STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495215	A. BUILDING ______ B. WING ______	C 02/23/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SENTARA REHABILITATION & CARE RESIDENCE-CHESAPEAKE	**776 OAK GROVE RD PO BOX 1277** **CHESAPEAKE, VA 23320**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid Abbreviated Standard (complaint investigation) was conducted from 2/22/17 through 2/23/17. Two complaints were investigated during the survey. Significant Corrections are required for compliance with the following 42 CFR Part 483 Federal Long Term Care requirement. The census in this 120 certified bed facility was 85 at the time of the survey. The survey sample consisted of 4 Resident reviews, two current resident reviews (Residents #1 through 2) and two closed record reviews (Residents #3 through 4).	F 000		
F 280 SS=D	RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP CFR(s): 483.10(c)(2)(i-ii,iv,v)(3),483.21(b)(2) 483.10 (c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. (iv) The right to receive the services and/or items included in the plan of care.	F 280		4/7/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 03/16/2017

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.

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F 280	Continued From page 1	F 280		

Continued From page 1

(v) The right to see the care plan, including the right to sign after significant changes to the plan of care.

(c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must--

(i) Facilitate the inclusion of the resident and/or resident representative.

(ii) Include an assessment of the resident’s strengths and needs.

(iii) Incorporate the resident’s personal and cultural preferences in developing goals of care.

483.21
(b) Comprehensive Care Plans

(2) A comprehensive care plan must be-

(i) Developed within 7 days after completion of the comprehensive assessment.

(ii) Prepared by an interdisciplinary team, that includes but is not limited to--

(A) The attending physician.

(B) A registered nurse with responsibility for the resident.

(C) A nurse aide with responsibility for the resident.

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F 280	Continued From page 2 (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review and review of the facility's policy the facility staff failed to review and revise the person-centered plan of care for 1 of 4 residents (Resident #3), in the survey sample. The facility staff failed to revise Resident #3's person-centered plan of care to include a fall resulting in an injury. The findings included: Resident #3 was originally admitted to the facility 10/16/16 and was discharged to an acute care hospital on 1/22/17. Resident #3 diagnoses included: acid reflux, dementia, glaucoma and	F 280	1. Resident #3 no longer resides in facility. 2. All residents with falls have the potential to be affected. 3. Licensed nursing staff educated regarding requirements to update care plan each time a resident falls. 4. The IDT and clinical team will review falls and care plan interventions daily. Findings will be reported to QAPI for 3 months.	

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nerve pain.

The admission Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 10/23/16 coded the resident as not having the ability to complete the Brief Interview for Mental Status (BIMS). The staff interview was coded for short term memory problems as well as modified independence with daily decision making abilities. In section "G" (Physical functioning) the resident was coded as requiring extensive assistance of 1 person with bed mobility, locomotion on the unit, personal hygiene, bathing, dressing, and toilet use. The resident required extensive assistance of 2 person with transfers.

A nurses' note dated 11/6/16 at 11:30 p.m., stated Resident #3 was observed lying on the floor on the right side. A "visible laceration to the right temporal with active bleeding, bruising and swelling noted. Attempted to sit resident up and resident complained of headache and dizziness. Resident laid back down and said the dizziness stopped but she still had a headache. 911 called for transport to the emergency room for evaluation. Responsible party notified, Medical doctor notified". The investigation of the fall read; the cause was impulsive and non-compliant. No further information such as if the care planned alarm was sounding and the location of the resident prior to the fall was documented. Neither was the care plan updated to reflect the fall and new interventions instituted to prevent further falls.

Resident #3's Fall Risk Assessment completed

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Continued From page 4
on 10/23/16. It revealed the resident was a very high fall risk resident.

The care plan dated 10/18/16 had a care plan problem which read; At risk for falls related to new environment. The goal read; (Resident's name) will demonstrate the ability to ambulate/transfer without fall related injuries over the next 90 day review period 1/17/17. The goals included; Keep areas free of obstructions to reduce the risk of falls or injury. Place call bell/light within easy reach. Remind; (Resident's name) to call for assistance before moving from bed to chair, chair to bed. Use alarm to monitor attempts to rise. Footwear will fit properly and have non-skid soles.

A review of a Care Plan did not include the actual fall on 11/6/16 resulting in injuries and requiring transport to the local emergency room for evaluation and treatment nor interventions for the fall.

An interview was conducted with Registered nurse supervisor #1 on 2/23/17 at approximately 1:45 p.m. She stated all falls are reviewed by the team, the resident's care plan is updated and direct care staff is updated regarding the new interventions. Registered nurse supervisor #1 could not explain what happened in Resident #3 case.

The above information was addressed with the Administrator and Director of Nursing on 2/23/17 at approximately 6:00 p.m. The Director of

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F 280	Continued From page 5 Nursing stated the facility follows the RAI manual for care planning.	F 280		
F 314 SS=E	TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES CFR(s): 483.25(b)(1) (b) Skin Integrity - (1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, clinical record review, staff interviews and facility documentation, the facility staff failed to ensure pressure ulcers were properly assessed so an effective pressure ulcer treatment and prevention program could be developed to promote healing and prevent new pressure ulcers from developing for 3 of 4 residents (Resident #1, 3 and 4), in the survey sample. 1. Resident #1's weekly skin condition progress report incorrectly identified the tissue type present	F 314	1. Resident #1's wound documentation was immediately corrected to reflect resident's current condition. Residents #3 and #4 no longer reside in facility. 2. All residents with pressure ulcers have the potential to be affected. 3. All residents with pressure ulcers have been reassessed, with appropriate documentation of condition included in medical record. Licensed nursing staff educated on facility policy/procedure for assessment, prevention, care and documentation.	4/7/17

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F 314	Continued From page 6 in the sacral wound or the stage of the sacral wound was inaccurate. Resident#1's pressure ulcer was not consistently reassessed every seven days. 2. Resident #3's clinical note dated 12/13/16 incorrectly identified the pressure ulcer tissue type in three new pressure ulcers or the three new pressure ulcers were not accurately staged. 3. Resident #4's Minimum Data Set (MDS) assessment with an assessment reference date of 6/14/16 incorrectly identified the pressure ulcer tissue type in the admitted with pressure ulcer or the admitted with pressure ulcer was not staged accurately. The facility staff measured the skin problems/pressure ulcers in inches. The findings included; 1. Resident #1 was originally admitted to the facility 9/16/16 and readmitted 1/27/17 after an acute hospital stay. The current diagnoses include endstage kidney disease with dialysis three days per week, high cholesterol, diabetes, heart failure and pressure ulcers. The significant change Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 2/7/17 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 14 out of a possible 15. This indicated Resident #1's cognitive abilities for daily decision making were intact. The MDS assessment also was coded that Resident #1 has little pleasure in doing things, has little energy and a poor appetite two to six days over a two week period and no	F 314	4. The IDT and clinical team will review pressure ulcer documentation weekly for accuracy. Findings will be reported to QAPI for the next 3 months.	

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behavior problems. The resident was coded as requiring total care of two people with bed mobility and transfers, total care of one person with locomotion, bathing, dressing and toilet use, extensive assistance of 1 person with personal hygiene and eating.
In the Skin Conditions section of the MDS the resident was coded for two stage two pressure ulcers and two unstageable pressure ulcers because of eschar.

The skin condition progress report dated 2/20/17 indicated on 2/13/17 the two open areas to the sacrum merged and is currently considered one sacral pressure ulcer. It measured 6.0 centimeters by 3 centimeters by 0.4 centimeter and contain 50 percent granulating tissue and 50 percent slough (dead tissue). The report stated the sacral wound was with a small amount of straw/red drainage and was without odor.

The right ischium pressure ulcer and the coccyx pressure ulcer were reassessed on 12/20/16 but the left buttock pressure ulcer was not reassessed until 12/26/16. The left buttock pressure ulcer was not assessed on 1/2/17 but the right ischium pressure was documented as measuring 2.5 centimeters by 2.0 centimeters by 0.5 centimeters and having and 20 percent granulating tissue and 80 percent slough (non-viable tissue) and the coccyx pressure ulcer measured 8.0 centimeters by 6.0 centimeters with 100 percent granulating tissue.

The above information was addressed with the Administrator and Director of Nursing on 2/23/17 at approximately 6:00 p.m.

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2. Resident #3 was originally admitted to the facility 10/16/16 and was discharged to an acute care hospital on 1/22/17. Resident #3 diagnoses included; acid reflux, dementia, glaucoma and nerve pain.

The admission Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 10/23/16 coded the resident as not having the ability to complete the Brief Interview for Mental Status (BIMS). The staff interview was coded for short term memory problems as well as modified independence with daily decision making abilities. In section "G" (Physical functioning) the resident was coded as requiring extensive assistance of 1 person with bed mobility, locomotion on the unit, personal hygiene, bathing, dressing, and toilet use. The resident required extensive assistance of 2 person with transfers.

The facility's clinical notes revealed on 12/13/16 Resident #3 was observed to have three new pressure ulcers; a stage two pressure ulcer of the right ischium measuring 1.5 centimeters by 1.5 centimeters and 100 percent granulating tissue, a stage two pressure ulcer of the left buttock measuring 1.0 centimeters by 1.6 centimeters and with 100 percent granulating tissue and a stage two pressure ulcer of the coccyx fold measuring 1.0 centimeters by 0.5 centimeters also with 100 percent granulating tissue.

The right ischium pressure ulcer and the coccyx pressure ulcer were reassessed on 12/20/16 but

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the left buttock pressure ulcer was not reassessed until 12/26/16. The left buttock pressure ulcer was not assessed on 1/2/17 but the right ischium pressure was documented as measuring 2.5 centimeters by 2.0 centimeters by 0.5 centimeters and having and 20 percent granulating tissue and 80 percent slough (non-viable tissue) and the coccyx pressure ulcer measured 8.0 centimeters by 6.0 centimeters with 100 percent granulating tissue.

The above information was addressed with the Administrator and Director of Nursing on 2/23/17 at approximately 6:00 p.m

3. Resident #4 was originally admitted to the facility 6/7/16 and was discharged to an home on 7/30/16. Resident #4's diagnoses included; multiple fractures secondary to a motor vehicle accident, hypertension, fibromyalgia and rheumatoid arthritis.

The admission Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 06/14/16 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 15 out of a possible 15. This indicated Resident #4's cognitive abilities for daily decision making were intact. The MDS assessment also was coded for no mood or behavior problems. In section "G" (Physical functioning) the resident was coded as requiring supervision of one person with locomotion off the unit and eating, extensive assistance of two person with transfers, extensive assistance of

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one person with bed mobility, locomotion on the unit, personal hygiene, bathing, dressing, and toilet use.

A pressure ulcer weekly wound progress note dated 6/7/16 identified a right buttock pressure ulcer as a stage two. The 6/7/16 wound progress note stated the pressure ulcer measured 2 centimeters by 0.5 centimeter. It was documented as having a small amount of straw drainage and healthy/intact tissue surrounding the pressure ulcer.

Resident #4's MDS assessment dated 06/14/16 was coded for a stage two pressure ulcer, present on admission 6/7/16. The MDS was coded at "M0700" worse tissue type as, granulation tissue.

On 6/22/16 at 10:59 p.m., a nurses' note read "two small excoriations noted on middle right buttocks. One approximately on inch circumference and 1/2 inch circumference, red with puncture, bleeding. Cleaned and treated with protective cream. Instructed certified nursing assistant to report all changes in condition.

Document pressure ulcer size in centimeters. Always assess and document length (head to toe direction) times width (hip to hip direction) times depth (deepest part of visible wound bed). (http://woundconsultant.com/DOCUMENTATION.pdf)

According to the Centers of Medicaid and

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F 314	Continued From page 11 Medicare Resident Assessment Indicator Version 3.0 Manual which drives the skin assessment in section M0700; stage 2 pressure ulcers by definition have partial-thickness loss of the dermis. Granulation tissue, slough or eschar is not present in Stage 2 pressure ulcers. Therefore, Stage 2 pressure ulcers should not be coded as having granulation, slough or eschar tissue and should be coded as 1 for this item. (MDS 3.0, Resident Assessment Instrument user's manual, chapter 3 section M page M-24 dated October 2016) The above information was addressed with the Administrator and Director of Nursing on 2/23/17 at approximately 6:00 p.m. The Director of Nursing stated all licensed nursing staff had been educated on pressure ulcers at the skills fair and they are more knowledgeable than the documentation indicates. The Administrator stated a new wound care physician is now on the team and he would ensure the staff was educated further in pressure ulcer assessment and management.	F 314		
F 441 SS=D	INFECTION CONTROL, PREVENT SPREAD, LINENS CFR(s): 483.80(a)(1)(2)(4)(e)(f) (a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: (1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff,	F 441		4/7/17

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F 441	Continued From page 12 volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2); (2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and	F 441		

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F 441	Continued From page 13 (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. (4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. (e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. (f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and review of the facility's policy, the facility staff failed to ensure infection control measures were maintained for 1 of 4 residents (Resident #1), in the survey sample. The facility staff failed to adhere to hand hygiene procedures during Resident #1's pressure ulcer care. The findings included: Resident #1 was originally admitted to the facility 9/16/16 and readmitted 1/27/17 after an acute hospital stay. The current diagnoses include endstage kidney disease with dialysis three days per week, high cholesterol, diabetes, heart failure and pressure ulcers. The significant change Minimum Data Set (MDS)	F 441	1. Nurse performing wound care for resident #1 did not follow proper infection control measures. Nurse was immediately educated on proper infection control technique. 2. All residents requiring wound care have the potential to be affected. 3. Licensed nursing staff educated regarding proper infection control techniques while providing wound care. 4. Clinical Manager and/or designee will observe wound care treatment on 25% of residents requiring wound care treatments monthly for the next 3 months to ensure proper infection control techniques are followed. Findings will be reported to QAPI for the next 3 months. ***** Preparation and/or execution of this plan of correction does not constitute	

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F 441	Continued From page 14 assessment with an assessment reference date (ARD) of 2/7/17 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 14 out of a possible 15. This indicated Resident #1's cognitive abilities for daily decision making were intact. The MDS assessment also was coded that Resident #1 has little pleasure in doing things, has little energy and a poor appetite two to six days over a two week period and no behavior problems. The resident was coded as requiring total care of two people with bed mobility and transfers, total care of one person with locomotion, bathing, dressing and toilet use, extensive assistance of 1 person with personal hygiene and eating. In the Skin Conditions section of the MDS the resident was coded for two stage two pressure ulcers and two unstageable pressure ulcers because of eschar. The skin condition progress report dated 2/20/17 indicated on 2/13/17 the two open areas to the sacrum merged and is currently considered one sacral pressure ulcer. It measured 6.0 centimeters by 3 centimeters by 0.4 centimeter and contain 50 percent granulating tissue and 50 percent slough (dead tissue). The report stated the sacral wound was with a small amount of straw/red drainage and was without odor. On 2/22/17 at approximately 2:20 p.m., Resident #1 was observed reclining in bed, on a low air loss mattress inflated to maximum. The surveyor introduced self to the resident and asked if wound care could be observed the following day. The resident stated yes.	F 441	admission or agreement by the provider of the accuracy of the facts alleged or conclusion set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495215	A. BUILDING ______ B. WING ______	C 02/23/2017

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On 2/23/17 at approximately 2:00 p.m.; Registered nurse supervisor #1 informed the surveyor the resident was ready to have the sacral pressure ulcer care completed. Registered nurse supervisor #1 was assisted by certified nursing assistant #1. Registered nurse supervisor #1 placed the needed supplies on the lower part of the mattress, directly on the bottom sheet the resident was lying on; they were scissors, a pen, gloves, wound cleanser, 4 by 4 gauze, Calmoseptine , normal saline solution, Santyl ointment, an adhesive dressing and a roll of stretch tape.

Resident #1 wore a hospital gown open in the back, the incontinence brief and pad were rolled beneath the resident and a clean pad and brief was partially down to be put on the resident after the wound care.

Registered nurse supervisor #1 and certified nursing assistant #1 applied their gloves and positioned the resident to expose the sacral pressure ulcer. Registered nurse supervisor #1 moved the trash can over closer to the bed with gloved hands, removed the old gloves donned another pair of gloves, removed the old sacral dressing dated 2/22/17 and removed the gloves, applied another pair of gloves, sprayed the wound with wound cleanser and wiped the pressure ulcer from innermost to outermost; spraying and cleaning the pressure three times, changing the gloves each time.

The sacral pressure ulcers wound bed was covered with stringy dark yellow tissue, there was no drainage or odor. The tissue surrounding the pressure ulcer was excoriated and redden. Registered nurse supervisor #1 with gloved

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F 441	Continued From page 16	F 441		

hands applied Calmoseptine to the excoriated skin around the pressure ulcer and the gloves were changed, another pair of gloves were donned, Santyl ointment was applied to the pressure ulcer with gauze and saline soak gauze was used to cover the pressure ulcer. The gloves were again changed and another pair donned. An adhesive dressing was applied over the pressure ulcer. Registered nurse supervisor #1 had no gloves left, she keep the gloves she was wearing, walked over near the door obtained more gloves and scissors, put the items down, removed the gloves she was wearing , applied another pair of gloves and dated the tape and applied it to the adhesive dressing.

Registered nurse supervisor #1 and certified nursing assistant #1 closed the clean brief on the resident removed the soiled incontinence brief and positioned the clean linen and the resident. The supplies were gathered and the trash bagged and taken out.

Registered nurse supervisor #1 did not wash her hands or use sanitizer during the entire pressure ulcer dressing change and offered no response when the surveyor brought it to her attention.

The Policy and Procedure titled "Life Care - Hand Hygiene" with a revision date of 6/12/15, read under Purpose: Guidelines are provided for proper and effective hand hygiene to prevent transmission of infections. Appropriate 20 second hand washing must be performed under the following conditions: Before performing resident care. After handling soiled items"

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F 441	Continued From page 17 The Policy and Procedure titled: "Life Care - Wound Care" with a revision date of 6/23/16 read under Purpose: To provide aseptic wound care in accordance the with Physician's orders. Required Action steps: #4. Set up clean area with supplies. 5. Wash hands thoroughly and put on gloves. 7. Discard Equipment and Wash hands. The above information was addressed with the Administrator and Director of Nursing on 2/23/17 at approximately 6:00 p.m. No addition information was provided by the facility staff.	F 441		