STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495422	A. Building B. Wing	05/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Dockside Health & Rehab Center	74 Mizpah Road Locust Hill, VA 23092

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 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. 31199 Based on staff interview, clinical record review and facility documentation review, the facility failed to ensure that a Medicare Advanced Beneficiary Notice (ABN) was completed and issued to 1 Resident, (Resident #25) in a survey sample of 3 ABN Residents. For Resident #25, the facility failed to ensure receipt for notification of insurance coverage loss was documented on the ABN prior to the loss of coverage. The findings included; On 5-30-24 during the course of the survey, the Administrator was asked for ABN records for three skilled nursing discharged individuals. The documents were received and revealed that one of the three documents had not been signed by the beneficiary nor a responsible party and correctly completed. For Resident's #25, staff have no record of the Resident receiving the Advanced Beneficiary notices and signing them. This indicated that the Resident would be unaware of insurance coverage loss date, and thus have no ability to enact their right to appeal the judgement and continue services until a review was conducted by the Centers for Medicare/Medicaid services (CMS), or their contractors. On 5-30-24 at 5:00 p.m., during the end of day debrief, the Administrator was asked why no signature appeared in the Resident documents denoting when the Resident's insurance would lapse, and she stated We will look into that. On 5-31-24 at 3:00 p.m., during the end of day debrief the Administrator was again made aware of the incomplete ABN documents for Resident #25. She stated it simply wasn't done, and we have nothing further to provide.

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40026 Based on interview, clinical record review and facility documentation the facility staff failed to ensure that Residents receive adequate supervision and assistance to prevent accidents for 1 Resident (#18) in a survey sample of 24 residents. The findings included: For Resident #18 the facility staff failed to ensure supervision of the resident from the dining room to the hallway on the New Wing causing Resident #18 to trip and fall. On 5/29/24 a review of the clinical record revealed that Resident # 18 was admitted to the facility on [DATE] with diagnoses that included but were not limited to hypo and hypertension, anemia, dementia with behavioral disturbances and history falls and wandering. Resident #18's most recent MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 2/27/24 coded Resident #18 as having a BIMS (Brief Interview of Mental Status) score of 2 out of 15, indicating severe cognitive impairment. A review of the care plan revealed that Resident #18 is care planned for wandering, falls, cognitive decline, resistance to care and redirection, with appropriate interventions in place. On 5/29/24 a review of the progress notes revealed that on 5/14/23, Resident #18 had a fall while ambulating from the dining room after dinner. A review of the fall investigation revealed the following excerpts: Event date: 5/14/24 at 5:17 PM Event details: Fall with minor injury. Location of fall: Hallway What was resident doing prior to fall? Leaving out of dining room walking back to unit. Location of injury: Hands, right knee and shoulder bruised. ROM [Range of Motion]: X 4 without pain or limitations. The fall investigation revealed that first aid was provided, and pain was addressed, the care plan was updated to reflect the fall, the family and physician were notified. (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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/30/24 at approximately 1:00 PM the area from the hallway of the New Wing leading into the dining room was observed and found that the threshold between the hallway and the dining room was not a smooth transition there was a metal strip that created a trip hazard. The Administrator was made aware as well Employees D (maintenance) and H (Regional [NAME] President). Employee D under the direction of Employee H immediately began to remove the threshold strip and make repairs to floor to ensure it would not become a further trip hazard. A review of the incidents and accidents since the New Wing was built revealed this fall to be an isolated incident no falls were noted prior to or since this fall.

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 31199 Based on observation and staff interview the facility staff failed to maintain a clean and sanitary food preparation area in accordance with professional standards for food service safety. The findings included; On 5-28-24 at approximately 12:40 PM, the kitchen area of the facility was inspected. The fire suppression hood over the large industrial stove was covered in debris and dust with a fur like appearance, which could not be removed by simply wiping, as the debris was adhered with a sticky greasy substance. The metal food preparation tables in the center of the kitchen immediately parallel to the stove had a shelf under each one running the entire length under the tables. Those shelves were also coated with the sticky substance which could not be wiped off. Adhered to the sticky substance on the shelves was food debris, tiny gnat like insects, and paper particles. There were also multiple clear plastic bins under the tables, and on the shelves, containing clean cooking utensils. The clean items as stated by the Dining Director, and bins, were also noted to have food debris and paper particles in them. The dining Director stated we have someone coming next month to do a deep cleaning here in the kitchen, and they will do the stove hood as well. The inspection observations continued in the walk in freezer, and refrigerator. The walk in refrigerator was noted to have clear plastic strips making a curtain in the refrigerator which had the purpose of being easily pushed aside to access the inner refrigerator while maintaining refrigeration as the door was open for deliveries. The plastic strip curtain was noted to have a black mildew substance 18 inches from the floor upward coating each strip. The substance was easily removed with a paper towel. The Corporate Registered Dietician, and Dining Director were present and stated that they would begin to clean the kitchen immediately. On 5-29-24 the kitchen had been cleaned. No further information was provided.