	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		495423	B. WING		10/16/2019	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
BONVIEW	REHABILITATION AND			7246 FOREST HILL AVE		
				RICHMOND, VA 23225		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD F CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION	
F 000	INITIAL COMMENT	S	F 000			
	complaint survey wa through 10/16/2019. conducted 10/9/201 Significant correction compliance with 42 Term Care Requirem investigated during to The census in this 1	CFR Part 483 Federal Long nents. Eight complaints were he survey. 59 bed facility was 153 at the				
F 558 SS=D	of 7 Resident review	nodations Needs/Preferences	F 558	3	11/20/19	
	services in the facilit accommodation of r preferences except endanger the health other residents. This REQUIREMEN by: Based on observati documentation revie in the course of a co facility failed to acco need of mechanical for one Resident (Re sample of 7 Resider The findings include Resident #7 was dis 6/28/19. A closed re	esident needs and when to do so would or safety of the resident or T is not met as evidenced on, staff interview, facility w, clinical record review and implaint investigation, the mmodate the Resident's lift assistance with transfers, esident #7) in a survey its. d: charged from the facility on ecord review was conducted.		 Resident #7 no longer resides in the facility as of 06/28/2019 Residents who reside in the facility have the potential to be affected. Qua review of residents that are in house w be completed by the DON or designed ensure that residents have the appropriate documentation to support care was provided. Follow up based of findings. Certified Nursing Staff will be re- educated by the DON or designee on documenting ADLS that support care to support the support care to 	lity vill ≩ to ADL n	
		Imitted to the facility on	_	was provided to the resident.		
BORATORY	DIRECTOR'S OR PROVIDER	SUPPLIER REPRESENTATIVE'S SIGNATUR	E	TITLE	(X6) DATE	

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.

		ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 12/02/2019 MAPPROVED D: 0938-0391
STATEMENT C	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495423	B. WING				C 16/2019
NAME OF PF	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
BONVIEW	REHABILITATION AND			73	246 FOREST HILL AVE		
BOITTLE				R	RICHMOND, VA 23225		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 558	limited to: amyotrophi neuromuscular dysfur weakness, and contra Resident #7's most re- set) (an assessment reference coded as a quarterly a was coded as having Memory Status) score cognitive impairment. requiring total assista for her activities of da transfers, personal hy On 10/15/19 from 11: observations were ma facility; sit to stand lift floor. After staff obtai from the nurse, the st demonstrate the sit to On 10/15/19 and 10/1 conducted of Resider Review of the nursing dated 5/7/19 at 14:00 breakfast and lunch n not eat in the bed. G with consuming meals propped up in the bed refused. Guest was r devices were not in w	es included but were not ic lateral sclerosis (ALS), inction of bladder, muscle acture of left hand. ecent MDS (minimum data tool) with an ARD ce date) of 6/21/19 was assessment. Resident #7 a BIMS (Brief Interview for e of 15, which indicated no . She was also coded as ince with two staff members illy living, which included /giene, bathing, and toileting. 04 A.M. until 2:41 PM ade on all three floors of the is were observed on each ined a battery for each lift taff were able to o stand lift was operational. 16/19 a review was in #7's closed record. g notes revealed an entry "Guest has refused neal stating that she could uest was offered assistance is and was also offered to be d at highest point and still made aware that left [sic]	F	558		vill sults nted	
	bed. Lift was being us	o stand] lift to assist guest to sed, guest made aware". An e nursing notes on 6/12/19 at					

If continuation sheet Page 2 of 51

HUMAN SERVICES EDICAID SERVICES				FORM	APPROVED 0. 0938-0391
(1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				COMP	LETED
495423	B. WING _				」 16/2019
		ST	REET ADDRESS, CITY, STATE, ZIP CODE		
ALTHCARE					
EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL CIDENTIFYING INFORMATION)	ID PREFI) TAG	x			(X5) COMPLETION DATE
e able to retrieve the SST lift elevator being down guest f Resident #7's careplan #7 required assistance d by a focus statement revised on 3/1/19 that an ADL self-care related to] ALS and ord for Resident #7 9 transfer assistance was care with assistance of 2 her assistance with ted on the date of 6/12/19. M an interview was When asked about the stand lift ,CNA B stated, to look for it. It may be f the facility policy titled reviewed and read, "An completed for each shift by the CNA assigned DON were informed of the commodate the needs of 9 during a complaint was provided.	F	558			
	EDICAID SERVICES 1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495423 ALTHCARE MENT OF DEFICIENCIES UST BE PRECEDED BY FULL DENTIFYING INFORMATION) Able to retrieve the SST lift elevator being down guest F Resident #7's careplan #7 required assistance d by a focus statement revised on 3/1/19 that an ADL self-care related to] ALS and ord for Resident #7 0 transfer assistance was care with assistance of 2 her assistance with ted on the date of 6/12/19. M an interview was When asked about the tand lift ,CNA B stated, to look for it. It may be f the facility policy titled eviewed and read, "An completed for each hift by the CNA assigned DON were informed of the commodate the needs of 9 during a complaint was provided.	EDICAID SERVICES 1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULT A. BUILDI 495423 B. WING FALTHCARE ID EMENT OF DEFICIENCIES IDENTIFYING INFORMATION) ID PREFIDENTIFYING INFORMATION) PREFIDENTIFYING INFORMATION) F Resident #7's careplan #7 required assistance d by a focus statement revised on 3/1/19 that an ADL self-care elated to] ALS and prd for Resident #7 D p transfer assistance was care with assistance of 2 ner assistance with ted on the date of 6/12/19. M an interview was When asked about the tand lift ,CNA B stated, to look for it. It may be f the facility policy titled eviewed and read, "An completed for each hift by the CNA assigned OON were informed of the commodate the needs of D during a complaint vas provided.	EDICAID SERVICES 1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE A. BUILDING 495423 B. WING 495423 B. WING FALTHCARE TZ RI EMENT OF DEFICIENCIES IDENTIFYING INFORMATION) PREFIX TAG F PESCEDED BY FULL CIDENTIFYING INFORMATION) PREFIX TAG F Resident #7's careplan #7 required assistance d by a focus statement revised on 3/1/19 that an ADL self-care elated to] ALS and ord for Resident #7 0 transfer assistance was care with assistance of 2 her assistance with led on the date of 6/12/19. M an interview was When asked about the tand lift, CNA B stated, to look for it. It may be . If the facility policy titled eviewed and read, "An completed for each hift by the CNA assigned OON were informed of the commodate the needs of 9 during a complaint Vas provided.	Display Description (2) MULTIPLE CONSTRUCTION ABUILDING	EDICAID SERVICES ONE NO 1) PROVIDER/SUPPLER/CLA (X2) MULTIPLE CONSTRUCTION (X3) DATE 495423 B. WING (X1) 495423 B. WING (X1) ALTHCARE STREET ADDRESS, CITY, STATE, ZIP CODE (X2) ALTHCARE STREET ADDRESS, CITY, STATE, ZIP CODE (X2) INUET REPRECEDED BY FULL PREFIX FACH CORRECTION (Y2) IDENTIFYING INFORMATION PREFIX (EACH CORRECTION DETORECTION (Y2) IDENTIFYING INFORMATION PREFIX (EACH CORRECTION DETORECTION DETORECTION (Y2) IDENTIFYING INFORMATION PREFIX (EACH CORRECTION DETORECTION (Y2) IDENTIFYING INFORMATION PREFIX (EACH CORRECTION) (Y2) IDENTIFYING INFORMATION PREFIX (EACH CORRECTION) (Y2) IDENTIFYING INFORMATION PREFIX (EACH CORRECTION) (Y2) IDENTIFYING INFORMATION PREFIX (Y2) (Y2) (Y2) Abble to retrieve the SST lift (Y2) (Y2) (Y2) (Y2) Stafer assistance (Y2) (Y2) (Y2) (Y2) Y2 Tan Con

Facility ID: VA0418

If continuation sheet Page 3 of 51

ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA ID PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY	
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		CC	MPLETED
		495423	B. WING		C 10/16/2019	
NAME OF P	ROVIDER OR SUPPLIER	I	STF	REET ADDRESS, CITY, STATE, ZIP CODE		10/10/2010
BONVIEW	REHABILITATION AND	HEALTHCARE		6 FOREST HILL AVE CHMOND, VA 23225		
(X4) ID PREFIX TAG	(EACH DEFICIENC	SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF COF (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE ADDEFICIENCY			HOULD BE	(X5) COMPLETION DATE
F 567	Continued From page	e 3	F 567			
F 567 SS=D	Protection/Manageme CFR(s): 483.10(f)(10	ent of Personal Funds (i)(ii)	F 567			11/20/19
	the right to know, in a facility may impose a funds. (i) The facility must ne deposit their persona resident chooses to d the facility, upon writt resident, the facility ne resident's funds and l and account for the p deposited with the face section. (ii) Deposit of Funds. (A) In general: Excep IO)(ii)(B) of this section any residents' person an interest bearing ac separate from any of accounts, and that con- resident's funds to tha accounts, there must for each resident's sh maintain a resident's exceed \$100 in a nor interest-bearing acco (B) Residents whose The facility must depo- funds in excess of \$5 account (or accounts	ancial affairs. This includes idvance, what charges a gainst a resident's personal of require residents to I funds with the facility. If a leposit personal funds with en authorization of a nust act as a fiduciary of the hold, safeguard, manage, ersonal funds of the resident cility, as specified in this t as set out in paragraph (f)(n, the facility must deposit hal funds in excess of \$100 in count (or accounts) that is the facility's operating edits all interest earned on				

If continuation sheet Page 4 of 51

		ND HUMAN SERVICES MEDICAID SERVICES			FOR	D: 12/02/20 MAPPROVE 0. 0938-039	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 · ·	E CONSTRUCTION		E SURVEY PLETED C	
		495423	B. WING		10	/16/2019	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	•		
BONVIEW	REHABILITATION AND	HEALTHCARE	7246 FOREST HILL AVE RICHMOND, VA 23225				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE	
F 567	The facility must main not exceed \$50 in a r interest-bearing acco This REQUIREMENT by: Based on Resident in clinical record review review and in the cou investigation, the facil residents' right to ma residents (Residents sample of 7 residents The findings included 1. For Resident #5, th provide access to the (RTF). Resident #5, a 76 yea the facility on 01/30/1 revealed that Residen Responsible Party. On 10/15/19 at appro- interview was conduct stated, "I know I'm su I have never gotten a have no idea where r are stealing it all from me about it when I as phone and it was time but nobody here wou money for my phone cut off so I just gave to keep because what w	htain personal funds that do noninterest bearing account, unt, or petty cash fund. Γ is not met as evidenced Interview, staff interview, , facility documentation urse of a complaint lity staff failed to protect the nage their own money for 2 #5 and #3) in a survey s. I: the facility staff failed to a Resident's Trust Fund ar old male, was admitted to 8. Clinical record review int #5 was his own	F 567		 /2019. A /2019. A greement provided esident # 3 as of de ident Trust ative are e facility I. Quality puse was A and r to ensure eir account p based enue Cycle or, HRC- ment mess ent Trust right to punts. tement te resident al funds igned hdraw 		

Event ID: RIWW11

Facility ID: VA0418

If continuation sheet Page 5 of 51

		ID HUMAN SERVICES MEDICAID SERVICES				FORI	D: 12/02/2019 MAPPROVED D. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· <i>`</i>		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495423	B. WING				C / 16/2019
NAME OF P	ROVIDER OR SUPPLIER	•		ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
BONVIEW	REHABILITATION AND	HEALTHCARE			246 FOREST HILL AVE ICHMOND, VA 23225		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 567	the Authorization and Resident Funds was Resident #5's written copy of the Resident Statement for Reside his Resident Trust Fu- requested and receiv on 10/17/18 for \$12.0 "Barbershop" and a v \$15.00 with a referen were no other withdra Cost payments for the Verification of authori \$12.00 and \$15.00, v On 10/15/19 at appro- interview was conduc Business Office Mana confirmed that author 10/17/18 for the Barb because the "Daily R Charges" dated 10/1/ #5's signature for pay stated that in the eve witnesses would be r however the verification witness signatures for On 10/16/19 at appro- follow-up interview wa #5 who stated, "I hav about trying to find ou never received any m anything about withdow wanted money to pay year but that never has phone service, no on	Agreement to Handle provided and contained signature. Additionally, a Fund Management Service int #5 from the opening of und to present was ed. There was a withdrawal 00 with a notation withdrawal on 4/12/19 for ce #953331 noted. There awal entries other than Care e Facility room and board. zation for the 2 withdrawals, was requested and provided. eximately 3:00 PM, an cted with the Interim ager (Employee I) who rization for the \$12.00 on eershop was not sufficient eport of Beauty Shop '18 did not contain Resident vment authorization. She in the could not sign, two equired to sign on his behalf, fon did not contain two r authorization either.	F	567	account will be reconciled at that time Residents who open a trust Account in have the Executive Director signature ¿ The Executive Director will comp quality monitoring weekly for 8 weeks ensure compliance with RFMS accound statements, and account reconciliation The results of the quality monitoring weekly for review, analys and further recommendations. ¿ Date of compliance 11-20-19	must e. lete to nts, n vill e	

Facility ID: VA0418

If continuation sheet Page 6 of 51

		ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 12/02/2019 MAPPROVED D. 0938-0391
STATEMENT (OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPL	E CONSTRUCTION	(X3) DATE	SURVEY
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	NG _			
		495423	B. WING				C 16/2019
NAME OF PI	ROVIDER OR SUPPLIER		ł	5	STREET ADDRESS, CITY, STATE, ZIP CODE	•	
BONVIEW	REHABILITATION AND	HEALTHCARE			7246 FOREST HILL AVE RICHMOND, VA 23225		
	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE
F 567	 567 Continued From page 6 first time but it's not right and no one has bothered to go over it with me to answer my questions-they just dropped it off and said they will be around sometime later, there are several folks in here that they do the same thing too, it's just not rightI cannot even have what is supposed to be rightfully mine". In summary, the facility staff failed to provide Resident #5 access to his Resident Trust Fund. 		F	567	,		
	questions-they just dr will be around sometii folks in here that they just not rightI canno	opped it off and said they me later, there are several do the same thing too, it's t even have what is					
	In summary, the facili	ty staff failed to provide					
	Resident #5 access to	o his Resident Trust Fund.					
	COMPLAINT DEFICI	ENCY					
	Resident to set-up a p and deposit funds wit already stated a desir Resident #3 was origi on 12-28-16, with a re following a hospitaliza discharged from the fa Resident's diagnoses disease, dementia, di heart failure, claustrop hypothyroidism, hype benign tumor of the m brain.	rtension, hallucination, and neninges covering of the					
	Data Set, was a disch Assessment Reference coded Resident #3 as and to be understood	recent (MDS) Minimum harge assessment, with an ce Date of 8-13-19, and s being able to understand, by others. The Resident memory deficits, and was					
	moderately cognitively	y impaired. The Resident					

Facility ID: VA0418

If continuation sheet Page 7 of 51

	-					FOF	RM APPROVED IO. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
		495423	B. WING			1	C 0/16/2019
NAME OF PI	ROVIDER OR SUPPLIER	L		:	STREET ADDRESS, CITY, STATE, ZIP CODE	_ _	
BONVIEW	REHABILITATION AND	HEALTHCARE			7246 FOREST HILL AVE RICHMOND, VA 23225		
(X4) ID PREFIX TAG	IDENTIFICATION NUMBER: IDENTIFICATION NUMBER: 495423 REHABILITATION AND HEALTHCARE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 7 required extensive assistance from staff for bed mobility, transferring, dressing and toileting. A review of the closed record was conducted. On 10-16-19 during a closed record review, it was revealed that Resident #3 had executed a durable power of attorney (POA) appointing her daughter as her authorized representative to act on her behalf prior to admission to the facility. Or 12-28-16 during the admission process, Resident #3's daughter/POA signed pages 10 and page 12 of the admissions agreement indicating she did not want to open a Resident Trust Fund Account. Despite this request, the facility business office manager sent Resident #3's daughter/POA a letter on 3-15-17, along with a "corrected patient trust account agreement" asking her to sign to open an account, due to a cash payment being received. On 10-16-19 during a closed record review, it was also revealed that Resident #3's daughter/POA had signed page 19 of the admissions agreemen on 12-28-16, stating "I do not want my social security check assigned to [facility name redacted]." Despite this request by Resident #3's POA, the facility staff completed an application to become Representative Payee for Resident #3's social security benefits on 12-29-16. The facility physician then completed on 1-5-17 a		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 567	required extensive as mobility, transferring, A review of the closed On 10-16-19 during a revealed that Resider durable power of atto daughter as her autho on her behalf prior to 12-28-16 during the a #3's daughter/POA si of the admissions agr not want to open a Re Despite this request, manager sent Reside letter on 3-15-17, alor trust account agreem open an account, due received. On 10-16-19 during a also revealed that Re had signed page 19 c on 12-28-16, stating ' security check assign redacted]." Despite th POA, the facility staff become Representati social security benefit physician then compl "Physician's/Medical patient's capability to that Resident #3 was financial affairs, maki #3's written POA exec daughter to handle he behalf, in the event R	sistance from staff for bed dressing and toileting. d record was conducted. d record was conducted. d record was conducted a rney (POA) appointing her orized representative to act admission to the facility. On admission process, Resident gned pages 10 and page 12 reement indicating she did esident Trust Fund Account. the facility business office ent #3's daughter/POA a ng with a "corrected patient ent" asking her to sign to a to a cash payment being d closed record review, it was sident #3's daughter/POA of the admissions agreement 'I do not want my social led to [facility name his request by Resident #3's completed an application to twe Payee for Resident #3's ts on 12-29-16. The facility eted on 1-5-17 a Officer's statement of manage benefits" indicating unable to handle her ng no reference to Resident cuted 6-11-10 appointing her er financial affairs on her esident #3 was no longer	F	567	7		
	daughter to handle he	er financial affairs on her esident #3 was no longer					

Facility ID: VA0418

If continuation sheet Page 8 of 51

		ID HUMAN SERVICES MEDICAID SERVICES				FORI	D: 12/02/2019 MAPPROVED D. 0938-0391	
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		CONSTRUCTION	(X3) DATE SURVEY COMPLETED C		
		495423	B. WING				/16/2019	
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE			
BONVIEW	REHABILITATION AND	HEALTHCARE		73	246 FOREST HILL AVE			
				R	CICHMOND, VA 23225			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 567	F 567 Continued From page 8		F	567				
	was identified that fro were a total of 4 com addressed to the facil behalf of Resident #3 Social Security Admir application from the fa- representative payee On 10-16-19 during the was identified that fro were 8 cash withdraw Resident Trust Fund Each of these cash w illegible signatures, la Resident signed. Resident signed. Resident signed. Resident facilities' assessment physician had indicate to handle financial aff	ity [name redacted] on . The first being that the histration had received the acility applying to be for Resident #3. the closed record review it m 3-2-18 until 5-24-19 there vals from Resident #3's Account, which totaled \$370. withdrawals contained ack of 2 witnesses, or the sident #3 had a diagnosis of ed decision making per the of the Resident, and the ed the Resident was unable fairs. However, the facility thdrawals without sufficient						
	Employee J, the Region Office Services when trust account, Employ it, I know it's not good and there aren't two services On 10/16/19 at approvide was conducted of the "Resident Trust Fund Representative Payer of 6/28/19. The polic from the Care Center Business Office Mana	ximately 3:30 PM a review facility policy titled						

Facility ID: VA0418

If continuation sheet Page 9 of 51

		ID HUMAN SERVICES MEDICAID SERVICES				FORM): 12/02/2019 // APPROVED). 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION		LETED
		495423	B. WING _				C 16/2019
NAME OF PF	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
BONVIEW	REHABILITATION AND	HEALTHCARE			246 FOREST HILL AVE NCHMOND, VA 23225		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 567	stated, "The business for Representative Par the resident is not cap funds". This policy do allow the Resident to selected representative attorney to manage the behalf. The facility staff were of the facility policy vie manage his or her fina afternoon of 10-16-19 On 10-16-19 at appro- facility staff made revi- titled "Resident Trust Representative Payees survey team with the revisions included the the Resident the right affairs and the facility Representative Payee Resident. No further information	 manner". erenced above, further a office manager should file ayee in those cases where bable of handling their own besn't take into account or allow their previously we such as a power of heir financial affairs on their made aware of the concern bating Resident #3's right to ancial affairs on the ximately 6:00 PM, the isions to the facility policy Fund- Application for e Status," and presented the updated policy. The regulation text which allows to manage their financial to only apply for e upon written request of the 	F	567			
F 568 SS=D	CFR(s): 483.10(f)(10) §483.10(f)(10)(iii) Acc (A) The facility must e system that assures a	rds of Personal Funds	F	568			11/20/19
	0.						

Facility ID: VA0418

If continuation sheet Page 10 of 51

		ND HUMAN SERVICES				FO	ED: 12/02/20 RM APPROVE <u>NO. 0938-03</u>
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495423	B. WING			1	C 0/16/2019
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
	REHABILITATION AND			72	246 FOREST HILL AVE		
	REHABILITATION AND	HEALTHCARE		R	RICHMOND, VA 23225		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	ULD BE	(X5) COMPLETIO DATE
F 568	Continued From page	e 10	F	568			
				000			
		principles, of each resident's sted to the facility on the					
	(B) The system must	preclude any commingling n facility funds or with the					
fun	funds of any person of	other than another resident. ancial record must be					
	available to the resid						
	statements and upon	•					
		Γ is not met as evidenced					
	by:						
		on, resident interview, staff			¿ Resident # 5 was provided a		
	interview, clinical rec	w and in the course of a			his account statement on 10/15/2 ¿ Residents who reside in the f		
		on, the facility staff failed to			¿ Residents who reside in the f have the potential to be affected.		
	provide financial reco	-			review of residents that are in hou	-	
		urvey sample of 7 residents.			completed by the Regional BOM a Travel Business Office Manager t	and	
	The findings included	1 :			that residents have a copy of their statements. Follow up based on fi	r account	
		facility staff failed to provide			¿ The Vice President of Rever	ue Cycle	
		of the Resident's Trust Fund			educated the Admissions Director		
	(RTF).				Payroll □AP, Business Developm	ent	
	Posidont #5 a 76	ar old male, was admitted to			Coordinator, Executive Director,		
	· · ·	ar old male, was admitted to 18. Clinical record review			Receptionist and Assistant Busine Manager on Resident Trust Fund		
	revealed that Reside				Residents will be provided a state		
	Responsible Party.				quarterly and upon request. If the		
					resident chooses to deposit their		
	On 10/15/19 at appro	oximately 11:00 AM, an			funds with the facility; they must s		
		cted with Resident #5 and he			authorization. Residents who with	-	
		upposed to get \$40 a month,			money will be provided a receipt a	at the	
		anything, no money at all, I			time of withdraw upon request.		
		my money has gone, they			Residents who open a trust Accou		
	-	n me, nobody will even talk to			have the Executive Director signa	ture to	
	me about it when I as	SK".			ensure proper execution.	malete	
	On 10/15/10 -+	wimataly 2:00 DM ar			¿ The Executive Director will co		
		oximately 3:00 PM, an			quality monitoring weekly for 8 we		
	interview was conduc	clea with the interim			ensure compliance with RFMS ac	counts,	

Facility ID: VA0418

If continuation sheet Page 11 of 51

	-	ID HUMAN SERVICES MEDICAID SERVICES			FO	ED: 12/02/2019 RM APPROVED IO. 0938-039
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495423	B. WING		1	C 0/16/2019
NAME OF P	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP COD		
BONVIEW	REHABILITATION AND	HEALTHCARE		7246 FOREST HILL AVE RICHMOND, VA 23225		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTIOI CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE APPROPRIATE	(X5) COMPLETION DATE
F 568 F 602 SS=J	confirmed that there Resident #5 received his Resident Trust Fu account in May 2018 quarterly statements acknowledge his rece requires, I cannot say quarterly statement to A facility policy was m Facility policy entitled RTF Quarterly Statement 2/26/2019, read: "Pol Resident Trust Fund resident", "Procedure in-house statements acknowledgment from In summary, the facil quarterly statements Resident Trust Fund. COMPLAINT DEFICH Free from Misapprop CFR(s): 483.12 S483.12 The resident has the neglect, misappropria and exploitation as de includes but is not lim corporal punishment,	ager (Employee I) who was no evidence that I any quarterly statements of ind since the opening of the and stated, "None of his have been signed by him to eipt of them, which our policy y that he received any o date". equested and received. I, "Resident Trust Fund - nent", revision date licy: A quarterly written statement is issued to the e: 7. A signed copy of should be obtained as n all competent residents". ity staff failed to provide to Resident #5 regarding his ENCY riation/Exploitation right to be free from abuse, ation of resident property, efined in this subpart. This nited to freedom from involuntary seclusion and	F 568	statements, and account reco The results of the quality mor be presented to the Quality A committee monthly for review and further recommendations ¿ Date of compliance 11-2	nitoring will ssurance /, analysis s.	11/20/19
	Resident Trust Fund. COMPLAINT DEFICI Free from Misapprop CFR(s): 483.12 §483.12 The resident has the neglect, misappropria and exploitation as de includes but is not lim corporal punishment, any physical or chem	ENCY riation/Exploitation right to be free from abuse, ation of resident property, efined in this subpart. This nited to freedom from	F 602	2		11/20

Event ID: RIWW11

Facility ID: VA0418

If continuation sheet Page 12 of 51

		ID HUMAN SERVICES MEDICAID SERVICES					NTED: 12/02/20 FORM APPROVE B NO. 0938-039
STATEMENT (DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		NSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495423	B. WING _				C 10/16/2019
NAME OF P	ROVIDER OR SUPPLIER	•		STRE	ET ADDRESS, CITY, STATE, ZIP CODE		
				7246	FOREST HILL AVE		
BONVIEW	REHABILITATION AND	HEALTHCARE		RICH	IMOND, VA 23225		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 602		e 12 n review, clinical record rd review, and in the course	F 6	0	n 6-4-19 from the facility RFMS a n the amount of \$887.00 and a ch		
	to prevent misapprop resident financial ass (Resident #6, #5, #3)			\$ R re	rom the operating account on 6-5- 847.00. The Regional Vice Presid Revenue reviewed the statement v esident #5 provided his quarterly tatement on 10/15/2019. Residen	dent of with nt #5 will	
	called on 10/16/2019 on 10/16/2019 at 4:3	for Residents #6 and #5 was at 3:43 PM. It was removed 0 PM. After removal, it was solated for Residents #6 and		re ir د ن		resides ent	
	The findings include:			c R	Funds Management System (RFM Furrent residents will be conducted Regional Director of Business Offic	d by the	
	representative payee without the permissio	plied for and received status from Social Security n or knowledge of Resident responsible party. Because		re fa	Services (RDBOS) to ensure that esidents signed agreements for th acility to become their rep payee. If current residents in house with I	Review	
	lost his apartment an	ave access to his money, he d his furnishings. His sychological harm including		P	accounts was conducted to ensure Physician statement was accurate completed for those incapable of		
		sment, fear, becoming		n s	nanaging their own funds and soc ecurity check assignment. Noted liscrepancies will be corrected		
				ir th w	nmediately. Facility will pay restin nose residents, as deemed appro vith regard to investigative finding. Review of current residents for	priate,	
	situation induced ong feelings of helplessne inability to communic	oing fear and anxiety, ess, fear of identity theft, and ate with advocates, including		rr Ir ذ	nisappropriation was completed b nterdisciplinary team 10-16-19. , A)Regional Vice President of	-	
		to have no access to his counts. This situation and anxiety causing		fa H	Revenue conducted education wil acility Business Office Manager, IR/Payroll, Admissions Coordinat D on 10-16-19 to ensure underst	or and	
	3. For Resident #3 th	e facility staff Resident's funds by applying		0 0	f the center⊡s Policy and Proced btaining Representative Payee, pplication process, maintaining re	ure for	

Facility ID: VA0418

If continuation sheet Page 13 of 51

		ND HUMAN SERVICES				FORM	D: 12/02/20 MAPPROVE D. 0938-03
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í	(X2) MULTIPLE CONSTRUCTION A. BUILDING			SURVEY PLETED
		495423	B. WING _				C 16/2019
NAME OF PI	ROVIDER OR SUPPLIER	•		ST	REET ADDRESS, CITY, STATE, ZIP CODE	•	
	REHABILITATION AND			72	46 FOREST HILL AVE		
BOINVIEW	REHABILITATION AND	HEALINGARE		RI	ICHMOND, VA 23225		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	ĸ	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETIO DATE
F 602	Continued From page	e 13	F 6	502			
					funde banking system and providing		
	to become represent	curity Income, despite the			funds, banking system and providing quarterly statements. Education was a	also	
		Attorney stating they did not			provided on federal regulation 483.10		
		his and the facility permitted			(10) in regard to resident s rights to	(.)	
		from the Resident's account			manage his or her financial affairs and	d the	
	without sufficient sup				procedure for managing accounts if th	ne	
					resident thus chooses to deposit his c	or	
					her money in the RFMS.		
		i 54 year old who was			B) Executive Director will review socia		
		y on 2/6/19. His diagnoses			security check assignment for accurate	су	
	included Legal Blindr				and completeness upon admission.		
		iparesis Following Cerebral			C) Authorization to open an RFMS		
	Generalized Muscle	eft Non-Dominant Side,			account will be reviewed by the execu director or don for accuracy prior to a		
		eumatoid Arthritis, Major			account being opened.	1	
		, and Anxiety Disorder.			D) Quarterly statements will be issued	t to	
					the resident or designated representa		
	The Minimum Data S	Set, which was a Quarterly			A signed copy of in-house statements		
		Assessment Reference Date			be obtained as acknowledgment from		
	of 5/16/19 was review	wed. Resident #6 was coded			competent residents and filed with co	pies	
	as having a Brief Inte	erview of Mental Status			of mailed statements.		
		ig no cognitive impairment.			E) Executive Director will review		
		ed as having no rejection of			Physician/Medical officer statement o		
		bal behavioral issues. He had			patient⊡s capability to manage benef	its	
		otion in both his upper, and			with DON prior to request. Upon	iou	
	physical assistance of	the left side. He required the			completion, Executive Director will rev and validate NO/NO prior to submissi		
		alking, bathing, eating,			SSA to become rep payee on behalf of		
	dressing, toileting, ar				resident.		
	, construig, di				¿ Quality Monitoring will be conduct	ted	
	Resident #6's care pl	lan was reviewed. There was			by the RVPR for compliance with proc		
		at he was a danger to			to ensure resident⊡s rights to manage		
	himself or others. As	his own responsible party,			or her financial affairs and the proced		
		ed his right to determine			for managing accounts if the resident		
		tments he would attend. An			chooses to deposit his or her money i	n	
		e plan read, "wishes to stay			the RFMS. Quality Monitoring will be		
		Term Care)Diabetes			conducted for 8 weeks, and then 1 x		
		edication as ordered by			monthly for 4 months to ensure contin		
	aoctor. wonitor/docu	ment for side effectsAt risk			compliance. Findings of the RDBOS	WIII	

Facility ID: VA0418

If continuation sheet Page 14 of 51

DEPARTMENT OF HEALTH AN CENTERS FOR MEDICARE & I				FOR	D: 12/02/2019 M APPROVED D. 0938-0391	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
	495423	B. WING			C /16/2019	
NAME OF PROVIDER OR SUPPLIER		·	STREET ADDRESS, CITY, STATE, ZIP CO	DE		
BONVIEW REHABILITATION AND			7246 FOREST HILL AVE			
BONVIEW REHABILITATION AND	HEALINCARE		RICHMOND, VA 23225			
PREFIX (EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
 Psychoactive drug us Anticipate and meet ti anti-anxiety medication Monitor for side effect medication r/t Depress effects and effectiven SHIFT]bladder inco Mobility and vision. Th septicemia will be mir function r/t Blindness, of Daily Living] self-ca balance. Assist with A On 10/9/19 a review v complaint submitted t excerpt read: "the fac check without his per discharge date was 6 had his clothes packet him to leave the faciliti alleges that he has be any other place that he The Discharge Summ reviewed. There was discharge, no physicia status measurements requirements, no mer no list of medications, and no facility staff sig On 10/9/19, a review was conducted, revea facility's attending phy 1) 2/26/19. Physician' Statement of Patient's Benefits. An excerpt r 	 Gait/balance problems, we, Vision/hearing problems. he resident's needsuses ons r/t Anxiety Disorder. tsuses antidepressant asion. Monitor/document side ess Q-SHIFT [EVERY ntinence r/t Impaired he resident's risk for nimizedimpaired visual , GlaucomaADL [Activities are deficit r/t Impaired ADLs as needed." was conducted of a to the State Agency. An willity took his Social Security missionhis scheduled /14/19, the administrator ad on 6/7/19 and ordered ty in the rainResident een sleeping at Walmart and ne can find." hary dated 6/7/19 was no physician evaluation of an's signature, no medical s, no nutritional status and ntal and psychosocial status, no reason for discharge, gnature. of facility documentation aling 2 documents by the ysician. 	F 6		vill then report Quality provement) ths for ance and/or		

Facility ID: VA0418

If continuation sheet Page 15 of 51

		ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 12/02/2019 MAPPROVED D. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` <i>`</i>		E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		495423	B. WING				C / 16/2019
NAME OF PI	ROVIDER OR SUPPLIER	•	•	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
				7	246 FOREST HILL AVE		
BONVIEW	W REHABILITATION AND HEALTHCARE			R	RICHMOND, VA 23225		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 602	No." 2) 5/7/19. Do you bell managing or directing benefits in his or her Record says he is leg wants to manage his expect the patient to the future? Yes." On 10/15/19 at appro- interview was conduce Business Office Mana- regular Business Office "unavailable, and not due to the fact that sh due to 'financial issue according to the Seni (Employee E). The In Manager was asked to signed Resident Trus Beneficiary form. The Resident #6's name to signed by him or any- not authorized the face Trust Account, neither to be his Beneficiary. In addition, she subm Security. One addressed to Re- in part "We are writing information that show your money and mee- this information, we p Security benefits to [r	ieve the patient is capable of g the management of own best interest? Unsure. gally blind. However he own finances. Do you be able to manage funds in eximately 12:22 P.M. an exted with the Interim ager (Employee I). The ce Manager was allowed to return to work he was being investigated es in the Business office", for Operations Director interim Business Office for a copy of Resident #6's t Account Agreement and e form she submitted had yped on it, but was not witnesses. Resident #6 had cility to establish a Resident r did he authorize the facility	F	602			
	Another dated 6/28/1	9 which was addressed to					

Facility ID: VA0418

If continuation sheet Page 16 of 51

	OF DEFICIENCIES	MEDICAID SERVICES		PLE CONSTRUCTION		10. 0938-039 TE SURVEY		
	CORRECTION	IDENTIFICATION NUMBER:	. ,	G	· · ·	MPLETED		
			A. BUILDING			С		
		495423	B. WING					
		+30+20		STREET ADDRESS, CITY, STATE, ZIP CODI		0/16/2019		
NAME OF P	ROVIDER OR SUPPLIER				=			
BONVIEW	REHABILITATION AND	HEALTHCARE		7246 FOREST HILL AVE RICHMOND, VA 23225				
				· · ·				
(X4) ID PREFIX TAG	(EACH DEFICIENC	IATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COL (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE		
F 602	Continued From pag	e 16	F 60	12				
		rt, "We have decided that it me of Resident #6] to have						
	-	m. The money you will need						
	to return includes say							
		rned money you have left						
		s we sent youany checks						
		ter the date of this letter."						
	On 10/16/10 from 10	:10 A.M. until 11:00 A. M., a						
		was conducted with Resident						
	-	sion to be on speakerphone						
		y team present. During the						
		6 related the circumstances						
		the facility. Resident #6						
	-	ed during the interview. He						
	-	veteran. Resident #6 was						
		e impact the discharge and						
		Social Security funds had on						
		felt embarrassed, humiliated,						
		are afraid because I can't						
		ything to me. I don't have the						
		contacts. You become numb						
		vitness what's going on and						
	they lie so fluently."							
	Resident #6 stated th	nat the facility Vice President						
		es since the previous night						
		im to return to the facility,						
	,	trator and Business Office						
		vorked at the facility. 'I said to						
	• •	you invite me back to the						
		igged? You caused me to						
	-	ecause I couldn't pay for my						
		everything in it'. They gave						
		e Social Security checks						
		as too late by then. I had lost						
		omeless. About a month ago,						
		spital I'm supposed to get an						
	infusion every 6 wee		1			1		

Facility ID: VA0418

If continuation sheet Page 17 of 51

	-	ND HUMAN SERVICES MEDICAID SERVICES				F	NTED: 12/02/2019 ORM APPROVED 3 NO. 0938-0391	
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	IPLE CONSTR		(X3) DATE SURVEY COMPLETED		
		495423	B. WING				C 10/16/2019	
NAME OF P	ROVIDER OR SUPPLIER	1		STREET AD	DDRESS, CITY, STATE, ZIP CO	DE		
BONVIEW	REHABILITATION AND	HEALTHCARE						
	(X4) ID SUMMARY STATEMENT OF DEFICIENCIES			RICHMON	ND, VA 23225			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE	
F 602	Continued From page	e 17	F 6	02				
	to the facility on 01/3 revealed that Resider Responsible Party. R alert and oriented to situation and was abl On 10/15/19 at appro- interview was conduct stated, "I know I'm su I have never gotten a have no idea where r are stealing it all from me about it when I as phone and it was tim- but nobody here wou money for my phone cut off so I just gave to keep because what v here? It's just not right ignore me".	Resident #5 presented as person, place, time, and le to converse easily. Eximately 11:00 AM, an cted with Resident #5 and he upposed to get \$40 a month, unything, no money at all, I my money has gone, they in me, nobody will even talk to skI came here with my cell e for me to pay my phone bill ld listen that I needed my bill, my phone service got my phone to my sister to vas the point of having it th thow I am treated, they						
	the Authorization and Resident Funds was Resident #5's written copy of the Resident Statement for Residen his Resident Trust Fu requested and receiv on 10/17/18 for \$12.0 "Barbershop" and a v \$15.00 with a referen	ed. There was a withdrawal						

Facility ID: VA0418

If continuation sheet Page 18 of 51

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION		LETED
		495423	B. WING				C 16/2019
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
BONVIEW	REHABILITATION AND	HEALTHCARE			246 FOREST HILL AVE RICHMOND, VA 23225		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 602	Cost payments for the Verification of authorit \$12.00 and \$15.00, w On 10/15/19 at appro- interview was conduct Business Office Mana- confirmed there was in #5 received any quart Resident Trust Fund s account in May 2018. that authorization for 10/17/18 to the Barbe- because the "Daily Re Charges" dated 10/1/ #5's signature for pay stated that in the even witnesses would be re however the verificati witness signatures for On 10/16/19 at appro- follow-up interview wa #5 who stated, "I have about trying to find ou never received any m don't know anything a account, I wanted mo back last year but tha my cell phone service received a copy of my yesterday for the first one has bothered to g my questions-they just	e Facility room and board. zation for the 2 withdrawals, vas requested and provided. ximately 3:00 PM, an ted with the Interim ager (Employee I) who no evidence that Resident terly statements of his since the opening of the Employee I also confirmed withdrawal of \$12.00 on ershop was not sufficient eport of Beauty Shop 18 did not contain Resident ment authorization. She nt he could not sign, two equired to sign on his behalf, on did not contain two r authorization either. ximately 9:00 AM, a as conducted with Resident e made a lot of requests at where my money is, I have noney or statements and I about withdrawals in my ney to pay my cell phone bill t never happened so I lost a, no one caresI finally y account statement time but it's not right and no go over it with me to answer at dropped it off and said ometime later, there are hat they do the same thing cannot even have what is	F	602			

If continuation sheet Page 19 of 51

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391	
STATEMENT (DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			(X3) DATE		
		495423	B. WING				C 16/2019	
NAME OF P	ROVIDER OR SUPPLIER			:	STREET ADDRESS, CITY, STATE, ZIP CODE			
	REHABILITATION AND				7246 FOREST HILL AVE			
BOINVIEW	REHABILITATION AND	HEALTHCARE			RICHMOND, VA 23225			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	E ACTION SHOULD BE COME		
F 602	Resident #5 stated, "I all of my life and I hav managed my money. much in my life but I w what I did have and I point that I arrived hei agreed to allow them Social Security check have been asking to s time, over a year, and my identity has been like [S**T] every day. and nobody cares. It's can't stop thinking ab room anymore, I used anymore". Immediate Jeopardy w 3:43 PM The facility Removal I facility on 10/16/19 ar implemented. The Im abated at 4:30 P.M. The plan read: 1. Resident #6 receive 6-4-2019 from the fac Management System \$887.00, and a check on 6-5-2019 for \$847. President of Revenue with Resident #5 and	have been a working man ve always paid my bills and I may not have had very worked long and hard for managed myself up to the re. When I came here, I [the facility] to take my to pay for my room but I see my account for a long d nothing. I feel as though stolen. I feel robbed. I feel I am a victim of this system s on my mind every day, I out it. I don't go out of my d to go outside but I don't go was called on 10/16/2019 at Plan was submitted by the nd verified as having been mediate Jeopardy was eed a refund check on sility RFMS (Resident Funds) account in the amount of c from the operating account .00. The Regional Vice e reviewed the statement provided his quarterly 019. Resident #5 will have	F	602	2			

Facility ID: VA0418

If continuation sheet Page 20 of 51

		ID HUMAN SERVICES MEDICAID SERVICES					RINTED: 12/02/2 FORM APPRO MB NO. 0938-0	VED
STATEMENT (ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA D PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495423	B. WING				C 10/16/2019	
NAME OF PI	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE	I		
				72	46 FOREST HILL AVE			
BUNVIEW	SONVIEW REHABILITATION AND HEALTHCARE			RI	CHMOND, VA 23225			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETI DATE	
F 602	Director of Business of ensure that residents facility to become the Review of current res accounts was conduct statements were accounts incapable of managin Security check assign will be corrected immerestitution to those re appropriate with regareview of current resident to the completed by the 10-16-2019. 3. A) Regional Vice P conducted education Office Manager, Hume Admissions Coordination Office Manager, Hume Admissions Coordination on 10/16/2019 to ensist Center's policy and p Representative Payer maintaining resident to providing quarterly statist also provided on feder regarding resident rig affairs, and the proce if the resident choose RFMS.	hts' RFMS for current ducted by the Regional Office Services (RDBOS) to signed agreements for the ir representative payee. bidents in house with RFMS beted to assure the physician urately completed for those og their own funds and Social ment. Noted discrepancies ediately. Facility will pay sidents as deemed rd to investigative findings. A dents for misappropriation e interdisciplinary team on President of Revenue with the facility Business han Resources/Payroll, tor, and Executive Director ure understanding of the rocedure for obtaining e, application process, funds, banking system, and atements. Education was eral regulation 483.10(f) (10) ths to manage their financial dure for managing accounts as to deposit money in the	F	602				
	reviewed by the Exec	ben an RFMS account will be cutive Director or Director of prior to an account being					ion choot Dogo 21	

Facility ID: VA0418

If continuation sheet Page 21 of 51

	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED 0. 0938-0391		
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED		
		495423	B. WING				C / 16/2019		
NAME OF PI	ROVIDER OR SUPPLIER		I	S	STREET ADDRESS, CITY, STATE, ZIP CODE	•			
BONVIEW	REHABILITATION AND	HEALTHCARE			7246 FOREST HILL AVE RICHMOND, VA 23225				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE		
F 602	resident of designated copy of in-house state acknowledgement fro and filed with copies of E) Executive Director Physician/Medical Off capability to manage Nursing prior to reque Executive Director with NO/NO prior to subm Representative Payed Regional Vice Preside compliance with proce and then monthly for continued compliance 4. Ad-Hoc QAPI held deficient practice and BO-427. Findings will Executive Director wh findings to the QAPI r continued substantial 3. For Resident #3 the misappropriated the F to become representat Resident's Social Sec Resident's Power of A authorize or desire th multiple withdrawals f without sufficient supp	nts will be issued to the d representative. A signed ements will be obtained as m all competent residents of mailed statements. will review ficer statement of patient benefits with the Director of est. Upon completion Il review and validate ission to become e on behalf of the resident. ent of Revenue will review esses weekly for 8 weeks, 4 months to ensure e. on 10-16-19 to review the changes to company policy I be reported to the no will then report these monthly x 6 months for compliance and/or revision. e facility staff Resident's funds by applying ative payee for the curity Income, despite the Attorney stating they did not is and the facility permitted from the Resident's account porting evidence.	F	602					
	Resident #3 was origi	inally admitted to the facility							

Facility ID: VA0418

If continuation sheet Page 22 of 51

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391		
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED		
		495423	B. WING				C 16/2019		
NAME OF P	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE	1			
BONVIEW	REHABILITATION AND	HEALTHCARE			7246 FOREST HILL AVE RICHMOND, VA 23225				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	CTION SHOULD BE COMIN			
F 602	on 12-28-16, with a refollowing a hospitalizadischarged from the fresident's diagnoses disease, dementia, di heart failure, claustrophypothyroidism, hypebenign tumor of the mbrain. The Resident's most Data Set, was a discharged Resident #3 as and to be understood as moderately impaired. extensive assistance transferring, dressing A review of the closed On 10-16-19 during a revealed that Resider durable power of atto daughter as her author on her behalf prior to 12-28-16 during the a #3's daughter/POA si of the admissions agr not want to open a Re Despite this request, manager sent Reside letter on 3-15-17, alor trust account agreem	eadmission on 8-1-17, ation. Resident #3 was acility on 8-13-19. The included; Parkinson's abetes, epilepsy, congestive phobia, anxiety, rtension, hallucination, and heninges covering of the recent (MDS) Minimum harge assessment, with an ce Date of 8-13-19, and s being able to understand, by others. She was coded ed for daily decision making The Resident was coded as ts, and was moderately The Resident required from staff for bed mobility, and toileting. d record was conducted.	F	602					

If continuation sheet Page 23 of 51

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM): 12/02/2019 // APPROVED). 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE SURVE COMPLETED	
		495423	B. WING				C 16/2019
NAME OF P	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE		
				7	7246 FOREST HILL AVE		
BONVIEW	REHABILITATION AND	HEALTHCARE		1	RICHMOND, VA 23225		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 602	Continued From page	23	F	602	2		
	also revealed that Rehad signed page 19 con 12-28-16, stating " security check assign redacted]." Despite th POA, the facility staff become Representati social security benefit physician then comple "Physician's/Medical patient's capability to that Resident #3 was financial affairs, makin #3's written POA exect daughter to handle he behalf, in the event R able to manage her a On 10-16-19 during th was identified that frowere a total of 4 commaddressed to the facili behalf of Resident #3 Social Security Admir application from the farepresentative payee On 10-16-19 during th was identified that frow Resident Trust Fund A Each of these cash withdraw Resident signed. Resident signed. Resident signed. Resident as the facility assessment, the facility assessment, the facility assessment is the facility assessment.	is request by Resident #3's completed an application to ve Payee for Resident #3's is on 12-29-16. The facility eted on 1-5-17 a Officer's statement of manage benefits" indicating unable to handle her ng no reference to Resident cuted 6-11-10 appointing her er financial affairs on her esident #3 was no longer ffairs herself. The closed record review it m 6-20-18 until 9-4-19 there munications found ity [name redacted] on . The first being that the histration had received the acility applying to be for Resident #3. The closed record review it m 3-2-18 until 5-24-19 there vals from Resident #3's Account, which totaled \$370.					

Facility ID: VA0418

If continuation sheet Page 24 of 51

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	D. 0938-0391 SURVEY PLETED
		495423	B. WING				C 16/2019
NAME OF PF	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
BONVIEW	REHABILITATION AND	HEALTHCARE			7246 FOREST HILL AVE RICHMOND, VA 23225		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 602	affairs but the facility p withdrawals without s signatures/authorizati On 10-16-19 at 6:52 F Employee J, the Regi Office Services when trust account, Employ it, I know it's not good and there aren't two s On 10/16/19 at approx was conducted of the "Resident Trust Fund- Representative Payee of 6/28/19. The policy from the Care Center Business Office Mana and mail the Request application in a timely This same policy, refe stated, "The business for Representative Pa the resident is not cap funds". This policy do allow the Resident to selected representative attorney to manage th behalf. The facility staff were of the facility policy via manage his or her fina afternoon of 10-16-19 On 10-16-19 at appro-	permitted the cash ufficient on. PM during an interview with onal Director of Business asked about Resident #3's ree J stated, "I've looked at d, signatures are not legible ignatures". ximately 3:30 PM a review facility policy titled - Application for e Status" with a revision date y read, "Upon notification 's Executive Director, the ager will initiate, complete, for Representative Payee manner". erenced above, further s office manager should file ayee in those cases where bable of handling their own besn't take into account or allow their previously ye such as a power of heir financial affairs on their made aware of the concern olating Resident #3's right to ancial affairs on the ximately 6:00 PM, the isions to the facility policy	F	602			
		isions to the facility policy					

Facility ID: VA0418

If continuation sheet Page 25 of 51

CENTER	S FOR MEDICARE &	ND HUMAN SERVICES MEDICAID SERVICES			OMB	RM APPROVE NO. 0938-039
	DF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CC A. BUILDING			TE SURVEY MPLETED
		495423	B. WING		1	C 0/16/2019
NAME OF P	ROVIDER OR SUPPLIER			EET ADDRESS, CITY, STATE, ZIP CO	DE	
BONVIEW	REHABILITATION AND	HEALTHCARE	-	FOREST HILL AVE HMOND, VA 23225		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 602	survey team with the revisions included the the Resident the right affairs and the facility Representative Paye Resident. No further information COMPLAINT DEFICI Transfer and Dischar CFR(s): 483.15(c)(1) §483.15(c) Transfer a §483.15(c)(1) Facility (i) The facility must premain in the facility, discharge the resider (A) The transfer or dis resident's welfare and cannot be met in the (B) The transfer or dis because the resident sufficiently so the res services provided by (C) The safety of indi endangered due to the status of the resident (D) The health of indi otherwise be endang (E) The resident has appropriate notice, to under Medicare or Me Nonpayment applies submit the necessary payment or after the	e Status," and presented the updated policy. The e regulation text which allows t to manage their financial t to only apply for e upon written request of the n was provided. ENCY. ge Requirements (i)(ii)(2)(i)-(iii) and discharge- requirements- ermit each resident to and not transfer or nt from the facility unless- scharge is necessary for the d the resident's needs facility; scharge is appropriate 's health has improved ident no longer needs the the facility; viduals in the facility is ne clinical or behavioral ; viduals in the facility would ered; failed, after reasonable and o pay for (or to have paid edicaid) a stay at the facility. if the resident does not paperwork for third party	F 602			11/20/19

Facility ID: VA0418

If continuation sheet Page 26 of 51

		ND HUMAN SERVICES				RM APPROVE 10. 0938-03
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495423	B. WING		1	C 0/16/2019
NAME OF PI	ROVIDER OR SUPPLIER	•	STF	REET ADDRESS, CITY, STATE, ZIP CO		
	REHABILITATION AND		724	6 FOREST HILL AVE		
BOINVIEW	REHABILITATION AND	HEALINGARE	RIC	CHMOND, VA 23225		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETIO DATE
F 622	Continued From page	- 26	F 622			
1 022			F 022			
		ay for his or her stay. For a				
		es eligible for Medicaid after /, the facility may charge a				
		le charges under Medicaid;				
	or					
	(F) The facility ceases to operate.					
	(ii) The facility may not transfer or discharge the					
		peal is pending, pursuant to				
	-	pter, when a resident				
		ight to appeal a transfer or				
		n the facility pursuant to §				
		chapter, unless the failure to would endanger the health				
		ent or other individuals in the				
		nust document the danger				
		or discharge would pose.				
	§483.15(c)(2) Docum					
		sfers or discharges a				
		the circumstances specified				
)(A) through (F) of this				
	-	ust ensure that the transfer nented in the resident's				
	•	ppropriate information is				
		receiving health care				
	institution or provider	-				
		the resident's medical record				
	must include:					
	(A) The basis for the(i) of this section.	transfer per paragraph (c)(1)				
		agraph (c)(1)(i)(A) of this				
	section, the specific r	esident need(s) that cannot				
		pts to meet the resident				
		ce available at the receiving				
	facility to meet the ne					
		n required by paragraph (c)				
	(2)(i) of this section m	nust be made by- ysician when transfer or				
	TAT THE RESIDENT'S DN	vsicial when transler or				1

Facility ID: VA0418

If continuation sheet Page 27 of 51

	-	ID HUMAN SERVICES MEDICAID SERVICES				FC	TED: 12/02/201 DRM APPROVE <u>NO. 0938-039</u>	
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •		CONSTRUCTION		(X3) DATE SURVEY COMPLETED C	
		495423	B. WING				10/16/2019	
NAME OF PI	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STATE, ZIP CODE			
BONVIEW	REHABILITATION AND	HEALTHCARE			246 FOREST HILL AVE RICHMOND, VA 23225			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 622	 (A) or (B) of this secti (B) A physician when necessary under para this section. (iii) Information provide must include a minimini (A) Contact information responsible for the car (B) Resident represent contact information (C) Advance Directive (D) All special instruction (D) All special instruction (F) All other necessant copy of the resident's consistent with §483. 	ry under paragraph (c) (1) ion; and transfer or discharge is agraph (c)(1)(i)(C) or (D) of ded to the receiving provider um of the following: on of the practitioner are of the resident. intative information including e information tions or precautions for ropriate. are plan goals; ary information, including a	F	622				
	by: Based on resident in clinical record review review, and in the con investigation, the faci one of seven residen remain in the facility v	is not met as evidenced terview, staff interview, , facility documentation urse of a complaint lity staff failed to ensure that ts (Resident #6) was able to while his appeal to the of Medical Assistance			 ¿ Resident #6 no longer resid facility as of 06/07/2019. No con actions were taken. ¿ Residents who reside in the have the potential to be affected Discharges are being reviewed i morning meeting to ensure a sai discharge plans and needs are no ¿ Licensed Nursing Staff and 	rective a facility I. in the fe met.		
	though he had appea Resident #6 was a 54 to the facility on 2/6/1	harged on 6/7/19 even			2 Licensed Nursing Stall and workers will be educated on app and safe discharge planning by or designee. The Executive Dire DON will be educated by the Re Director of Clinical Services on t process for appealing discharge include no resident may be discl during the appeal process. Discl	oropriate the DON ector and egional the s to harged		

Facility ID: VA0418

CENTERS FOR MEDICARE & ME				OMB NC	APPROVED . 0938-0391
STATEMENT OF DEFICIENCIES (X1 AND PLAN OF CORRECTION	1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	IPLE CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
	495423	B. WING _			C 16/2019
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIF		
			7246 FOREST HILL AVE		
BONVIEW REHABILITATION AND HEA	ALIHCARE		RICHMOND, VA 23225		
PREFIX (EACH DEFICIENCY MU	MENT OF DEFICIENCIES UST BE PRECEDED BY FULL IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIEI	CTION SHOULD BE D THE APPROPRIATE	(X5) COMPLETION DATE
and Anxiety Disorder. The Minimum Data Set, y Assessment with an Asse of 5/16/19 was reviewed as having a Brief Intervie Score of 15, indicating no Resident #6 was coded a care, physical or verbal b impaired range of motion lower extremities on the physical assistance of or mobility, transfers, walkir dressing, toileting, and p On 10/9/19 a review was documentation, revealing Discharge Notices that w #6. The first one was a 5	Cerebral Infarction nant Side, Generalized betes Mellitus, Type 2, ajor Depressive Disorder, which was a Quarterly sessment Reference Date I. Resident #6 was coded ew of Mental Status to cognitive impairment. as having no rejection of behavioral issues. He had in in both his upper, and left side. He required the ne person for bed ng, bathing, eating, bersonal hygiene. s conducted of facility g 2 different Involuntary were given to Resident 5-Day Involuntary 4/23/19. An excerpt read, t you will be rom our facility to SAFE .RGE BASED ON diffective 4/30/19. You are se the health and safety sidents or staff is Transfer Discharge 6/19. An excerpt read: t you will be rom our facility to SAFE .RGE BASED ON diffective 5/6/19 You are	F 6	be reviewed during the day ensure plans have been of implement a safe dischar Executive Director will en discharges have been and resident who has request ¿ Quality monitoring w by the Executive Director ensure residents have a si discharge plan weekly for the Regional Director of 0 will validate compliance of The results of the quality be presented to the Qual committee monthly for re- and further recommendat ¿ Date of compliance:	outlined to ge and the isure that no ranged for any ted an appeal. ill be conducted or designee to safe and proper r 8 weeks and Clinical Services nonthly. monitoring will ity Assurance view, analysis tions.	

If continuation sheet Page 29 of 51

		ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED D. 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMF	
		495423	B. WING				U /16/2019
NAME OF P	ROVIDER OR SUPPLIER		•	:	STREET ADDRESS, CITY, STATE, ZIP CODE		
BONVIEW	REHABILITATION AND	HEALTHCARE			7246 FOREST HILL AVE RICHMOND, VA 23225		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 622	of the resident, other endangered." Resident #6 appealed the facility administra Commonwealth of Vin Medical Assistance S #6's Appeal Request. #6] filed an appeal re- discharge from your f entitled to a pre-dispo- process requirements Therefore, [Resident facility pending the de officer." On 10/10/19 a review was conducted. There outcome of the Appea On 10/15/19, at appro Facility Senior Opera stated that he didn't k Appeal. At approxima email correspondence excerpt from the ema The Virginia Departm Services read: "10/15 inquiring about his ap was ever held, and if be able to provide us excerpt from the resp Department of Medica read:"10/15/19 at 5:2 hearing took place as administratively resol	residents or staff is d the decision. On 4/30/19 tor received a letter from the rginia, Department of ervices, regarding Resident An excerpt read, "[Resident garding the proposed acility. [Resident #6] is osition hearing under the due s of Goldberg v Kelly. #6] must remain in the ecision of the hearing of facility documentation e was no evidence of the als Hearing. bximately 2:00 P.M. the tions Director [Employee E] now the outcome of the tely 6:00 P.M., he submitted e regarding the Appeal. An il written by Employee E to ent of Medical Assistance 5/19 at 3:46 PM. We are peal hearing and whether it it was canceled is you would with the reason why." An onse email from the Virginia al Assistance Services 3 PM. As discussed, no the case was ved. This typically means harge was withdrawn. The	F	622	2		

If continuation sheet Page 30 of 51

		MEDICAID SERVICES				O. 0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·	E CONSTRUCTION	· · ·	E SURVEY
			A. BUILDING			С
		495423	B. WING			D/16/2019
	ROVIDER OR SUPPLIER	100.120		STREET ADDRESS, CITY, STATE, ZIP C		J/16/2019
				7246 FOREST HILL AVE	JODE	
BONVIEW	REHABILITATION AND	HEALTHCARE		RICHMOND, VA 23225		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF	CORRECTION	(X5)
PREFIX TAG		CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	THE APPROPRIATE	COMPLETION
F 622	Continued From pag	e 30	F 622			
	-	was conducted of Resident				
		evealing the a nurse's				
	progress note. An ex	cerpt read, "5/24/19. Met				
	with resident and discussed that we will be					
	assisting him to get payee for his Social Security					
		ide aware that the Notice of				
	Discharge was resci	ndea.				
	Fourteen Days later	on 6/7/19 at 6:12 P.M., an				
		cial Service progress note				
		ocial worker] reiterated today				
		late. Resident again stated				
		ere to pick him up on Friday				
		ated that the ED [Executive				
		rove of that. ED requested est together to reiterate				
		ayattending this meeting				
	-	pirector of Nursing] Nurse				
		pply Manager and guestEd				
	again informed gues	t that today is his discharge				
	-	was not an option because				
		criteria for LTC [Long Term				
		axi will be called and he will				
	discharge at 1:30 P.I	was calling 911. Two officers				
		ith resident. As a result per				
		it the building at 4:05 P.M.				
		s would return to escort him				
		rtly after 4:00 P.M. a young				
		guest up. Guest was unable				
		gings in the vehicle and				
		e back tomorrow to gather g this note the same young				
		rlier returned to gather the				
		n belonging to [Resident #6]".				
		oximately 9:00 A.M., an				
		cted with the Director of				
	Social Services (Em	ployee P) in the conference				1

Facility ID: VA0418

If continuation sheet Page 31 of 51

STATEMAN OF CORRECTION [M1] PROVIDENSINPPLIENCIAL [ADJUNITIEL CONSTRUCTION [ADJUNITIEL CON			ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12 FORM APF OMB NO. 093	PROVE
10/16/2013 INVICE 10/16/2013 INVICE OF SUPPROVIDER OF SU	STATEMENT C	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	. ,		(X3) DATE SURV COMPLETED	ΈY
IMME OF PROVIDER OR SUPPLER STREET ADDRESS, CITY, STATE, ZIP CODE 200 VIEW REHABILITATION AND HEALTHCARE 7246 FOREST HILLAVE RECHMOND, VAX 32225 IVAI 00 PREFIX TAG SUMMARY STREEMENT OF DEFICIENCIES UNDERCHMOND, RECHMOND, VAX 3225 PROVIDER'S HURLAVE RECHMOND, VAX 3225 F 622 Continued From page 31 room with another surveyor present. When asked about the circumstances of Resident #65 discharge, she stated, "We have kept other people here many times until we could find a place to go. When we went up to peak to him he said he feit threatened. It was me, the ED and the Medical Suppl you; who is a very big you! Idin't decide who was there. The ED asked the supply guy to come." F 622 When Employee P was asked if she had ever fift threatened by Resident #6, she said 'I din't ever feel threatened by him "He called me a few days after he left to ask for help regarding his medications. I told him that I did't cover that area. I did not document, or follow-up with anyone at the facility regarding his request." The facility policy on Transfer/Discharge Notification & Right to Appeal, dated 3/26/16 was reviewed. An excerpt read, "Transfer and discharges of residents initiated by the center will be conduced accoming to Fodera and/or State regulatory requirements. The center must permit each resident to remain in the center, and not transfer or discharge the resident for the papeal a ransfer or discharge the resident for the papeal a ransfer or discharge row up with anger or the resident to remain the danger or the resident to remain the danger the resident to remain the danger or discharge the resident toremain or discharge or discharge or discharge or discharge			495423	B. WING		_	019
EXPONENCE REHABILITATION AND HEALTHCARE RICHMOND, VA 23225 (XX) [0] ISUMMARY STATEMENT OF DEFICIENCES ID REPERT PROVIDER SPLAY OF CORRECTIVE REGULATION OR LSC DENTIFYING INFORMATION) ID PREFIX ID REPERT PROVIDER SPLAY OF CORRECTIVE REGULATION OR LSC DENTIFYING INFORMATION) ID PREFIX ID REPERT ID RECULATION OR LSC DENTIFYING INFORMATION) ID PREFIX ID RECULATION OR LSC DENTIFYING INFORMATION) ID RECULATION OR LSC DENTIFYING INFORMATION) ID REFIX	NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP		
Partix Tao SHAMARY STATEMENT OF DEFICIENCES (ECA) CORRECTION 2 MUST BE PRECEDED BY PLUL REGULATORY OR LSC IDINIFIVING INFORMATION) PM PM PMONDERS PLAN OF CORRECTION (ECA) CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE OPS F 622 Continued From page 31 room with another surveyor present. When asked about the circumstances of Resident #6's discharge, she stated, "We have kept other people here many times until we could find a place to go. When we went up to speak to him he said he feit threatened. It was me, the ED and the Medical Supply guy, who is a very big guy. I didn't decide who was there. The ED asked the supply guy to come." F 622 When Employee P was asked if she had ever feit threatened by Resident #6, she said "I didn't ever feel threatened by him" "the called me a few days after he left to ask for holp roganid gnis medications. I told him that I didn't cover that area. I did not document, or follow-up with anyone at the facility regulinements. The center must permit each resident is initiated by the center will be conducted according to Federal and/or State regulatory requirements. The center must permit each resident to remain in the center, and not transfer or discharge the resident form the center unlessThe center may not transfer of discharge the resident while the appeal is pending, when a resident exercises this or her right to appeal a transfer or discharge mould moding the health or safety of the resident or other individuals in the center. The center must document the danger that failure to transfer or discharge would pose." On 10/16/19 from 10:10 A.M., until 11:00 A.M., a					7246 FOREST HILL AVE		
Prefry Tag (EACH CORRECTIVE ACTION SHOLD BE REGULATORY OR LSC DERTIFYING INFORMATION) PREFX Tag CEACH CORRECTIVE ACTION SHOLD BE CROSS-REFERENCED TO THE APPROPRIATE Com/LETING DEFICIENCY) F 622 Continued From page 31 room with another surveyor present. When asked about the circumstances of Resident #6's discharge, she stated, "We have kept other people here many times unlil we could find a place to go. When we went up to speak to him he said he felt threatened. It was me, the ED and the Medical Supply guy, who is a very big guy. I clight decide who was there. The ED asked the supply guy to come." F 622 When Employee P was asked if she had ever felt threatened by Resident #6, she said "I clight ver feel threatened by him." He called me a few days after he left to ask for help regarding his medications. I told him that I clight cover that area. I clight to Appeal, dated 326/18 was reviewed. An excerpt read, "Transfer and discharges of residents initiated by the center will be conducted according to Federal and/or State regulatory requirements. The center must permit each resident to main in the center, and not transfer or discharge the resident for manger the heath or safety of the resident or other individuals in the center. The center must permit each resident to manger the heath or safety of the resident or other individuals in the center. The center must permit each resident to analger the heath or safety of the resident or other individuals in the center. The center must permit the transfer or discharge mould pose." On 10/16/19 from 10:10 A.M. until 11:00 A.M., a	BONVIEW	REHABILITATION AND	HEALTHCARE		RICHMOND, VA 23225		
room with another surveyor present. When asked about the circumstances of Resident #6's discharge, she stated. "We have kept other people here many times until we could find a place to go. When we went up to speak to him he said he fel threatened. It was me, the ED and the Medical Supply guy, who is a very big guy. I didn't decide who was there. The ED asked the supply guy to come." When Employee P was asked if she had ever felt threatened by Resident #6, she said "I didn't ever feel threatened by kim" "He called me a few days after he left to ask for help regarding his medications. I told him that I didn't cover that area. I did not document, or follow-up with anyone at the facility regarding his request." The facility regarding his request." The facility regarding his request." The facility regarding his request. The facility regarding his request. The facility regarding his request. The facility regarding his request. The resident to enser. The center will be conducted according to Federal and/or State regulatory requirements. The center must permit each resident to remain in the center, and not transfer or discharge he resident from the center unlessThe center must permit each resident to rulted by the canter dilure to discharge or transfer or discharge the resident while the appeal is pending, when a resident exercises his or her right to appeal a transfer or discharge noticeunless the failure to discharge or transfer or discharge moules the failure to discharge or transfer or discharge would pose." On 10/16/19 from 10:10 A.M. until 11:00 A. M., a	PRÉFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE AC CROSS-REFERENCED TO	TION SHOULD BE COM THE APPROPRIATE	IPLETION
telephone interview was conducted with Resident #6, who gave permission to be on speakerphone	F 622	room with another su about the circumstand discharge, she stated people here many tim place to go. When we said he felt threatene Medical Supply guy, decide who was there guy to come." When Employee P we threatened by Reside feel threatened by Reside feel threatened by Reside feel threatened by kin after he left to ask for medications. I told hin area. I did not docum at the facility regardin The facility policy on Notification & Right to reviewed. An excerpt discharges of residen be conducted accord regulatory requirement each resident to rema transfer or discharge unlessThe center m the resident exercises his transfer or discharge discharge or transfer or safety of the reside center. The center mu that failure to transfer On 10/16/19 from 100 telephone interview w	rveyor present. When asked ces of Resident #6's 4, "We have kept other hes until we could find a e went up to speak to him he d. It was me, the ED and the who is a very big guy. I didn't e. The ED asked the supply as asked if she had ever felt ent #6, she said "I didn't ever m" "He called me a few days thelp regarding his m that I didn't cover that ent, or follow-up with anyone ing his request." Transfer/Discharge o Appeal, dated 3/26/18 was read, "Transfer and its initiated by the center will ing to Federal and/or State ints. The center must permit ain in the center, and not the resident from the center hay not transfer or discharge e appeal is pending, when a s or her right to appeal a noticeunless the failure to would endanger the health ent or other individuals in the ust document the danger or discharge would pose."	F 6			

If continuation sheet Page 32 of 51

ATEMENT (S FOR MEDICARE & OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
D PLAN OF	CORRECTION	IDENTIFICATION NUMBER.	A. BUILDING			C
		495423	B. WING		1	0/16/2019
AME OF P	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CO	DE	
ONVIEW	REHABILITATION AND	HEALTHCARE		7246 FOREST HILL AVE RICHMOND, VA 23225		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF C		(X5)
PREFIX TAG	(EACH DEFICIENC	SCIDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE E APPROPRIATE	COMPLETIC
F 622	Continued From page	e 32	F 622			
		nstances of his discharge		-		
	from the facility, he st	tated, "[Interim Business				
		bloyee I. (She had not yet				
		he Interim Manager as of the on 6/7/19)] came up to my				
	room and said she wa	as going to call the police on				
		sgusting I was. She said,				
		m gonna call the police and The Director of Nursing				
		etter. The Nurse Manager				
		to me. It said I was a danger				
	-	The Head of Housekeeping nad to get out. I'm 6'4", 340				
		, I wear diamonds in my ear.				
		So in the eyes of some				
		part so automatically I'm the at day, the housekeeping				
	-	he hall so he walked up on				
	me. He was in my pe	rsonal space, one foot in				
		move my rollator. He said I				
	to move out of my wa	respectful to staff. I told him av. The Unit Manager				
		aged me to go downstairs				
		b Human Resources. The				
	· ·	it Manager Employee Q] e and read me a letter. She				
		corporate office saying that				
	I had to vacate."					
	After that, I found ou	it that they had a meeting				
	with certain CNA's [C	certified Nursing Assistants],				
		id my room. I asked the DON				
		it. I reported it to the Appeals of Medical Assistance				
	Services] people and					
				1		44/00/40
F 624	CFR(s): 483.15(c)(7)	Orderly Transfer/Dschrg	F 624	+		11/20/19

Facility ID: VA0418

If continuation sheet Page 33 of 51

	-	ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12/02/2019 FORM APPROVED OMB NO. 0938-039
STATEMENT O	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
		495423	B. WING		C 10/16/2019
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP (
BONVIEW	REHABILITATION AND	HEALTHCARE		7246 FOREST HILL AVE RICHMOND, VA 23225	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE COMPLETION THE APPROPRIATE DATE
F 624	preparation and orien safe and orderly trans facility. This orientation form and manner that understand. This REQUIREMENT by: Based on resident in clinical record review. review, and in the coor investigation, the faci- of seven residents (R and orderly discharge Jeopardy. Immediate Jeopardy 1 2:30 P.M. It was rem A.M. After removal, it isolated. The Findings Includer 1. Resident #6 was of his will in an unsafe in location with an unkn failed to give him edu manage his medication scale insulin. The fac 50 Tablets of Lorazep narcotic. Resident #6 was a 54 to the facility on 2/6/1 Legal Blindness, Hyp	tion for transfer or a and document sufficient tation to residents to ensure after or discharge from the on must be provided in a t the resident can T is not met as evidenced terview, staff interview, facility documentation urse of a complaint lity staff failed to orient one esident #6) to ensure a safe a, resulting in Immediate was called on 10/9/19 at oved on 10/10/19 at 11:45 was lowered to a level 3 d: lischarged on 6/7/19 against nanner to an unknown own individual. The facility cation and a glucometer to on, which included sliding cility also gave the resident bar, which is a controlled 4 year old who was admitted 9. His diagnoses included ertension, Hemiplegia and	F 62	 ¿ Resident #6 was discl facility on 06/07/ 2019 acc male friend and did not dis location he was going to. T speak with resident #6 on offer readmission and he of ¿ Residents that reside have the potential to be aff facility Social Worker will of review of residents with per discharge within the next tf facility Social Worker and of will ensure that arrangement for a safe discharge to incl limited education on safe at medication, medically nece equipment, a safe discharge given proper discharge inst form and manner that the funderstand. ¿ The Regional Director Services will educate the fit and IDT staff regarding the process to include: arrangement of the safe discharge in the service of the safe discharge in the process to include: arrangement of the service of the service of the safe discharge in the service of the safe discharge in the service of the service of the safe discharge in the service of the service of the service of the service of the safe discharge in the service of the service o	harged from the ompanied by a sclose the The facility did 10/8/2019 to declined. in the facility fected. The sonduct a quality ending plans to wo weeks. The Charge Nurse ents are made lude but not and proper of all essary ge location, and structions in a resident can
FORM CMS-256	Hemiparesis Followin Affecting Left Non-Do	g Cerebral Infarction ominant Side, Generalized		made for a safe discharge not limited to education on	

Facility ID: VA0418

If continuation sheet Page 34 of 51

						10.0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				TE SURVEY MPLETED
			A. BUILDING	;		С
		495423	B. WING			0/16/2019
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C		0/10/2019
				7246 FOREST HILL AVE		
BONVIEW	REHABILITATION AND	HEALTHCARE		RICHMOND, VA 23225		
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF	CORRECTION	(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	THE APPROPRIATE	COMPLETION
F 624	Continued From pag	e 34	F 62	4		
	Muscle Weakness, D	Diabetes Mellitus, Type 2,		proper medication adminis	tration, usage	
		, Major Depressive Disorder,		medically necessary equip		
	and Anxiety Disorder			discharge location, and the		
	The Minimum Date S	Set, which was a Quarterly		or responsible party will be discharge instructions in a		
		Assessment Reference Date		manner that the resident c		
		wed. Resident #6 was coded		Executive Director, Directo		
	as having a Brief Inte	erview of Mental Status		Social Services, and Licen	-	
		ig no cognitive impairment.		were educated as of midni	ght on 10-9-19.	
		led as having no rejection of		ز Quality monitoring will		
		bal behavioral issues. He had		to ensure residents have a		
		otion in both his upper, and		proper discharge 3 times a	week x 3	
		the left side. He required the of one person for bed		months.	20-19	
		alking, bathing, eating,			-20-19	
	dressing, toileting, ar					
		lan was reviewed. There was				
		at he was a danger to				
		his own responsible party, d his right to determine				
		itments he would attend. An				
		e plan read, "wishes to stay				
	· ·	Term Care)Diabetes				
		edication as ordered by				
		ment for side effectsAt risk				
		p] Gait/balance problems,				
		se, Vision/hearing problems.				
	-	the resident's needsuses				
	anti-anxiety medications r/t Anxiety Disorder. Monitor for side effectsuses antidepressant					
	medication r/t Depression. Monitor/document side					
	effects and effectiveness Q-SHIFT [EVERY					
	_	ontinence r/t Impaired				
	-	he resident's risk for				
		nimizedimpaired visual				
		, GlaucomaADL [Activities				
	or Daily Living sell-c	are deficit r/t Impaired				1

Facility ID: VA0418

If continuation sheet Page 35 of 51

	MENT OF HEALTH AN	ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 12/02/2019 M APPROVED D. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·		CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		495423	B. WING				/16/2019
NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE	1	
BONVIEW	REHABILITATION AND	HEALTHCARE			246 FOREST HILL AVE ICHMOND, VA 23225		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 624	Continued From page	35	F	624			
	documentation, revea Discharge Notices tha #6. The first one was Discharge Notice date "This is to notify you to transferred/discharge LOCATION OF DISC RESIDENT'S NEEDS being discharged beco of the resident, other endangered." The second Involunta Notice was issued on "This is to notify you to transferred/discharge LOCATION OF DISC RESIDENT'S NEEDS being discharged beco of the resident, other endangered." RESIDENT'S NEEDS being discharged beco of the resident, other endangered." Resident #6 appealed discharged. On the day of the disc excerpt from the Soci read, "6/7/19. SW (so as guest discharge dat that his son will be he of next week. SW stat Director] did not approve we meet with the gue discharge will be todat was the ED, DON [Dir Manager Central Sup	ed 4/23/19. An excerpt read, hat you will be d from our facility to SAFE HARGE BASED ON 3, effective 4/30/19. You are ause the health and safety residents or staff is any Transfer Discharge 5/6/19. An excerpt read: hat you will be d from our facility to SAFE HARGE BASED ON 5, effective 6/6/19 You are ause the health and safety					

Facility ID: VA0418

If continuation sheet Page 36 of 51

	-	ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12/02/20 FORM APPROV OMB NO. 0938-03
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED C
		495423	B. WING		10/16/2019
NAME OF PF	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP CO	•
BONVIEW	REHABILITATION AND	HEALTHCARE		7246 FOREST HILL AVE RICHMOND, VA 23225	
	(X4) ID SUMMARY STATEMENT OF DEFICIENCIES			PROVIDER'S PLAN OF C	
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		ON SHOULD BE COMPLETIC HE APPROPRIATE DATE
F 624	Continued From page	a 36	F 62	24	
1 021		was not an option because	F 02	24	
		criteria for LTC [Long Term			
	•	ixi will be called and he will			
	discharge at 1:30 P.M				
	••	was calling 911. Two officers			
		th resident. As a result per			
		t the building at 4:05 P.M. would return to escort him			
		rtly after 4:00 P.M. a young			
		uest up. Guest was unable			
	· •	ings in the vehicle and			
		e back tomorrow to gather			
		this note the same young			
		rlier returned to gather the			
	remainder of the item	belonging to [Resident #6]".			
	On 10/10/19 at appro	oximately 9:00 A.M., an			
		cted with the Director of			
		bloyee P) in the conference			
	about the circumstan	rveyor present. When asked			
		d, "We have kept other			
		nes until we could find a			
	place to go. When we	e went up to speak to him he			
		d. It was me, the ED and the			
		who is a very big guy. I didn't			
	decide who was there guy to come."	e. The ED asked the supply			
	When Employee P w	as asked if she had ever felt			
		ent #6, she said "I didn't ever			
	-	m" "He called me a few days			
	after he left to ask for				
		m that I didn't cover that ient, or follow-up with anyone			
	at the facility regardir				
	There was no docum	entation that the facility			
	provided Resident #6				

Facility ID: VA0418

If continuation sheet Page 37 of 51

		ID HUMAN SERVICES MEDICAID SERVICES			FOR	D: 12/02/201 MAPPROVEI D. 0938-039	
STATEMENT C	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING		(X3) DATE SURVEY COMPLETED C 10/16/2019		
		495423	B. WING				
NAME OF PR	ROVIDER OR SUPPLIER		STF	REET ADDRESS, CITY, STATE, ZIP COD			
BONVIEW	REHABILITATION AND		724	16 FOREST HILL AVE			
BOINVILW	Renablemation and	HEALMOARE	RIC	CHMOND, VA 23225			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 624	physician ordered slid signed physician order Solution. Inject as per 301 - 400 =4; 401-500 According to the Med during the 7 day perio 6/7/19, Resident #6's 146 to 405, requiring On 10/10/19, an inter Director of Nursing (E approximately 10:00 a with another surveyor Discharged Resident and stated the Reside his medications that w cart." An excerpt reac Tablets 1 Tab by mou Narcotic. Quantity 50 Unit as per sliding sca meals. Quantity 1." When asked how Resident DON stated that she if it was normal practi unaware who the resi went. The DON stated discharge, "I would as	e could safely self-administer ding scale insulin. The er read, "6/1/19. Novolog r sliding scale: If 201-300 =2; 0 = 6;501-600 =call MD ication Administration, od prior to Discharge on blood sugars ranged from various amounts of insulin.	F 624				
	drop. He could die. Th parameters with the r When asked if it was resident 50 Ativan tak them, the DON stated know. We should hav	he nurse should go over the					

Facility ID: VA0418

If continuation sheet Page 38 of 51

		ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12/02/201 FORM APPROVE OMB NO. 0938-039		
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DATE SURVEY COMPLETED		
		495423	B. WING		C 10/16/2019		
NAME OF P	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CO	DE		
5011/51				7246 FOREST HILL AVE			
BONVIEW	REHABILITATION AND	HEALIHCARE		RICHMOND, VA 23225			
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE COMPLETION TE APPROPRIATE DATE		
F 624	he signed in the right ask about discharging When asked about the residents with educate instructions prior to d "So they will have an going on or how their The Discharge Summ reviewed. There was discharge, no physici status measurements requirements, no men no list of medications and no facility staff sign The facility policy on Notification & Right to reviewed. An excerpt discharges of resident be conducted accord regulatory requirements each resident to rema transfer or discharge unlessThe center m	place. I think nurses should g residents with Ativan." e importance of providing ion, a glucometer, and ischarge, the DON stated, understanding of what's stay was." hary dated 6/7/19 was no physician evaluation of an's signature, no medical s, no nutritional status and htal and psychosocial status, , no reason for discharge, gnature. Transfer/Discharge o Appeal, dated 3/26/18 was read, "Transfer and hts initiated by the center will ing to Federal and/or State nts. The center must permit ain in the center, and not the resident from the center hay not transfer or discharge	F 62-				
	resident exercises his transfer or discharge discharge or transfer or safety of the reside center. The center me that failure to transfer On 10/16/19 from 10: telephone interview w #6, who gave permiss with the entire survey	e appeal is pending, when a s or her right to appeal a noticeunless the failure to would endanger the health ent or other individuals in the ust document the danger or discharge would pose." (10 A.M. until 11:00 A. M., a vas conducted with Resident sion to be on speakerphone team present. When asked instances of his discharge					

Facility ID: VA0418

If continuation sheet Page 39 of 51

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` <i>`</i>		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		495423	B. WING				C 16/2019
NAME OF P	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
BONVIEW	REHABILITATION AND	HEALTHCARE			246 FOREST HILL AVE RICHMOND, VA 23225		
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTIO						(X5) COMPLETION DATE
F 624	Office Manager- Emp been designated as the date of the discharge room and said she wa me. She said how dis "You better believe I'r get you out of here. T [Employee B] had a la [Employee Q] read it to myself and others housekeeping guy wa walked up on me. He one foot in front of me rollator. He said I was to staff. I told him to n Unit Manager [Emplo downstairs and report Resources. The next Employee] calls me i letter. She said it carr saying that I had to va Resident #6 often pat interview. He stated the discharge had on was told this by the he get out in the rain, I h at Walmart that night. humiliated, it's not an because I can't see. T I don't have the resou become numb inside going on and they lie ago, I ended up in the get an infusion every	ated, "[Interim Business loyee I. (she had not yet he Interim Manager as of the on 6/7/19)] came up to my as going to call the police on gusting I was. She said, in gonna call the police and he Director of Nursing etter. The Nurse Manager to me. It said I was a danger Later that day, the as walking up the hall so he was in my personal space, e, I couldn't move my to loo loud and disrespectful nove out of my way. The yee Q] encouraged me to go t it. I went to Human thing I knew [Unit Manager nto her office and read me a he from the corporate office acate." used and cried during the hat he was a veteran. ed to describe the impact him. He stated, "When I pousekeeping guy, I had to ad nowhere to go so I slept I felt embarrassed,	F	624			

If continuation sheet Page 40 of 51

	-	ID HUMAN SERVICES MEDICAID SERVICES				F	TED: 12/02/2019 DRM APPROVED NO. 0938-0391	
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /			(X3) DATE SURVEY COMPLETED		
		495423	B. WING				10/16/2019	
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	•		
BONVIEW	REHABILITATION AND	HEALTHCARE			246 FOREST HILL AVE RICHMOND, VA 23225			
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL				PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 624	via ambulance. He pr Pain level 10, Altered Weakness. An excerp intravenous tissue pla Unilateral weakness, alert. Admitted to the Resident #6 was disc facility on 8/22/19. Immediate Jeopardy 2 :30 P.M. The facility Removal 1 facility on 10/10/19 ar implemented. The Im removed on 10/10/19 The removal plan rea 1. Resident #6 was d June 7, 2019 accomp did not disclose the lo 2. Residents that resi potential to be affecte has conducted a qual pending plans to disc Worker and Charge N arrangements are ma include education on administration of narc discharge location, ar instructions. 3. The Regional Direc educate the licensed regarding the dischar	en to the emergency room resented with Abdominal I Mental Status, and pt read, "Received asminogen activator. Patient paged as a stroke Intensive Care Unit." charged to a long term care was called on 10/9/19 at Plan was submitted by the nd verified as having been mediate Jeopardy was at 11:45 A.M. d: ischarged from the facility on panied by a male friend and pocation he was going to. de in the facility have the ed. The facility have the ed. The facility Social Worker lity review of residents with charge. The facility Social Nurse will ensure that ade for a safe discharge to safe and proper medication cotics and insulin, a safe and given proper discharge	F	624				

Facility ID: VA0418

If continuation sheet Page 41 of 51

	-	ID HUMAN SERVICES MEDICAID SERVICES				M APPROVE 0. 0938-039
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495423	B. WING		10	C)/16/2019
NAME OF PI	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE		
BONVIEW	REHABILITATION AND	HEALTHCARE		7246 FOREST HILL AVE RICHMOND, VA 23225		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 624 F 658 SS=D	administration to inclu narcotics and insulin, discharge location, and responsible party will instructions. Current 1 of Nursing, Social Se educated as of midnin nursing staff will not with 4. The interdisciplinand with plans to discharg meeting to ensure disc been made to detail of transportation, medic health services, treated appointment needs of 5. Adhoc QAPI meeti 10/9/2019 at 4:15 P.M Services Provided Me CFR(s): 483.21(b)(3) §483.21(b)(3) Compr The services provided as outlined by the com must- (i) Meet professional This REQUIREMENT by:	safe and proper medication ade but not limited to facility will have a safe and the resident and or be given proper discharge Executive Director, Director rvices, licensed nurses were ght on 10-9-19. Licensed vork until educated. Ty team will review residents ge weekly in morning scharge arrangements have discharge location, ation management, home ment, and follow-up f resident as necessary. Ing held with the IDT on <i>A</i> . eet Professional Standards (i) ehensive Care Plans d or arranged by the facility, mprehensive care plan,	F 62	4	I from the	11/20/19
	review, clinical record a complaint investiga for 2 of 7 residents (F	I review, and in the course of tion, the facility staff failed Residents #4 and #3) to provided to residents met		facility on 5/7/2019. Resident #3 discharged from the facility on 8/ No corrective actions were taken ¿ Residents that reside in the have the potential to be affected. review will be conducted by the I Clinical Services for late medicat	was 13/2019. facility . A quality Director of	

Event ID: RIWW11

Facility ID: VA0418

If continuation sheet Page 42 of 51

		ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 12/02/2019 MAPPROVED D. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		495423	B. WING _				C 16/2019
NAME OF P	ROVIDER OR SUPPLIER	•		ST	REET ADDRESS, CITY, STATE, ZIP CODE		
				72	46 FOREST HILL AVE		
BOINVIEW	REHABILITATION AND	HEALINCARE		RI	ICHMOND, VA 23225		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 658	Continued From page	ə 42	F 6	58			
	1. Resident #4, a 73 y admitted to the facility discharged on 5/7/20 coronary artery disea Resident #4's MDS (I ARD (Assessment Re was coded as a disch a BIMS (Brief Intervie 13/15 indicating no co was coded as needin one person for her ac was coded as being a occasionally incontine An examination of the Administration Audit F medications for Resid hours past the schede occasions. The following are phy scheduled and time g	year old female was y on 4/27/2019 and 19. Her diagnoses included se, and obesity. Minimum Data Set) with an efference Date) of 5/7/2019 harge assessment. She had ew of Mental Status) score of ognitive impairment. She g the limited assistance of ctivities of daily living and always continent of stool and ent of bladder. e facility Medication Report revealed that dent #4 were given many uled time on many visician orders, time given: ulin 20 units every 12 hours 8/2019 00:34 2/2019 06:01 2019 01:49 gram) every 12 hours 7/2019 23:42 2/2019 06:01 4/2019 00:09			administration and Physician and RPI will be notified as indicated and follow based on findings. ¿ The Director of Nursing or design including external nurse consultant wi re-educate all licensed nursing staff o following the six rights of medication administration and following MD order administering medications and treatment timely. Provider will be notified when medications were not administered. ¿ Unit Managers and or designee w conduct medication and treatments administration observations weekly fo weeks to cover each shift to validation that medications and treatments are administered per physician order. Variances will be addressed, and corrective action and or education will provided. Findings to be reported to G committee monthly and updated as indicated. Quality monitoring schedule modified based on findings ¿ Date of compliance:11-20-19	vill be De DAPI	

If continuation sheet Page 43 of 51

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391	
STATEMENT O	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED	
		495423	B. WING _			OULD BE COMPLETION		
NAME OF PI	ROVIDER OR SUPPLIER		_ . [S	TREET ADDRESS, CITY, STATE, ZIP CODE	•		
BONVIEW	REHABILITATION AND	HEALTHCARE			246 FOREST HILL AVE ICHMOND, VA 23225			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE INTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY) DEFICIENCY)					
F 658	Continued From page	÷43	F	658				
	Levocetirizine 5 mg d 5/03/2019 21:00, 5/04 5/6/2019 21:00, 5/7/2 Coreg 6.25.mg every 4/27/2019 21:00, 4/27 5/0/2019 21:00, 5/0/2 5/6/2019 21:00, 5/0/2 Pravastatin 20 mg da 5/03/2019 22:00, 5/04 An interview was com Director of Clinical Set 4:15 PM. She stated medications and char time. Facility Policies and F Records 11/30/2014 v "2. The date and time administration and the	aily 4/2019 00:13 019 01:57 12 hours 7/2019 22:44 019 00:08 019 01:49 ily 4/2019 00:13 ducted with Employee C, ervices on 10/15/2019 at that nurses often administer t the information at a later Procedures for Medication was examined. It stated; e of medication e name or initials of the staff the medication shall be		900				
	nursing standards and Perry "Fundamentals 841 describes nursing medication administra "Standards are those	actions that ensure safe six rights of medication the following:						

Facility ID: VA0418

If continuation sheet Page 44 of 51

	-	D HUMAN SERVICES MEDICAID SERVICES				FORM): 12/02/2019 (I APPROVED): 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	\` <i>'</i>		CONSTRUCTION	(X3) DATE	
		495423	B. WING				C 16/2019
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
				7	246 FOREST HILL AVE		
BONVIEW	REHABILITATION AND	HEALTHCARE		R	RICHMOND, VA 23225		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 658	 The right route The right time The right docume No further information 	entation.	F	658			
	8-1-17, and discharge Resident's diagnoses disease, dementia, di heart failure, claustrop hypothyroidism, hype	ed on 8-13-19. The included; Parkinson's abetes, epilepsy, congestive					
	Data Set, was a disch Assessment Reference coded Resident #3 as and to be understood was coded as having moderately cognitively required extensive as	recent (MDS) Minimum aarge assessment, with an ce Date of 8-13-19, and being able to understand, by others. The Resident memory deficits, and y impaired. The Resident sistance from staff for bed dressing and toileting.					
	On 10-17-19 a review #3's clinical record, re nursing notes, and Tr Records (TARs) docu Resident #3's signed "7-22-19, Neck pillow bedtime, related to low was ordered on 7-22-	d record was conducted. was conducted of Resident evealing physician's orders, eatment Administration mented by nursing staff. physician order read, behind neck every night at w back pain." The pillow 19, and was placed on the tion Record on that day. On					

Facility ID: VA0418

If continuation sheet Page 45 of 51

STATEMENT	DF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495423	B. WING		C 10/16/2019	
NAME OF P	ROVIDER OR SUPPLIER	L	STRI	EET ADDRESS, CITY, STATE, ZIP CO		
			7246	FOREST HILL AVE		
BONVIEW	REHABILITATION AND	HEALTHCARE	RIC	HMOND, VA 23225		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	DN SHOULD BE COMPLETIN IE APPROPRIATE DATE	
F 658 F 880 SS=E	7-22-19, 7-23-19, and signed the document not used, and document notes for an explanation those 3 days were reve explanation why the p days were documente administered as order The facility was notified the end of day meetin was provided. Infection Prevention & CFR(s): 483.80(a)(1) §483.80 Infection Con The facility must esta infection prevention a designed to provide a comfortable environment development and tran- diseases and infection §483.80(a) Infection program. The facility must esta and control program (a minimum, the follow §483.80(a)(1) A systeme reporting, investigatin and communicable di staff, volunteers, visite providing services un arrangement based u	d 7-24-19 nursing staff stating that the pillow was ented to refer to the nursing ion. The nursing notes for viewed and there was no billow was omitted. All other ed that the pillow was red. ed of findings on 10-18-19 at ng. No further information & Control (2)(4)(e)(f) htrol blish and maintain an and control program a safe, sanitary and hent and to help prevent the hismission of communicable ns. prevention and control blish an infection prevention (IPCP) that must include, at ving elements: em for preventing, identifying, ng, and controlling infections seases for all residents, ors, and other individuals der a contractual pon the facility assessment to §483.70(e) and following	F 658		11/20/19	

If continuation sheet Page 46 of 51

TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA ND PLAN OF CORRECTION UMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		495423	B. WING			С		
	ROVIDER OR SUPPLIER	+00+20			EET ADDRESS, CITY, STATE, ZIP COD		10/16/2019	
					6 FOREST HILL AVE			
BONVIEW	REHABILITATION AND	HEALTHCARE			HMOND, VA 23225			
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	×	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE APPROPRIATE	(X5) COMPLETIO DATE	
F 880	 §483.80(a)(2) Written procedures for the pro- but are not limited to: (i) A system of surveil possible communication infections before they persons in the facility (ii) When and to whow communicable disease reported; (iii) Standard and trar to be followed to prevention (iv) When and how is consident; including but (A) The type and duration depending upon the initian involved, and (B) A requirement that least restrictive possilic circumstances. (v) The circumstance must prohibit employed disease or infected shows and the pro- disease or infected shows and the pro- disease or infected shows and the pro- disease or infected shows and the pro- templot of the pro- temp	a standards, policies, and ogram, which must include, llance designed to identify ole diseases or or can spread to other ; m possible incidents of se or infections should be nomission-based precautions rent spread of infections; olation should be used for a t not limited to: ation of the isolation, infectious agent or organism at the isolation should be the ble for the resident under the s under which the facility ees with a communicable kin lesions from direct s or their food, if direct		380				
	(vi)The hand hygiene by staff involved in dir §483.80(a)(4) A syste identified under the fa corrective actions tak §483.80(e) Linens. Personnel must hand	procedures to be followed rect resident contact. em for recording incidents acility's IPCP and the						

Facility ID: VA0418

If continuation sheet Page 47 of 51

	S FOR MEDICARE &						NO. 0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION	· /	TE SURVEY MPLETED
			A. BUILD	ING _			С
		495423	B. WING			1	0/16/2019
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
				72	246 FOREST HILL AVE		
BONVIEW	REHABILITATION AND	HEALTHCARE		R	RICHMOND, VA 23225		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 880	Continued From page	0.47	Í -	000			
1 000	Continued From pag		F	880			
		uct an annual review of its eir program, as necessary.					
		T is not met as evidenced					
	by:						
	-	on, staff interview, facility			¿ The shower rooms on 2nd and 3rd	ł	
		w, and in the course of a			floor were cleansed and disinfected by		
	complaint investigati	on, the facility staff failed to			housekeeping staff on 10/15/2019 and	the	
		ipment and the shower room			pink substance was removed. The sho	wer	
	-	to prevent the spread of			stretchers on 2nd and 3rd floor were		
	infection in 2 of 3 sh	ower rooms.			cleansed and disinfected by		
	.				housekeeping staff on 10/15/2019 and	the	
	The findings include	d:			brown material was removed.		
	1) On 10/15/19 at 2			¿ Quality monitoring of shower room was conducted by the Executive Direct			
	the 2nd floor was ob			as of 10/16/2019 to ensure that the			
		r mat was lifted by CNA D			shower rooms and equipment were		
		ble areas of brown residue			cleansed and sanitized to prevent the		
	that appeared to be				spread of infection and no pink or brow	/n	
		as asked what the matter			substance was noted.		
		looks like hair" as she picked			¿ The Executive Director will educat	e	
	up a quarter size pie	ce of the brown substance			the housekeeping staff and certified		
	with a gloved hand.	It was a solid matter with			nursing assistants, on facility infection		
		of hair intertwined in it.			control practices regarding the prevent	ion	
		sked what the procedure is			of nosocomial infection and proper		
		equipment, CNA D stated,			cleansing and sanitation of shower roo	ms	
		ng people or we use bleach used to do it after each			and equipment. ¿ The Executive Director to conduct		
		ed if she would say it was			¿ The Executive Director to conduct random quality monitoring of shower		
	-	t use, CNA D stated "I			rooms and equipment weekly to ensure	е	
	wouldn't, to be hone	-			proper cleansing and disinfecting in	-	
					between residents. Quality Monitoring	to	
	On 10/15/19 at 2:41	PM an interview was			be conducted weekly x 8 weeks and as		
	-	E while in the shower room			needed thereafter. Findings to be repo		
		en asked about the cleaning			to QAPI committee monthly and update		
		t, CNA E stated "we are			as indicated. Quality monitoring schedu	ule	
		ne entire shower room every			modified based on findings.		
	shift and the equipm	ent atter each use".			¿ Date of Compliance: 11-20-19		

Facility ID: VA0418

If continuation sheet Page 48 of 51

	-	D HUMAN SERVICES			PRINTED: 12/02/2019 FORM APPROVED OMB NO. 0938-0391		
CENTERS FOR MEDICARE & M STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		495423	B. WING		C 10/16/2019		
NAME OF PI	ROVIDER OR SUPPLIER		STRI	EET ADDRESS, CITY, STATE, ZIP CO			
			7246 FOREST HILL AVE				
BOINVIEW	REHABILITATION AND	HEALTHUARE	RIC	HMOND, VA 23225			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BECOMPLETIONIE APPROPRIATEDATE		
F 880	OVIDER OR SUPPLIER REHABILITATION AND HEALTHCARE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL		F 880	DEFICIENCY			

Facility ID: VA0418

If continuation sheet Page 49 of 51

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES): 12/02/2019 1 APPROVED): 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495423	B. WING			C 10/16/2019	
NAME OF PF	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE				
BONVIEW	REHABILITATION AND I		7246 FOREST HILL AVE				
BOITIEN			RICHMOND, VA 23225				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)	TION SHOULD BE COMPLETION THE APPROPRIATE DATE	
F 880	Continued From page 49		F 880				
	Continued From page 49 3) On 10/15/19 at 2:41 PM an observation of the shower room on the 3rd floor was made with CNA E present. A pink colored substance was observed on the wall and floor around the toilet in the shower room. CNA E was asked what the substance was and CNA E stated "I do not know". On 10/15/19 at 2:58 PM the Facility Administrator (Employee A) accompanied this writer to the shower room on the 2nd floor. The Housekeeping manager (Employee H) was in the shower room with two housekeeping staff. The housekeepers stepped out and left the Administrator, Employee H and Employee K in the shower room with this writer. This writer asked what the pink colored substance on the floor and wall was. Employee H stated "I don't know what it is". Employees A, H and K were notified that a complaint had been received alleging mold in the shower room. The Centers for Disease Control and Prevention (CDC) recognizes in their Emerging Infectious Disease article Volume 25, Number 11-November 2019 "Serratia marcescens, which can cause nosocomial outbreaks, and urinary tract and wound infections, is abundant in damp environments. It can be easily found in bathrooms, including shower corners and basins, where it appears as a pink-orange-red discoloration, due to the pigment known as prodigiosin." article accessed online at : https://wwwnc.cdc.gov/eid/article/25/11/et-2511_a rticle						
	No further information	-					
	COMPLAINT DEFICI	ENCY.					

If continuation sheet Page 50 of 51

DEPARTMENT OF HEALTH AND HUMAN SERVICES						D: 12/02/2019 M APPROVED D. 0938-0391	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495423	B. WING _			C 10/16/2019	
NAME OF P	ROVIDER OR SUPPLIER		1	STREET ADDRESS, CITY, STATE, ZIP CODE			
BONVIEW	REHABILITATION AND	HEALTHCARE		7246 FOREST HILL AVE			
0(0)15				RICHMOND, VA 23225 PROVIDER'S PLAN OF CORRECTION (X5)			
(X4) ID PREFIX TAG	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG				

Event ID: RIWW11

Facility ID: VA0418

If continuation sheet Page 51 of 51