STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495283	A. Building B. Wing	07/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rosedale Health & Rehabilitation	1719 Bellevue Avenue Richmond, VA 23227

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 42106 Based on observation, clinical record review, staff interview, and facility document review, it was determined that the facility staff failed to implement the comprehensive care plan for five of 15 residents in the survey sample, Residents #8, #3, #4, #2 and #6. The findings include: 1. For Resident #8 (R8), the facility staff failed to implement the comprehensive care plan to maintain contact precautions for a diagnosis of C-diff (clostridium difficile) (1). On 7/30/24 at approximately 10:22 a.m., an observation was made of the facility. Observation of R8's room revealed a sign posted outside of the door with stop signs on the corners of the notice. The signage documented Contact Precautions Everyone Must: Clean their hands, including before entering and when leaving the room. Providers and Staff must also: Put on gloves before entry. Discard gloves before room exit. Put on gown before room entry. Discard gown before room exit. Do not wear the same gown and gloves for the care of more than one person. Use dedicated or disposable equipment. Clean and disinfect reusable equipment before use on another person. On 7/30/24 at 12:45 p.m., a facility staff member was observed entering R8's room carrying a lunch tray. The staff member was observed wearing a surgical mask with no other PPE (personal protective equipment). The staff member was observed touching contents of R8's overbed table to make room for the lunch tray. The staff member was observed using alcohol based hand sanitizer prior to exit of R8's room. On 7/30/24 at 4:09 p.m., a facility staff member was observed in R8's room at the bedside with the resident. The staff member was observed wearing a surgical mask, disposable gown and gloves. The staff member was observed to come outside of the room at 4:10 p.m. wearing the same gown and gloves and go to the medication cart across the hallway. The staff member was observed to open the medication cart with the gloves on and obtain medication for R8 and then return to the residents room. After administering the medication to R8, the staff member was observed to remove the gloves in the room and return to the medication cart with the same gown on at 4:12 p.m. The staff member was observed to doff the gown in trash can on the medication cart in the hallway at the medication cart at that time and sanitize their hands with alcohol based sanitizer. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The comprehensive care plan for R8 documented in part, The resident has infection/C-diff. Date Initiated: 06/27/2024. Revision on: 06/27/2024. Under Interventions it documented in part, .Maintain Contact precautions when providing resident care. Date Initiated: 06/27/2024. Revision on: 06/27/2024 . The physician order's for R8 documented in part, Contact Isolation Precautions d/t positive C-diff every shift for positive for C-diff. Order Date: 07/29/2024. On 7/30/24 at 1:12 p.m., an interview was conducted with CNA (certified nursing assistant) #2. CNA #2 stated that when a resident was on contact precautions the staff were supposed to put on a gown and gloves before they went into the room. She stated that this was done to prevent the spread of germs. She stated that staff should wash their hands before they go in the room and when leaving the room and they normally used the alcohol based hand sanitizer unless their hands were soiled and then they washed their hands with soap and water. On 7/30/24 at 4:12 p.m., an interview was conducted with LPN (licensed practical nurse) #3. LPN #3 stated that R8 was on contact precautions for a diagnosis of C-diff. She stated that when staff go in the room they were to put on gloves and a gown prior to entering the room. She stated that they were supposed to take the gloves and gown off inside the room at the door prior to exit and normally there was a trash bin for them but R8's room did not have one. She stated that staff could use alcohol based hand sanitizer or wash their hands with soap and water after being in the room and only needed to use soap and water if they touched the resident directly. On 7/31/24 at 12:57 p.m., an interview was conducted with CNA #1. CNA #1 stated that when a resident was on contact precautions there was a sign on the door telling them what they needed to wear in the room. She stated that contact precautions required gown and gloves and it was to protect themselves and prevent spread of infection. She stated that the gown and gloves should be worn anytime they went into the room and when a resident was diagnosed with C-diff they had to wash their hands with soap and water prior to leaving the room. On 7/31/24 at 1:52 p.m., an interview was conducted with LPN #1. LPN #1 stated that the purpose of the care plan was to alert all staff involved in the residents care what the goals were for that person and what the recommendations were for the safety of that resident. She stated that the care plan was used to track any improvement or decline in condition and it was to be implemented because it was part of the process to care for the resident. On 7/31/24 at 2:57 p.m., an interview was conducted with ASM (administrative staff member) #2, the assistant director of nursing and infection preventionist. ASM #2 stated that R8 was on contact precautions for a diagnosis of C-diff and the expectation was for all staff to follow the signage on the door and put on a gown and gloves prior to entry. ASM #2 stated that the hand hygiene for C-diff diagnosed residents should be soap and water because it was more effective than alcohol based hand sanitizers. ASM #2 stated that there were no exceptions to following the isolation precautions. The facility policy Care Planning- Comprehensive Person-Centered, undated, documented in part, .The facility will develop and implement a comprehensive person-centered care plan for each resident, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs as identified throughout the comprehensive Resident Assessment Instrument (RAI) process .The resident will receive the services and/or items included in the plan of care . (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 7/31/24 at approximately 3:50 p.m., ASM #1, the administrator, ASM #2, the assistant director of nursing, and ASM #3, the regional director of clinical services were notified of the findings. No further information was provided prior to exit. Reference: (1) C. diff bacteria are commonly found in the environment, but people usually only get C. diff infections when they are taking antibiotics. That's because antibiotics not only wipe out bad germs, but they also kill the good germs that protect your body against infections. The effect of antibiotics can last as long as several months. If you come in contact with C. diff germs during this time, you can get sick. You are more likely to get a C. diff infection if you take antibiotics for more than a week. This information was obtained from the website: https://vsearch.nlm.nih.gov/vivisimo/cgi-bin/query-meta?v%3Aproject=medlineplus&v%3Asources=medlineplus-bundle&query=c.+diff+infections 2. For Resident #3 (R3), the facility staff failed to implement the comprehensive care plan to monitor the dialysis AV (arterio-venous) fistula (1) for function on 4/12-4/13/24, 5/30/24, 6/1-6-4/24 and 6/6/24. The comprehensive care plan for R3 documented in part, The resident has ESRD (end stage renal disease) (2) and receives {Hemo/Peritoneal} dialysis . Date Initiated: 06/06/2024. Revision on: 06/07/2024 . Under Interventions it documented in part, .Auscultation/palpation of the AV fistula (pulse, bruit and thrill) to assure adequate blood flow per protocols. Date Initiated: 06/06/2024. Revision on: 06/07/2024 . The physician orders for R3 documented in part, Assess Dialysis Fistula/Graft (left) for Thrill and Bruit Daily and signs and symptoms of infection. every shift. Order Date: 04/15/2024. Review of the eTARs (electronic treatment administration records) for R8 dated 4/1/24-4/30/24, 5/1/24-5/31/24 and 6/1/24-6/30/24 failed to evidence assessment of the dialysis fistula on 4/12-4/13/24, 5/30/24, 6/1-6-4/24 and 6/6/24. On 7/31/24 at 1:52 p.m., an interview was conducted with LPN (licensed practical nurse) #1. LPN #1 stated that the purpose of the care plan was to alert all staff involved in the residents care what the goals were for that person and what the recommendations were for the safety of that resident. She stated that the care plan was used to track any improvement or decline in condition and it was to be implemented because it was part of the process to care for the resident. LPN #1 stated that they worked with R3 at the facility. She stated that the staff should monitor a resident with a dialysis fistula each shift and they should check the site for bruit and thrill, look for any bleeding or signs of infection. She stated that this was evidenced by documentation in the clinical record. On 7/31/24 at 3:50 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the assistant director of nursing and infection preventionist and ASM #3, the regional director of clinical services were made aware of the findings. No further information was provided prior to exit. Reference: (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	(1) AV (arterio-venous) fistula: A vascular access is an opening made in your skin and blood vessel during a short operation. When you have dialysis, your blood flows out of the access into the hemodialysis machine. After your blood is filtered in the machine, it flows back through the access into your body. There are 3 main types of vascular accesses for hemodialysis. These are described as follows. Fistula: An artery in your forearm or upper arm is sewn to a vein nearby. This allows needles to be inserted into the vein for dialysis treatment. A fistula takes from 4 to 6 weeks to heal and mature before it is ready to use. Graft: An artery and a vein in your arm are joined by a U-shaped plastic tube under the skin. Needles are inserted into the graft when you have a dialysis. A graft can be ready to use in 2 to 4 weeks. Central venous catheter: A soft plastic tube (catheter) is tunneled under your skin and placed in a vein in your neck, chest, or groin. From there, the tubing goes into a central vein that leads to your heart. A central venous catheter is ready to use right away. It is usually used only for a few weeks or months . This information was obtained from the website: https://medlineplus.gov/ency/patientinstructions/000591.htm (2) end-stage kidney disease The last stage of chronic kidney disease. This is when your kidneys can no longer support your body's needs. This information was obtained from the website: https://medlineplus.gov/ency/article/000500.htm. 3. For Resident #4 (R4), the facility staff failed to implement the comprehensive care plan to provide colostomy (1) care every shift during shifts on 3/8-3/11/24, 3/17/24, 3/26/24, 3/28/24, 3/29/24, 3/31/24, 4/12/24 and 5/3/24. The comprehensive care plan for R4 documented in part, [Name of R4] has an alteration in gastro-intestinal status r/t (related to) Colostomy. Date Initiated: 10/26/2023. Revision on: 06/01/2024. Under Interventions it documented in part, Provide colostomy care Q (every) shift and PRN (as needed). Date Initiated: 10/26/2023. Revision on: 06/01/2024. The physician orders for R4 documented in part, Colostomy Care as needed AND every shift On hold from 02/01/2024 23:13 to 02/03/2024 23:12. Order Date: 01/03/2024. Review of the eTARs (electronic treatment administration records) for R4 dated 3/1-3/31/24, 4/1- 4/30/24 and 5/1-5/31/24 failed to evidence colostomy care provided during shifts on 3/8-3/11/24, 3/17/24, 3/26/24, 3/28/24, 3/29/24, 3/31/24, 4/12/24 and 5/3/24. On 7/31/24 at 12:57 p.m., an interview was conducted with CNA (certified nursing assistant) #1. CNA #1 stated that they worked with R4 at the facility. She stated that the CNA staff emptied the colostomy bags and burped the bag to let gas out. She stated that the nurses changed the bags and evidenced the care by charting it in the medical record. On 7/31/24 at 1:52 p.m., an interview was conducted with LPN (licensed practical nurse) #1. LPN #1 stated that the purpose of the care plan was to alert all staff involved in the residents care what the goals were for that person and what the recommendations were for the safety of that resident. She stated that the care plan was used to track any improvement or decline in condition and it was to be implemented because it was part of the process to care for the resident. LPN #1 stated that colostomy sites were assessed daily and care was provided every shift when they worked. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 7/31/24 at 3:50 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the assistant director of nursing and infection preventionist and ASM #3, the regional director of clinical services were made aware of the findings. No further information was provided prior to exit. Reference: (1) Colostomy is a surgical procedure that brings one end of the large intestine out through an opening (stoma) made in the abdominal wall. Stools moving through the intestine drain through the stoma into a bag attached to the skin of the abdomen. This information was obtained from the website: https://medlineplus.gov/ency/article/002942.htm 49369 4. The facility staff failed to implement the comprehensive care plan regarding incontinence care for Resident #2. On the most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 3/25/24, R2 was coded as being severely cognitively impaired for making daily decisions, having scored five out of 15 on the BIMS (brief interview for mental status). R2 was coded as being dependent for toileting hygiene. A review of R2's clinical record revealed a facility document, Documentation Survey Report V2 for March 2024 that includes documentation for ADL- Toilet Use, it revealed there were shifts where no incontinence care was provided. A review of R2's care plan, revealed in part: Encourage with BR (bathroom) as able and allowed to facilitate BM (bowel movement)/ resident may show increase movement in bed when toileting is needed .If resident is awakens during the night encourage toileting .The resident has bowel incontinence. The resident will continue to be continent during daytime through review date. Observe pattern on incontinence, and initiate toileting schedule if indicated. Provide peri-care after each incontinent episode. On 7/31/24 at 1:52 p.m., an interview was conducted with LPN (licensed practical nurse) #1. LPN #1 stated that the purpose of the care plan was to alert all staff involved in the residents' care what the goals were for that person and what the recommendations were for the safety of that resident. She stated that the care plan was used to track any improvement or decline in condition, and it was to be implemented because it was part of the process to care for the resident. On 7/31/24 at 3:50 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the assistant director of nursing, and ASM #3, the regional director of clinical services, were made aware of above concerns. No further information was provided prior to exit. 5.The facility staff failed to implement the comprehensive care plan for Resident # 6. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On the most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 3/25/24, R6 was coded as being dependent for toileting hygiene. A review of R6's clinical record revealed a facility document, Documentation Survey Report V2 for July 2024 that includes documentation for ADL- Toilet Use, it revealed there were shifts where no incontinence care was provided. A review of R6's care plan, revealed in part: Encourage resident with toileting after supper and before HS (hour of sleep) .Encourage toileting after meals as allowed .The resident has bowel incontinence. The resident will be continent during daytime through the review date. Observe pattern of incontinence, and initiate toileting schedule if indicated. Provide peri-care after each incontinent episode. On 7/31/24 at 1:52 p.m., an interview was conducted with LPN (licensed practical nurse) #1. LPN #1 stated that the purpose of the care plan was to alert all staff involved in the residents' care what the goals were for that person and what the recommendations were for the safety of that resident. She stated that the care plan was used to track any improvement or decline in condition, and it was to be implemented because it was part of the process to care for the resident. On 7/31/24 at 3:50 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the assistant director of nursing, and ASM #3, the regional director of clinical services, were made aware of above concerns. No further information was provided prior to exit.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. 49369 Based on staff interview, clinical record review and facility document review, it was determined that the facility staff failed to provide incontinence care for three of fifteen residents in the survey sample, Residents #2, #5 and #6. The findings include: 1. The facility staff failed to provide incontinence care for a dependent resident for Resident # 2. On the most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 3/25/24, R2 was coded as being severely cognitively impaired for making daily decisions, having scored five out of 15 on the BIMS (brief interview for mental status). R2 was coded as being dependent for toileting hygiene. A review of R2's clinical record revealed a facility document, Documentation Survey Report V2 for March 2024 that includes documentation for ADL- Toilet Use, it revealed there were shifts where no incontinence care was provided. A review of R2's care plan, revealed in part: Encourage with BR (bathroom) as able and allowed to facilitate BM (bowel movement)/ resident may show increase movement in bed when toileting is needed .If resident is awakens during the night encourage toileting .The resident has bowel incontinence. The resident will continue to be continent during daytime through review date. Observe pattern on incontinence, and initiate toileting schedule if indicated. Provide peri-care after each incontinent episode. On 7/31/24 at 1:01 p.m., CNA (certified nursing assistant) #1 was interviewed. CNA #1 stated that for incontinence care, the CNAs should perform care if resident needs and to also check on the resident every 2 hours and see if they need care. She also stated that they document incontinence in resident 's clinical record. She also mentioned that if the resident refuses incontinence care they would let a nurse know and the nurse would educate the patient and document in the clinical record. She also mentioned that incontinence care should be given even if the resident has a guest. She adds that when you provide the care ask the family to step out, provide privacy and document it. On 7/31/24 at 3:50 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the assistant director of nursing, and ASM #3, the regional director of clinical services, were made aware of above concerns. The facility policy titled, Urinary Continence and Incontinence-Assessment and Management documented, The staff and practitioner will appropriately screen for, and manage, individuals with urinary and/ or fecal incontinence .The physician/practitioner and staff will provide appropriate services and treatment to help residents restore or improve bladder/bowel function and prevent infections to the extent possible .Facility staff will provide and/or assist the resident with incontinence care as needed .Facility staff will provide peri-care timely and will apple barrier creams to promote good skin integrity. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	No further information was provided prior to exit. 2. The facility staff failed to provide incontinence care for a dependent resident for Resident #5. On the most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 3/25/24, R5 was coded as being cognitively intact for making daily decisions, having scored 15 out of 15 on the BIMS (brief interview for mental status). R5 was coded as being dependent for toileting hygiene. A review of R5's clinical record revealed a facility document, Documentation Survey Report V2 for July 2024 that includes documentation for ADL- Toilet Use, it revealed there were shifts where no incontinence care was provided. On 7/31/24 at 1:01 p.m., CNA (certified nursing assistant) #1 was interviewed. CNA #1 stated that for incontinence care, the CNAs should perform care if resident needs and to also check on the resident every 2 hours and see if they need care. She also stated that they document incontinence in resident 's clinical record. She also mentioned that if the resident refuses incontinence care they would let a nurse know and the nurse would educate the patient and document in the clinical record. She also mentioned that incontinence care should be given even if the resident has a guest. She adds that when you provide the care ask the family to step out, provide privacy and document it. On 7/31/24 at 3:50 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the assistant director of nursing, and ASM #3, the regional director of clinical services, were made aware of above concerns. The facility policy titled, Urinary Continence and Incontinence-Assessment and Management documented, The staff and practitioner will appropriately screen for, and manage, individuals with urinary and/ or fecal incontinence .The physician/practitioner and staff will provide appropriate services and treatment to help residents restore or improve bladder/bowel function and prevent infections to the extent possible .Facility staff will provide and/or assist the resident with incontinence care as needed .Facility staff will provide peri-care timely and will apple barrier creams to promote good skin integrity. No further information was provided prior to exit. 3. The facility staff failed to provide incontinence care for a dependent resident for Resident # 6. On the most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 3/25/24, R6 was coded as being dependent for toileting hygiene. A review of R6's clinical record revealed a facility document, Documentation Survey Report V2 for July 2024 that includes documentation for ADL- Toilet Use, it revealed there were shifts where no incontinence care was provided. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of R6's care plan, revealed in part: Encourage resident with toileting after supper and before HS (hour of sleep) .Encourage toileting after meals as allowed .The resident has bowel incontinence. The resident will be continent during daytime through the review date. Observe pattern of incontinence, and initiate toileting schedule if indicated. Provide peri-care after each incontinent episode. On 7/31/24 at 1:01 p.m., CNA (certified nursing assistant) #1 was interviewed. CNA #1 stated that for incontinence care, the CNAs should perform care if resident needs and to also check on the resident every 2 hours and see if they need care. She also stated that they document incontinence in resident 's clinical record. She also mentioned that if the resident refuses incontinence care they would let a nurse know and the nurse would educate the patient and document in the clinical record. She also mentioned that incontinence care should be given even if the resident has a guest. She adds that when you provide the care ask the family to step out, provide privacy and document it. On 7/31/24 at 3:50 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the assistant director of nursing, and ASM #3, the regional director of clinical services, were made aware of above concerns. The facility policy titled, Urinary Continence and Incontinence-Assessment and Management documented, The staff and practitioner will appropriately screen for, and manage, individuals with urinary and/ or fecal incontinence .The physician/practitioner and staff will provide appropriate services and treatment to help residents restore or improve bladder/bowel function and prevent infections to the extent possible .Facility staff will provide and/or assist the resident with incontinence care as needed .Facility staff will provide peri-care timely and will apple barrier creams to promote good skin integrity. No further information was provided prior to exit.

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F 0691 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate colostomy, urostomy, or ileostomy care/services for a resident who requires such services. 42106 Based on clinical record review, staff interview and facility document review, it was determined that the facility staff failed to provide care and services for a colostomy for one of 15 residents in the survey sample, Resident #4. The findings include: For Resident #4 (R4), the facility staff failed to provide colostomy (1) care during shifts on 3/8-3/11/24, 3/17/24, 3/26/24, 3/28/24, 3/29/24, 3/31/24, 4/12/24 and 5/3/24. On the most recent MDS (minimum data set), a significant change assessment with an ARD (assessment reference date) of 5/23/24, the resident was assessed as having an ostomy. The physician orders for R4 documented in part, Colostomy Care as needed AND every shift On hold from 02/01/2024 23:13 to 02/03/2024 23:12. Order Date: 01/03/2024. Review of the eTARs (electronic treatment administration records) for R4 dated 3/1-3/31/24, 4/1- 4/30/24 and 5/1-5/31/24 failed to evidence colostomy care provided during shifts on 3/8-3/11/24, 3/17/24, 3/26/24, 3/28/24, 3/29/24, 3/31/24, 4/12/24 and 5/3/24. The comprehensive care plan for R4 documented in part, [Name of R4] has an alteration in gastro-intestinal status r/t (related to) Colostomy. Date Initiated: 10/26/2023. Revision on: 06/01/2024. Under Interventions it documented in part, Provide colostomy care Q (every) shift and PRN (as needed). Date Initiated: 10/26/2023. Revision on: 06/01/2024. On 7/31/24 at 12:57 p.m., an interview was conducted with CNA (certified nursing assistant) #1. CNA #1 stated that they worked with R4 at the facility. She stated that the CNA staff emptied the colostomy bags and burped the bag to let gas out. She stated that the nurses changed the bags and evidenced the care by charting it in the medical record. On 7/31/24 at 1:52 p.m., an interview was conducted with LPN (licensed practical nurse) #1. LPN #1 stated that colostomy sites were assessed daily and care was provided every shift when they worked. The facility policy Colostomy/Ileostomy Care, undated, documented in part, .Colostomy and ileostomy care will be provided by a licensed nurse and as ordered by the physician/practitioner . On 7/31/24 at 3:50 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the assistant director of nursing and infection preventionist and ASM #3, the regional director of clinical services were made aware of the findings. No further information was provided prior to exit. Reference: (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rosedale Health & Rehabilitation	1719 Bellevue Avenue Richmond, VA 23227

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F 0691 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(1) Colostomy is a surgical procedure that brings one end of the large intestine out through an opening (stoma) made in the abdominal wall. Stools moving through the intestine drain through the stoma into a bag attached to the skin of the abdomen. This information was obtained from the website: https://medlineplus.gov/ency/article/002942.htm

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. 42106 Based on staff interview, clinical record review and facility document review, it was determined that staff failed to provide feeding assistance for one of 15 residents, Resident #2 (R2). The findings include: The facility staff failed to provide feeding assistance for Resident #2 on March 23, 2024. On the most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 3/25/24, R2 was coded as being severely cognitively impaired for making daily decisions, having scored five out of 15 on the BIMS (brief interview for mental status). R2 was coded as being partial/moderate assistance for eating. A review of R2's clinical record revealed a facility document, Documentation Survey Report V2 for March 2024 that includes documentation for ADL- Eating and nutrition revealed resident did not receive feeding assistance or eat on March 23, 2024. A review of R2's physician orders dated 3/18/24 revealed, Mechanical Soft texture, Regular/Thin consistency, Diet: Mech Soft Liquids Thin for diet. A review of R2's care plan, revealed in part: Resident is at risk for potential nutritional problems r/t (related to) new admission and facility adjustment, Poor PO intake, Mechanically altered diet, hospice .Maintain stable weight 3-5# through next review .Diet as ordered. On 7/31/24 at 11:36 p.m., CNA (certified nursing assistant) #1 was interviewed. She stated that CNA's especially agency CNA ' s will know if a resident requires feeding assistance when they get report on them or during morning report. CNA #1 also stated that they document if a resident eats, how much they eat and if they need assistance in the electronic clinical record. CNA#1 also added that if a resident refuses to eat they tell the nurse, and the nurse will document that. On 7/31/24 at 1:53 p.m., LPN (licensed practical nurse) #1 was interviewed. She stated that R2 did not have any issues with eating when she cared for them. LPN#1 stated that if there were any concerns there were probably from another shift. She also stated that she would feed the resident herself if the family was not there. LPN#1 added that R2's family were concerned about R2 not getting enough food. LPN #1 added that R2 was a slow eater and that she did not do well if she was rushed, and she often educated staff that she was someone that took longer and to make sure that they had ample time when doing that task. On 7/31/24 at 3:50 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the assistant director of nursing, and ASM #3, the regional director of clinical services, were made aware of above concerns. No further information was provided prior to exit.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. 42106 Based on clinical record review, staff interview and facility document review, it was determined that the facility staff failed to provide complete dialysis care and services for one of 15 residents in the survey sample, Resident #3. The findings include: For Resident #3 (R3), the facility staff failed to monitor the dialysis AV (arterio-venous) fistula (1) for function on 4/12-4/13/24, 5/30/24, 6/1-6-4/24 and 6/6/24. The physician orders for R3 documented in part, Assess Dialysis Fistula/Graft (left) for Thrill and Bruit Daily and signs and symptoms of infection. every shift. Order Date: 04/15/2024. Review of the eTARs (electronic treatment administration records) for R3 dated 4/1/24-4/30/24, 5/1/24-5/31/24 and 6/1/24-6/30/24 failed to evidence assessment of the dialysis fistula on 4/12-4/13/24, 5/30/24, 6/1-6-4/24 and 6/6/24. The comprehensive care plan for R3 documented in part, The resident has ESRD (end stage renal disease) (2) and receives {Hemo/Peritoneal} dialysis . Date Initiated: 06/06/2024. Revision on: 06/07/2024 . Under Interventions it documented in part, .Auscultation/palpation of the AV fistula (pulse, bruit and thrill) to assure adequate blood flow per protocols . On 7/31/24 at 1:52 p.m., an interview was conducted with LPN (licensed practical nurse) #1. LPN #1 stated that they worked with R3 at the facility. She stated that the staff should monitor a resident with a dialysis fistula each shift and they should check the site for bruit and thrill, look for any bleeding or signs of infection. She stated that this was evidenced by documentation in the clinical record. The facility policy, Hemodialysis Access Care, undated, documented in part, .Care of AVFs (arterio-venous fistula) and AVGs (arterio-venous graft). 1. Care involves the primary goals of preventing infection and maintaining patency of the catheter (preventing clots). 2. To prevent infection and/or clotting: .3. Check for signs of infection (warmth, redness, tenderness, or edema) at the access site when performing routine care and at regular intervals . 6. Check patency of the site at regular intervals. Palpate the site to feel the thrill, or use a stethoscope to hear the whoosh or bruit of blood flow through the access . It further documented, . Documentation. The facility nurse will monitor and document every shift for: 1. Type of access. 2. Presence of bruit and thrill for AVG and AVG [sic]. 3. Signs and symptoms of infection. 4. Condition of dressing and interventions completed if needed. 5. Bleeding and interventions completed if needed. On 7/31/24 at 3:50 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the assistant director of nursing and infection preventionist and ASM #3, the regional director of clinical services were made aware of the findings. No further information was provided prior to exit. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reference: (1) AV (arterio-venous) fistula: A vascular access is an opening made in your skin and blood vessel during a short operation. When you have dialysis, your blood flows out of the access into the hemodialysis machine. After your blood is filtered in the machine, it flows back through the access into your body. There are 3 main types of vascular accesses for hemodialysis. These are described as follows. Fistula: An artery in your forearm or upper arm is sewn to a vein nearby. This allows needles to be inserted into the vein for dialysis treatment. A fistula takes from 4 to 6 weeks to heal and mature before it is ready to use. Graft: An artery and a vein in your arm are joined by a U-shaped plastic tube under the skin. Needles are inserted into the graft when you have a dialysis. A graft can be ready to use in 2 to 4 weeks. Central venous catheter: A soft plastic tube (catheter) is tunneled under your skin and placed in a vein in your neck, chest, or groin. From there, the tubing goes into a central vein that leads to your heart. A central venous catheter is ready to use right away. It is usually used only for a few weeks or months . This information was obtained from the website: https://medlineplus.gov/ency/patientinstructions/000591.htm (2) end-stage kidney disease The last stage of chronic kidney disease. This is when your kidneys can no longer support your body's needs. This information was obtained from the website: https://medlineplus.gov/ency/article/000500.htm.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 42106 Based on observation, clinical record review, staff interview, and facility document review, it was determined that the facility staff failed to maintain transmission based precautions as ordered for three of 15 residents in the survey sample, Residents #5, #8, and #10. The findings include: 1. For Resident #5 (R5), the facility staff failed to maintain contact precautions for a diagnosis of C-diff (clostridium difficile) (1). On 7/30/24 at approximately 10:22 a.m., an observation was made of the facility. Observation of R5's room revealed a sign posted outside of the door with stop signs on the corners of the notice. The signage documented Contact Precautions Everyone Must: Clean their hands, including before entering and when leaving the room. Providers and Staff must also: Put on gloves before entry. Discard gloves before room exit. Put on gown before room entry. Discard gown before room exit. Do not wear the same gown and gloves for the care of more than one person. Use dedicated or disposable equipment. Clean and disinfect reusable equipment before use on another person. A bin containing disposable gowns, gloves and trash bags was observed in the hallway near R5's room. On 7/30/24 at 12:58 p.m., a facility staff member was observed entering R5's room carrying a lunch tray. The staff member was observed wearing a surgical mask with no other PPE (personal protective equipment). The staff member was observed touching contents of R5's overbed table to place the lunch tray on the table. The staff member was observed exiting R5's room and did not wash their hands. The staff member was observed obtaining another residents tray from the meal cart and entering another residents room to deliver the tray and was observed using alcohol-based sanitizer prior to exiting that room. The comprehensive care plan for R5 documented in part, The resident has C. Difficile r/t (related to) recent antibiotic usage. Date Initiated: 07/12/2024. The physician order's for R5 documented in part, Contact Isolation Precautions every shift for positive for C-diff. Order Date: 07/30/2024. On 7/30/24 at 1:12 p.m., an interview was conducted with CNA (certified nursing assistant) #2. CNA #2 stated that when a resident was on contact precautions the staff were supposed to put on a gown and gloves before they went into the room. She stated that this was done to prevent the spread of germs. She stated that staff should wash their hands before they go in the room and when leaving the room and they normally used the alcohol based hand sanitizer unless their hands were soiled and then they washed their hands with soap and water. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 7/31/24 at 12:57 p.m., an interview was conducted with CNA #1. CNA #1 stated that when a resident was on contact precautions there was a sign on the door telling them what they needed to wear in the room. She stated that contact precautions required gown and gloves and it was to protect themselves and prevent spread of infection. She stated that the gown and gloves should be worn anytime they went into the room and when a resident was diagnosed with C-diff they had to wash their hands with soap and water prior to leaving the room. On 7/31/24 at 2:57 p.m., an interview was conducted with ASM (administrative staff member) #2, the assistant director of nursing and infection preventionist. ASM #2 stated that the expectation when a resident was on contact precautions for a diagnosis of C-diff was for all staff to follow the signage on the door and put on a gown and gloves prior to entry. ASM #2 stated that the hand hygiene for C-diff diagnosed residents should be soap and water because it was more effective than alcohol based hand sanitizers. ASM #2 stated that there were no exceptions to following the isolation precautions. The facility policy Hand hygiene, undated, documented in part, The facility promotes hand hygiene as a simple and effective method for preventing the spread of infections. Glove use is not a substitute for hand hygiene. All staff are to perform hand hygiene during all care activities and while working in all locations within the facility . Use soap and water: i. When hands are visibly soiled. ii. After caring for a person with know or suspected diarrhea. iii. After know of suspected exposure to spores such as C. difficile . The facility policy Transmission-Based Precautions, undated, documented in part, . Contact precautions: . Personal Protective Equipment (PPE). A. Gloves. a. Staff and visitors will wear gloves when entering the room for all interactions that may involve contact with the resident and/or resident's environment. b. Staff and visitors will remove gloves and perform hand hygiene prior to leaving the resident's room . B. Gowns. a. Staff and visitors will wear a gown when entering the room for all interactions that may involve contact with the resident and/or the resident's environment. b. Staff and visitors will remove the gown and perform hand hygiene prior to leaving the resident's room . According to the CDC (centers for disease control) C. diff fact sheet for healthcare professionals dated 3/15/24, documented in part, .C. diff spreads when people touch surfaces that are contaminated with poop from an infected person. Or when people don ' t wash their hands with soap and water . Healthcare professionals can help prevent C. diff by: . Wearing gloves and gowns when treating patients with C. diff-and remembering that hand sanitizer doesn ' t kill C. diff . This information was obtained from the website: https://www.cdc.gov/c-diff/hcp/resources/ On 7/31/24 at approximately 3:50 p.m., ASM #1, the administrator, ASM #2, the assistant director of nursing, and ASM #3, the regional director of clinical services were notified of the findings. No further information was provided prior to exit. Reference: (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	(1) C. diff bacteria are commonly found in the environment, but people usually only get C. diff infections when they are taking antibiotics. That's because antibiotics not only wipe out bad germs, but they also kill the good germs that protect your body against infections. The effect of antibiotics can last as long as several months. If you come in contact with C. diff germs during this time, you can get sick. You are more likely to get a C. diff infection if you take antibiotics for more than a week. This information was obtained from the website: https://vsearch.nlm.nih.gov/vivisimo/cgi-bin/query-meta?v%3Aproject=medlineplus&v%3Asources=medlineplus-bundle&query=c.+diff+infections 2. For Resident #8 (R8), the facility staff failed to maintain contact precautions for a diagnosis of C-diff (clostridium difficile) (1). On 7/30/24 at 10:22 a.m., an observation was made of the facility. Observation of R8's room revealed a sign posted outside of the door with stop signs on the corners of the notice. The signage documented Contact Precautions Everyone Must: Clean their hands, including before entering and when leaving the room. Providers and Staff must also: Put on gloves before entry. Discard gloves before room exit. Put on gown before room entry. Discard gown before room exit. Do not wear the same gown and gloves for the care of more than one person. Use dedicated or disposable equipment. Clean and disinfect reusable equipment before use on another person. A bin containing disposable gowns, gloves and trash bags was observed in the hallway near R8's room. On 7/30/24 at 12:45 p.m., a facility staff member was observed entering R8's room carrying a lunch tray. The staff member was observed wearing a surgical mask with no other PPE (personal protective equipment). The staff member was observed touching contents of R8's overbed table to make room for the lunch tray. The staff member was observed using alcohol based hand sanitizer prior to exit of R8's room. On 7/30/24 at 4:09 p.m., a facility staff member was observed in R8's room at the bedside with the resident. The staff member was observed wearing a surgical mask, disposable gown and gloves. The staff member was observed to come outside of the room at 4:10 p.m. wearing the same gown and gloves and go to the medication cart across the hallway. The staff member was observed to open the medication cart with the gloves on and obtain medication for R8 and then return to the residents room. After administering the medication to R8, the staff member was observed to remove the gloves in the room and return to the medication cart with the same gown on at 4:12 p.m. The staff member was observed to doff the gown in trash can on the medication cart in the hallway at the medication cart at that time and sanitize their hands with alcohol based sanitizer. The physician order's for R8 documented in part, Contact Isolation Precautions d/t positive C-diff every shift for positive for C-diff. Order Date: 07/29/2024. The comprehensive care plan for R8 documented in part, The resident has infection/C-diff. Date Initiated: 06/27/2024. Revision on: 06/27/2024. Under Interventions it documented in part, .Maintain Contact precautions when providing resident care. Date Initiated: 06/27/2024. Revision on: 06/27/2024 . (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 7/30/24 at 1:12 p.m., an interview was conducted with CNA (certified nursing assistant) #2. CNA #2 stated that when a resident was on contact precautions the staff were supposed to put on a gown and gloves before they went into the room. She stated that this was done to prevent the spread of germs. She stated that staff should wash their hands before they go in the room and when leaving the room and they normally used the alcohol based hand sanitizer unless their hands were soiled and then they washed their hands with soap and water. On 7/30/24 at 4:12 p.m., an interview was conducted with LPN (licensed practical nurse) #3. LPN #3 stated that R8 was on contact precautions for a diagnosis of C-diff. She stated that when staff go in the room they were to put on gloves and a gown prior to entering the room. She stated that they were supposed to take the gloves and gown off inside the room at the door prior to exit and normally there was a trash bin for them but R8's room did not have one. She stated that staff could use alcohol based hand sanitizer or wash their hands with soap and water after being in the room and only needed to use soap and water if they touched the resident directly. On 7/31/24 at 12:57 p.m., an interview was conducted with CNA #1. CNA #1 stated that when a resident was on contact precautions there was a sign on the door telling them what they needed to wear in the room. She stated that contact precautions required gown and gloves and it was to protect themselves and prevent spread of infection. She stated that the gown and gloves should be worn anytime they went into the room and when a resident was diagnosed with C-diff they had to wash their hands with soap and water prior to leaving the room. On 7/31/24 at 2:57 p.m., an interview was conducted with ASM (administrative staff member) #2, the assistant director of nursing and infection preventionist. ASM #2 stated that R8 was on contact precautions for a diagnosis of C-diff and the expectation was for all staff to follow the signage on the door and put on a gown and gloves prior to entry. ASM #2 stated that the hand hygiene for C-diff diagnosed residents should be soap and water because it was more effective than alcohol based hand sanitizers. ASM #2 stated that there were no exceptions to following the isolation precautions. On 7/31/24 at approximately 3:50 p.m., ASM #1, the administrator, ASM #2, the assistant director of nursing, and ASM #3, the regional director of clinical services were notified of the findings. No further information was provided prior to exit. Reference: (1) C. diff bacteria are commonly found in the environment, but people usually only get C. diff infections when they are taking antibiotics. That's because antibiotics not only wipe out bad germs, but they also kill the good germs that protect your body against infections. The effect of antibiotics can last as long as several months. If you come in contact with C. diff germs during this time, you can get sick. You are more likely to get a C. diff infection if you take antibiotics for more than a week. This information was obtained from the website: https://vsearch.nlm.nih.gov/vivisimo/cgi-bin/query-meta?v%3Aproject=medlineplus&v%3Asources=medlineplus-bundle&query=c.+diff+infections 3. For Resident #10 (R10), the facility staff failed to maintain droplet precautions for a diagnosis of COVID-19 (1). (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 7/30/24 at approximately 10:22 a.m., an observation was made of the facility. Observation of R10's room revealed a sign posted outside of the door with stop signs on the corners of the notice. The signage documented Droplet Precautions Everyone Must: Clean their hands, including before entering and when leaving the room. Make sure their eyes, nose and mouth are fully covered before room entry. Remove face protection before room exit. The signage documented photos of a person wearing a full face shield with mask or eye goggles and a mask. A bin containing disposable gowns, N95 masks (2), gloves and trash bags was observed near R10's room. No eye protection was observed in the bin near R10's room. On 7/30/24 at 12:56 p.m., a staff member wearing a surgical mask was observed entering R10's room with a meal tray. The staff member was observed to not don a gown or gloves prior to entering the room and was observed delivering the tray to R10 on the window side of the room. The staff member was observed to sanitize their hands prior to exit from the room and return to the meal cart. The comprehensive care plan for R10 documented in part, COVID-19: Confirmed Positive Resident has tested positive for COVID-19 and is symptomatic. Date Initiated: 07/24/2024. The physician order's for R10 documented in part, Droplet Precautions. Order Date: 07/24/2024. On 7/30/24 at 1:12 p.m., an interview was conducted with CNA (certified nursing assistant) #2. CNA #2 stated that R10 was on droplet precautions for COVID-19 and that the staff were supposed to put on a mask, gown and gloves before they went into the room. She stated that this was done to prevent the spread of COVID-19. She stated that she was not sure about eye protection or a face mask. On 7/31/24 at 12:57 p.m., an interview was conducted with CNA #1. CNA #1 stated that when a resident was on droplet precautions there was a sign on the door telling them what they needed to wear in the room. She stated that droplet precautions required a mask, gown and gloves and it was to protect themselves and prevent spread of infection. On 7/31/24 at 2:57 p.m., an interview was conducted with ASM (administrative staff member) #2, the assistant director of nursing and infection preventionist. ASM #2 stated that the expectation when a resident was on droplet precautions for COVID-19 isolation was for staff to follow the signage on the door wearing the PPE (personal protective equipment) that it advised. He stated that the preferred mask was an N95 mask and that they stocked everything for the staff in the bins in the hallways. ASM #2 stated that there were no exceptions to following the isolation precautions. The facility policy Coronavirus Disease (COVID-19)- Identification and Management of Ill Residents, created 3/23, documented in part, .Staff who enter the room of a resident with suspected or confirmed SARS-CoV-2 infection will adhere to standard precautions and use a NIOSH-approved particulate respirator with N95 filters or higher, gown, gloves and eye protection (i.e., goggles or a face shield that covers the front and sides of the face) . (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495283	A. Building B. Wing	07/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rosedale Health & Rehabilitation	1719 Bellevue Avenue Richmond, VA 23227

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	According to CDC (centers for disease control) guidance, dated 6/24/24 Infection Control Guidance: SARS-CoV-2, it documented in part, This guidance applies to all U.S. settings where healthcare is delivered, including nursing homes and home health. The recommendations in this guidance continue to apply after the expiration of the federal COVID-19 Public Health Emergency Personal Protective Equipment. HCP (health care providers) who enter the room of a patient with suspected or confirmed SARS-CoV-2 infection should adhere to Standard Precautions and use a NIOSH Approved particulate respirator with N95 filters or higher, gown, gloves, and eye protection (i.e., goggles or a face shield that covers the front and sides of the face) . This information was obtained from the website: https://www.cdc.gov/covid/hcp/infection-control/ On 7/31/24 at approximately 3:50 p.m., ASM #1, the administrator, ASM #2, the assistant director of nursing, and ASM #3, the regional director of clinical services were notified of the findings. No further information was provided prior to exit. Reference: (1) COVID-19: COVID-19 most often causes respiratory symptoms that can feel much like a cold, the flu, or pneumonia. COVID-19 may attack more than your lungs and respiratory system. Other parts of your body may also be affected by the disease. Most people with COVID-19 have mild symptoms, but some people become severely ill. This information was obtained from the website: https://www.cdc.gov/covid/about/index.html (2) The N95 respirator is the most common of the seven types of particulate filtering facepiece respirators. This product filters at least 95% of airborne particles but is not resistant to oil-based particles. This information was obtained from the website: https://www.cdc.gov/niosh/npptl/topics/respirators/disp_part/n95list1.html