Department of Health & Human Services
Centers for Medicare & Medicaid Services

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495206	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/08/2025
NAME OF PROVIDER OR SUPPLIER: Northern Cardinal Rehabilitation and Nursing		STREET ADDRESS, CITY, STATE, ZIP CODE: 4775 Bridge Road Suffolk, VA 23435	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview, clinical record review and facility document review, it was determined the facility staff failed to provide complete and accurate documentation for one of eight residents, R3. The findings include: The facility staff failed to evidence complete and accurate documentation for turning and repositioning for R3. R3 was admitted to the facility on [DATE] with diagnosis that included but were not limited to fracture right femur, CVA (cardiovascular accident) and hemiplegia/hemiparesis. R3's most recent MDS (minimum data set) assessment, an admission assessment, with an ARD (assessment reference date) of 10/7/24, coded the resident as scoring a 11 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was moderately cognitively impaired. A review of the MDS Section G-functional status coded the resident as maximal assist for bed mobility/transfer, toileting and eating/hygiene. A review of R3's comprehensive care plan dated 10/7/24 revealed, FOCUS: The resident is at risk for weight loss or malnutrition related to CVA, hemiplegia, hemiparesis and loss of mobility. INTERVENTIONS: Monitor for trouble chewing/swallowing and amount of meal eaten. A review of the physician progress notes 10/12/22 at 1:00 AM revealed, SKIN: No redness, rashes, or ulcerations, temperature is warm and dry. Poor appetite. Severe protein-calorie malnutrition. A review of the progress note dated 10/12/22 at 9:04 PM revealed, SKIN Are their changes in residents skin integrity? No. ADLs: bed mobility - how residents move to/from lying position, turns side to side and positions body while in bed alternate sleep furniture: Extensive Assistance - Staff Support Provided, One-person physical assist. A review of the progress note dated 10/18/22 at 11:29 AM revealed, SKIN: Are there changes in residents skin integrity? No. ADLs- bed mobility - how residents move to/from lying position, turns side to side and positions body while in bed alternate sleep furniture, Total Dependence - Two+ persons physical assist. (continued on next page)

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.

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

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	495206	A. Building B. Wing	01/08/2025

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of two current resident medical records, R6 (BIMS of 14, indicating no cognitive impairment) and R7 (BIMS of 9, indicating moderate cognitive impairment), documentation of wound care, skin assessments and turning, repositioning were all documented without issues. Both R6 and R7 wounds were resolved during survey. An interview was conducted on 1/8/25 at approximately 8:15 AM with ASM (administrative staff member) #1, the administrator. When asked about documentation for turning and repositioning R3, ASM #1 stated, we had bought this facility and they changed from the previous EMR to our current EMR, we found out in auditing the documentation after the install that not all of the ADL (activities of daily living) documentation fields were installed. An interview was conducted on 1/8/25 at approximately 8:40 AM with R6. When asked about wound care, R6 stated, they have done a really good job with wound care and turning me, which is not easy as I have cerebral palsy and I cannot stay in one position too long. An interview was conducted on 1/8/25 at approximately 9:24 AM with RN (registered nurse) #1, when asked about the EMR, RN #1 stated, we were changing EMR systems on 10/1/22 to PCC and it evidently was not set up with all pieces. An interview was conducted on 1/8/25 at 1:25 PM with CNA (certified nursing assistant) #1. When asked about turning residents, CNA #1 stated, we turn every 2 hours and document in the ADL record, if it is not documented it could be documentation issue, instead of it not being done. An interview was conducted on 1/8/25 at 1:45 PM with CNA #2. When asked about turning residents, CNA #2 stated, the residents are turned every two hours. If there is missing documentation, the care was probably provided but just not charted. No, the chart is not complete and accurate. On 1/8/25 at approximately 3:25 PM, ASM (administrative staff member) #1, the administrator and ASM #5, the regional director of clinical services was made aware of the findings. No further information was provided prior to exit.