracy. 4) The DON or designee will audit new admissions assessments/care plans weekly x 8 weeks to ensure accurate ADL assessments and care plans are	4/15/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495204	A. BUILDING _____ B. WING _____	C 03/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLD DOMINION REHABILITATION AND NURSING	4 RIDGEWOOD PARKWAY 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 689	Continued From page 105 Difficulty in walking. Quarterly-5 day, Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 9/01/21 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 10 out of a possible 15. This indicated Resident #316 cognitive abilities for daily decision making were moderately impaired. In section"G"(Physical functioning) the resident was coded as requiring extensive assistance of two persons with bed mobility and toilet use. Requiring extensive assistance of one person with dressing, personal hygiene and eating. Requiring limited assistance of one person with transfers. Requires total dependence with bathing. The care plan dated 8/26/21 reads: Focus: The resident has an ADL (Activity of Daily Living) Self Care Performance Deficit r/t debility. Goal: The resident will maintain current level of function in ADL scores through the review date. Intervention: BATHING: The resident requires total help of 1 staff participation with bathing. Focus: The resident is at risk for falls r/t debility. Fall Risk Assessment. Goals: The resident will be free of falls through the review date. Interventions: Be sure the resident's personal items and call light are within reach. Review of Resident #316's clinical record revealed that Resident #316 had fallen on the following dates: 5/12/21- Right Trochanter (hip) pain present. No injuries. Neuro checks completed. 6/24/21-Clinician and RP notified. No injuries.	F 689	completed. Results of these audits will be presented to the QAPI committee for additional oversight and recommendations.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495204	A. BUILDING _____ B. WING _____	C 03/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLD DOMINION REHABILITATION AND NURSING	4 RIDGEWOOD PARKWAY 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 689	Continued From page 106	F 689		

Neuro checks completed.
10/06/20-Fall with no injuries in the shower, unassisted and unsupervised.
11/21/20 Resident transferred to local hospital due to falling.
11/23/20-Resident reported that she fell near her bed and was able to get self back up about a week ago. Staff was not aware of fall.
Neuro checks were completed following each fall above by the facility staff.

A review of nursing progress notes below reads:

"On 10/6/2020 at 11:28 AM. Resident received alert and verbal. She tolerated her medications well. She was assisted into the shower and shower chair. When transferring out at 11:05 AM she was lowered to the floor with the aides assist. She was able to assist with standing from the floor with one person assist. Resident was able to move all extremities to her baseline and denied having any pain at this time. She also denied having any noted dizziness on this shift. She did not have any head injury noted at this time. No noted open areas, bruises, or skin tears. her daughter was called and made aware of fall and situation. NP (Nurse Practitioner) in the building and she was notified of the fall. Resident is currently sitting in her wheel chair at her bedside. Will continue to monitor."

A review of the Rehabilitation Screening dated 10/07/20 revealed that Resident #316 stated that she was left unattended and unsupervised in the shower on the the 10/6/20 fall as a different account from the above nursing progress note. Resident stated that while she was in her shower that she slipped from the chair to the floor while reaching forward to turn off the water. Resident

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495204	A. BUILDING _____ B. WING _____	C 03/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLD DOMINION REHABILITATION AND NURSING	4 RIDGEWOOD PARKWAY 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 689	Continued From page 107 reported that her aide wasn't present and that she thought that she was on her cell phone at the time. The unit manager was emailed by rehab., staff regarding these concerns. On 3/01/22 at approximately, 12:15 PM., an interview was conducted with LPN (Licensed Practical Nurse) #5 concerning the above allegations. She stated, "She did fall in the bathroom. She was independent. She would get up and transfer herself. We asked her to call for help but she wouldn't. She was wearing a wrist brace for a fracture that occurred here." This was contrary to Resident #316's care plan that indicated she needed assistance and supervision while showering. On 3/03/22 at approximately, 11:50 AM., an interview was conducted with RN (Registered Nurse) #1 concerning the above allegations. She stated, "I interacted with the family often. The daughters were conflicted and didn't get along. One of the daughters was the RP (Responsible Party) and said she was at risk for falls. Yes, she fractured her wrist from a previous fall. She also had a small fracture in her back prior to admission. She had osteoporosis and chronic pain issues." The above findings were shared with the Administrator and Director of Nursing on 3/03/2022 at approximately 9:00 PM. No comments were voiced. This is a complaint deficiency!	F 689		
F 697 SS=D	Pain Management CFR(s): 483.25(k)	F 697		4/15/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495204	A. BUILDING _____ B. WING _____	C 03/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLD DOMINION REHABILITATION AND NURSING	4 RIDGEWOOD PARKWAY 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 697	Continued From page 108 §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 observations, resident interview, staff interview, and clinical record review, the facility staff failed to address, assess and treat a resident's pain for 1 of 35 residents (Resident #6), in the survey sample. The findings included: Resident #6 was originally admitted to the facility 11/29/19 and readmitted 12/31/20 after an acute care hospital stay. The current diagnoses included; dementia and heart failure. The quarterly Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 12/10/21 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 5 out of a possible 15. This indicated Resident #6's cognitive abilities for daily decision making were severely impaired. In section "G" (Physical functioning) the resident was coded as requiring extensive assistance of one person with bed mobility, transfers, dressing, toileting, and bathing, limited assistance of one person with personal hygiene, and supervision after set-up with eating and locomotion. On 2/28/22 at approximately 7:50 p.m., sitting in a wheel chair in her room, Resident #6 stated she was experiencing left ear pain, rating 7 out of 10. The resident was told to let her nurse know of the	F 697	1) Pain medication was offered to resident #6 on 3-3-22 and resident declined the medication. 2) All residents are at risk for pain. 3) LPN/RN staff were educated on 3-17-22 regarding pain management. 4) The DON or designee will audit 5 residents weekly x 8 weeks to ensure pain management is being provided per resident request.Results of these audits will be presented to the QAPI committee for additional oversight and recommendations.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495204	A. BUILDING _____ B. WING _____	C 03/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLD DOMINION REHABILITATION AND NURSING	4 RIDGEWOOD PARKWAY 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 697	Continued From page 109	F 697		

ear pain. Resident #6 was observed on 3/1/22 at approximately 10:15 a.m., lying in bed with her neck ill-positioned; the resident stated her neck and left ear were painful, rating 7 out of 10. The resident was observed on 3/3/22 at approximately 3:05 p.m., the resident again stated she was experiencing left ear pain, rating 7 out 10, and the nurse was notified of her concern.

On 3/3/22 at approximately 3:10 p.m., Licensed Practical Nurse LPN) # 4 was interviewed regarding the residents left ear and neck pain. LPN #4 stated the resident hadn't informed her of left ear or neck pain. LPN #1 assisted the resident to pull her pants up and put shoes but she didn't address pain with her. LPN #4 stated she would put the resident's concern in the physician's book therefore the resident would be seen when the physician is in the facility again. LPN left the facility after her shift concluded without documenting the resident's pain in the clinical record but it was written in the physician's book as she stated.

An interview was conducted with Registered Nurse (RN) #1, on 3/3/22 at approximately 4:50 p.m. RN #1 stated she had spoken with LPN #4 and she stated she didn't assess the resident because she didn't tell her she had pain but she put the concern in the physician's book for the resident to be follow-up on. LPN #4 stated it wasn't necessary to telephone the physician for a practitioner would be in the family tomorrow. RN #1 stated she instructed LPN #4 whenever a resident has a concern the individual should be assessed and a progress note should be written in the clinical record. RN #1 stated the resident's daughter was present when she went in to assess the resident and the daughter stated the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495204	A. BUILDING _____ B. WING _____	C 03/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLD DOMINION REHABILITATION AND NURSING	4 RIDGEWOOD PARKWAY 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 697	Continued From page 110 resident had a history of wax build-up. RN #1 stated the resident stated she wasn't experiencing pain at that time. On 3/3/22 at approximately 9:00 p.m., the above findings were shared with the Administrator, Director of Nursing and Corporate Consultant. The Director of Nursing stated the expectation is for the nurse to assess the the resident, administer as added needed medication if indicated and document in the clinical record so the oncoming nurse can follow-up with the resident. The Director of Nursing stated putting a note in the physician's book is not an appropriate action.	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 observation, resident interview, staff interview, clinical record review, the facility staff failed to have ongoing communication, coordination and collaboration with the dialysis center regarding acute changes in the resident's status for 1 of 35 residents (Resident #64), in the survey sample. The findings included: Resident #64 was originally admitted to the facility 3/25/19 and readmitted 3/17/21 after an acute	F 698	1) The dialysis center for resident was informed of a workup conducted on resident #64 by the facility on 3-2-22. 2) All residents on dialysis are at risk if services are not coordinated including changes in condition and lab results. All dialysis centers were updated on the status of each dialysis recipient on 3-7-22. 3) Education was provided to licensed professional staff on 3-17-22 and 3-31-22 regarding coordination with dialysis centers, completion of communication	4/15/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495204	A. BUILDING _____ B. WING _____	C 03/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLD DOMINION REHABILITATION AND NURSING	4 RIDGEWOOD PARKWAY 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 111 care hospital stay. The current diagnoses included; end-stage renal disease requiring dialysis and benign prostatic hyperplasia. The quarterly Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 2/23/22 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 15 out of a possible 15. This indicated Resident #64's cognitive abilities for daily decision making were intact. Section O100J was coded for receiving dialysis services and at section "G" (Physical functioning) the resident was coded as requiring total care of two people with transfers, total care of one person with bathing and toileting, extensive assistance of one person with bed mobility, personal hygiene and dressing, and supervision after set-up with eating. On 2/28/22 at approximately 7:20 p.m., a sign was observed outside of Resident #64's room stating isolation and an isolation set-up was observed at the doorway. An interview was conducted with the resident who stated he didn't know he was on isolated precautions. Therefore an interview was conducted with Licensed Practical Nurse (LPN) #7 who stated the resident had been on an antibiotic for extended spectrum beta-lactamase (ESBL) but currently wasn't on an antibiotic therefore she would follow-up on the resident's status for isolation because in report she wasn't made aware of the isolation. Extended spectrum beta-lactamase (ESBL) is an enzyme found in some strains of bacteria which is difficult to treat because of it's resistance to many antibiotics. Isolation precautions good handwashing and personal protective equipment should be utilized until the resident has completed	F 698	tool, and elements of F698. 4) The DON or designee will audit 2 dialysis records weekly x 8 weeks to assure communication is being done.Results of these audits will be presented to the QAPI committee for additional oversight and recommendations.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495204	A. BUILDING _____ B. WING _____	C 03/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLD DOMINION REHABILITATION AND NURSING	4 RIDGEWOOD PARKWAY 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 112	F 698		

the antibiotic therapy.

On 3/1/22 at approximately 10:15 a.m., the isolation sign and set-up was no longer observed at Resident #64's door.

On 3/1/22 at approximately 3:30 p.m., an interview was conducted with LPN #5 regarding the Nurse Practitioner's (NP) visit with Resident #64. LPN #5 stated the NP was following-up on an abnormal lab result which identified plus 3 blood in the resident's urine. LPN #5 stated the NP ordered an ultrasound of the kidneys.

On 3/2/22 at approximately 11:50 a.m., a technician arrived at the facility to complete the ultrasound ordered for Resident #64 but the resident was at the dialysis center.

On 3/2/22 Registered Nurse #2 was interviewed at approximately 3:05 p.m., she stated Resident #64 was at dialysis and she wasn't aware of the scheduled ultrasound or if the information was communicated with the dialysis center for the resident was gone upon when she started her shift.

On 3/3/22 at approximately 1:15 p.m., the Unit Secretary stated Resident #64's communication sheet is sent to the dialysis center by the nurse with each visit, afterwhich it is reviewed by the nurse and added to the residents electronic record. The Unit Secretary opened the resident's communication book and produced the communication form 3/2/22, which only had documentation from the dialysis center to the facility. It included the time the dialysis started and stopped, vital signs, placement of the shunt and the name of medication administered while at

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495204	A. BUILDING _____ B. WING _____	C 03/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLD DOMINION REHABILITATION AND NURSING	4 RIDGEWOOD PARKWAY 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 113	F 698		

dialysis. Review of all of the dialysis communications from 2/2/22 through 3/2/22 revealed no documentation from the facility to the dialysis center. The Unit Secretary further stated if there is information which needs to be communicated to the dialysis center the nurse calls the center.

On 3/3/22 at approximately 3:40 p.m., a call was made to the dialysis center regarding communication from the facility to the dialysis center in reference to Resident #64. The person identified themselves as the Receptionist and stated the nurse was too busy to talk and the Social Worker was at another facility and she wasn't aware of any communications from the facility to the dialysis center stating the resident had acute problems which were being addressed.

Review of Resident #64's clinical record revealed a NP progress note dated 2/9/22, which stated on 2/3/22 the practitioner was notified the resident had blood in his urine and a urinalysis and urine culture and sensitivity were ordered. The NP's note further revealed the resident stated the staff hadn't obtained a urine specimen and he was unaware if he was still eliminating urine with blood in it because of incontinence. The progress not further stated the resident denied pain during urination and abdominal pain. The NP's note further stated the resident needed a complete blood count, urinalysis and urine culture and sensitivity.

Further review of the clinical record revealed no lab results for the complete blood count, urinalysis and urine culture and sensitivity but there was an order on the Medication Administration Record (MAR) for Fosfomycin

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495204	A. BUILDING _____ B. WING _____	C 03/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLD DOMINION REHABILITATION AND NURSING	4 RIDGEWOOD PARKWAY 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 114 Tromethamine Packet 3 Grams - Give 1 packet by mouth one time a day for a urinary tract infection (UTI) for one Day one time dose for ESBL -Start Date 2/17/22 and Macrobid Capsule 100 MG - Give 1 capsule by mouth every 12 hours for UTI for 7 Days until finished - Start Date 2/16/22. On 3/3/22 at approximately 9:00 p.m., the above findings were shared with the Administrator, Director of Nursing and Corporate Consultant. An opportunity was offered to the facility's staff to present additional information but no additional information was provided and no concerns were voiced.	F 698		
F 727 SS=D	RN 8 Hrs/7 days/Wk, Full Time DON CFR(s): 483.35(b)(1)-(3) §483.35(b) Registered nurse §483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by: Based on information obtained during the Sufficient and Competent Nurse Staffing task, the facility staff failed to staff a Registered Nurse (RN) for eight consecutive hours a day on	F 727	Facility failed to provide evidence of 8hr coverage of RN daily 1) Facility has 8hrs of RN coverage documented in hosted time or on	4/15/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495204	A. BUILDING _____ B. WING _____	C 03/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLD DOMINION REHABILITATION AND NURSING	4 RIDGEWOOD PARKWAY 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 727	Continued From page 115 2/27/22, which could potentially affect all residents care. The findings included: During the nursing staff review for February 28, 2022 through March 3, 2022 the facility staff was unable to verify RN presence in the facility for at least 8 consecutive hours on 2/27/22.. On 3/03/22 at approximately 4:38 p.m., the Staffing Coordinator (OSM/Other Staff Member #10) stated that she was unable to present any information verifying a RN was present in the facility for 8 consecutive hours on 2/27/22. She also stated that there should always be an RN on staff. The above findings were shared with the Administrator and Director of Nursing and the Corporate Consultant on 3/03/22 at approximately 9:00 p.m., No comments were made concerning the above issue.	F 727	administrative log to show facility RN coverage 2) All residents are at risk if required RN coverage is not provided. 3) Scheduler educated on 3-4-22 regarding 8hr RN requirement and escalation process to DON if unable to find coverage 4) The BOM/designee will audit hosted time records weekly x 8 weeks to ensure RN coverage meets requirement. Results of these audits will be presented to the QAPI committee for additional oversight and recommendations.	
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.	F 756		4/15/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495204	A. BUILDING _____ B. WING _____	C 03/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLD DOMINION REHABILITATION AND NURSING	4 RIDGEWOOD PARKWAY 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 116 (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 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 observation, clinical record review and staff interview the facility, the failed to ensure 3 of 35 residents, Residents (#30, #55 and #6) in the survey sample was seen by the pharmacist for Medication Regimen Review (MRR) on a monthly basis. The findings included: 1. The facility staff failed to review Resident #30's medication regimen for the month of 10/21 and 11/21. Resident #30 was admitted to the	F 756	Facility failed to complete pharmacy review with MD monthly for 4 residents #30, #50, #6 and #55 1) Pharmacy reviews for residents # 30, #50, #6 and #55 were completed on 2-28-22. 2) All residents are at risk if a pharmacy review is not conducted. All residents received a pharmacy review in February 2021. 3) The Administrator confirmed with Pharmacy representatives the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495204	A. BUILDING _____ B. WING _____	C 03/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLD DOMINION REHABILITATION AND NURSING	4 RIDGEWOOD PARKWAY 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 117 facility on 08/23/17. Diagnosis for Resident #30 included but not limited to Dementia with behavioral disturbance and major depressive disorder. Resident #30's Minimum Data Set (MDS), a quarterly Assessment Reference Date (ARD) of 12/23/21 scored a 99 indicating short and long term memory problems and with severe cognitive impairment - never/rarely made decisions. The MDS coded Resident #30 requiring total dependence of two with transfer, total dependence of one with dressing, eating, toilet use, personal hygiene and bathing and extensive assistance of one with bed mobility for Activities of Daily Living (ADL) care. Resident #30's comprehensive care plan documented with a revision date of 05/12/21 identified Resident #30 is on an antipsychotic medication (Zyprexa) related to dementia with behaviors. The goal set for the resident by the staff is to remain free of drug related complications or cognitive/behavioral impairment. Some of the interventions/approaches the staff would use to accomplish this goal is to administer medication as ordered (monitor/document for side effects and effectiveness) and consult with pharmacy, MD to consider dose reduction when clinically appropriate. Review of Resident #30's Order Summary Report for 03/22 revealed the Resident #30 was taking 12 scheduled medication to include Zyprexa, Remeron and Prozac. Review of Resident #30's clinical record did not include a pharmacy progress note for 10/21 and 11/21.	F 756	requirement for monthly medication management reviews on 3-31-22. 4) The DON or designee will audit 8 residents monthly x 2 months to ensure medication reviews have been completed. Results of these audits will be presented to the QAPI committee for additional oversight and recommendations.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495204	A. BUILDING _____ B. WING _____	C 03/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLD DOMINION REHABILITATION AND NURSING	4 RIDGEWOOD PARKWAY 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 118	F 756		

An interview was conducted with the Regional Director of Clinical Services on 03/03/22 at approximately 2:00 p.m. She stated, (name of new company) was to take over ownership in October 2021 but did not start until December 2021, so at that point we did not have pharmacist to review Resident #30's monthly medication review until December 2021; that's why the clinical record is missing monthly pharmacy reviews for 10/21 and 11/21.

A debriefing was held with the Administrator, Director of Nursing and Corporate support on 03/03/22 at approximately 3:00 p.m. The Administration team were informed of the above findings; no further information was provided prior to exit.

Definitions:

-Zyprexa is used to treat the symptoms of schizophrenia (a mental illness that causes disturbed or unusual thinking, loss of interest in life, and strong or inappropriate emotions) (https://medlineplus.gov/drug).

-Remeron is used to treat depression. Mirtazapine is in a class of medications called antidepressants. It works by increasing certain types of activity in the brain to maintain mental balance (https://medlineplus.gov/drug).

-Prozac is used to treat depression, obsessive-compulsive disorder (bothersome thoughts that won't go away and the need to perform certain actions over and over), some eating disorders, and panic attacks (sudden, unexpected attacks of extreme fear and worry

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495204	A. BUILDING _____ B. WING _____	C 03/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLD DOMINION REHABILITATION AND NURSING	4 RIDGEWOOD PARKWAY 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 119	F 756		

about these attacks)
(https://medlineplus.gov/drug).

2. The facility staff failed to review Resident #55's medication regimen for the month of 10/21 and 11/21. Resident #55 was originally admitted to the nursing facility on 09/01/20. Diagnosis for Resident #55 included but not limited to major depression and Atrial Fibrillation (A-Fib).

The current Minimum Data Set (MDS) a quarterly assessment with an Assessment Reference Date (ARD) of 02/09/22 coded the resident with a 15 of a total possible score of 15 on the Brief Interview for Mental Status (BIMS), indicating no cognitive impairment.

Resident #55's comprehensive care plan documented Resident #55 is on an antidepressant related to depression. The goal set for the resident by the staff is to remain free from discomfort or adverse reactions related to antidepressant therapy. Some of the interventions/approaches the staff would use to accomplish this goal is to educate the resident/family/caregivers about risks, benefits and the side effects and/or toxic symptoms and to give antidepressant medications ordered by he physician.

Resident #55's comprehensive care plan documented Resident #55 is on an anticoagulant related to A-Fib. The goal set for the resident by the staff is to remain free from discomfort or adverse reactions related to anticoagulant use. Some of the interventions/approaches the staff would use to accomplish this goal is to administer anticoagulant medication as ordered by the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495204	A. BUILDING _____ B. WING _____	C 03/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLD DOMINION REHABILITATION AND NURSING	4 RIDGEWOOD PARKWAY 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 120	F 756		

physician, monitor for side effects and effectiveness every shift, monitor/document/report adverse reactions of anticoagulant therapy.

Review of Resident #55's Order Summary Report for 03/22 revealed the resident was taking 17 scheduled medication to include Wellbutrin and Xarelto.

Review of Resident #55's clinical record did not include a pharmacy progress note for 10/21 and 11/21.

An interview was conducted with the Regional Director of Clinical Services on 03/03/22 at approximately 2:00 p.m. She stated, (name of new company) was to take over ownership in October 2021 but did not start until December 2021, so at that point we did not have pharmacist to review Resident #55's monthly medication review until December 2021.

A debriefing was held with the Administrator, Director of Nursing and Corporate support on 03/03/22 at approximately 3:00 p.m. The Administration team were informed of the above findings; no further information was provided prior to exit.

Definitions:

-Atrial fibrillation (A-Fib) is a problem with the speed or rhythm of the heartbeat. is the most common type of arrhythmia. The cause is a disorder in the heart's electrical system (https://medlineplus.gov/drug).

-Wellbutrin is used to treat depression

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495204	A. BUILDING _____ B. WING _____	C 03/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLD DOMINION REHABILITATION AND NURSING	4 RIDGEWOOD PARKWAY 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 121	F 756		

(https://medlineplus.gov/drug).

-Xarelto is used to help prevent strokes or serious blood clots (https://medlineplus.gov/drug).

3. Resident #6 was originally admitted to the facility 11/29/19 and readmitted 12/31/20 after an acute care hospital stay. The current diagnoses included; dementia and heart failure.

The quarterly Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 12/10/21 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 5 out of a possible 15. This indicated Resident #6's cognitive abilities for daily decision making were severely impaired. In section "G" (Physical functioning) the resident was coded as requiring extensive assistance of one person with bed mobility, transfers, dressing, toileting, and bathing, limited assistance of one person with personal hygiene, and supervision after set-up with eating and locomotion.

Review of the pharmacy monthly reviews for twelve months (March 2021 through February 2022) revealed no reviews for October 2021 and November 2021.

The Corporate Consultant stated they was a delay in the new pharmacist moving into the position and as a result there was no pharmacist to conduct the October 2021 and November 2021 reviews.

On 3/3/22 at approximately 9:00 p.m., the above findings were shared with the Administrator, Director of Nursing and Corporate Consultant. The Director of Nursing stated the expectation is for monthly pharmacy reviews by a licensed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495204	A. BUILDING _____ B. WING _____	C 03/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLD DOMINION REHABILITATION AND NURSING	4 RIDGEWOOD PARKWAY 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 122 pharmacist and recommendation if appropriate.	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: (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	F 758		4/15/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495204	A. BUILDING _____ B. WING _____	C 03/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLD DOMINION REHABILITATION AND NURSING	4 RIDGEWOOD PARKWAY 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 758	Continued From page 123 §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 prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on staff interviews, clinical record review and facility documentation, the facility staff failed to ensure the recommendation for do a Gradual Dose Reduction (GDR) made on 01/20/22 by the facility's Nurses Practitioner (NP) for 1 of 35 resident (Resident #30) in the survey sample. Resident #30 received 41 extra doses of the unnecessary psychotropic medication Zyprexa 5 mg. The findings included: Resident #30 was admitted to the facility on 08/23/17. Diagnosis for Resident #30 included but not limited to Dementia with behavioral disturbance. Resident #30's Minimum Data Set (MDS), a quarterly Assessment Reference Date (ARD) of 12/23/21 scored a 99 indicating short and long term memory problems and with severe cognitive impairment - never/rarely made decisions. The MDS coded Resident #30 requiring total dependence of two with transfer, total dependence of one with dressing, eating, toilet	F 758	NP note reflected change in psychotropic meds; order not placed- 1 resident # 30 received add'l doses of meds 1) The gradual dose reduction (GDR) recommendation for resident # 30 was presented to the MD on 3-25-22 and a new order was written. 2) All residents receiving psychotropic medications who require a GDR are at risk. A 100% review was conducted by the pharmacist on 3-30-22 to determine if any other residents require a GDR. The Pharmacist will review all residents on antipsychotic medications monthly to determine need for a GDR and to make recommendations. 3) The policy for GDR for antipsychotic medications was reviewed on 3-3-22. No changes were necessary. The IDT members were educated on elements of a risk meeting to determine GDR needs for residents. 4) Results of these audits will be presented to the QAPI committee for additional oversight and	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495204	A. BUILDING _____ B. WING _____	C 03/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLD DOMINION REHABILITATION AND NURSING	4 RIDGEWOOD PARKWAY 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 758	Continued From page 124	F 758		

use, personal hygiene and bathing and extensive assistance of one with bed mobility for Activities of Daily Living (ADL) care.

Resident #30's comprehensive care plan documented with a revision date of 05/12/21 identified Resident #30 is on an antipsychotic medication (Zyprexa) related to dementia with behaviors. The goal set for the resident by the staff is to remain free of drug related complications or cognitive/behavioral impairment. Some of the interventions/approaches the staff would use to accomplish this goal is to administer medication as ordered (monitor/document for side effects and effectiveness) and consult with pharmacy, MD to consider dose reduction when clinically appropriate.

On 01/20/22, a progress note entered by Nurse Practitioner #1 revealed the following information: "Resident #30 is being seen today for follow up GDR. Resident #30 is seen in her room in no distress. The nurse does not report any agitation, anxiety, insomnia, depression or psychotic process and has been tolerating GDR without any worsening of symptoms. Resident is currently taking Zyprexa 2.5 mg in the morning and 5 mg at bedtime. The recommendation is to decrease Zyprexa to 2.5 mg in the evening."

The physician Order Sheet (POS) for March 2022 included the following order:
Zyprexa 5 mg tablet by mouth daily in the evening at 6:00 p.m., for agitation.

1. Review of January 2022 Medication Administration Record (MAR) revealed Zyprexa 5 mg was administered 01/21/22 - 01/31/22.

recommendations.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495204	A. BUILDING _____ B. WING _____	C 03/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLD DOMINION REHABILITATION AND NURSING	4 RIDGEWOOD PARKWAY 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 758	Continued From page 125	F 758		

2. Review of February 2022 Medication Administration Record (MAR) revealed Zyprexa 5 mg was administered 02/01/22 - 02/28/22.

3. Review of March 2022 Medication Administration Record (MAR) revealed Zyprexa 5 mg was administered 03/01/22 - 03/03/22.

A debriefing was held with the Administrator, Director of Nursing and Cooperate support on 03/03/22 at approximately 3:00 p.m. A copy of the (NP's) progress note dated 01/20/22 and Resident #30's MAR's from 01/22 - 03/22 were reviewed with the Administration team. They were in agreement that the GDR for Zprexa from 5 mg to 2.5 mg was not implemented. The Administration team reviewed the provided documents mentioned above with no further information being provided prior to exit.

The facility's policy titled Gradual Dose Reduction of Psychotropic Drug; implemented on 11/01/21. Residents who use psychotropic drugs receive gradual dose reduction and behavioral interventions, unless clinically contraindicated, to discontinue these drugs.

GDR is the stepwise tapering of a dose to determine if symptoms, conditions, or risks can be managed by a lower dose or if the dose or medication can be discontinued.

Definitions:
-Zyprexa is used to treat the symptoms of schizophrenia (a mental illness that causes disturbed or unusual thinking, loss of interest in life, and strong or inappropriate emotions) (https://medlineplus.gov/drug).

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495204	A. BUILDING _____ B. WING _____	C 03/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLD DOMINION REHABILITATION AND NURSING	4 RIDGEWOOD PARKWAY 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 758	Continued From page 126 -Dementia with behavioral disturbances is frequently the most challenging manifestations of dementia and are exhibited in almost all people with dementia (https://www.ncbi.nlm.nih.gov/pubmed/22644311) .	F 758		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations, clinical record review, staff interviews, and facility document review the	F 761	A respiratory inhaler was found at resident bedside brought in by wife - not	4/15/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495204	A. BUILDING _____ B. WING _____	C 03/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLD DOMINION REHABILITATION AND NURSING	4 RIDGEWOOD PARKWAY 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 761	Continued From page 127 facility staff failed to ensure a medication was securely stored for 1 of 35 residents in the survey sample, Resident #53. The facility staff failed to securely store a respiratory inhaler that was observed at the bedside of Resident #53. The findings included: Resident #53 was admitted to the facility on 2/1/22 with diagnoses to include but not limited to Chronic Obstructive Pulmonary Disease and Pneumonia. Resident #53's most recent Minimum Data Set (MDS) was a 5 day/admission assessment with an Assessment Reference Date of 2/4/22. The Brief Interview for Mental Status (BIMS) was coded as a 15 out of a possible 15 indicating that Resident #53 was cognitively intact and capable of daily decision making. On 3/1/22 at 11:50 a.m. during a room visit with Resident #53 the following observation was made. On the residents nightstand there was one unlabeled Advair 250 mg(milligram) respiratory inhaler with 58 doses remaining. The Unit Manager Registered Nurse (RN #1) entered Resident #53's room and was asked about the inhaler and if it should be at the bedside. RN #1 stated, "No of course not, because of an overdose or another resident can walk in and get it. It should be locked in the medication cart. No medications should be left at the bedside. Sometimes his wife brings things in and doesn't tell us. The one he had in the medication cart is labeled and from our pharmacy. I will call his wife."	F 761	securely stored for 1 resident #53 1) The inhaler stored at the bedside of resident #3 was removed on 3-1-22. 2) All residents are at risk if medications are stored at the bedside when a resident has not been properly assessed to self-administer said medication. A 100% room to room check was conducted on 3-2-22 to assure no other medications were left at the bedside. 3) The policy on medication administration was revised to note that medications may not be left at the bedside unless the resident is assessed, and care planned to do so. Direct care staff were educated on 3-17-22 regarding medication administration. 4) The DON or designee will observe 3 residents weekly x 8 weeks to ensure no medications are at bedside. Results of these audits will be presented to the QAPI committee for additional oversight and recommendations.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495204	A. BUILDING _____ B. WING _____	C 03/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLD DOMINION REHABILITATION AND NURSING	4 RIDGEWOOD PARKWAY 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 761	Continued From page 128	F 761		

RN #1 removed the inhaler from Resident #53's room.

Resident #53's Progress Notes were reviewed and are documented in part, as follows:

3/2/2022 16:24 (4:24 p.m.) Nursing Progress Note: This writer spoke to resident's wife to discuss medications at bedside. Resident's wife stated she brought medications into facility, that were provided by the hospital and she thought he could have them. This writer explained nursing will provide all medications and if she would like anything added, nursing would be happy to assist with obtaining orders. This writer asked wife to take medications home. Wife verbalized understanding and expressed no further questions or concerns at this time.

The facility policy titled "Medication Storage" last revised 11/1/21 was reviewed and is documented in part, as follows:

Policy: It is the policy of this facility to ensure all medications housed on our premises will be stored in the pharmacy and/or medication rooms according to the manufacturer's recommendations and sufficient to ensure proper sanitation, temperature, light, ventilation, moisture control, segregation, and security.

Policy Explanation and Compliance Guidelines:
1. General Guidelines:
a. All drugs and biologicals will be stored in locked compartments (i.e., medication carts, cabinets, drawers, refrigerators, medication rooms).

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495204	A. BUILDING _____ B. WING _____	C 03/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLD DOMINION REHABILITATION AND NURSING	4 RIDGEWOOD PARKWAY 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 761	Continued From page 129 On 3/3/22 at 4:30 p.m. a pre-exit debriefing was held with the Administrator, the Director of Nursing and the Regional Director of Clinical Services were the above findings were shared. The Administrator was asked what are the expectations for medications in the facility. The Administrator stated, "My expectation is that all medications will be securely locked up and to educate the families to not bring medications in and leave at the beside." Prior to exit no further information was provided.	F 761		
F 775 SS=E	Lab Reports in Record - Lab Name/Address CFR(s): 483.50(a)(2)(iv) §483.50(a)(2) The facility must- (iv) File in the resident's clinical record laboratory reports that are dated and contain the name and address of the testing laboratory. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, and clinical record review, the facility staff failed to have laboratory reports filed in the resident's clinical record for 1 of 35 residents (Resident #64), in the survey sample. The findings included: Resident #64 was originally admitted to the facility 3/25/19 and readmitted 3/17/21 after an acute care hospital stay. The current diagnoses included; end-stage renal disease requiring dialysis and benign prostatic hyperplasia. The quarterly Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 2/23/22 coded the resident as	F 775	Staff failed to have lab reports filed in resident records and take down isolation signs when 1 resident #64 was off isolation 1) Lab results from 2-3-22 were scanned into resident #64 medical record on 4-8-22. 2) All residents are at risk if lab results are not in medical record for providers to review. 3) Staff member was assigned to scan documents into medical records. 4) The DON or designee will audit 5 residents weekly x 8 weeks to ensure lab results are scanned into medical records Results of these audits will be presented to the QAPI committee for additional	4/15/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495204	A. BUILDING _____ B. WING _____	C 03/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLD DOMINION REHABILITATION AND NURSING	4 RIDGEWOOD PARKWAY 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 775	Continued From page 130	F 775		

completing the Brief Interview for Mental Status (BIMS) and scoring 15 out of a possible 15. This indicated Resident #64's cognitive abilities for daily decision making were intact. Section O100J was coded for receiving dialysis services and at section "G" (Physical functioning) the resident was coded as requiring total care of two people with transfers, total care of one person with bathing and toileting, extensive assistance of one person with bed mobility, personal hygiene and dressing, and supervision after set-up with eating.

On 2/28/22 at approximately 7:20 p.m., a sign was observed outside of Resident #64's room stating isolation and an isolation set-up was observed at the doorway. An interview was conducted with the resident who stated he didn't know he was on isolated precautions. Therefore an interview was conducted with Licensed Practical Nurse (LPN) #7 who stated the resident had been on an antibiotic for extended spectrum beta-lactamase (ESBL) but currently wasn't on an antibiotic therefore she would follow-up on the resident's status for isolation because in report she wasn't made aware of the isolation.

Extended spectrum beta-lactamase (ESBL) is an enzyme found in some strains of bacteria which is difficult to treat because of it's resistance to many antibiotics. Isolation precautions good handwashing and personal protective equipment should be utilized until the resident has completed the antibiotic therapy.

On 3/1/22 at approximately 10:15 a.m., the isolation sign and set-up was no longer observed at Resident #64's door.

On 3/1/22 at approximately 3:30 p.m., an

oversight and recommendations.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495204	A. BUILDING _____ B. WING _____	C 03/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLD DOMINION REHABILITATION AND NURSING	4 RIDGEWOOD PARKWAY 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 775	Continued From page 131	F 775		

interview was conducted with LPN #5 regarding the Nurse Practitioner's (NP) visit with Resident #64. LPN #5 stated the NP was following-up on an abnormal lab result which identified plus 3 blood in the resident's urine. LPN #5 stated the NP ordered an ultrasound of the kidneys. LPN #5 stated labs are put in the physician's book until they are reviewed and signed by the physician then they are added to the resident's record.

Review of Resident #64's clinical record revealed a NP progress note dated 2/9/22, which stated on 2/3/22 the practitioner was notified the resident had blood in his urine and a urinalysis and urine culture and sensitivity were ordered. The NP's note further revealed the resident stated the staff hadn't obtained a urine specimen and he was unaware if he was still eliminating urine with blood in it because of incontinence. The progress not further stated the resident denied pain during urination and abdominal pain. The NP's note further stated the resident needed a complete blood count, urinalysis and urine culture and sensitivity.

Further review of the clinical record revealed no lab results for the complete blood count, urinalysis and urine culture and sensitivity but there was an order on the Medication Administration Record (MAR) for Fosfomycin Tromethamine Packet 3 Grams - Give 1 packet by mouth one time a day for a urinary tract infection (UTI) for one Day one time dose for ESBL -Start Date 2/17/22 and Macrobid Capsule 100 MG - Give 1 capsule by mouth every 12 hours for UTI for 7 Days until finished - Start Date 2/16/22.

An interview was conducted with the Unit

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495204	A. BUILDING _____ B. WING _____	C 03/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLD DOMINION REHABILITATION AND NURSING	4 RIDGEWOOD PARKWAY 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 775	Continued From page 132 Manager on 3/3/22 on 3/3/22 at approximately 4:45 p.m., the Unit Manager stated she retrieved the most recent laboratory report dated 2/28/22, from the "to be filed" box but was unable to locate any previous laboratory reports. On 3/3/22 at approximately 9:00 p.m., the above findings were shared with the Administrator, Director of Nursing and Corporate Consultant. The Director of Nursing stated currently they don't have a medical records clerk therefore documents are stored and waiting to be scanned into the clinical record.	F 775		
F 810 SS=D	Assistive Devices - Eating Equipment/Utensils CFR(s): 483.60(g) §483.60(g) Assistive devices The facility must provide special eating equipment and utensils for residents who need them and appropriate assistance to ensure that the resident can use the assistive devices when consuming meals and snacks. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, medical record review and facility document review the facility staff failed to ensure assistive devices for meal consumption was provided for 1 of 35 resident's in the survey sample, Resident #3. The facility staff failed to ensure Resident # 3's issued built up weighted rocker knife and foam built up fork for self feeding were provided on each meal tray. The findings included: Resident #3 was originally admitted on 7/23/19	F 810	Staff failed to provide a weighted rocker knife and foam built up fork for 1 resident #3 1) All adaptive utensils were provided for resident #3 on 4-8-22. 2) All residents who require adaptive utensils or plates are at risk. A 100% audit was completed by the Occupational Therapy assistant for residents requiring adaptive feeding devices to determine if others have been affected by this practice. No additional residents were identified. 3) Staff were educated on identifying adaptive equipment needs and how to	4/15/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495204	A. BUILDING _____ B. WING _____	C 03/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLD DOMINION REHABILITATION AND NURSING	4 RIDGEWOOD PARKWAY 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 810	Continued From page 133	F 810		

and readmitted on 11/29/2021 with diagnoses to include but not limited to Left Hemiparesis, Bipolar Disorder and Muscle Weakness.

Resident #3's most recent Minimum Data Set (MDS) was a quarterly assessment with an Assessment Reference Date (ARD) of 12/2/21. The Brief Interview for Mental Status (BIMS) was coded as 15 out of a possible 15, indicating the resident was cognitively intact and capable of daily decision making. Under Section G Functional Status, Resident #3 was coded as independent with no set up or physical help for eating.

Resident #3's current Physician Orders were reviewed and are documented in part, as follows:

Resident was issued built up weighted rocker knife and foam built up fork for self feeding to be used for every meal. Order Status: Active. Order Date: 8/31/21.

On 3/1/22 at 12:45 p.m. Resident #3's lunch tray was observed at his bedside while eating. The resident's tray had a regular plastic black knife and fork and a weighted black spoon placed on it for meal consumption. Resident #3 was asked about the observed tray utensils and stated, "They send that spoon but never the special knife and fork I'm supposed to have. It's hard for me to hold the plastic silverware." Resident #3's diet preference sheet on his tray dated 3/1/22 Tuesday LUNCH was reviewed and is documented in part, as follows: BLACK BUILT UP FORK/KNIFE.

On 3/2/22 at 9:15 a.m. Resident #3's breakfast tray was observed at his bedside while eating.

report for follow up 4-1-22. A list of residents requiring such devices was developed as a quick reference for staff. All care plans were updated if applicable to reflect devices used.
4) The OTA will audit 3 residents weekly X 8 weeks to assure adaptive devices are being provided. Results of these audits will be presented to the QAPI committee for additional oversight and recommendations.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495204	A. BUILDING _____ B. WING _____	C 03/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLD DOMINION REHABILITATION AND NURSING	4 RIDGEWOOD PARKWAY 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 810	Continued From page 134	F 810		

The resident's tray had a regular plastic black knife and fork and a weighted black spoon placed on it for meal consumption. Resident #3's diet preference sheet on his tray dated 3/2/22 WEDNESDAY BKFAST (breakfast) was reviewed and is documented in part, as follows: BLACK BUILT UP FORK/KNIFE.

On 3/2/22 at 12:50 p.m. Resident #3's lunch tray was observed in the day room while eating. The resident's tray had a regular plastic black knife and fork and a weighted black spoon placed on it for meal consumption. Resident #3's diet preference sheet on his tray dated 3/2/22 Wednesday LUNCH was reviewed and is documented in part, as follows: BLACK BUILT UP FORK/KNIFE.

On 3/3/22 at 9:30 a.m. an interview was conducted with the Food Service Director regarding Resident #3's meal tray observations, meal preference sheets and physician ordered adaptive eating utensils. The Food Service Director stated, "What is listed on the preference card is what should be placed on the meal tray when the resident receives the tray." The Food Service Director was asked the importance if having a residents ordered eating adaptive equipment placed on the tray for each meal. The Food Service Director stated, "Because if they have it ordered they need that adaptive equipment to be able to eat."

The facility's policy titled "Adaptive Feeding Equipment" last revised 1/4/2022 was reviewed and is documented in part, as follows:

Policy: Residents requiring assistance in feeding are potential candidates for a restorative dining

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495204	A. BUILDING _____ B. WING _____	C 03/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLD DOMINION REHABILITATION AND NURSING	4 RIDGEWOOD PARKWAY 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 810	Continued From page 135 program or adaptive utensil use. Policy Explanation and Compliance Guidelines: 5. The dietary department should be notified of residents needing adaptive equipment; the equipment is stored and maintained in the dietary department. Appropriate utensils should be placed on the resident's food tray, at each meal, and returned to the dietary department, on the food tray for sanitization. On 3/3/22 at 4:30 p.m. a pre-exit debriefing was held with the Administrator, the Director of Nursing and the Regional Director of Clinical Services were the above findings were shared. The Administrator was asked what are the expectations for Resident #3's eating adaptive equipment. The Administrator stated, "My expectation is that the resident's adaptive equipment is available and put on the tray for each meal to maintain his independence and nutrition." Prior to exit no further information was provided.	F 810		
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	F 812		4/15/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495204	A. BUILDING _____ B. WING _____	C 03/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLD DOMINION REHABILITATION AND NURSING	4 RIDGEWOOD PARKWAY 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 812	Continued From page 136 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 observations and staff interviews, the facility staff failed to store utensils in a clean and sanitary manner. The findings included: On 03/01/22 from 11: 08 AM until 11:58 AM staff were observed with the refrigerator door open retrieving drinks, fruit cups, and sodas from within. The outside refrigerator temperature gauge indicated 43 degrees at the start of the meal tray preparation. The outside temperature gauge registered 56 degrees at (11: 58 AM). At around 12: 12 PM an estimated 14 plate tops fell to the floor in the dining room area from the kitchen serving line. A staff seated in the dining area placed the plates back on serving tray line. On 03/02/22 at 11:18 AM the Dietary Manager was observed to drop a serving spoon on the kitchen floor. The spoon was observed to remain on the floor for approximately 23 minutes. The Dietary Manager was observed to pick the spoon up and place it on the shelf were the bread used to make sandwich's were stored. During an interview on 3/3/22 at 9:02 AM with the Dietary Administrator he was informed of the	F 812	Facility failed to ensure temperature for meal prep met quality standards, ensured meal trays were clean on tray line and dirty utensils were cleaned prior to storage 1) No immediate correction can be made regarding the temperature checked during meal prep on 3-1-22. Plate warmers and identified spoon was removed and cleaned on 3-1-22. 2) All residents are at risk if utensils and equipment are not stored and/or served to residents in a sanitary condition. 3) All food service staff received education on kitchen cleanliness, equipment use, and proper storage of utensils and devices on 3-17-22. 4) The Administrator or designee will round 3 X weekly X 8 weeks to assure in kitchen items are being cleaned and stored properly. Results of these audits will be presented to the QAPI committee for additional oversight and recommendations.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495204	A. BUILDING _____ B. WING _____	C 03/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLD DOMINION REHABILITATION AND NURSING	4 RIDGEWOOD PARKWAY 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 812	Continued From page 137 observations. The Dietary Administrator stated the items should have been placed on a cart and taken to the dish wash area.	F 812		
F 814 SS=D	Dispose Garbage and Refuse Properly CFR(s): 483.60(i)(4) §483.60(i)(4)- Dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility staff failed to ensure garbage and refuse were disposed of properly. The findings included: Two outside trash dumpster's were observed open with over flowing trash and flies on 3/1/22 at 1:15 P.M. and on 3/2/22 at 12:45 P.M. During an interview with the Maintenance Director on 3/2/22 at 12:45 PM, he stated, the trash was supposed to have been picked up on Monday Feburary 28, 2022.	F 814	1) All biohazard waste was removed from the dumpster area on 3-4-22. 2) All residents are at risk if garbage is not disposed of properly. 3) The Maintenance Director was educated by the Regional Director of Operations on 3-3-22 regarding proper disposal of garbage/waste. The contract for trash disposal and hazardous waste was reviewed on 3-31-22. The frequency of the picking of garbage was reviewed and increased due to need. 4) The Administrator or designee will observe the dumpster area 3 X weekly X 8 weeks to assure trash and hazardous waste is being disposed of properly. Results of these audits will be presented to the QAPI committee for additional oversight and recommendations.	4/15/22
F 868 SS=C	QAA Committee CFR(s): 483.75(g)(1)(i)-(iii)(2)(i) §483.75(g) Quality assessment and assurance. §483.75(g)(1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee;	F 868		4/15/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495204	A. BUILDING _____ B. WING _____	C 03/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLD DOMINION REHABILITATION AND NURSING	4 RIDGEWOOD PARKWAY 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 868	Continued From page 138 (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; §483.75(g)(2) The quality assessment and assurance committee must: (i) Meet at least quarterly and as needed to identifying issues with respect to which quality assessment and assurance activities are necessary. This REQUIREMENT is not met as evidenced by: Based on staff interview and review of facility documents, the facility staff failed to maintain a quality assessment and assurance committee which meets at least quarterly. The findings included: On 3/3/22 at approximately 9:00 p.m., a Quality assessment and assurance (QA&A) interview was conducted with the Administrator. The Administrator stated there had been no QA&A meeting since she arrived 2/7/22 and she was unable to provide documentation of previous QA&A meetings because she was unable to locate the QA&A note book. The Administrator further stated a QA&A meeting had not not scheduled. The Administrator also stated staffing is a system failures and it hadn't been addressed with the Medical Director. On 3/3/22 at approximately 9:00 p.m., the above findings were shared with the Administrator, Director of Nursing and Corporate Consultant. An opportunity was offered to the facility's staff to present additional information but no additional information was provided and no concerns were	F 868	Facility failed to ensure QAPI meeting minutes were available 1) QAPI meeting minutes found at facility for January 2021 on 3-4-22. QAPI meeting was held on 3-31-22. 2) All residents are at risk when a facility does not have an active QAPI program. 3) The Medical Director was updated on facility activities and survey findings on 3-31-22. The Administrator was educated by the Regional Director of Operations on 3-3-22 regarding elements of an effective QAPI program. The policy on QAPI was reviewed on 3-10-22. No revisions were necessary. 4) The Regional Director of Operations will review QAPI meeting minutes quarterly X 2 Quarters to assure completion. Results of these audits will be presented to the QAPI committee for additional oversight and recommendations.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495204	A. BUILDING _____ B. WING _____	C 03/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLD DOMINION REHABILITATION AND NURSING	4 RIDGEWOOD PARKWAY 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 868	Continued From page 139 voiced.	F 868		
F 881 SS=E	Antibiotic Stewardship Program CFR(s): 483.80(a)(3) §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(3) An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review, and it was determined that the facility staff failed to maintain an effective antibiotic stewardship program. The findings included: An interview was conducted with the Director of Nursing (DON) on 03/01/22 at approximately 10:52 a.m. When asked who is responsible for the Antibiotic Stewardship and Infection Prevention and Control Program (IPCP), the DON stated, "I guess that would be me." When asked what is the process for tracking and trending infections, the DON stated "I only monitor culture with sensitivity results." She stated, "I don't have the time to track and monitor any other antibiotics." The DON said the last time antibiotic monitoring was done for the facility is by the previous Infection Preventionist (IP) and she left November 31, 2021. The surveyor requested the Infection Control Logs from June 2021 until November 2021. The DON said she was not	F 881	Facility failed to ensure an ATB Stewardship program was in place □ no infection control program with antibiotic stewardship; need infection control preventionist with certificate 1) The Antibiotic Stewardship program was established on 3-4-22. 2) All residents are at risk from lack of oversight for trending infections and monitoring antibiotic stewardship. 3) The DON will complete training by 4-30-22 for Infection Preventionist activities to serve as a backup. The IP/DON will work to trend data and complete reports beginning 2-1-2022. The Pharmacist will provide a monthly ABX stewardship report. All data regarding infections and antibiotic use will be collected and documented on a line listing for review by the medical director. Antibiotic stewardship and disease tracking will be presented at each QAPI meeting for evaluation by the Medical	4/15/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495204	A. BUILDING _____ B. WING _____	C 03/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLD DOMINION REHABILITATION AND NURSING	4 RIDGEWOOD PARKWAY 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 881	Continued From page 140 been able to locate any of the Infection Control Logs for the last 6 months but did provide the phone number for the previous (IP). A phone interview was conducted with the previous (IP) on 03/03/22 at approximately 11:18 a.m., who said her last day with (name of previous nursing facility) was on November 31, 2021. She said the Infection Control Log was last updated on 11/31/21 (prior to new ownership). On the same day at approximately 12:35 p.m., the (IP) provided the completed Infection Control Logs from June 2021 through November 2021. A briefing was held with the Administrator, Director of Nursing and Corporate support on 03/03/22 at approximately 3:00 p.m. The Administration team were informed of the above findings; no further information was provided prior to exit. Facility policy titled, Antibiotic Stewardship Program with a revision date of 10/01/21. It is the policy of this facility to implement an Antibiotic Stewardship Program as part of the facility's overall infection prevention and control program. The purpose of the program is to optimize the treatment of infection while reducing the adverse associated with antibiotic use. Policy Explanation and Compliance Guidelines: 1. The Infection Preventionist, with oversite from the Director of Nursing, serves as the leader of the Antibiotic Stewardship Program and receives support from the Administrator and other governing officials of the facility. 1. (A) Infection Preventionist - coordinates all antibiotic stewardship activities, maintains documentation, and services as a resource for all	F 881	Director. 4) The DON or designee will audit monthly ABX Stewardship reports X 2 months to assure completion. Results of these audits will be presented to the QAPI committee for additional oversight and recommendations.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495204	A. BUILDING _____ B. WING _____	C 03/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLD DOMINION REHABILITATION AND NURSING	4 RIDGEWOOD PARKWAY 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 881	Continued From page 141	F 881		

clinical staff.
1. (B) Director of Nursing - serves as back up coordinator for antibiotic stewardship activities, provides support and oversite, and ensure adequate resources for carrying out the program.

4 (a). The program includes antibiotic use protocols and a system to monitor antibiotic use.
Antibiotic use protocols:
(i) Nursing staff shall assess residents who are suspected to have an infection and complete an SBAR from prior to notify the physician.
(ii) Laboratory testing shall be in accordance with current standards of practice.
(iii) The facility uses the (CDC's NHSN Surveillance definitions) to define infections.
(iv) All prescriptions for antibiotics shall specify the dose, duration, and indication for use.
(v) Reassessment of empiric antibiotics is conducted after 2-3 days for appropriateness and necessity, factoring in results of diagnostic tests, laboratory reports, and/or changes in the clinical status of the resident.

4 (b) Monitoring antibiotic use:
(i). Antibiotic orders obtained upon admission, whether new admission or readmission, to the facility shall be reviewed for appropriateness by the License Nurse admitting the resident and followed up with review in clinical meeting.
(ii) Antibiotic orders obtained from consulting, specialty, or emergency providers shall be reviewed for appropriateness in clinical meeting.
(iii) Random audits of antibiotic prescriptions shall be performed to verify completeness and appropriateness in clinical meeting.
(iv) Antibiotic use shall be measured by (monthly prevalence, antibiotics starts, and/or antibiotic days of therapy).

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495204	A. BUILDING _____ B. WING _____	C 03/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLD DOMINION REHABILITATION AND NURSING	4 RIDGEWOOD PARKWAY 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 882 SS=D	Infection Preventionist Qualifications/Role CFR(s): 483.80(b)(1)-(4)(c) §483.80(b) Infection preventionist The facility must designate one or more individual(s) as the infection preventionist(s) (IP) (s) who are responsible for the facility's IPCP. The IP must: §483.80(b)(1) Have primary professional training in nursing, medical technology, microbiology, epidemiology, or other related field; §483.80(b)(2) Be qualified by education, training, experience or certification; §483.80(b)(3) Work at least part-time at the facility; and §483.80(b)(4) Have completed specialized training in infection prevention and control. §483.80 (c) IP participation on quality assessment and assurance committee. The individual designated as the IP, or at least one of the individuals if there is more than one IP, must be a member of the facility's quality assessment and assurance committee and report to the committee on the IPCP on a regular basis. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and facility documentation, the facility staff failed to designate at least one qualified staff member as the facility's Infection Preventionist (IP). The finding included: An interview was conducted with the Director of Nursing (DON) on 03/01/22 at approximately	F 882	Facility failed to ensure a dedicated infection preventionist was in place with a certification 1) The DON has been assigned as of 3-3-22 to assist with tracking and trending of infections as well as Covid and other communicable disease monitoring until IP is hired. 2) All residents are at risk from lack of	4/15/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495204	A. BUILDING _____ B. WING _____	C 03/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLD DOMINION REHABILITATION AND NURSING	4 RIDGEWOOD PARKWAY 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 882	Continued From page 143 10:52 a.m. When asked who is responsible for the Infection Prevention and Control Program (IPCP), the DON stated, "I guess that would be me." The DON was asked to provide a copy of her completed specialized training in infection prevention and control, she replied, "I have not completed the necessary training." The DON was asked if she had started the specialized training, she replied, "No, I have not had time." The DON stated, "We have not had an IP since the new (name of company) took over on 12/01/21. A briefing was held with the Administrator, Director of Nursing and Corporate support on 03/03/22 at approximately 3:00 p.m. When asked if the facility had an (IP), the Administrator replied, "No." When asked if the facility should have an (IP), they stated, "Yes." The surveyor asked, what is the responsibility of the (IP), the statement was made to safeguard the resident's to prevent the spread of infection and illness. The facility's policy titled Infection Preventionist, revised on 10/01/21. The facility will employ one or more individuals with the responsibility for implementing the facility's infection prevention and control program. -The Infection Preventionist is defined as the individual designated by the facility to be responsible for the infection prevention and control program. Policy Explanation and Compliance Guidelines read in part: 1. The facility will designate a qualified individual as infection Prevention who primary role is to coordinate and be actively accountable for the	F 882	oversight for trending infections and monitoring antibiotic stewardship. 3) The position for IP has been posted for recruitment on Apploi. The DON will complete training for Infection Preventionist activities to serve as a backup. 4) The status of recruitment will be presented weekly X 8 weeks by the Director of Talent Acquisition to the Administrator. The DON or designee will audit monthly ABX Stewardship reports and line listings X 2 months to assure completion. Results of these audits will be presented to the QAPI committee for additional oversight and recommendations.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495204	A. BUILDING _____ B. WING _____	C 03/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLD DOMINION REHABILITATION AND NURSING	4 RIDGEWOOD PARKWAY 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 882	Continued From page 144 facility's IPCP. 2. The facility will ensure the IP works at least part-time at the facility, is adequately qualified, and meets the eligibility requirements: A. Current licensure in nursing. C. Education, training, experience or certification in infection control and prevention. D. Completed specialized training in infection prevention and control through accredited continuing education. 3. The IP reports to the Director of Nursing. 4. Responsibilities of the IP include but are not limited to: a. Develop and implement an ongoing IPCP to prevent, recognize and control the onset and spread of infections in order to provide a safe, sanitary and comfortable environment. b. Establish facility-wide systems for the prevention, identification, reporting, investigation and control of infections a communicable disease of resident, staff and visitors.	F 882		
F 886 SS=E	COVID-19 Testing-Residents & Staff CFR(s): 483.80 (h)(1)-(6) §483.80 (h) COVID-19 Testing. The LTC facility must test residents and facility staff, including individuals providing services under arrangement and volunteers, for COVID-19. At a minimum, for all residents and facility staff, including individuals providing services under arrangement and volunteers, the LTC facility must: §483.80 (h)((1) Conduct testing based on parameters set forth by the Secretary, including but not	F 886		4/15/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495204	A. BUILDING _____ B. WING _____	C 03/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLD DOMINION REHABILITATION AND NURSING	4 RIDGEWOOD PARKWAY 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 886	Continued From page 145	F 886		

limited to:
(i) Testing frequency;
(ii) The identification of any individual specified in this paragraph diagnosed with COVID-19 in the facility;
(iii) The identification of any individual specified in this paragraph with symptoms consistent with COVID-19 or with known or suspected exposure to COVID-19;
(iv) The criteria for conducting testing of asymptomatic individuals specified in this paragraph, such as the positivity rate of COVID-19 in a county;
(v) The response time for test results; and
(vi) Other factors specified by the Secretary that help identify and prevent the transmission of COVID-19.

§483.80 (h)((2) Conduct testing in a manner that is consistent with current standards of practice for conducting COVID-19 tests;

§483.80 (h)((3) For each instance of testing:
(i) Document that testing was completed and the results of each staff test; and
(ii) Document in the resident records that testing was offered, completed (as appropriate to the resident's testing status), and the results of each test.

§483.80 (h)((4) Upon the identification of an individual specified in this paragraph with symptoms consistent with COVID-19, or who tests positive for COVID-19, take actions to prevent the transmission of COVID-19.

§483.80 (h)((5) Have procedures for addressing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495204	A. BUILDING _____ B. WING _____	C 03/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLD DOMINION REHABILITATION AND NURSING	4 RIDGEWOOD PARKWAY 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 886	Continued From page 146 residents and staff, including individuals providing services under arrangement and volunteers, who refuse testing or are unable to be tested. §483.80 (h)((6) When necessary, such as in emergencies due to testing supply shortages, contact state and local health departments to assist in testing efforts, such as obtaining testing supplies or processing test results. This REQUIREMENT is not met as evidenced by: Based on staff interviews, facility document and facility documentation, the facility staff failed to provide evidence of the facility's COVID-19 staff testing for an unvaccinated employee based on the level of community transmission according for the recommended frequency of twice a week. The findings included: An interview was conducted with the Director of Nursing (DON) on 03/01/22 at approximately 10:52 a.m. When asked who is responsible for ensuring the unvaccinated staff (housekeeper #1) was tested for COVID-19 based on the level of community transmission of twice a week, she stated, "I guess that would be me." The DON was asked to provide the following: the community transmission level from 01/29/22 - 02/26/22 along with housekeeper #1's as-worked schedule and all her COVID-19 testing from 01/29/22 - 02/26/22. The DON stated, the housekeeper should have been tested twice a week since 01/29/22 until current but it wasn't done. On 03/02/22 at approximately 9:28 a.m., an interview was conducted with housekeeper #1	F 886	Facility failed to ensure non-up-to-date vaccinated staff members or those with exemptions were tested for COVID-19 based on the community transmission level. 1) All non-up-to-date staff or those with exemptions were covid tested on 3-7-22. 2) All residents are at risk of exposure to Covid from non-up-to-date vaccinated staff or those with exemptions who may be asymptomatic yet positive. 3) The policy for Covid testing was reviewed on 3-7-22. No updates were necessary. The DON was educated by the Regional Director of Clinical Services on testing requirements according to the community transmission level. The transmission level for Newport News, Virginia is moderate as of 3-7-2022. Moderate levels of transmission require weekly testing for non-up-to-date vaccinated and exempted staff. Facility will ensure COVID-19 testing is completed as required/needed based on the community transmission level. 4) The Regional Director of Clinical Services or Designee will monitor testing	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495204	A. BUILDING _____ B. WING _____	C 03/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLD DOMINION REHABILITATION AND NURSING	4 RIDGEWOOD PARKWAY 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 886	Continued From page 147 who stated, "I'm have a religious exemption and I'm not vaccinated." When asked, when is COVID-19 testing being done in the building, she replied, "COVID-19 testing days are doe every Monday and Thursday." When asked, if she should be tested twice a week based on her vaccination status, she replied, "Yes." The housekeeper was asked if she was tested twice a week routinely for COVID-19, she replied, "I'm not really sure." On 03/03/22 at approximately 2:05 p.m., housekeeper #1's as-worked scheduled revealed the following days worked in February 2022: 02/01-02/04, 02/07-02/09, 02/11-02/13, 02/15-02/16, and 02/22-02/26/22. The facility was only able to provide COVID-19 testing on housekeeper #1 for 02/03/22 and 02/07/22. A debriefing was held with the Administrator, Director of Nursing and Corporate support on 03/03/22 at approximately 3:00 p.m. The Administration team were informed of the above findings; no further information was provided prior to exit. Policy titled Employee COVID-19 Vaccination - created on 12/01/21. It is the policy of Eastern Healthcare Group to ensure that all eligible employees are vaccinated against COVID-19 as per applicable Federal, State, and local guidelines. Compliance Guidelines read in part: 1. (Name of company) will ensure that all eligible employees are fully vaccinated against COVID-19, unless religious or medical exemptions are granted.	F 886	logs weekly X 8 weeks to assure testing is being completed as required. Results of these audits will be presented to the QAPI committee for additional oversight and recommendations.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495204	A. BUILDING _____ B. WING _____	C 03/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLD DOMINION REHABILITATION AND NURSING	4 RIDGEWOOD PARKWAY 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 886	Continued From page 148 7. (Name of company) will implement additional precautions to mitigate the transmission and spread of COVID-19 for all staff who are not fully vaccinated for COVID-19. Masking, screening, and testing will be completed for all unvaccinated staff according to community transmission rates.	F 886		
F 887 SS=D	COVID-19 Immunization CFR(s): 483.80(d)(3)(i)-(vii) §483.80(d) (3) COVID-19 immunizations. The LTC facility must develop and implement policies and procedures to ensure all the following: (i) When COVID-19 vaccine is available to the facility, each resident and staff member is offered the COVID-19 vaccine unless the immunization is medically contraindicated or the resident or staff member has already been immunized; (ii) Before offering COVID-19 vaccine, all staff members are provided with education regarding the benefits and risks and potential side effects associated with the vaccine; (iii) Before offering COVID-19 vaccine, each resident or the resident representative receives education regarding the benefits and risks and potential side effects associated with the COVID-19 vaccine; (iv) In situations where COVID-19 vaccination requires multiple doses, the resident, resident representative, or staff member is provided with current information regarding those additional doses, including any changes in the benefits or risks and potential side effects associated with the COVID-19 vaccine, before requesting consent for administration of any additional doses; (v) The resident or resident representative, has the opportunity to accept or refuse a COVID-19	F 887		4/15/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495204	A. BUILDING _____ B. WING _____	C 03/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLD DOMINION REHABILITATION AND NURSING	4 RIDGEWOOD PARKWAY 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 887	Continued From page 149 vaccine, and change their decision; Note: States that are not subject to the Interim Final Rule - 6 [CMS-3415-IFC], must comply with requirements of 483.80(d)(3)(v) that apply to staff under IFC-5 [CMS-3414-IFC] and (vi) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident representative was provided education regarding the benefits and potential risks associated with COVID-19 vaccine; and (B) Each dose of COVID-19 vaccine administered to the resident; or (C) If the resident did not receive the COVID-19 vaccine due to medical contraindications or refusal; and (vii) The facility maintains documentation related to staff COVID-19 vaccination that includes at a minimum, the following: (A) That staff were provided education regarding the benefits and potential risks associated with COVID-19 vaccine; (B) Staff were offered the COVID-19 vaccine or information on obtaining COVID-19 vaccine; and (C) The COVID-19 vaccine status of staff and related information as indicated by the Centers for Disease Control and Prevention's National Healthcare Safety Network (NHSN). This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interviews and clinical record review, the facility staff failed to ensure 1 out of 35 resident (Resident #35) in the survey sample, was given the opportunity to either refuse or accept a COVID-19 vaccine. The findings included:	F 887	Facility failed to ensure COVID-19 Immunization policies and procedure in place. 1) COVID-19 Immunization Policy Reviewed and Updated 2) All residents/staff has potential to be affected when policies are not reviewed	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495204	A. BUILDING _____ B. WING _____	C 03/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLD DOMINION REHABILITATION AND NURSING	4 RIDGEWOOD PARKWAY 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 887	Continued From page 150 Resident #45 was admitted to the nursing facility on 01/25/22. Diagnosis for Resident #45 included but not limited to Congestive Heart Failure and COVID-19. The most recent Minimum Data Set (MDS) an admission -5 day assessment with an Assessment Reference Date (ARD) of 01/28/22 coded Resident #45 with an 08 out of a possible score of 15 on the Brief Interview for Mental Status (BIMS), indicating moderate cognitive impairment. An interview was conducted with Resident #45 on 03/03/22 at approximately 10:30 a.m. The resident stated no one has spoken to me about receiving the COVID-19 vaccine. The resident further stated, I'm willing to get the vaccine but I need to be educated on the vaccine first. Resident #45 stated, "I'm open to receiving the vaccine especially if my doctor tells me it okay to receive, I don't believe in refusing anything that will work for me health wise." Review of Resident #45's immunization record and clinical record did not display the COVID-19 vaccine was either offered or declined. A debriefing was held with the Administrator, Director of Nursing and Corporate support on 03/03/22 at approximately 3:00 p.m., where the above information was shared. When asked for the process for offering new admission the COVID-19 vaccine, they replied, "The process starts with admission but at the moment, we do not have an admission person. The admission person will have the conversation with the newly admitted resident if they are interested in receiving the COVID-19 vaccination and the conversation will be documented in their clinical	F 887	and updated. 3) Staff and Resident will be educated on the COVID-19 Immunization Policy. The DON was educated by the Regional Director of Clinical Services on immunization requirements. Facility will ensure COVID-19 Immunization is completed as required. 4) The Regional Director of Clinical Services or Designee will monitor Immunization Records weekly X 8 weeks to assure immunizations are is being offered/completed as required. Results of these audits will be presented to the QAPI committee for additional oversight and recommendations.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495204	A. BUILDING _____ B. WING _____	C 03/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLD DOMINION REHABILITATION AND NURSING	**4 RIDGEWOOD PARKWAY 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 887	Continued From page 151 record if the vaccine was either offered/accepted or declined."	F 887		