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 10/20/2016

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 standard survey was conducted 10/18/2016 - 10/20/2016. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. One complaint was investigated during the survey. The Life Safety Code survey/report will follow. The census in this 120 bed facility was 104 at the time of the survey. The survey sample consisted of 19 current residents (1-18 and 23) and four closed records (19-22).	F 000		
F 157 SS=E	NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) CFR(s): 483.10(b)(11) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a	F 157		12/1/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed | TITLE | (X6) DATE 11/11/2016

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.

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 10/20/2016

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F 157	Continued From page 1 change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility documentation and clinical record review, the facility staff failed to ensure the physician and RP (responsible party) were notified of changes in condition for five residents (Resident #2, #11, #16, #6 and Resident #12) in a survey sample of 23 residents. 1. For Resident #2, the facility staff failed to notify the physician of blood sugars greater than 400, per physician order. 2. For Resident #11, the facility staff failed to notify the physician of a blood sugar greater than 400 on 10/3/16, per physician order. 3. For Resident #16, the facility staff failed to notify the physician of a fall that occurred on 7/18/16. 4. For Resident #6, the facility staff failed to notify the physician of a high blood sugar reading. 5. For Resident # 12, the facility staff failed to notify the physician and responsible party of a fall on 10/15/2016.	F 157	1. The facility did not notify the physician of blood sugar levels greater than 400 for residents #2,#6, and #11. The facility did not notify the physician of falls for residents #12 and #16. 2. All residents with blood sugar orders or that incur falls have the potential to be affected. 3. Licensed nursing staff educated on the facility's policy and procedure regarding timely physician notification. 4. Clinical Manager and/or designee will verify weekly for the next 60 days that the physician and legal representative have been appropriately notified of changes and that notifications are properly reflected in the clinical record. Findings will be reported to the Quality Assurance & Performance Improvement (QAPI) committee monthly for the next 60 days.	

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	495215	A. BUILDING ______ B. WING ______	C 10/20/2016

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SENTARA REHABILITATION & CARE RESIDENCE-CHESAPEAKE	776 OAK GROVE RD PO BOX 1277 CHESAPEAKE, VA 23320

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F 157	Continued From page 2	F 157		

The findings included:

1. Resident #2 was admitted to the facility on 9/11/14 and readmitted after hospitalization on 8/29/16. Diagnoses included hypertension, depression, and diabetes.

Resident #2's most recent MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 9/19/16 was coded as a significant change in status assessment. Resident #2 was coded as having short and long term memory problems and as having modified independence in making decisions regarding tasks of daily life. Resident #2 was also coded as requiring extensive to total assistance of one to two staff members to perform activities of daily living.

On 10/18/16 at 6:40 p.m., Resident #2 was observed in his room, sitting in his wheelchair. Resident #2 responded appropriately to conversation when spoken to by his nurse.

On 10/19/16 at 8:30 a.m., a review of Resident #2's electronic clinical record was conducted and revealed the following:

a. A physician's order dated 8/30/16, "Humalog 100 unit/ml (milliliter) subcutaneous solution Four Times Daily, Therapeutic Range; Sliding Scale Insulin: Blood Sugar is < (less than) 30 or > (greater than) 400 Notify MD (Medical Doctor). Blood Sugar is 180 -200 - 2 Units; Blood Sugar is 201-250 = 4 Units; Blood Sugar is 251-300 = 6 Units; Blood Sugar is 301-350 = 8 Units; Blood Sugar is 351-400 = 10 Units. If the Blood Sugar is greater than 400 = 14 Units. Notify Dr. if above 400 after giving 14 units."

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 10/20/2016

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 157	Continued From page 3	F 157		

b. September and October 2016 MARs (Medication Administration Records) revealed undocumented blood sugar (BS) readings and BS readings that were greater than 400 on the following dates and times:

9/15 - Late Afternoon - BS reading 473
9/18 - Afternoon - BS reading 424; Late Afternoon 403; Bedtime 403
9/29 - Bedtime - BS reading 405
9/17 - Morning and Afternoon -No documented BS reading
9/21 - Late Afternoon -No documented BS reading
9/22 - Late Afternoon -No documented BS reading
9/26 - Morning and Late Afternoon -No documented BS reading
10/7 - Bedtime - BS reading 402
10/9 - Late Afternoon -No documented BS reading
10/13 - Late Afternoon and Bedtime -No documented BS reading
10/15 - Late Afternoon -No documented BS reading

c. There was no documentation in Resident #2's electronic clinical record that the physician had been notified of the blood sugars that were greater than 400 or the blood sugar readings that were not documented as having been obtained.

The following interviews were conducted regarding the blood sugar readings that were greater than 400, the blood sugars measurements that were not documented and evidence of physician notification:

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 10/20/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 157	Continued From page 4	F 157		

a. On 10/19/16 at 5:00 p.m., during an end of day briefing, the Administrator and the Director of Nursing (DON) were informed. Copies of Resident #2's MARs and Progress notes were provided. There were no comments or explanation provided at this time.

b. On 10/19/16 at 5:40 p.m., LPN (Licensed Practical Nurse) B, was interviewed regarding the six occasions she documented Resident #2's BS greater than 400 and the seven occasions her initials were documented in areas designated for the blood sugar measurements. After reviewing the clinical record, LPN B said she could not provide any documentation of physician notification of the blood sugars greater than 400. Regarding the undocumented blood sugar readings during her care of Resident #2, LPN B stated, "I'm not sure what happened. I know I documented them."

c. On 10/19/16 at 4:00 p.m., the nurse supervisor, RN (Registered Nurse) D was shown Resident #11's September and October MARs. After reviewing the MARs, RN C stated, "The expectation is for the nurses to notify the doctor whenever the blood sugars are greater than 400, that's the facility standard practice." RN C did not provide an explanation for the blood sugar measurements that were not documented as having been obtained. RN C provided a copy of the STANDING ORDER FOR SLIDING SCALE.

d. On 10/20/16 at 11:20 a.m., the unit manager, RN C, was interviewed. After reviewing Resident #11's September and October MARs and the above mentioned concerns, RN C stated, "I don't know, I'm not sure what's going on with the documentation."

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 10/20/2016

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

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F 157	Continued From page 5	F 157		

A review of the facility's STANDING ORDER FOR SLIDING SCALE read, "Greater than 400, give 14 units and call MD."

A review of the facility's Procedure for Hyperglycemia read, "Notify physician or follow orders previously specified by M.D. Monitor blood glucose levels, using glucose monitor."

On 10/20/16 at 6:00 p.m., the Administrator and DON were informed of the facility staff's failure to notify Resident #2's physician when the blood sugar reading were greater than 400, per the physician ordered parameter.

2. For Resident #11, the facility staff failed to notify the physician of a blood sugar greater than 400 on 10/3/16, per physician order.

Resident #11 was admitted to the facility on 12/28/15. Diagnoses included stroke, heart failure, renal insufficiency and diabetes.

Resident #11's most recent MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 7/30/16 was coded as a quarterly assessment. Resident #11 was coded as having a BIMS (Brief Interview of Mental Status) score of "15" out of a possible 15, or cognitively intact. Resident #11 was also coded as requiring extensive assistance of one to two staff members to perform activities of daily living, such as bed mobility and transfer.

On 10/19/16 at 9:30 a.m., Resident #11 was observed in her room, lying in bed. She had just received assistance with toileting. Resident #11 was pleasant and denied having any concerns

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 10/20/2016

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 157	Continued From page 6	F 157		

regarding her care.

On 10/19/16 at 10:00 a.m., a review of Resident #11's electronic clinical record was conducted. The review revealed the following:

a. A physician's order dated 8/16/16, "Humalog 100 unit/ml (milliliter) per sliding scale. Subcutaneous. Accuchecks before meals and at bedtime. Blood Sugar is 180-200 = 2 Units; Blood Sugar is 201-250 = 4 Units; Blood Sugar is 251-300 = 6 Units; Blood Sugar is 301-350 - 8 Units; Blood Sugar is 351-400 = 10 Units. If the Blood Sugar is greater than 400 = 14 Units. Sliding Scale Insulin: Blood Sugar is < (less than) 60 or > (greater than) 400 Notify MD (Medical Doctor)."

b. The October 2016 MARs (Medication Administration Records) revealed on 10/3/16 a blood sugar (BS) reading of 438 and the administration of 14 units of Humalog. On 10/5 and 10/9 there were '=' signs documented for the blood sugar readings.

c. There was no documentation in Resident #11's electronic clinical record that the physician had been notified of the blood sugar measurement of 438 or the blood sugar measurements that were not documented on 10/5/16 and 10/9/16.

The following interviews were conducted regarding the blood sugar measurement that was greater than 400, the blood sugar readings that were not documented and physician notification:

a. On 10/19/16 at 5:00 p.m., during an end of day briefing, the Administrator and the Director of

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 10/20/2016

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 157 Continued From page 7 F 157

Nursing (DON) were informed. Copies of Resident #11's MARs and Progress notes were provided. No comment or explanation was offered.

b. On 10/19/16 at 4:00 p.m., the nurse supervisor, RN (Registered Nurse) D was shown Resident #11's October MARs. After reviewing the MARs, RN C stated, "The expectation is for the nurses to notify the doctor whenever the blood sugars are greater than 400, that's the facility's standard practice." RN C did not provide an explanation for the blood sugar measurements that were not documented as having been obtained. RN C provided a copy of the STANDING ORDER FOR SLIDING SCALE.

A review of the facility's STANDING ORDER FOR SLIDING SCALE read, "Greater than 400, give 14 units and call MD."

A review of the facility's procedure for Hyperglycemia read, "Notify physician or follow orders previously specified by M.D. Monitor blood glucose levels, using glucose monitor."

On 10/20/16 at 6:00 p.m., the Administrator and DON were informed of the facility staff's failure to notify Resident #11's physician of the blood sugar reading that greater than 400 on 10/3/16, per the physician ordered parameters.

3. For Resident #16, the facility staff failed to notify the physician of a fall that occurred on 7/18/16.

Resident #16 was admitted to the facility on 3/19/15 and readmitted after hospitalization on

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 10/20/2016

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 157	Continued From page 8	F 157		

5/20/16. Diagnoses included dementia, heart failure, chronic obstructive pulmonary disease, and hypertension.

Resident #16's most recent MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 8/8/16 was coded as a quarterly assessment. Resident #16 was coded as having short and long term memory problems and as having severely impaired cognitive skills for making daily decisions. Resident #16 was also coded as requiring extensive to total assistance of one staff member to perform activities of daily living, such as bed mobility. Resident #2 was coded for two falls with minor injuries.

On 10/20/16 at 10:20 a.m., Resident #16 was observed in her room, lying in bed asleep. Her bed was in the low position and there were fall mats on each side of the bed. A riser alarm was positioned on the mattress underneath Resident #16.

On 10/20/16 at 10:00 a.m., a review of Resident #16's electronic clinical record was conducted and revealed the following:

a. A comprehensive care plan that included a care plan for Actual Falls on 7/3/16 and 7/19/16. Under Interventions read, "Report falls/injuries and treat per order. Starting 7/3/16"

b. A clinical note dated 7/18/16 that read, "Resident is post fall on 3-11. Resident found on knees on the side of the bed with no mat. Resident SOB (short of Breath) and diaphoretic. O2 (Oxygen) sat (saturation 100% on 2-3 L (liters) Oxygen and bp (blood pressure) 180/89. P (pulse) 114. Notified daughter of incident. During

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 10/20/2016

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 157	Continued From page 9	F 157		

assessment, knees observed red with left knee with sm (small) abrasion. Ice pack applied. Neuro checks started. Will continue to monitor."

Further review of the clinical record did not reveal any evidence of physician notification.

On 10/20/16 at 2:30 p.m., an interview was conducted with the staff educator, RN (Registered Nurse) F, regarding the notification of the physician of a fall. RN F said the expectation was for staff to document physician notification in the clinical notes. RN F stated, "The physician is suppose to be notified when a resident has a fall."

Review of the facility's Fall Prevention Program-Post Fall Protocol, under Notification read as follows:

"1. Notify MD, or physician designee, immediately when injury is sustain.
2. The physician, or physician designee, will be notified of falls with no injury within 24 hours of the incident."

On 10/20/16 at 6:00 p.m., the Administrator and the Director of Nursing were informed of the facility staff's failure to notify Resident #16's physician of a fall that occurred on 7/18/16.

4. For Resident #6, the facility staff failed to notify the doctor of a blood glucose level above 400, and failed to notify the doctor of omitted blood sugars and insulin, per physician's orders.

The findings included:

Resident #6, was admitted to the facility on 9-12-14, and readmitted on 5-20-15. Diagnoses

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 10/20/2016

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 157	Continued From page 10	F 157		

included; cardiac artery disease, non-Alzheimer's dementia, peripheral vascular disease, diabetes, arthritis gout, gastro-esophageal reflux disease (GERD), and hypertension.

Resident #6's most recent Minimum Data Set assessment was a quarterly assessment with an assessment reference date of 9-29-16. The Resident was coded with mild to moderate cognitive impairment and required extensive assistance with activities of daily living. The Resident was frequently incontinent of bowel and bladder.

Review of the physician's orders, and Medication and Treatment Administration Records (MAR/TAR), revealed an order for Sliding Scale Insulin (SSI) to be given according to the following order dated 8-31-16; "Humalog 100 units per milliliter subcutaneous solution (sliding scale) three times daily. Sliding scale insulin blood sugar is less than 65 or greater than 400 notify the doctor.
Blood sugar 180-200 give 2 units,
Blood sugar 201-250 give 4 units,
Blood sugar 251-300 give 6 units,
Blood sugar 301-350 give 8 units,
Blood sugar 351-400 give 10 units."

On 10-5-16 the Resident's (finger stick blood sugar) FSBS registered 450, no documentation was found in the MAR/TAR, nursing progress notes, or physician progress notes, that the physician was ever notified of the high reading, and only 10 units of insulin was administered in error, and was ordered to be given for an FSBS reading of 351 to 400.

FSBS Blood sugar checks were ordered to be

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 10/20/2016

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 157		F 157		

Continued From page 11
obtained three times daily at 7:30 a.m., 11:30 a.m., and 4:30 p.m.. The order was dated 8-15-16. According to the October 2016 MAR, blood sugars were not documented as having been obtained, and no insulin SSI was documented as having been administered on the following dates:
10-4-16, at 11:30 a.m.
10-4-16, at 4:30 p.m.
10-9-16, at 4:30 p.m.

Further review of the physician's orders, and Medication and Treatment Administration Records (MAR/TAR), revealed an order for "Humalog 100 units per milliliter subcutaneous solution (5 units) twice per day, ordered to start 9-10-16, and discontinued on 10-5-16, to be administered at 11:30 a.m., and 4:30 p.m. The order was changed on 10-5-16, to increase the dose from 5 units to 8 units. No insulin was documented as having been administered for either order, according to those respective orders on the following dates:
On 10-4-16 at 4:30 p.m.
On 10-9-16 at 4:30 p.m.

No documentation was found in the MAR/TAR, nursing progress notes, or physician progress notes, that the physician was ever notified of the omitted FSBS accuchecks, or omitted insulin.

The Resident's diabetic comprehensive care plan dated 4-21-16, with a goal date of 1-5-17 was reviewed and revealed the following interventions;
1) Administer medications as ordered.
2) Monitor labs as ordered.
3) Monitor meal consumption and snacking. Encourage diet compliance.
4) Monitor for signs and symptoms of

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 10/20/2016

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 157	Continued From page 12	F 157		

hypo/hyperglycemia, neuropathy, and retinopathy. Notify doctor of findings, and treat as ordered.
5) Administer insulin or oral diabetic medications as ordered.
6) Provide good foot care. Refer to podiatrist as needed.

On 10-19-16 at 11:00 a.m., an interview was conducted with LPN (A). LPN A stated that anytime the Resident was away from the facility a leave of absence (LOA) form, in the computer, was filled out. LPN (A) supplied a copy of the LOA form for Resident #6. The form revealed that the Resident was present in the facility at the times the insulin and FSBS were omitted.

The facility policy on Medication Administration, and Hypo/Hyperglycemia, was reviewed and revealed; "Notify physician immediately or follow orders as previously specified by MD (doctor). If medication doses are not taken by resident notate on reverse side of MAR." No reasons were notated for the omissions.

On 10-19-16, at the end of day debriefing, the issue with the Insulin medications and FSBS accuchecks were reviewed with the Administrator and Director of Nursing (DON). The DON stated that she had no reason why the FSBS and insulin was not administered or documented as such.

On 10-19-16 at the end of day debriefing at 5:00 p.m., the Administrator, DON, and a large staff contingent were made aware of the staff failure in medication administration. No further information was provided by the facility by the end of survey.

5. For Resident # 12, the facility staff failed to notify the physician and responsible party of a fall

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 10/20/2016

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 157	Continued From page 13	F 157		

on 10/15/2016.

Resident #12, a 92 year old female, was admitted to the facility on 8/20/2013. Diagnoses included but were not limited to Diabetes, Dementia, Hypertension, Major Depressive Disorder, Glaucoma, Vitamin D Deficiency, Peripheral Disease, and Left Below the Knee Amputation.

The most recent MDS (minimum data set) was a Quarterly Assessment with an ARD (assessment reference date) of 9/29/2016. Resident #12 was coded as having a Brief Interview for Memory Status of 12 indication no cognitive impairment. Resident #12 was coded as requiring extensive to total assistance of one staff person for her ADLs (activities of daily living), except requiring supervision of one staff person for eating and extensive assistance of two staff persons for bed mobility and transfers. Resident #12 was coded as always incontinent of bowel and bladder.

Review of Resident #12's clinical record revealed a Nurses Note dated 10/15/2016 at 10:30 AM that stated "CNA (Certified Nursing Assistant) brought to my attention that they were getting the resident up and they were afraid of dropping her so they sat her on the floor to get a better grip and then lifted her to chair. NO injuries to the resident occurred during this transfer." Signed by LPN F (Licensed Practical Nurse F). Further review of the Nurses Notes revealed no documentation of notification of the physician or the responsible party after the fall.

Review of the Fall Risk Assessment dated 10/15/2016 revealed a Fall Risk Assessment

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 10/20/2016

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**

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F 157	Continued From page 14	F 157		

Score of 16 indicating a High Fall Risk (High Risk if score of 10 or above). The Assessment was documented as assessed on 10/15/2016 by LPN F and signed on 10/20/2016 at 8:08 AM.

On 10/19/2016 at approximately 4 PM, the Director of Nursing was interviewed. The Director of Nursing (DON) stated the incident on 10/15/206 should have been treated as a fall since the resident was lowered to the floor. The DON stated that counted "as a near miss" and all near misses should be treated as an actual fall. The DON stated the physician and the responsible party should have been notified after the fall.

A thorough review of Resident #12's clinical record revealed no documentation Resident #12's physician was informed of the fall on 10/15/2016.

On 10/19/2016 at approximately 3 PM when interviewed, the Clinical Manager (RN A) (Registered Nurse A) stated Resident # 12's daughter comes to the facility every day and she was sure the daughter was made aware of the incident. RN A stated the physician should have been notified as well. RN A stated the nurse should have treated the incident as a fall and notified the physician and family and documented the information. the DON stated she had no further information about the physician not being informed. There was no documentation of notification of the physician and responsible party.

On 10/19/2016 during the end of day debriefing at approximately 5 PM, the administrator, DON, and corporate consultants were advised of the failure of the staff to inform Resident #12's physician and family of the fall on 10/15/2016.

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 10/20/2016

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

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F 157	Continued From page 15 On 10/20/2016 at approximately 2 PM, review of the facility documentation policy on falls revealed the following: Life Care: Fall Prevention Program; Post Fall Protocol, Original Date: July 15, 2002 Revision date: 9/16/2016 Under Notification:: The licensed nurse will assure that notification has occurred and document its completion. Notify MD, or physician designee, immediately when injury is sustained. Document the name of person notified, time of notification, and method of notification. Notify family and record the name of person notified, time and method of notification. The physician, or physician designee, will be notified of falls with no injury within 24 hours of the incident. The following information will be collected and provided to the physician, or physician designee, when the call is made: Date and Time of the incident Fall History Post Fall Assessment to include, Vital Signs, BP sitting and standing. Location of fall Bowel Sounds Glucometer Reading if diabetic Any Care Plan Revisions Exceptions: None " No further information was provided.	F 157		
F 225 SS=E	INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS CFR(s): 483.13(c)(1)(ii)-(iii), (c)(2) - (4)	F 225		12/1/16

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 10/20/2016

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 225	Continued From page 16	F 225		

The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.

The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).

The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.

The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.

This REQUIREMENT is not met as evidenced by:

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 10/20/2016

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

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F 225 Continued From page 17

Based on staff interview, facility documentation review, clinical record review and in the course of a complaint investigation the facility staff failed for 3 residents (Resident #13, #15, and #19) of 23 residents in the survey sample to investigate and report allegations of abuse to the state agency.

1. For Resident #13, the following allegations of abuse were not reported to the state agency and/or investigated:
a) 4/7/16- Resident punched a nursing student
b) 4/25/16- Swollen, bruised index finger
c) 5/22/16- Bruise to bridge of nose

2. For Resident #15, the facility staff failed to report and investigate verbal abuse that occurred between the resident and spouse.

3. For Resident #19, the facility staff failed to report an allegation of abuse to the state agency.

The findings included:

1. For Resident #13, the following allegations of abuse were not reported to the state agency and/or investigated:
a) 4/7/16- Resident punched a nursing student
b) 4/25/16- Swollen, bruised index finger
c) 5/22/16- Bruise to bridge of nose

Resident #13, a 64 year old, was admitted to the facility on 12/11/14. His diagnoses included dementia, diabetes, bipolar disease, hypertension, renal failure, and depression.

Resident #13's most recent Minimum Data Set assessment was a quarterly assessment with an assessment reference date of 7/21/16. He was coded with a Brief Interview of Mental Status

F 225

1. Facility did not report and investigate allegations of abuse for residents #13, #15 and #19.

2. All residents have the potential to be affected.

3. Administrator, Director of Nursing, Department Managers and Clinical Managers have reviewed investigating and reporting requirements for abuse allegations.

4. Administrator and Director of Regulatory Compliance will review all abuse allegation investigations weekly for the next 60 days and report findings to the QAPI committee.

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 10/20/2016

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 225	Continued From page 18	F 225		

score of 3 indicating severe cognitive impairment. He required extensive assistance with activities of daily living.

Resident #13's clinical record was reviewed. The following allegations of abuse were documented in the record:

a) 4/7/16- Resident #13 punched a nursing student
A nursing noted dated 4/7/16 at 3:22 p.m. read "Resident was physically abusive to a Student Nurse. He punched the student nurse on her side."

On 10/20/16 Registered Nurse F (RN F) was asked to see if the incident was reported to the state agency. At 3:30 p.m., she stated that the incident had not been reported or investigated.

Resident #13's care plan was reviewed. He had a care plan for the following "displays combative and verbally abusive behavior at times."

b) 4/25/16- Swollen, bruised index finger
The following nursing notes were documented regarding Resident #13's bruised index finger:
4/25/16, 3:51 p.m. "Resident noted to have swollen bruised index finger on his hand. (Doctor name) called, made aware. Order for xray. Resident observed holding the side rails to turn self /w (with) assistance. Resident noted to be combative toward caregivers during care. Message left with sister, (name) to call facility for update."
4/26/16, 2:50 p.m. "X-ray to left hand (fingers) came back negative for fractures. Will continue to monitor."
4/26/16, 10:07 p.m. "Left index finger and palm

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 10/20/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 225	Continued From page 19	F 225		

bruised (purple and green). Left ring finger joint is bent forward. X-ray results negative for fracture to index finger. Will clarify if whole hand was complete. Hand elevated to decrease swelling. Will continue to monitor."
5/3/16, 10:03 p.m. "(Name), RP (responsible party) came to visit brother. Concerned about bruise to left finger. Explained that it has been bruised for a week and a half. Told her that a staff member did try to reach her and left a message for her to call the facility."

On 10/20/16 Registered Nurse F (RN F) was asked to see if the incident was reported to the state agency. At 3:30 p.m., she stated that the incident had not been reported to the state agency. She stated that the incident was investigated. Copies of witness statements and copies of the nursing notes regarding the incident were provided. There was no statement from the resident or a conclusion as to how the injury occurred.

In one of the witness statements, Resident #13 had described a staff member who had hurt him. On 10/20/16 at the end of day meeting, the DON was asked if the facility had identified the staff from the description. After checking into the issue, the DON stated that the staffing sheets for the days prior to the injury were reviewed. No one fitting the description provided by the resident had worked the days prior to the injury. The staff member was not identified.

c) 5/22/16- Bruise to bridge of nose
The following nursing notes were documented regarding Resident #13's bruised bridge of nose:
5/22/16, 10:15 a.m. "Saturday- resident noted to have bruise to bridge of nose; unable to

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 10/20/2016

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 225	Continued From page 20	F 225		

determine cause. RP (responsible party) called x 2 with no answer. Called again on 4-22 (sic) and able to notify sister of bruise. Stated her understanding of resident being agitated at times and possibly causing the discoloration to nose."

On 10/20/16 Registered Nurse F (RN F) was asked to see if the incident was reported to the state agency. At 3:30 p.m., she stated that the incident had not been reported or investigated.

On 10/20/16 at 3:30 p.m., an interview was held with the Administrator and Employee A (Social Services). These staff indicated that they oversee the abuse reporting and investigation at the facility. When asked what types of abuse incidents they report to the state agency, the Administrator stated that they report intentional acts of abuse and mistreatment. When asked how they defined "allegation of abuse", neither staff answered. It was reviewed with the Administrator and Employee A that an allegation is considered any statement or report made by a resident claiming that they have been mistreated. It was reviewed that visible signs of abuse such as bruising and injuries of unknown origin are considered allegations of abuse. It was reviewed that it is required that all allegations of abuse and injuries of unknown origin be reported to the state agency and investigated.

On 10/20/16 at the end of day meeting, the Administrator and Director of Nursing were notified of the concerns that the allegations of abuse concerning Resident #13 were not reported or investigated. No further information was provided.

2. For Resident #15, the facility staff failed to

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 10/20/2016

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 225	Continued From page 21	F 225		

report to the state agency verbal abuse that occurred between the resident and spouse.

Resident #15, a 74 year old, was admitted to the facility on 10/10/16. Diagnoses included seizures, hypertension, depression and dementia.

A Minimum Data Set assessment has not been completed for the resident. It was in progress.

Resident #15 was observed sitting in her bed on 10/19/16 at approximately 8:30 a.m.. She was working with Occupational Therapy. Her breakfast tray was on the over bed table. The resident did not speak when spoken to by this surveyor.

Resident #15's clinical record was reviewed. The following nursing note written by Licensed Practical Nurse E (LPN E) was included "10/16/16 12:59 p.m., Res. OOB (out of bed) to gerichair sitting in front of nurses station. Res. Husband and son approached res. Res. could be heard saying "you pushed me". One of the men, husband, stated "why did you say that?". res. reiterated "you pushed me". Supervisor called to unit."

The next nursing note was written by Registered Nurse B (RN B) on 10/16/16 at 1:58 p.m. The note read "This nurse called to unit by staff nurse. (Name of Resident) husband and son talking with resident. This RN walks over to resident and asked "Are you alright, (name)? She states yes and shakes her head affirmatively. Within moments RN over hears "you shouldn't have said that", "you're the one that caused all of this", "I didn't push you down, you're lying". Resident begins visibly shaking and makes constant eye

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 10/20/2016

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 225	Continued From page 22	F 225		

contact with this RN At this point this RN explains to son that resident is under protective order and that they would have to leave. Both were very upset, but were compliant with request. Phone numbers for both facility social workers provided, family members exit facility."

RN B was interviewed on 10/20/16 at 4:00 p.m. When asked about the circumstances of the protective order, RN B stated she was unsure of the specifics. She stated that she overheard other nurses talking about a protective order prior to Resident #15's admittance to the facility. RN B stated that the verbal altercation with the husband took place at the nursing station. She stated she asked the husband and son to leave after providing them with the phone numbers of the facility social work staff. When asked about Resident #4's cognitive status, RN B stated the resident had periods of confusion.

On 10/20/16 at 4:15 p.m., the Clinical Manager and Director of Nursing were asked about the protective order in place for Resident #15. The Clinical Manager stated that there was no protective order in place. She stated that Adult Protective Services (APS) had been in the building on 10/18/16 as a follow up to the hospital's report of abuse. The Clinical Manager was asked to provide the hospital notes and any documentation from APS.

The Clinical Manger provided a facility social services note dated 10/18/16 at 8:26 a.m. written by Employee A, Social Services staff. The note read "APS to facility to follow up on report the hospital made due to Resident being pushed at home by her spouse. APS worker spoke with Resident at length. Resident stated she wanted

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 10/20/2016

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 225	Continued From page 23	F 225		

to remain in the facility and not return back home. Sister, who is also her POA (power of attorney), is actively in search of getting a restraining order in place so husband will not be able to visit with Resident.

The hospital discharge summary was also provided. The discharge summary was dated 10/10/16. The "Chief Complaint" read "Intractable back pain, spousal abuse." The "History of Present Illness" read "presents to the emergency room after having a verbal altercation with her husband, who ended up somehow pulling her to the ground. The patient ended up injuring her back." In addition, the summary read "The patient's family at bedside is reporting that her husband is verbally and physically abusive to her."

On 10/20/16 at 5:00 p.m., the Administrator was asked if the incident was reported to the state agency. The Administrator was unaware of the verbal altercation that took place in the facility. He was provided a copy of the nursing note to read. When asked how they planned to keep the resident safe if the husband returned, the Administrator did not answer. When asked if they planned to allow the husband to visit privately with the resident, the Administrator stated that he needed to check with the risk management person to see what the facility could do legally.

On 10/20/16 at 3:30 p.m., an interview was held with the Administrator and Employee A (Social Services). These staff indicated that they oversee the abuse reporting and investigation at the facility. When asked what types of abuse incidents they report to the state agency, the Administrator stated that they report intentional

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 10/20/2016

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 225	Continued From page 24	F 225		

acts of abuse and mistreatment. When asked how they defined "allegation of abuse", neither staff answered. It was reviewed with the Administrator and Employee A that an allegation is considered any statement or report made by a resident claiming that they have been mistreated. It was reviewed that visible signs of abuse such as bruising and injuries of unknown origin are considered allegations of abuse. It was reviewed that it is required that all allegations of abuse and injuries of unknown origin be reported to the state agency and investigated.

It is important to note that Employee A, the employee who shares the responsibility of abuse coordinator with the Administrator, is the employee who documented the 10/18/16 note regarding APS's visit with Resident #4.

The facility abuse policy was reviewed. The policy dated 1/13/15 titled "Abuse: Investigation, Protection and Reporting" read "Sentara facilities will thoroughly investigate all alleged violations involving mistreatment, neglect, abuse, including injuries of unknown source and misappropriation of resident's property." In addition, the policy read "Also, in accordance with state regulations and the Code of Virginia, Life Care employees will immediately report all incidents of alleged violations involving resident mistreatment, neglect or abuse, including injuries of unknown sources and misappropriation of resident property to their supervisors, the DON (director of nursing) and Administrator. The Administrator, or his/her designee, must report any incidents or suspected incidents of abuse to local authorities, (adult protective services and police) within 24 hours of having the reason to suspect abuse."
3. For Resident #19, on 3-2-16, the facility staff

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 10/20/2016

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 225	Continued From page 25	F 225		

failed in the following 3 areas:

1) To investigate an allegation of staff abuse.
2) To protect the Resident from the alleged abuser.
3) To report the allegation of abuse to the state agency.

And to send the final investigation of the injury (6/6/16) of unknown origin in timely manner.

The findings included:

Resident #19, was originally admitted to the facility on 7-9-12. Diagnoses included Hypertension, high cholesterol, Alzheimer's disease, osteoporosis, atrial fibrillation, and arthritis.

Resident #19's most recent Minimum Data Set (MDS) assessment was a discharge assessment with an Assessment Reference Date (ARD) of 6-6-16. The Resident was not coded with a Brief Interview of Mental Status score, however was coded with "moderately impaired cognition". Resident #19 required extensive assistance with dressing, personal hygiene, and bathing. The Resident was coded as always incontinent of bowel and occasionally incontinent of bladder.

Review of the clinical record nursing progress notes, an Adult Protective Services Report, a complaint report, and a facility report, revealed documentation of 1 alleged case of abuse, and 1 injury of unknown origin situation. Further information gathered from those reports follow:

On 6-6-16, the Resident experienced a fractured hip, which was an injury of unknown origin. The

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 10/20/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 225	Continued From page 26	F 225		

Resident also was noted to have bruising to the left wrist according to a facility nursing note, a bruise on the right wrist and a bruise on the right arm according to the APS report. The Resident received a portable x-ray at the request of the Resident's daughter, while still in the nursing facility on 6-6-16, and an acute hip fracture was identified. The Resident was transferred to the hospital for treatment and never returned to the facility.

The facility Administration did report the incident to the state agency on Monday 6-6-16, however did not send a 5 working day final follow up report until Monday 6-13-16 (6 working days later). This was the only "Facility Reported Incident" (FRI), the facility reported to the state agency for the past year. According to the Administrator, it was the only one they felt they needed to report.

On 6-6-16, the receiving hospital reported the injury, and suspicious bruising on both of the Resident's arms to the Virginia Department of Social Services Adult Protective Services (APS), alleging physical abuse. APS then forwarded the information to the Virginia Department of Health (OLC) Office of licensure and Certification (state agency) for further investigation. Included in the information received by the OLC was an allegation of staff abuse which was reported by a second staff member, which occurred prior to the 6-6-16 incident. Three staff members of the nursing facility were named in the reports, and identified during the survey. Registered Nurse (RN) (C) received the allegation of abuse of Resident #19, from Licensed Practical Nurse (LPN) (G), who named the alleged abuser as Certified Nursing Assistant (CNA) (E).

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 10/20/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 225	Continued From page 27	F 225		

An interview was conducted on 10-19-16 with RN (C) unit manager. RN (C) stated that the Resident required assistance for transfers, and the Resident was not able to stand or walk alone, and that is why she fell so often. The Resident would try to stand unaided and would fall.

RN (C) was then asked, if the assessments revealed that the Resident could not transfer alone without falling, and was extensive assistance of one staff member for bed mobility, how did the Resident manage to sit on the side of the bed with her feet dangling over the side, as the reports stated, with a hip fracture, if no one assisted her. RN (C) stated that no one witnessed a fall, but it was possible that a fall had occurred with the Resident's history. RN (C) stated an investigation was conducted after the fall, and that allegations of abuse were made, because of suspicious bruising, and that the Administrator had that information.

RN (C) was also asked if an investigation had been completed for the allegation of abuse made by LPN (G), naming CNA (E) as the abuser, and reported to LPN (G) back in March, and again several weeks before the 6-6-16 incident. RN (C) stated "yes", she had been aware of the situation in March 2016, and supplied a documented statement from CNA (E) to surveyors, and stated "this is all I have." RN (C) denied knowing of an allegation of abuse several weeks before the 6-6-16 incident, when similar arm bruising was reported to a family member allegedly by RN (C). RN (C) stated the 3-2-16 allegation was not found by the facility to be abuse, so it was not reported.

RN (C) was asked if LPN (G) had been suspended pending the allegation of abuse, so as

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 10/20/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 225	Continued From page 28 to protect the Resident during the investigation from further potential abuse, and she stated "no". She went on to say that CNA (E) no longer worked at the facility, however, CNA (E) had only recently resigned, sometime before 6-22-16. She stated she knew that CNA (E) was no longer employed at the time of the staff education on "Dementia Care and Behavior Roaming Inservice" which happed 6-22-16, and was a a direct result of the 6-6-16 incident with Resident #19. RN (C) stated she did not know if CNA (E) was working with the Resident on 6-6-16. The statement supplied by RN (C) was a hand written statement dated 3-2-16, and written by CNA (E). CNA (E)'s statement revealed that Resident #16 was in another resident's room, and LPN (G) requested that CNA (E) remove Resident #19 from the room. CNA (E) complied and went to Resident #19's room with her to lay her in bed. CNA (E) stated the Resident tried to get into bed knees first, and she grabbed the Resident by the hips, and the Resident fell into the bed. CNA (E) stated that LPN (G) was there in the room at the time, and they laughed at the way the Resident fell into the bed. On 10-20-16 at 2:30 p.m., the Administrator was interviewed regarding the allegation of abuse on 3-2-16. The Administrator stated that he did not know of the situation, and an investigation was not done. He went on to state that all reporting to the state agency of allegations of abuse were completed by him, after he investigated, and ascertained if the allegations of abuse were legitimate and founded. When asked what types of incidents the facility would report to the state agency, the Administrator stated abuse, neglect, and misappropriation. The Administrator was	F 225		

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 10/20/2016

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

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F 225	Continued From page 29	F 225		

asked what kind of allegations of abuse he would report. He stated "if a resident said "she turned me too hard", it is not an allegation of abuse." He went on to say that if he reported all of those situations, he would be reporting hundreds of FRI's every year.

The facility policy titled "Abuse Investigation, Protection and Reporting" was reviewed.

The "Purpose" section on page 1 of 2, paragraph 1, sentence 2, read; "The Resident will be protected against further potential incidents while the investigation is in progress. "The results of the investigation" (facility investigation) "will be reported to officials in accordance to state and federal regulation."

Paragraph 2 of the same area of the document, "Also in accordance with state regulations and the code of Virginia, (Name) employees will immediately report all incidents of alleged violations involving resident mistreatment, neglect or abuse, including injuries of unknown sources and misappropriation of resident property to their supervisors, the DON (Director of Nursing) and Administrator. The Administrator, or his/her designee must report any incidents or suspected incidents of abuse to local authorities, (adult protective services and police) within 24 hours of having the reason to suspect abuse, failure to do so may result in fines."

Review of this policy revealed that, the reporting of staff to their superiors is stated as state regulation, which is incorrect. All health care providers in the state of Virginia are mandated reporters, and as mandated reporters the obligation to report is to the state and local

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 10/20/2016

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

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F 225	Continued From page 30	F 225		

authorities. Reporting to a supervisor in the facility does not relieve the burden of reporting to the state agency. The policy also reveals that the facility will conduct their own internal investigation, and decide if they think an allegation of abuse is reportable or not. This is not in accordance with federal regulation. If the facility decides it is reportable, they will report it to local authorities (adult protective services and police). No mention of the state agency is made, and this is not in accordance with federal regulation.

On 10-20-16 at 2:30 p.m., the federal regulation regarding abuse and the facility abuse policy were reviewed with the Administrator. It was discussed that all allegations of abuse must be reported to the state agency immediately, and no later than 24 hours after the report is known, in keeping with federal law. It was reviewed that the facility must investigate all allegations of abuse, however, the final facility investigation does not need to be completed for 5 business days after the initial report is forwarded to the state agency within 24 hours of initially receiving an allegation. The facility was also informed that the federal law does not allow for the facility to determine what constitutes abuse, and then decide what they wish to report, or not report. The facility Administrator was further made aware that injuries of unknown origin included any injury for which the resident could not state what had happened or any suspicious injury that was not witnessed.

The facility did not protect Resident #19 from further abuse after an allegation of staff abuse was reported for Resident #19, allegedly at the hands of CNA (E) on 3-2-16. The facility did not

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 10/20/2016

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

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F 225	Continued From page 31 investigate, nor report to the state agency the allegation of abuse for Resident #19 in regard to the 3-2-16 incident, and further, the facility policy does not reflect, and is not in accordance with the federal regulation. On 10-20-16 at 2:30 p.m., the Administrator and Director of Nursing were made aware of the staff failure to protect from abuse, investigate, and report to the state agency an allegation of abuse for Resident #19 on 3-2-16, and that their abuse policy was not in accordance with federal and state law. No further information was provided by the facility.	F 225		
F 226 SS=D	DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES CFR(s): 483.13(c) The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, facility documentation review, and in the course of a complaint investigation, the facility staff failed to ensure the abuse policy reflected federal abuse guidelines. The facility policy regarding the reporting of abuse is incorrect, and not in accordance with federal and state law. The policy revealed that the facility will conduct their own internal investigation, and decide if they think an allegation of abuse is	F 226	1. Facility abuse policy has been revised to reflect federal abuse guidelines. 2. All residents have the potential to be affected. 3. Facility staff educated regarding changes to the abuse policy. 4. Director of Nursing and/or designee will conduct random staff interviews for	12/1/16

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 10/20/2016

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 226	Continued From page 32	F 226		

reportable or not. All allegations of abuse need to be reported to the state agencies.

The findings included:

Review of the facility abuse program was conducted during an investigation of allegations of abuse included in a complaint received by the Virginia Department of Health Office of licensure and Certification. The complaint involved a Resident, who was identified during survey as a closed record, and included in the sample as Resident #19.

Resident #19, was originally admitted to the facility on 7-9-12. Diagnoses included; hypertension, high cholesterol, Alzheimer's disease, osteoporosis, atrial fibrillation, and arthritis.

Resident #19's most recent Minimum Data Set (MDS) assessment was a discharge assessment with an Assessment Reference Date (ARD) of 6-6-16. The Resident was not coded with a Brief Interview of Mental Status score, however was coded with "moderately impaired cognition". Resident #19 required extensive assistance with dressing, personal hygiene, and bathing. The Resident was coded as always incontinent of bowel and occasionally incontinent of bladder.

Review of the clinical record nursing progress notes, an Adult Protective Services Report, and A facility report, revealed documentation of 12 falls occurring between March 26, 2016 and June 6, 2016, (approximately 10 weeks). Further information gathered from those reports follow:

On 6-6-16, the Resident experienced a fractured

the next 60 days to evaluate staff's understanding of the policy. Findings will be reported to QAPI for the next 60 days.

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 10/20/2016

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

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F 226	Continued From page 33	F 226		

Continued From page 33

hip, which was an injury of unknown origin. The Resident also was noted to have bruising to the left wrist according to a facility nursing note, a bruise on the right wrist and a bruise on the right arm according to the APS report. The Resident received a portable x-ray at the request of the Resident's daughter, while still in the nursing facility on 6-6-16, and an acute hip fracture was identified. The Resident was transferred to the hospital for treatment and never returned to the facility.

The facility Administration did report the incident to the state agency on Monday 6-6-16, however did not send a 5 working day final follow up report until Monday 6-13-16 (6 working days later). This was the only "Facility Reported Incident" (FRI), that the facility reported to the state agency for the past year. According to the Administrator, it was the only one they felt they needed to report.

On 6-6-16, the receiving hospital reported the injury, and suspicious bruising on both of the Resident's arms to the Virginia Department of Social Services Adult Protective Services (APS), alleging physical abuse. APS then forwarded the information to the Virginia Department of Health (OLC) Office of licensure and Certification (state agency) for further investigation. Included in the information received by the OLC was an allegation of staff abuse which was reported by a second staff member, which occurred prior to the 6-6-16 incident. Three staff members of the nursing facility were named in the reports, and identified during the survey. RN (C) received the allegation of abuse of Resident #19, from LPN (G), who named the alleged abuser as CNA (E).

An interview was conducted on 10-19-16 with RN

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 10/20/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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 226		F 226		

Continued From page 34
(C) unit manager. RN (C) stated that the Resident required assistance for transfers, and the Resident was not able to stand or walk alone, and that is why she fell so often. The Resident would try to stand unaided and would fall.

RN (C) was then asked, if the assessments revealed that the Resident could not transfer alone without falling, and was extensive assistance of one staff member for bed mobility, how did the Resident manage to sit on the side of the bed with her feet dangling over the side, as the reports stated, with a hip fracture, if no one assisted her. RN (C) stated that no one witnessed a fall, but it was possible that a fall had occurred with the Resident's history. RN (C) stated an investigation was conducted after the fall, and that allegations of abuse were made, because of suspicious bruising, and that the Administrator had that information.

RN (C) was also asked if an investigation had been completed for the allegation of abuse made by LPN (G), naming CNA (E) as the abuser, and reported to LPN (G) back in March, and again several weeks before the 6-6-16 incident. RN (C) stated "yes", she had been aware of the situation in March 2016, and supplied a documented statement from CNA (E) to surveyors, and stated "this is all I have." RN (C) denied knowing of an allegation of abuse several weeks before the 6-6-16 incident, when similar arm bruising was reported to a family member allegedly by RN (C). RN (C) stated the 3-2-16 allegation was not found by the facility to be abuse, so it was not reported.

RN (C) was asked if LPN (G) had been suspended pending the allegation of abuse, so as to protect the Resident during the investigation

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 10/20/2016

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 226	Continued From page 35	F 226		

from further potential abuse, and she stated "no". She went on to say that CNA (E) no longer worked at the facility, however, CNA (E) had only recently resigned, sometime before 6-22-16. She stated she knew that CNA (E) was no longer employed at the time of the staff education on "Dementia Care and Behavior Roaming Inservice" which happed 6-22-16. RN (C) stated she did not know if CNA (E) was working with the Resident on 6-6-16.

The statement supplied by RN (C) was a hand written statement dated 3-2-16, and written by CNA (E). CNA (E)'s statement revealed that Resident #16 was in another resident's room, and LPN (G) requested that CNA (E) remove Resident #19 from the room. CNA (E) complied and went to Resident #19's room with her to lay her in bed. CNA (E) stated the Resident tried to get into bed knees first, and she grabbed the Resident by the hips, and the Resident fell into the bed. CNA (E) stated that LPN (G) was there in the room at the time, and they laughed at the way the Resident fell into the bed.

On 10-20-16 at 2:30 p.m., the Administrator was interviewed regarding the allegation of abuse on 3-2-16. The Administrator stated that he did not know of the situation, and an investigation was not done. He went on to state that all reporting to the state agency of allegations of abuse were completed by him, after he investigated, and ascertained if the allegations of abuse were legitimate and founded. When asked what types of incidents the facility would report to the state agency, the Administrator stated abuse, neglect, and misappropriation. The Administrator was asked what kind of allegations of abuse would he report. He stated "if a resident said 'she turned

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 10/20/2016

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 226	Continued From page 36	F 226		

me too hard', it is not an allegation of abuse." He went on to say that if he reported all of those situations, he would be reporting hundreds of FRI's every year.

The facility policy titled "Abuse Investigation, Protection and Reporting" was reviewed.

The "Purpose" section on page 1 of 2, paragraph 1, sentence 2, read; "The Resident will be protected against further potential incidents while the investigation is in progress. "The results of the investigation" (facility investigation) "will be reported to officials in accordance to state and federal regulation."

Paragraph 2 of the same area of the document, "Also in accordance with state regulations and the code of (name) employees will immediately report all incidents of alleged violations involving resident mistreatment, neglect or abuse, including injuries of unknown sources and misappropriation of resident property to their supervisors, the DON (Director of Nursing) and Administrator. The Administrator, or his/her designee must report any incidents or suspected incidents of abuse to local authorities, (adult protective services and police) within 24 hours of having the reason to suspect abuse, failure to do so may result in fines."

Review of this policy revealed that, the reporting of staff to their superiors is stated as state regulation, which is incorrect. All health care providers in the state of Virginia are mandated reporters, and as mandated reporters the obligation to report is to the state and local authorities. Reporting to a supervisor in the facility does not relieve the burden of reporting to

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 10/20/2016

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 226	Continued From page 37	F 226		

the state agency. The policy also reveals that the facility will conduct their own internal investigation, and decide if they think an allegation of abuse is reportable or not. This is not in accordance with federal regulation. If the facility decides it is reportable, they will report it to local authorities (adult protective services and police). No mention of the state agency is made, and this is not in accordance with federal regulation.

On 10-20-16 at 2:30 p.m., the federal regulation regarding abuse and the facility abuse policy were reviewed with the Administrator. It was discussed that all allegations of abuse must be reported to the state agency immediately, and no later than 24 hours after the report is known, in keeping with federal law. It was reviewed that the facility must investigate, however, the facility investigation does not need to be completed for 5 business days after the initial report is forwarded to the state agency within 24 hours of initially receiving an allegation. The facility was also informed that the federal law does not allow for the facility to determine what constitutes abuse, and then decide what they wish to report, or not report.

The facility did not protect Resident #19 from further abuse after an allegation of staff abuse was reported for Resident #19, allegedly at the hands of CNA (E) on 3-2-16. The facility did not investigate, nor report to the state agency the allegation of abuse for Resident #19 in regard to the 3-2-16 incident, and further, the facility policy does not reflect, and is not in accordance with the federal regulation.

On 10-20-16 at 2:30 p.m. The Administrator and

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 10/20/2016

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 226	Continued From page 38 Director of Nursing were made aware of the staff failure to protect from abuse, investigate, and report to the state agency an allegation of abuse for Resident #19, and that their abuse policy was not in accordance with federal and state law. No further information was provided by the facility.	F 226		
F 250 SS=D	PROVISION OF MEDICALLY RELATED SOCIAL SERVICE CFR(s): 483.15(g)(1) The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, and facility documentation review the facility staff failed for 1 resident (Resident #7) of 23 residents in the survey sample to ensure medically related social services were provided. For Resident # 7, the social services staff failed to obtain physician ordered diabetic shoes. The findings included: Resident #7, a 96 year old, was admitted to the facility on 9/29/14. Her diagnoses included diabetes, hypertension, reflux and dementia. Her most recent Minimum Data Set assessment was a quarterly assessment with an assessment reference date of 8/15/16. She had a Brief Interview of Mental Status score of 9 indicating	F 250	1. Diabetic shoes have been obtained for Resident #7. 2. All residents that require diabetic shoes have the potential to be affected. 3. Social workers have been re-educated on process for obtaining diabetic shoes. 4. Social services director (and/or designee) will audit clinical records of residents with a diagnosis of diabetes monthly for the next 60 days to ensure physician orders for diabetic shoes are addressed. Findings will be reported to QAPI for the next 60 days.	12/1/16

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 10/20/2016

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

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F 250	Continued From page 39	F 250		

moderate cognitive impairment. She required assistance with her activities of daily living.

Resident #7's clinical record was reviewed. The following clinical note was written by Employee C (Social Services) on 3/10/16 "Resident care plan held today daughter and case manager invited. Concern regarding resident blood sugar levels are up and down. She had a DX (diagnosis) of cellulitis and CHF (congestive heart failure) and on lasix. Weight is 172.9 lbs (pounds), stable condition. Staff to talk to the doctor to see if, he would write an order for albuterol inhaler routine wanted to know about diabetic shoes (Insurance Name) to look into the diabetic shoes and let this writer know."

The next note that mentioned diabetic shoes was dated 8/25/16. This note was also written by Employee C. The note read "resident care plan held today with daughter and case manager (Name). Daughter would like for resident to have more fruit and not so much chocolate cake. Weight 182 lbs (pounds). Daughter stated resident need diabetic shoes SW (social work) will follow up with resident case manager from (Insurance Name)."

Employee C was interviewed on 10/20/16 at 10:30 a.m. When asked if Resident #7 had received diabetic shoes, Employee C stated no. It was reviewed with Employee C that the need for diabetic shoes was identified in March 2016. Employee C was asked to provide all documentation regarding the diabetic shoes.

Employee C provided a physician order for the diabetic shoes dated 3/18/16. Also provided was the fax cover sheet to the insurance company

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 10/20/2016

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 250	Continued From page 40 dated 3/18/16. At this time, Employee C stated that after she sent this information to the insurance company she never received a response back from them. Employee C stated that the diabetic shoes were not discussed again until the care plan meeting on 8/25/16. Another physician order for diabetic shoes was written on 9/9/16. It was faxed to the insurance company on 9/9/16. As of 10/20/16, Resident #7 had not received a new pair of physician ordered diabetic shoes. The Director of Nursing and Administrator were informed of the issue at the end of day meeting on 10/20/16.	F 250		
F 278 SS=D	ASSESSMENT ACCURACY/COORDINATION/CERTIFIED CFR(s): 483.20(g) - (j) The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than	F 278		12/1/16

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 10/20/2016

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 278 Continued From page 41 F 278

$1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment.

Clinical disagreement does not constitute a material and false statement.

This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview and clinical record review, the facility staff failed to complete an accurate MDS (Minimum Data Set) RAI (Resident Assessment Instrument) for three Residents (Residents #2, #11, and #19) in a survey sample of 23 Residents.

1. Resident #2's MDS with an ARD (Assessment Reference Date) of 9/19/16 did not include completion of a Pain Interview, diagnosis coding for Alzheimers and Sleep Apnea, and Resident #2's weight.

2. Resident #11's MDS with an ARD of 7/30/16 was not coded for Anxiety in the list of Active Diagnoses.

3. For Resident #19, the facility staff failed to code correctly the most recent, and previous MDS assessments at J1900. J1900 indicates the correct number and severity of falls. Incorrect coding results in false federal quality indicators and measures for the facility.

The findings included:

1. The Minimum Data Set (MDS) assessments for residents #2 and #11 have been corrected. Resident #19 was discharged 6/6/2016.

2. All residents have the potential to be affected.

3. MDS Coordinators will thoroughly review MDS and care plans documents to ensure that the assessment accurately reflects the resident's status.

4. Director of Nursing and/or designee will audit 10% of assessments submitted monthly for the next 60 days for accuracy. Findings will be reported to QAPI for the next 60 days.

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 10/20/2016

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

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F 278	Continued From page 42	F 278		

Continued From page 42

1. Resident #2 was admitted to the facility on 9/11/14 and readmitted after hospitalization on 8/29/16. Diagnoses included hypertension, depression, and diabetes.

Resident #2's most recent MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 9/19/16 was coded as a significant change in status assessment. Resident #2 was coded as having short and long term memory problems and as having modified independence in making decisions regarding tasks of daily life. Resident #2 was coded as requiring extensive to total assistance of one to two staff members to perform activities of daily living. Of note was coding/information that was missing in the following sections:

a. Resident #2 was coded for receiving scheduled pain medication (Section J0100); however, a Pain Assessment Interview was not conducted as evidence by '-s' (dashes) in the Pain Assessment Interview section of the MDS (Section J0300). There was also a dash in Section J0700 - Should the Staff Assessment for Pain be Conducted. In Section B, Resident #2 was coded as being able to make himself understood and as usually being able to understand others.

b. Section O0100, Special Treatments was coded for BIPAP (BiLevel Positive Airway Pressure) /CPAP (Continuous Positive Airway Pressure). Sleep Apnea was not identified as a diagnosis in the Active diagnoses portion of the MDS.

c. Section K0200 B. Weight was completed with

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 10/20/2016

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 278	Continued From page 43	F 278		

a '-'.

On 10/18/16 at 6:40 p.m., Resident #2 was observed in his room, sitting in his wheelchair. Resident #2 responded appropriately to conversation when spoken to by his nurse. A CPAP machine was observed on his bedside table.

On 10/19/16 at 8:30 a.m., a review of Resident #2's electronic clinical record was conducted and revealed the following:

a. Clinical Physician Notes dated 9/1/16 and 9/12/16 included multifactorial dementia as a diagnosis. This diagnosis was not included in Resident #2's MDS with an ARD of 9/16/16.

b. Resident #2's weight, measured on 9/14/16, was 167.3. Resident #2's weight was not coded in the MDS (Section K0200).

c. Resident #2's current Physician Order Sheet listed Sleep Apnea as a current diagnosis. Sleep Apnea was not listed in the Active Diagnoses section of the MDS.

d. Resident # 2 was coded as being able to express his needs and wants and as being able to understand others on the MDS; however, he was not interviewed in the Pain Assessment section of the MDS.

On 10/19/16 at 12:13 p.m., an interview was conducted with the MDS coordinator, RN (Registered Nurse) E. After reviewing Resident #2's MDS, RN E said the Dietitian was expected to put in the weight, but did not. RN E said Resident #2's weight was measured on 9/14/16,

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 10/20/2016

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 278		F 278		

Continued From page 44
during the ARD period. Regarding the Pain Assessment interview, RN E stated, "I was running behind so I elected to complete the Staff Assessment on the MDS."

Guidance was provided by the MDS 3.1 RAI 1.14 Manual, October 2016, page 1-16, "Medicare and Medicaid participating LTC facilities are required to conduct comprehensive, accurate, standardized and reproducible assessments of each resident's functional capacity and health status."

On 10/20/16 at 6:00 p.m., the Administrator, Director of Nursing were informed of the failure of the staff to prepare a complete and accurate MDS assessment for Resident #2.

2. Resident #11's MDS with an ARD of 7/30/16 was not coded for Anxiety in the list of Active Diagnoses.

Resident #11 was admitted to the facility on 12/28/15. Diagnoses included stroke, heart failure, renal insufficiency and diabetes.

Resident #11's most recent MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 7/30/16 was coded as a quarterly assessment. Resident #11 was coded as having a BIMS (Brief Interview of Mental Status) score of "15" out of a possible 15, or cognitively intact. Resident #11 was also coded as requiring extensive assistance of one to two staff members to perform activities of daily living, such as bed mobility and transfer. Section N: Medications was coded for 7 days of Antianxiety medication received during the assessment period. The MDS was not coded for

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 10/20/2016

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 278		F 278		

Continued From page 45
Anxiety under Section I: Active Diagnoses.

On 10/19/16 at 9:30 a.m., Resident #11 was observed in her room, lying in bed. She had just received assistance with toileting. Resident #11 was pleasant and denied having any concerns regarding her care.

On 10/19/16 at 10:00 a.m., a review of Resident #11's electronic clinical record was conducted. The review revealed the following:
a. A care plan starting 1/11/2016 that read, "[Resident's First Name] is receiving antianxiety drugs as needed. ." Interventions included monitoring for episodes of anxiety.

b. A current Physician Order Sheet signed 10/4/16 included an order originated on 12/28/15 for Diazepam 2 mg (milligram) As Needed Every Eight Hours starting 12/28/15.
"Diazepam is used to treat anxiety disorders. It affects chemicals in the brain that may be unbalanced in people with anxiety." drugs.com
c. Physician Clinical Notes dated 4/30/16 and 5/29/16, included the diagnosis of Anxiety.

d. A nurse's note dated 7/26/16 read, "Resident is resting quietly in bed with eyes closed. C/O (complaining of) anxiety and med given per orders."

e. The October 2016 MAR revealed Resident #11 received 13 PRN (as needed) doses of Diazepam between 10/1/16 through 10/19/16.

On 10/20/16 at 2:15 p.m., the MDS coordinator, RN E was interviewed and asked about Resident #11's MDS that was not coded for Anxiety. RN E reviewed Resident #11's MDS and clinical record

F 278 Continued From page 46 F 278

and provided copies of the MDS. RN E did not comment or provide any explanation.

On 10/20/16 at 6:00 p.m., the Administrator, Director of Nursing were informed of the failure of the staff to prepare a complete and accurate MDS assessment for Resident #11. No additional information was provided.

3. For Resident #19, the facility staff failed to code correctly the most recent, and previous MDS assessments at J1900. J1900 indicates the correct number and severity of falls. Incorrect coding sent to The Centers for Medicare and Medicaid Services (CMS), results in false federal quality indicators and measures for the facility.

Resident #19, was originally admitted to the facility on 7-9-12. Diagnoses included; hypertension, high cholesterol, Alzheimer's disease, osteoporosis, atrial fibrillation, and arthritis.

Resident #19's most recent Minimum Data Set (MDS) assessment was a discharge assessment with an Assessment Reference Date (ARD) of 6-6-16. The Resident was not coded with a Brief Interview of Mental Status score; however, was coded with "moderately impaired cognition". Resident #19 required extensive assistance with dressing, personal hygiene, and bathing. The Resident was coded as always incontinent of bowel and occasionally incontinent of bladder.

Review of the clinical record nursing progress notes, an Adult Protective Services Report, and a facility report, revealed documentation of falls occurring between March 26, 2016 and June 6,

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 10/20/2016

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 278	Continued From page 47	F 278		

2016, (approximately 10 weeks). On 6-6-16, the Resident experienced a fractured hip, which was an injury of unknown origin. The Resident received a portable x-ray at the request of the Resident's daughter, and an acute hip fracture was identified. The Resident was transferred to the hospital for treatment and never returned to the facility. Those 12 frequent falls during the 10 week period occurred on the following dates;
3-26-16
4-5-16
4-11-16
4-20-16
4-29-16
5-1-16
5-10-16
5-14-16
5-23-16
5-27-16
6-4-16
Fractured hip on 6-6-16.

Three MDS assessments were compared for accuracy. The most recent 6-6-16 assessment, the previous Significant change assessment, dated ARD of 5-20-16, and the 2-25-16 annual assessment, which was the one prior to the 5-20-16 assessment.

In the most recent MDS assessment dated ARD 6-6-16, Section J1900 "Number of falls since prior assessment", Resident #19 was coded as "2" falls with "no injury". The assessment was not signed as complete until 6-13-16. On 6-6-16 the Resident was diagnosed in the facility with a hip fracture by way of portable x-ray, and had falls on 5-23-16, 5-27-16, 6-4-16, and a presumed fall on 6-6-16 resulting in fracture. This would indicate 3 falls, if the fracture and 6-6-16 incident were not

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 10/20/2016

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 278	Continued From page 48	F 278		

coded. The facility information reveals that the 6-6-16 MDS was coded incorrectly,

On the Significant Change MDS dated 5-20-16, which was signed as completed on 5-27-16, the number of falls from the "prior assessment" was coded by the facility as "2" with "no injury". Between this assessment and the previous annual assessment, with an ARD date of 2-25-16, there were actually (8) falls, as documented in the facility and clinical records. The 5-20-16 MDS was also coded incorrectly providing a false picture of fall incidents in the facility.

Review of the comprehensive care plan for Resident #19, revealed that the care plan only denoted 4 of the 7 actual falls occurring from 3-26-16 to 5-10-16. Those 4 falls denoted on the care plan were; 3-26-16, 4-5-16, 4-20-16, and 5-10-16.

An interview was conducted on 10-19-16 with RN (C) unit manager. RN (C) stated that the Resident required assistance for transfers, and the Resident was not able to stand or walk alone, and that is why she fell so often. The Resident would try to stand unaided and would fall. RN (C) was asked, if the Resident could not transfer alone without falling, and was extensive assistance of one staff member for bed mobility and turning, how did the Resident manage to sit on the side of the bed with her feet dangling over the side, with a hip fracture if no one assisted her. RN (C) stated that no one witnessed a fall, but it was likely that a fall had occurred with the Resident's history. RN (C) stated an investigation was conducted after the fall, and that allegations of abuse were made, because of suspicious bruising, and that the Administrator had that

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 10/20/2016

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 278	Continued From page 49 information. RN (C) was asked if an investigation had been completed for the allegation of abuse made by another staff member, naming CNA (E) as the abuser, and reported by LPN (G). RN (C) stated yes, she had been aware of that situation and supplied documented statements from the staff involved. On 10-19-16 at the end of day debrief, the Administrator, MDS coordinator, and DON (director of nursing) were notified of the MDS incorrect coding of falls for Resident #19. No further information was provided by the facility.	F 278		
F 279 SS=D	DEVELOP COMPREHENSIVE CARE PLANS CFR(s): 483.20(d), 483.20(k)(1) A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).	F 279		12/1/16

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 10/20/2016

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 279	Continued From page 50 This REQUIREMENT is not met as evidenced by: Based on staff interview, facility documentation review and clinical record review the facility staff failed to develop a comprehensive care plan for services received at a PACE Program weekly for 1 Resident (Resident #6) of 23 residents in the survey sample. For Resident #6, the facility staff failed to care plan, or communicate interventions, and goals between the PACE program and facility. They failed to identify services received by the Resident there, and to include them as part of the clinical record. The findings included: Resident #6, was admitted to the facility on 9-12-14, and readmitted on 5-20-15. Diagnoses included; cardiac artery disease, non-Alzheimer's dementia, peripheral vascular disease, diabetes, arthritis gout, gastro-esophageal reflux disease (GERD), and hypertension. Resident #6's most recent Minimum Data Set assessment was a quarterly assessment with an assessment reference date of 9-29-16. The Resident was coded with mild to moderate cognitive impairment and required extensive assistance with activities of daily living. The Resident was frequently incontinent of bowel and bladder. During Clinical record review, a notation was found in the nursing progress notes on 10-6-16, and 10-11-16, denoting the Resident was receiving services from a PACE Program. Nowhere else in the clinical record could be	F 279	1. The PACE care plan for resident #6 in now contained in the resident's clinical record maintained at the facility. 2. All PACE participants have the potential to be affected. 3. Licensed nursing staff and the interdisciplinary care plan team educated regarding communicating with the PACE program to identify services received by the resident at the PACE program and to ensure inclusion of such documents in the resident's clinical record. 4. Clinical Manager and/or designee will audit 10% of PACE participants clinical records each month for the next 60 days. Findings will be reported to QAPI for the next 60 days.	

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 10/20/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 279	Continued From page 51	F 279		

found, the program specifics nor services identified that Resident #6 received. Also, no specifics could be found as to the number of days the Resident attended the program, the days of the week, or number of hours the Resident spent at the offsite program.

On 10-19-16 at 11:00 a.m., an interview was conducted with LPN (A). LPN A stated that anytime the Resident was away from the facility a leave of absence (LOA) form in the computer was filled out. LPN (A) supplied a copy of the LOA form for Resident #6. The form revealed that the Resident was present in the facility at the times insulin and FSBS were omitted for this Resident. The form was necessary for Resident #6 as LPN A stated that this Resident attended the PACE program outside of the facility, at least one day per week, and received medical services there. This was the first indication that the Resident left the building for these services, as nothing in the clinical record revealed what services were being provided by this program. LPN (A) was asked if the Resident saw doctors, nurses, therapists, social workers, or had labs drawn, and medication evaluations, or other services offered while the Resident was out at the day program. LPN (A) stated he was unsure of the services Resident #6 received while at the PACE Program.

The Resident's PACE Program comprehensive care plan dated 4-21-16, with a goal date of 12-29-16 was reviewed and revealed the following singular intervention;
1) Social worker/Nursing to contact the participant/family when needed.

No other information was given to staff regarding the Resident's program. This indicated that staff

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 10/20/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 279	Continued From page 52 was unaware of what services were received, or what follow ups were required at the program. No communication documents between the program and the facility had been completed, and so could not be accessed by the facility staff, or the PACE staff. No documents from the program were located in the clinical record. It is unknown if duplicate services were provided, or if needed services were omitted. On 10-19-16, at the end of day debriefing, the unknown services the Resident received at the PACE Program was reviewed with the Administrator, the Director of Nursing (DON), and Admin (E) who was a corporate member of the facility's company, and in charge of the PACE Program. Admin (E) stated that the facility staff would have no way to look in the fully computerized electronic medical record to see information about Resident #6's PACE Program, as the facility used the "Vision" software computer program, and the PACE Program used the "Epic" software computer program. She stated that these two computer based programs did not communicate with each other. When asked if the facility staff can access the "Epic" system from their computers, Admin (E) stated "No", the "Epic system is for acute care hospital use and long term care staff do not have access to it. On 10-19-16 at the end of day debriefing at 5:00 p.m., the Administrator, DON, and a large staff contingent were made aware of the staff lack of communication, and care planning for the Resident's PACE Program of unknown clinical services. No further information was provided by the facility by the end of survey.	F 279		
F 309	PROVIDE CARE/SERVICES FOR HIGHEST	F 309		12/1/16

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 10/20/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 309 SS=E	Continued From page 53 WELL BEING CFR(s): 483.25 Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review and clinical record review, the facility staff failed to provide care and services to maintain the highest practicable well being for 3 Residents (Residents #2, #11 and #6) in a survey sample of 23 Residents. 1. For Resident #2, the facility staff failed to obtain and document Intake and Output measurements, per physician orders. Also, on multiple occasions, the physician was not notified of blood sugars measurements greater than 400 per physician orders. 2. For Resident #11, the facility staff failed to follow the physician's order to be notified of a blood sugar greater than 400 milligrams/deciliter. On 10/3/16, Resident #11's blood sugar measurement was 438. 3. For Resident #6, the facility staff failed to obtain Finger stick blood sugars (FSBS), and failed to notify the doctor of a blood glucose level above 400, per physician's orders. The facility	F 309	1. Resident #2's input/output order has been discontinued. Resident #11's blood sugar level above 400 was not reported to the physician. Resident #6's blood sugar level was not obtained and level above 400 not reported to the physician. Facility did not identify services received at the PACE program and include such services in the clinical record. 2. All residents with orders for blood glucose monitoring and input/output orders and PACE participants have the potential to be affected. 3. Licensed nurses educated on process for notifying physician of blood sugar levels above 400, properly recording input/output measurements, and communicating with PACE program to accurately identify services received while at the PACE program site and to include documentation of such services in the clinical record.	

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 10/20/2016

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F 309 Continued From page 54

staff further failed to communicate with the PACE program, and identify services received by the Resident there, and include as part of the clinical record.

The findings included:

1. Resident #2 was admitted to the facility on 9/11/14 and readmitted after hospitalization on 8/29/16. Diagnoses included hypertension, depression, diabetes and urinary tract infection.

Resident #2's most recent MDS (minimum data set) with an ARD (assessment reference date) of 9/19/16 was coded as a significant change in status assessment. Resident #2 was coded as having short and long term memory problems and as having modified independence in making decisions regarding tasks of daily life. Resident #2 was also coded as requiring extensive to total assistance of one to two staff members to perform activities of daily living. Resident #2 was coded for an indwelling catheter.

On 10/18/16 at 6:40 p.m., Resident #2 was observed in his room, sitting in his wheelchair. A foley catheter bag was covered and visibly attached to the wheel chair.

On 10/19/16 at 8:30 a.m., a review of Resident #2's electronic clinical record was conducted and revealed the following:
a. A physician order dated 6/25/16, "Intake and Output (I&O) by shift."

b. Review of the October 2016 TAR (Treatment Administration Record) revealed no measurements of I&O on day shift of 10/7, 10/10, 10/14, 10/15. And there were no

F 309

4. Clinical Manager and/or designee will audit 10% of clinical records of residents with orders for blood glucose monitoring and input/output measurements monthly over the next 60 days for appropriate physician notification. 10% of clinical records of PACE participants will be audited monthly over the next 60 days to ensure services are properly reflected. Findings will be reported to QAPI over the next 60 days.

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 10/20/2016

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SENTARA REHABILITATION & CARE RESIDENCE-CHESAPEAKE	**776 OAK GROVE RD PO BOX 1277 CHESAPEAKE, VA 23320**

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F 309	Continued From page 55	F 309		

measurements of I&O on the night shift 10/6 and 10/8.

c. A physician's order dated 8/16/16, "Humalog 100 unit/ml (milliliter) per sliding scale. Subcutaneous. Accuchecks before meals and at bedtime. Blood Sugar is 180-200 = 2 Units; Blood Sugar is 201-250 = 4 Units; Blood Sugar is 251-300 = 6 Units; Blood Sugar is 301-350 - 8 Units; Blood Sugar is 351-400 = 10 Units. If the Blood Sugar is greater than 400 = 14 Units. Sliding Scale Insulin: Blood Sugar is <(less than) 60 or > (greater than) 400 Notify MD (Medical Doctor)."

d. September and October 2016 MARs (Medication Administration Records) revealed undocumented blood sugar (BS) readings and BS readings that were greater than 400 on the following dates and times:

9/15 - Late Afternoon - BS reading 473
9/18 - Afternoon - BS reading 424; Late Afternoon 403; Bedtime 403
9/29 - Bedtime - BS reading 405
9/17 - Morning and Afternoon -No documented BS reading
9/21 - Late Afternoon -No documented BS reading
9/22 - Late Afternoon -No documented BS reading
9/26 - Morning and Late Afternoon -No documented BS reading
10/7 - Bedtime - BS reading 402
10/9 - Late Afternoon -No documented BS reading
10/13 - Late Afternoon and Bedtime -No documented BS reading
10/15 - Late Afternoon -No documented BS

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 10/20/2016

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**

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F 309	Continued From page 56	F 309		

reading

e. There was no documentation in Resident #2's electronic clinical record that the physician had been notified of the blood sugars that were greater than 400 or the blood sugar readings that were not documented as not having been obtained.

The following interviews were conducted regarding the I&O measurements that were not documented as having been obtained, the blood sugar readings that were greater than 400 without evidence of physician notification, and the blood sugars measurements that were not documented:

a. On 10/19/16 at 5:00 p.m., during an end of day briefing, the Administrator and the Director of Nursing (DON) were informed. Copies of Resident #2's MARs and Progress notes were provided. There were no comments or explanation provided at this time.

b. On 10/19/16 at 5:40 p.m., LPN (Licensed Practical Nurse) B, was interviewed regarding the six occasions she documented Resident #2's BS greater than 400 and the seven occasions her initials were documented in areas designated for the blood sugar measurements. LPN B stated, "I'm not sure what happened. I know I documented them."
After reviewing the clinical record, LPN B said she could not provide any documentation of physician notification of the blood sugars greater than 400. LPN B did not provide an explanation regarding the undocumented blood sugar measurements.

c. On 10/19/16 at 4:00 p.m., the nurse

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 10/20/2016

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 309	Continued From page 57	F 309		

supervisor, RN (Registered Nurse) D was shown Resident #11's September and October MARs. After reviewing the MARs, RN C stated, "The expectation is for the nurses to notify the doctor whenever the blood sugars are greater than 400, that's the facility standard practice." RN C did not provide an explanation for the blood sugar measurements that were not documented as having been obtained or the I&O measurements that were not documented. RN C provided a copy of the STANDING ORDER FOR SLIDING SCALE.

d. On 10/20/16 at 11:20 a.m., the unit manager, RN C, was interviewed. After reviewing Resident #11's September and October MARs and the above mentioned concerns, RN C stated, "I don't know, I'm not sure what's going on with the documentation."

A review of the facility's STANDING ORDER FOR SLIDING SCALE read, "Greater than 400, give 14 units and call MD."

A review of the facility's Procedure for Hyperglycemia read, "Notify physician or follow orders previously specified by M.D. (Medical Doctor). Monitor blood glucose levels, using glucose monitor."

On 10/20/16 at 6:00 p.m., the Administrator and DON were informed of the findings. No additional information was provided.

2. For Resident #11, the facility staff failed to follow the physician's order to be notified of a blood sugar greater than 400. On 10/3/16, Resident #11's blood sugar measurement was

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 10/20/2016

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

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F 309		F 309		

Continued From page 58
438.

Resident #11 was admitted to the facility on 12/28/15. Diagnoses included stroke, heart failure, renal insufficiency and diabetes.

Resident #11's most recent MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 7/30/16 was coded as a quarterly assessment. Resident #11 was coded as having a BIMS (Brief Interview of Mental Status) score of "15" out of a possible 15, or cognitively intact. Resident #11 was also coded as requiring extensive assistance of one to two staff members to perform activities of daily living, such as bed mobility and transfer.

On 10/19/16 at 9:30 a.m., Resident #11 was observed in her room, lying in bed. She had just received assistance with toileting. Resident #11 was pleasant and denied having any concerns regarding her care.

On 10/19/16 at 10:00 a.m., a review of Resident #11's electronic clinical record was conducted. The review revealed the following:

a. A physician's order dated 8/16/16, " Humalog 100 unit/ml (milliliter) per sliding scale. Subcutaneous. Accuchecks before meals and at bedtime. Blood Sugar is 180-200 = 2 Units; Blood Sugar is 201-250 = 4 Units; Blood Sugar is 251-300 = 6 Units; Blood Sugar is 301-350 - 8 Units; Blood Sugar is 351-400 = 10 Units. If the Blood Sugar is greater than 400 = 14 Units. Sliding Scale Insulin: Blood Sugar is <(less than) 60 or > (greater than) 400 Notify MD (Medical Doctor)."

b. The October 2016 MARs (Medication

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 10/20/2016

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 309	Continued From page 59	F 309		

Continued From page 59

Administration Records) revealed on 10/3/16 a blood sugar (BS) reading of 438 and the administration of 14 units of Humalog. On 10/5 and 10/9 there were '=' signs documented for the blood sugar readings.

c. There was no documentation in Resident #11's electronic clinical record that the physician had been notified of the blood sugar measurement of 438 or the blood sugar measurements that were not documented on 10/5/16 and 10/9/16.

The following interviews were conducted regarding the blood sugar measurement that was greater than 400, the blood sugar readings that were not documented and physician notification:

a. On 10/19/16 at 5:00 p.m., during an end of day briefing, the Administrator and the Director of Nursing (DON) were informed. Copies of Resident #11's MARs and Progress notes were provided. No comment or explanation was offered.

b. On 10/19/16 at 4:00 p.m., the nurse supervisor, RN (Registered Nurse) D was shown Resident #11's October MARs. After reviewing the MARs, RN C stated, "The expectation is for the nurses to notify the doctor whenever the blood sugars are greater than 400, that's the facility's standard practice." RN C did not provide an explanation for the blood sugar measurements that were not documented as having been obtained. RN C provided a copy of the STANDING ORDER FOR SLIDING SCALE.

A review of the facility's STANDING ORDER FOR SLIDING SCALE read, "Greater than 400, give 14

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 10/20/2016

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 309		F 309		

Continued From page 60
units and call MD."

A review of the facility's procedure for Hyperglycemia read, "Notify physician or follow orders previously specified by M.D. Monitor blood glucose levels, using glucose monitor."

On 10/20/16 at 6:00 p.m., the Administrator and DON were informed of the facility staff's failure to notify Resident #11's physician of the blood sugar reading that greater than 400 on 10/3/16, per the physician ordered parameters. No additional information was provided.
3. For Resident #6, the facility staff failed to administer insulin, failed to obtain Finger stick blood sugars (FSBS), and failed to notify the doctor of a blood glucose level above 400, per physician's orders. The facility staff further failed to communicate with the PACE program, and identify services received by the Resident there, and to include them as part of the clinical record.

Resident #6, was admitted to the facility on 9-12-14, and readmitted on 5-20-15. Diagnoses included; cardiac artery disease, non-Alzheimer's dementia, peripheral vascular disease, diabetes, arthritis gout, gastro-esophageal reflux disease (GERD), and hypertension.

Resident #6's most recent Minimum Data Set assessment was a quarterly assessment with an assessment reference date of 9-29-16. The Resident was coded with mild to moderate cognitive impairment and required extensive assistance with activities of daily living. The Resident was frequently incontinent of bowel and bladder.

Review of the physician's orders, and Medication

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 10/20/2016

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 309	Continued From page 61	F 309		

and Treatment Administration Records (MAR/TAR), revealed an order for Sliding Scale Insulin (SSI) to be given according to the following order dated 8-31-16; "Humalog 100 units per milliliter subcutaneous solution (sliding scale) three times daily. Sliding scale insulin blood sugar is less than 65 or greater than 400 notify the doctor.
Blood sugar 180-200 give 2 units,
Blood sugar 201-250 give 4 units,
Blood sugar 251-300 give 6 units,
Blood sugar 301-350 give 8 units,
Blood sugar 351-400 give 10 units."

On 10-5-16 the Resident's FSBS registered 450, no documentation was found in the MAR/TAR, nursing progress notes, or physician progress notes, that the physician was ever notified of the high reading, and only 10 units of insulin was administered in error, and was ordered to be given for an FSBS reading of 351 to 400.

FSBS Blood sugar checks were ordered to be obtained three times daily at 7:30 a.m., 11:30 a.m., and 4:30 p.m.. The order was dated 8-15-16. According to the October 2016 MAR, blood sugars were not documented as having been obtained, and no insulin SSI was documented as having been administered on the following dates:
10-4-16, at 11:30 a.m.
10-4-16, at 4:30 p.m.
10-9-16, at 4:30 p.m.

Further review of the physician's orders, and Medication and Treatment Administration Records (MAR/TAR), revealed an order for "Humalog 100 units per milliliter subcutaneous solution (5 units) twice per day, ordered to start

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 10/20/2016

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 309	Continued From page 62	F 309		

9-10-16, and discontinued on 10-5-16, to be administered at 11:30 a.m., and 4:30 p.m. The order was changed on 10-5-16, to increase the dose from 5 units to 8 units. No insulin was documented as having been administered for either order, according to those respective orders on the following dates:
On 10-4-16 at 4:30 p.m.
On 10-9-16 at 4:30 p.m.

On 10-19-16 at 11:00 a.m., an interview was conducted with LPN (A). LPN A stated that anytime the Resident was away from the facility a leave of absence (LOA) form in the computer, was filled out. LPN (A) supplied a copy of the LOA form for Resident #6. The form revealed that the Resident was present in the facility at the times the insulin and FSBS were omitted. The form was necessary for Resident #6 as LPN A stated that this Resident attended the PACE program outside of the facility, at least one day per week, and received medical services there. This was the first indication that the Resident left the building for these services, as nothing in the clinical record revealed what services were being provided by this program. LPN (A) was asked if the Resident saw doctors, nurses, therapist's, social workers, or had labs drawn, and medication evaluations, or other services were offered while the Resident was out at the day program. LPN (A) stated he was unsure of the services Resident #6 received while at the PACE Program.

The Resident's diabetic comprehensive care plan dated 4-21-16, with a goal date of 1-5-17 was reviewed and revealed the following interventions;
1) Administer medications as ordered.
2) Monitor labs as ordered.

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 10/20/2016

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 309	Continued From page 63	F 309		

3) Monitor meal consumption and snacking. Encourage diet compliance.
4) Monitor for signs and symptoms of hypo/hyperglycemia, neuropathy, and retinopathy. Notify doctor of findings, and treat as ordered.
5) Administer insulin or oral diabetic medications as ordered.
6) Provide good foot care. Refer to podiatrist as needed.

The facility policy on Medication Administration, and Hypo/Hyperglycemia, was reviewed and revealed; "Notify physician immediately or follow orders as previously specified by MD (doctor). If medication doses are not taken by resident notate on reverse side of MAR." No reasons were notated for the omissions.

The Resident's PACE Program comprehensive care plan dated 4-21-16, with a goal date of 12-29-16 was reviewed and revealed the following singular intervention;
1) Social worker/Nursing to contact the participant/family when needed.

No other information was given to staff regarding the Resident's program. This indicated that staff was unaware of what services were received, or what follow ups were required at the program. No communication documents between the program and the facility had been completed, and so could not be accessed by the facility staff, or the PACE staff. No documents from the program were located in the clinical record.

On 10-19-16, at the end of day debriefing, the issue with the Insulin medications and FSBS accuchecks were reviewed with the Administrator and Director of Nursing (DON), as well as the

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 10/20/2016

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 309	Continued From page 64 unknown services the Resident received at the PACE Program. The DON stated that she had no reason why the FSBS and insulin was not administered or documented as such. Admin (E) who was a corporate member of the facility's company, and in charge of the PACE Program stated that the facility staff would have no way to look in the fully computerized electronic medical record to see information about Resident #6's PACE Program, as the facility used the "Vision" software computer program, and the PACE Program used the "Epic" software computer program. She stated that these two computer based programs did not communicate with each other. When asked if the facility staff can access the "Epic" system from their computers, Admin (E) stated "No", the "Epic system is for acute care hospital use, and long term care staff do not have access to it. On 10-19-16 at the end of day debriefing at 5:00 p.m., the Administrator, DON, and a large staff contingent were made aware of the staff failure in medication administration. They were also made aware of the lack of communication, and care planning for the Resident's PACE Program of unknown clinical services. No further information was provided by the facility by the end of survey.	F 309		
F 314 SS=D	TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES CFR(s): 483.25(c) Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having	F 314		12/1/16

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 10/20/2016

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 314	Continued From page 65 pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and clinical record review the facility staff failed for 2 residents (Resident #13 and #3) of 23 residents in the survey sample to ensure physician ordered pressure relieving devices were in place. 1. Resident #13 was observed on two occasions without his protective boots applied. 2. For Resident # 3, the facility staff applied Prevalon boots which were not ordered by a physician to be applied, and failed to ensure the HeelZup Supreme pressure relieving device was positioned properly to prevent pressure on her heels. The findings included: 1. Resident #13 was observed on two occasions without his protective boots applied. Resident #13, a 64 year old, was admitted to the facility on 12/11/14. His diagnoses included dementia, diabetes, bipolar disease, hypertension, renal failure, and depression. Resident #13's most recent Minimum Data Set assessment was a quarterly assessment with an assessment reference date of 7/21/16. He was coded with a Brief Interview of Mental Status score of 3 indicating severe cognitive impairment. He required extensive assistance with activities of	F 314	1. Resident #13 has received an education consultation on the importance of keeping his protective boots on. Resident #3's Heelzup Supreme pressure relieving device has been discontinued and she now has a physician order for Prevalon boots. 2. All residents have the potential to be affected. 3. Nursing staff educated regarding proper use of pressure relieving devices. 4. Clinical Manager and/or designee will monitor pressure relieving device use weekly during rounds for the next 60 days and physician orders will be verified for devices in use. Findings will be reported to QAPI for the next 60 days.	

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 10/20/2016

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 314	Continued From page 66	F 314		

daily living.

Resident #13 was observed on the initial tour of the facility on 10/18/16 at 6:20 p.m. His feet were bare. The bottoms of his feet were pressed flat up against the foot board. He was observed again on 10/19/16 at 8:40 a.m.. His feet were bare and pressed flat up against the foot board. Blue protective boots were observed on the floor at the foot of the bed.

An observation of Resident #13's feet was performed on 10/20/16 at 2:10 p.m. Resident #13 was wearing protective boots at this time. Facility staff removed the boots and Resident #13's skin was observed. No skin issues were observed. During the observation, a piece of paper was observed to be taped to Resident #13's trapeze bar. The paper directed that the protective boots be worn at all times.

Resident #13's physician orders were reviewed. An order dated 12/11/14 read "Boots to be worn at all times." A second order, also dated 12/11/14, read "Float heels when in bed."

At the end of day meeting on 10/20/16, the Administrator and Director of Nursing were informed that Resident #13 had been observed on two occasions without the protective boots applied.
2. For Resident #3, the facility staff applied Prevalon boots* which were not ordered by a physician to be applied, and failed to ensure that the HeelZup** pressure relieving device was positioned properly to prevent pressure on her heels.

Resident #3, a 95 year old female, was originally

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 10/20/2016

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 314		F 314		

Continued From page 67
admitted to the facility on 6/29/2015 and readmitted on 9/30/2015. Diagnoses included but were not limited to Diabetes, Psychotic Disorder, Hypertension, Hyperlipidemia, Glaucoma, Gastrostomy Tube and Urinary Retention.

The most recent MDS (minimum data set) was a Quarterly Assessment with an ARD (assessment reference date) of 8 /11/2016. Resident #3 was coded as having severe cognitive impairment. Resident #3 was coded as requiring extensive to total assistance of one staff person for her ADLs (activities of daily living), except requiring extensive assistance of two staff persons for bed mobility. Resident #3 was coded as having a catheter for bladder and always incontinent of bowel.

On initial tour on 10/18/2016 at 6:25 PM, Resident # 3 was observed lying in bed with a pressure relieving mattress on bed.

Review of the clinical record was conducted on 10/19/2016 at 8:30 AM.

Review of the Physicians Orders revealed orders for several treatments to prevent pressure ulcers:
"9/30-15-Turn and reposition resident per resident assessment and chart on TAR (Treatment Administration Record)
9/30/15-Rest Q (brand of mattress) Pressure Redistribution Surface Mattress
9/30/15-Apply Moisture Barrier Cream after Incontinent Episodes
1/2/16-Heels up while in bed by shift ordered
4/7/16-Skin Prep bilateral heels by shift ordered

9/30/15-High Risk for Skin Breakdown/Sentara Pressure Ulcer Prevention Protocol

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 10/20/2016

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 314	Continued From page 68	F 314		

Review of the documentation on the Weekly Skin Condition Progress Report showed the pressure ulcer to the left heel was healed on 3/28/2016 and right heel was healed on 6/23/2016.

Review of the last signed Physicians Orders sheets signed on 5/11/2016 revealed no order for Prevalon boots to be applied to the heels. Review of the unsigned October 2016 Physician Order sheets also revealed no order for Prevalon boots.

Review of the Nurses Notes revealed documentation on 7/4/2016 at 1:03 AM that stated "Resident continues to wear Prevalon Boots cradling both feet and lifting heels off the mattress. Continuing treatment for partial thickness loss of epidermis on right heel. Skin prep applied per facility protocol. Patient turned and repositioned per facility protocol. Will continue to monitor the patient's condition."

On 10/19/2016 at 9:25 AM, Resident #3 was observed lying in the bed. Her knees were were elevated on a "Heelzup" device. Prevalon Boots were noted on both feet. Resident # 3's heels were resting on the bed.

On 10/19/2016 at approximately 3 PM, an interview was conducted with Registered Nurse Supervisor, Registered Nurse D (RN D) who stated Resident #3 did not have a current pressure ulcer and that pressure ulcers had formed on both heels earlier in the year but were now healed. RN D stated as soon as one heel healed, the other heel opened up." RN D stated the pressure ulcers had been "healed for a long time now."

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 10/20/2016

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

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F 314	Continued From page 69	F 314		

On 10/20/2016 at 8:45 AM, Resident #3 was observed lying in bed. The Heelzup device was under her knees. Prevalon Boots were on both feet and Resident #3's heels were resting on the bed.

On 10/20/2016 at approximately 11:00 AM when interviewed about the documentation of a "partial thickness loss of epidermis on right heel" in July 2016, the Clinical Manager and Director of Nursing stated Resident # 3's pressure ulcers had healed months before July 2016. The surveyor informed the staff that the surveyor wanted to inspect the heels of Resident #3.

On 10/20/2016 at approximately 11:30 AM, two surveyors and two nurses, Clinical Manager (RN A) and RN B Supervisor (RN B), went to observe the skin on the heels of Resident # 3. The HeelZup device was under the knees of Resident #3. Prevalon boots were on both feet. The Certified Nursing Assistant (CNA D) helped to hold Resident # 3's feet up so the skin on the heels could be observed. The nurses (RN A and RN B) removed the Prevalon boots to expose the skin on the heels. The skin on the heels appeared to be very flaky. Large flakes of skin were observed peeling off of both heels and were on the inside of the Prevalon Boots. The Prevalon boots were reapplied and the sheet was pulled back over Resident #3.

Both nurses were asked by the surveyor if the HeelZup device was located appropriately. RN B stated "Oh. Do you want us to move the HeelZup? She has on Prevalon Boots so her heels are protected." Both nurses slid the HeelZup device to the calf area of both legs. RN A and RN B both stated the Prevalon Boots were

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 10/20/2016

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 314 — Continued From page 70 — F 314

on so her heels were protected.

On 10/20/2016 at approximately 11:50 AM, the Director of Nursing was informed of the findings and was requested to provide a copy of the instructions for the HeelZup device. The product instructions were provided.
Review of the Product instructions revealed statements:
"One of the leading challenges for the wound care community is heel pressure ulceration. Heels are naturally susceptible to pressure ulcers and even the most advanced support surfaces prove to be ineffective at prevention and treatment. Existing modalities of heel pressure ulcer prevention treatment have many drawbacks. Heel "boots" require frequent removal to inspect the skin integrity of the lower leg... The HeelZup Supreme Therapeutic Heel Elevating Cushion provides the most practical solution to this complex problem:
Extra thick construction provides higher elevation of the lower legs and heels.
The 1.5 "(inch) thick Visco-Elastic foam calf bed provides enhanced comfort and pressure redistribution to the lower leg.
Raised side bolsters prevent the legs from falling off of the sides of the cushion.
Stays neatly in place and does not require constant maintenance and adjustment.
4-Way stretch cover allows the legs to immerse more deeply into the Visco-Elastic foam calf bed, while the No-/slip bottom material helps the cushion to stay neatly in place. "

Under Specifications was written:
"The standard width is 30" with 4" elevated leg bolsters on both sides. The calf bed will allow free lateral movement while the bolsters prevent the

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 10/20/2016

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

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F 314	Continued From page 71 legs from falling off of the cushion." Review of the clinical record revealed a physician's order dated 1/2/2016 for "heels up while in bed by shift." Review of the care pan dated 8/25/2016 revealed an intervention for "pressure reducing mattress." On 10/20/2016, at the end of the day exit, the Administrator and DON (director of nursing) were notified of above findings. No further information was provided. *Prevalon boots help prevent heel ulcers by cradling the foot and lifting the heel off the mattress. **HeelZup is heel elevation cushion designed to off load heels.	F 314		
F 315 SS=D	NO CATHETER, PREVENT UTI, RESTORE BLADDER CFR(s): 483.25(d) Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced	F 315		12/1/16

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 10/20/2016

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 315	Continued From page 72 by: Based on observation, staff interview, and clinical record review, the facility staff failed to ensure physician ordered catheter care was provided for 2 residents (Residents #3 and # 4) in the survey sample of 23 residents. 1. For Resident # 3, the facility staff failed to ensure that the urine bag was changed every 2 weeks as ordered by the physician. 2. Resident #4's catheter bag was observed lying on the floor when the bed was in the low position. Findings included: 1. For Resident # 3, the facility staff failed to ensure that the urine bag was changed every 2 weeks as ordered by the physician. Resident # 3, a 95 year old female, was originally admitted to the facility on 6/29/2015 and readmitted on 9/30/2015 with diagnoses of but not limited to Diabetes, Psychotic Disorder, Hypertension, Hyperlipidemia, Glaucoma, Gastrostomy Tube and Urinary Retention. The most recent MDS (minimum data set) was a Quarterly Assessment with an ARD (assessment reference date) of 8 /11/2016. Resident # 3 was coded as having severe cognitive impairment. Resident # 3 was coded as requiring extensive to total assistance of one staff person for her ADLs (activities of daily living), except requiring extensive assistance of two staff persons for bed mobility. Resident # 3 was coded as having a catheter for bladder and always incontinent of bowel.	F 315	1. Resident #3's physician order for changing foley bag every two weeks has been discontinued. Resident #4's catheter bag was removed from the floor and placed in a dignity cover. 2. All residents with catheters have the potential to be affected. 3. Nursing staff educated on policy for catheter care. 4. Clinical Manager and/or designee will monitor all residents with catheters weekly for the next 60 days to ensure drainage bags are changed as ordered and are appropriately placed. Findings will be reported to QAPI for the next 60 days.	

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 10/20/2016

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 315	Continued From page 73 During initial tour on 10/18/2016 at 6:25 PM, Resident #3 was observed lying in bed. A urinary catheter bag dated 10/2/2016 was observed with 300 milliliters of yellowish colored urine noted in the bag. On 10/19/2016 at 9 AM, it was observed the urinary catheter bag dated 10/2/2016. Facility staff LPN A (Licensed Practical Nurse A) entered Resident's room immediately after the surveyor. When asked about the date on the catheter bag, LPN A stated "the catheter bag is supposed to be changed monthly so the date is fine." On 10/19/2016 at 9:00 AM, review of the clinical record was conducted. Review of the clinical record revealed a Physicians's Orders written on 10/14/2015 that read, "Change Foley bag two weeks starting 10/15/2015." During the end of day debriefing, the facility administrator, Director of Nursing and facility staff were informed of the 10/2/2016 date on the urinary catheter bag and the physicians orders for change Foley bag every two weeks. The Director of Nursing stated the orders to change the Foley bag had been changed to monthly and "we use a closed system here so monthly is fine. The bag does not need to be changed every two weeks. The doctor changed the order." On 10/20/2016 at 8:35 AM, observed the urinary catheter bag was dated 10/2/2016. On 10/20/2016 at 9:15 AM, an interview was conducted with the Clinical Manager (RN A) who stated the physician had given an order for the	F 315		

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 10/20/2016

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 315	Continued From page 74	F 315		

Foley bag to be changed one time monthly. The Surveyor requested a copy of the order with changes.

On 10/20/2016 at 9:40 AM, RN A presented two sheets of paper. One was the October 2016 Physician Order sheet with two orders and the Nurses Notes written on 10/2/2016. On the Physicians Order Sheet, the order was written 10/14/2015 to "Change Foley bag two weeks starting 10/15/2015." The other order was for "Foley change (16 F) (16 French) 1 time monthly on the 1st of each month" with an order date of 9/17/2016, and frequency One time monthly starting 10/1/2016 in the afternoon.

Review of the Nurses Notes revealed documentation of "Foley changed" and E-signed on 10/2/2016 at 10:52 AM. The note read "Monthly Foley change due. Foley catheter changed with new # (number) 16 Fr (French) with 10 cc (cubic centimeters) balloon with NS (Normal Saline) instilled. Balloon of old Foley intact. Balloon of new Foley checked prior to placement for patency. Sterile technique maintained. Foley draining yellow urine. Res. (Resident) tolerated procedure without difficulty. Will cont. (continue) to monitor.

RN A stated she was sure the order for the Foley catheter bag had been changed to monthly but stated she "could not find the order."

On 10/20/2016 at 1:30 PM, the Director of Nursing presented copies of the Treatment Administration Records from April through October 2016. Review of the October 2016 TAR (Treatment Administration Record) revealed computerized documentation of orders for

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 10/20/2016

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

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F 315	Continued From page 75	F 315		

treatment "Change Foley bag two weeks starting 10/15/2015" and time scheduled for 14:00 (2:00 PM). The computer generated sheet had an "x" in every date for the month of October except 10/13/2016 which had a nurse's initials documented in that block on 10/13/2016. On the "October 2016 Non-PRN (As Needed) Treatment Notes" page (page 7 of 7) showed the order Change Foley bag two weeks starting 10/15/2015, Order date 10/14/2015" with a note dated 10/13/2016 time 14:00 stating "not administered (other (Enter Administration Note))" and signed by LPN A. There was no documentation on the TAR of the Foley bag being changed on 10/2/2016 or any other day in October 2016.

On 10/20/2016 at 4 PM, the Foley catheter urinary bag was still observed with the date of 10/2/2016.

During the end of day debriefing on 10/20/2016, the facility Administrator and Director of Nursing were informed of the findings.

No further information was provided.

2. Resident #4's catheter bag was observed lying on the floor when the bed was in the low position.

Resident #4, a 73 year old, was admitted to the facility on 12/7/15. Her diagnoses included recent stroke, coronary artery disease, hypertension, elevated lipids and Parkinson's Disease.

Resident #4's most recent Minimum Data Set assessment was a quarterly assessment with an assessment reference date of 8/24/16. She was coded with a Brief Interview of Mental Status

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 10/20/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 315	Continued From page 76 score of 3 indicating severe cognitive impairment. She required extensive assistance with activities of daily living. On 10/19/16 at 3:20 p.m., three members of the survey team along with Certified Nursing Assistant A (CNA A) and the Registered Nurse A (RN A), Clinical Manager, entered Resident #4's room. Resident #4's bed was observed to be in the lowest position. The catheter bag was hung on the side of the bed closest to the door. The catheter bag was not in a privacy bag. The catheter bag was lying on the floor. At this time, CNA A was asked if Resident #4's bed was kept in the lowest position often. CNA A stated yes. Neither RN A or CNA A acknowledged the catheter bag on the floor. The Director of Nursing and Administrator were notified of the catheter bag issue at the end of day meeting on 10/20/16.	F 315		
F 325 SS=D	MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE CFR(s): 483.25(i) Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem.	F 325		12/1/16

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 10/20/2016

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F 325	Continued From page 77 This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility documentation review and clinical record review the facility staff failed for 1 resident (Resident #4) of 23 residents in the survey sample to prevent severe, significant weight loss. Resident #4 weighed 213 pounds on admission to the facility (12/7/15) and 149 pounds when most recently weighed (10/4/16). Multiple occurrences of significant, severe weight loss occurred during this 10 month time period without intervention. The findings included: Resident #4, a 73 year old, was admitted to the facility on 12/7/15. Her diagnoses included recent stroke, coronary artery disease, hypertension, elevated lipids, obesity and Parkinson's Disease. Resident #4's most recent Minimum Data Set assessment was a quarterly assessment with an assessment reference date of 8/24/16. She was coded with a Brief Interview of Mental Status score of 3 indicating severe cognitive impairment. She required extensive assistance with activities of daily living, to include total dependence for feeding. Resident #4's weights (in pounds) were documented as follows: 12/7/15- 213.6 12/14/16- 211.0 1/7/16- 208.5 2/4/16- 209.0 3/3/16- 192.6 4/13/16- 176.2 5/18/16- 171.3 5/25/16- 163.46 6/2/16- 165.8 6/8/16- 168.8	F 325	1. Nutritional interventions with goal to stabilize weight loss have been implemented for resident #4. 2. All residents with significant weight loss have the potential to be affected. 3. All residents with significant weight loss will be reviewed weekly during the "Standards of Care" meetings with recommended nutritional interventions forwarded to physician for approval. Care planning team educated on how to identify significant weight loss. 4. Director of Nursing and Registered Dietitian (or designee) will review recommendations weekly for the next 60 days to ensure timely implementation and appropriateness. Findings will be reported to QAPI for the next 60 days.	

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	495215	A. BUILDING ______ B. WING ______	C 10/20/2016

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F 325	Continued From page 78 6/14/16- 168.0 6/22/16- 167.7 7/27/16- 159.2 8/10/16- 158.8 8/17/16- 156.8 8/24/16- 156.3 9/21/16- 153.4 10/4/16- 149.8 The following periods of significant weight loss were calculated from the above weights: - 7.8% loss in 1 month (2/4/16- 209.0 pounds to 3/3/16- 192.6 pounds= 16.4 pounds). A loss greater than 5% in 1 month is considered a severe weight loss. - 8.5% loss in 1 month (3/3/16- 192.6 pounds to 4/13/16- 176.2 pounds= 16.4 pounds). A loss greater than 5% in 1 month is considered a severe weight loss. - 5.0% loss in 1 month (6/22/16- 167.7 pounds to 7/27/16- 159.2 pounds= 8.5 pounds) - 9.8% loss in 3 months (12/7/16- 211.0 pounds to 3/3/16- 192.6 pounds= 18.4 pounds). A loss greater than 7.5% in 3 months is considered a severe weight loss. - 22.3% loss in 6 months (12/7/15- 213.6 pounds to 6/2/16- 165.8 pounds= 47.8 pounds). A loss greater than 10% in 6 months is considered a severe weight loss. - 14.9% loss in 6 months (4/13/16- 176.2 pounds to 10/4/16- 149.8 pounds= 26.4 pounds). A loss greater than 10% in 6 months is considered a severe weight loss. On 10/19/16 at 8:40 a.m., Resident #4 was observed lying in bed. She had contractures to both hands. She was observed to have wash cloths between the palms and fingers of both hands. Resident was non-verbal. She does not move without assistance. Her breakfast tray sat on the over bed table. The tray included a scoop	F 325		

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	495215	A. BUILDING ______ B. WING ______	C 10/20/2016

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F 325	Continued From page 79	F 325		

of eggs, a scoop of ground meat and a bowl of oatmeal. No staff were in the room.
At 9:05 a.m., the tray was no longer in the room. When asked if the resident had eaten breakfast, Licensed Practical Nurse C (LPN C) stated that the tray was put back in the cart until a Certified Nursing Assistant (CNA) was available to feed the resident.
At 9:35 a.m., CNA B stated she had fed the resident. CNA B stated that the resident ate the oatmeal, drank orange juice and water. CNA B stated Resident #4 did not eat the eggs or meat, as the resident does not like these items.
Resident #4's skin breakdown to the buttocks began on 1/5/16. As of 10/20/16, this area had not healed. The area was observed by the survey team on 10/19/16 at 3:20 p.m. and described as severe excoriation.
The following nutrition notes were documented by the Registered Dietitian:
- Nutrition Assessment- Admission Assessment (no date on the print out provided). " Estimated Nutrient Needs " were documented as 1940 calories per day and 78-97 grams of protein per day. The "Clinical Nutrition Risk" section read "high nutr (nutrition) risk r/t (due to) new CVA (stroke) with change in diet texture." The "Care Area Assessment/ Nutrition Summary" included "Obesity related to excessive caloric intake as evidenced by BMI (body mass index)= 30-39.9, Textured modified diet related to physical impairment as evidenced by MD (doctor) prescribed order, @ (at) risk for weight loss r/t (due to) current state of obesity and eating 3 balanced meals AEB BMI". The "Nutrition Care Plan" section of the assessment read "gradual weight loss of <4.5% over the next review period."
- 1/13/16, 11:15 a.m. "Discussed in SOC (standards of care) mtg (meeting); resident with

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	495215	A. BUILDING ______ B. WING ______	C 10/20/2016

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F 325	Continued From page 80 skin breakdown buttocks and labia, add prostat 30cc SF (sugar free) BID (two times per day)." - 3/9/16, 11:15 a.m. "discussed in SOC mtg. weight loss 16.4 pounds x 1 month (-9%) resident is fed by staff and eats 75% at most meals weight loss is desirable as BMI was 36 and weight likely contributed to medical condition. Weight loss is a result of her current state of obesity and receiving 3 balanced meals/day." - 5/18/16, 12:22 p.m. "resident with significant weight loss x 6 months 20% or 43 pounds weight 171 LBS (pounds) IBW (ideal body weight) for 64" (inches)= 120 lbs Resident is 143% of IBW weight loss rate is 7.2 pounds/ month or 1.8 pounds per week This weight loss is healthy weight loss based on resident's admission BMI of 36 (level 2 obesity) REC (recommend): weekly weights to monitor weight loss is slowing as resident gets closer to IBW." - 6/22/16, 11:07 a.m. "weight stable 3 weeks" "REC: cont (continue) monitor weight weekly; add Prostat BID x 30 days". - 7/27/16, 11:14 a.m. "weight down another 9 pounds since last month; AVG (average) 2.25 pounds per week which is gradual; however, weight loss is significant x 6 months" - 8/3/16, 11:43 a.m. "Discussed in SOC; d/c (discontinue) weight loss order. weight stability is new goal. significant weight loss x 18% x 6 months Rec Ensure BID (two times per day)." - 9/21/16, 12:39 p.m. "Discussed in SOC mtg; excoriation healing Resident fed by staff on mech (mechanical) soft ground diet Awaiting September weight; weight remained stable through August Resident receives extra protein for skin integrity and Ensure for extra calories for wt stability August weight reflects that resident is 128% IBW (IBW= 122 lbs) Resident admitted with obesity and weight loss orders."	F 325		

F 325 Continued From page 81 F 325

- 10/5/16, 12:57 p.m. "Resident with cont. weight loss; PO (by mouth) intakes documented that breakfast meals> 75% or more and lunch and dinner less than 25% last couple of days. Con't with weekly weights, supplements and assistance.

The Physician progress notes were reviewed. The admission note was dated 12/8/16. The "objective" section, read "functional status, Poor" and "The rehabilitation potential., poor". The "Plan" section read "antihypertensive medication, PPI (proton pump inhibitor), physical therapy, antibiotics, elevation of the head of the bed."

There was no documentation in the physician progress notes that weight loss was desired by the physician. All physician progress notes provided by the facility documented Resident #4's appetite as "fair". Progress notes dated 4/30/16, 5/29/16, and 6/30/16 read "Nutrition Support, Vitamins" in the "plan" section. There were no specific nutrition related interventions documented.

Nutrition Related Physician Orders:
12/7/16- Vitamin B-12 1000 microgram daily (discontinued 8/8/16)
1/13/16- Prostat two times per day (current order)
5/4/16- "Gradual WEIGHT LOSS 2-4 lbs (pounds)/ week" (discontinued 8/3/16)
8/3/16- Ensure Enlive two times per day. This would provide 700 calories per day (current order)
There is no order for vitamin/ mineral supplementation other than vitamin B-12.

An interview was held with the Registered Dietitian (RD) on 10/19/16 at 5:30 p.m. It was reviewed that Resident #4 had lost 64 pounds in 10 months, involving multiple periods of significant, severe weight loss. The RD stated that obesity caused Resident #4's stroke and she

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	495215	A. BUILDING ______ B. WING ______	C 10/20/2016

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F 325	Continued From page 82	F 325		

needed to lose weight. It was reviewed that this amount of weight loss seemed aggressive, especially since significant and severe weight loss had occurred. The RD stated that she was aggressive. She stated that the resident was at the facility for skilled services and she (RD) wanted Resident #4 to lose weight before resident returned home. (It was verified with facility staff that Resident #4 did not receive skilled services while at the facility, see interview below).
The RD stated that Resident #4's family was aware of the weight loss. She referred to the following note written by the Clinical Manager "3/18/16 Discussed 8 lb. (pound) weight gain. resident above IBW (ideal body weight). POA (power of attorney) aware of weight gain, discussed WEIGHT LOSS PROGRAM." The RD was shown a print out of Resident #4's weights and was asked to show where Resident #4 had gained 8 pounds prior to 3/18/16 when the note was written. She stated that she did not write the note about the weight gain and the note needed to be reviewed with the person who had wrote it. It was reviewed with the RD that Resident #4 did not gain weight, rather as of March 2016 a 9.8% significant, severe weight loss had occurred since Resident #4's admittance to the facility on 12/7/16.
The RD stated that the weight loss was physician ordered. It was reviewed that the physician did not order the weight loss until 5/4/16. It was reviewed that the order was for 2-4 pounds gradual weight loss. It was reviewed that 2-4 pounds is not gradual weight loss. The RD stated that she cannot tell the physician what to do and that she cannot write orders. It was reviewed that while a RD cannot write orders, it is the function of a RD to recommend diet-related care to the

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F 325	Continued From page 83 physician and to address orders/ issues that are not in line with standards of nutritional care. It was reviewed that prior to the physician's weight loss order, Resident #4 had already experienced significant, severe weight loss: 7.8% loss in 1 month (2/4/16- 209.0 pounds to 3/3/16- 192.6 pounds) and 8.5% loss in 1 month (3/3/16- 192.6 pounds to 4/13/16- 176.2 pounds). The RD was asked why she would want to be aggressive with Resident #4 ' s weight loss given the resident's recent debilitating stroke and other health care issues that were certain to cause unintended weight loss. The RD stated she knew the resident was going to lose weight and that is why she wanted the doctor's order. She stated that she had been asking the physician for a weight loss order since the resident was admitted to the facility. Despite knowing the resident was going to lose weight, nothing was put into place to ensure a gradual weight loss. It was reviewed with the RD that it was hard to understand why the resident experienced severe weight loss for eight months without intervention and then on 8/3/16 the weight loss order was discontinued and Ensure twice daily was started on the same day. In the 3/9/16 nutrition note, the RD documented that a 16.4 pounds x 1 month (-9%) weight loss occurred. This equals a 4.1 pound weight loss per week. There was no intervention put into place to address this accelerated rate of weight loss. In the 5/18/16 note, the RD acknowledged a significant weight loss x 6 months, a 20% weight loss of 43 pounds. The RD calculated the weight loss rate as 7.2 pounds per month or 1.8 pounds per week. She documented this weight loss to be a healthy weight loss. The 7.2 pounds loss per month calculated by the	F 325		

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 10/20/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 325	Continued From page 84 RD was an average weight loss per month over a time period of 6 months. Actual monthly weight loss from 2/4/16 to 3/3/16 equaled 17 pounds. From 3/3/16 to 4/13/16, Resident #4 lost 16.4 pounds. This weight loss rate is significant and severe. There were no interventions put into place to slow the rate of weight loss. The Practical Guide Identification, Evaluation, and Treatment of Overweight and Obesity in Adults includes weight loss guidelines from the National Institutes of Health- National Heart, Lung, and Blood Institute. The publication was accessed on 10/26/16 at 9:08 a.m. at the website <http://www.nhlbi.nih.gov/files/docs/guidelines/prctgd_c.pdf> The section titled "Management" on page 2 read "An initial weight loss of 10 percent of body weight achieved over 6 months is a recommended target. The rate of weight loss should be 1 to 2 pounds each week. Greater rates of weight loss do not achieve better long-term results." The section titled "Therapies" on page 2 of the guide read "Caloric intake should be reduced by 500 to 1,000 calories per day (kcal/day) from the current level." Page 3 read "Reductions of 500 to 1,000 kcal/day will produce a recommended weight loss of 1 to 2 pounds per week." Vitamin supplementation was discussed on page 26. This read "Care should be taken to ensure that all of the recommended dietary allowances are met; this may require the use of a dietary or vitamin supplement. Another publication, Executive Summary: Guidelines (2013) for the Management of Overweight and Obesity in Adults, was published in the journal Obesity in July 2014. This publication was the analysis of the most current research with regards to the treatment of obesity.	F 325		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 325	Continued From page 85	F 325		

Page S14, Box 9 read "The Expert Panel recommends as an initial goal the loss of 5-10% of baseline weight within 6 months."

Resident #4's baseline weight was 213.6 pounds. Ten percent of her baseline weight is 21.3 pounds. According to weight loss guidelines, 21.3 pounds should have been her maximum weight loss goal for 6 months. Resident #4's actual 6 month weight loss was 47.8 pounds, more than double the recommended loss.
From 12/7/15 until 8/27/16, Resident #4 was provided a mechanical soft diet. The facility provided the caloric information for the mechanical soft diet and the Prostat supplement. The mechanical soft diet provided an average of 2,303 calories per day. The Prostat supplement provided a total of 144 calories per day. In total, Resident #4 was provided with 2447 calories per day. She was totally dependent on staff to feed her.
As documented in the above reference, a reduction of 1000 calories per day will produce a weight loss of 2 pounds per week. Using this information, a 2000 calorie reduction per day will produce a weight loss of 4 pounds per day. Calorie reductions are achieved either through the reduction of food intake or increased movement and exercise. As Resident #4 did not move (due to her stroke), her weight loss was mainly a result of reduction in food intake.
The RD calculated Resident #4 ' s daily caloric need of 1940 calories per day in the Nutrition Admission Assessment. The RD stated during her interview that she used 20 calories per kilogram in her calculation. According to established weight calculations, 20-30 calories per kilogram are used to calculate caloric needs to maintain weight, with 20 used for persons with

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F 325	Continued From page 86 low level of activity. During the time period of 2/4/16 to 3/3/16, Resident #4 lost 16.4 pounds, or 4.1 pounds per week. This would equal a 2000 calorie reduction per day from her actual need. According to diet information, 2447 calories were available to Resident #4 for daily consumption. Resident #4 required 1940 calories for weight maintenance. Her weight loss of 4 pounds per day resulted from a 2000 calorie daily reduction. Therefore, it appears that the appropriate amount of calories were available to Resident #4, but she consumed very little of the nutrition provided (1940 calories required- 2000 calorie reduction). On 10/20/16, Registered Nurse F (RN F) was asked to provide the dates for which Resident #4 received skilled services. At 3:30 p.m., RN F stated that Resident #4 did not receive skilled services while at the facility. Resident #4's care plan was reviewed. The plan "Resident unable to verbalize needs." was created. Another plan (no date) read "Resident is obese related to excessive caloric intake as evidenced by BMI 30-39.9. Resident has had a 18% weight loss in the last 180 days." The goal to this plan read "Weight stability over the next review period. Monitoring weekly that weight loss is slowing." The goal date is 11/25/16. "Interventions" included Monitor weight monthly or per MD order and Honor resident's right of choice. In summary, the RD's initial nutrition assessment documented the goal that Resident #4 would maintain a "gradual weight loss of <4.5% over the next review period." Resident #4's weight was assessed again by the RD on 3/9/16 (next review period). At this time, Resident #4 had experienced a 9.8% weight loss in this time period of 3 months. This is a significant, severe	F 325		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 325	Continued From page 87 weight loss, exceeding the goal of gradual weight loss established by the RD in the admission nutrition assessment. No interventions were put into place to slow the weight loss. In addition, the resident experienced other periods of significant weight loss. The RD stated that the weight loss was desired by the physician. There is no documentation in the physician progress notes that weight loss was desired. On 5/4/16 the physician did order weight loss of 2-4 pounds per week. This is not gradual weight loss and exceeds the recommended 1-2 pounds of weight loss per week. At the time of the weight loss order, Resident #4 had already lost 37.4 pounds, a significant, severe weight loss that exceeds the recommendation of a decrease of 10% body weight in the first 6 months. The physician weight loss order was discontinued on 8/3/16 and Ensure, a supplement to provide 700 extra calories per day, was ordered the same day as the weight loss order was discontinued. The Ensure was ordered 8 months after Resident #4 had been experiencing significant, severe weight loss. Resident #4's had skin breakdown to the buttocks that began on 1/5/16. As of 10/20/16, this area was not healed. Lastly, the resident did not receive any vitamin or mineral supplementation (except vitamin B12) while experiencing significant, severe weight loss and an extremely low caloric intake. The Administrator and Director of Nursing were notified of the weight loss concern at the end of day meeting on 10/19/16 and 10/20/16.	F 325		
F 386 SS=D	PHYSICIAN VISITS - REVIEW CARE/NOTES/ORDERS CFR(s): 483.40(b) The physician must review the resident's total	F 386		12/1/16

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 10/20/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 386	Continued From page 88 program of care, including medications and treatments, at each visit required by paragraph (c) of this section; write, sign, and date progress notes at each visit; and sign and date all orders with the exception of influenza and pneumococcal polysaccharide vaccines, which may be administered per physician-approved facility policy after an assessment for contraindications. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to ensure clinician orders were signed in a timely manner for one Resident (Resident #3) in a survey sample of 23 Residents. For Resident # 3, the facility staff failed to ensure Physicians orders were signed timely. No signed Physicians orders were noted since 5/11/2016 resulting in 162 days since the last signed orders. Findings included: Resident # 3, a 95 year old female, was originally admitted to the facility on 6/29/2015 and readmitted on 9/30/2015. Diagnoses included but were not limited to Diabetes, Psychotic Disorder, Hypertension, Hyperlipidemia, Glaucoma, Gastrostomy Tube and Urinary Retention. The most recent MDS (minimum data set) was a Quarterly Assessment with an ARD (assessment reference date) of 8 /11/2016. Resident # 3 was coded as having severe cognitive impairment. Resident # 3 was coded as requiring extensive to total assistance of one staff person for her ADLs (activities of daily living), except requiring	F 386	1. Resident #3's most recent physician orders have been signed. 2. All residents have the potential to be affected. 3. Physicians have received written notification of requirements for timely signing of physician order sheets. 4. Medical records clerk or designee will audit 10% of each physicians order sheets monthly for the next 60 days. Findings will be reported to QAPI for the next 60 days.	

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 10/20/2016

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F 386	Continued From page 89	F 386		

extensive assistance of two staff persons for bed mobility. Resident # 3 was coded as having a catheter for bladder and always incontinent of bowel.

Review of Resident #3's clinical record revealed his most recently signed "Physician's Orders" were dated as having been signed on 5/11/2016. A thorough review of Resident #3's clinical record revealed no more recently signed orders. There was documentation of Physicians Orders Sheets sent on 10/3/2016, 9/2/2016, 8/1/2016 but they had not been returned as signed electronically by the physician.

On 10/19/2016 at 4 PM, the Clinical Manager (RN A) and Director of Nursing were informed that the last signed Physicians Order noted in the electronic medical record was dated on 5/11/2016. The surveyor asked for a copy of the most recent signed Physicians Order Sheet. At 4:40 PM, RN A presented a copy of the October 2016 Physicians Order Sheet. Review of the October 2016 order sheet revealed it was not signed by the physician.

During the end of day debriefing on 10/19/2016 at 4: 30 PM, the facility administrator, Director of Nursing, corporate consultants and several facility staff members were informed of no signed Physicians Orders since 5/11/2016. The Director of Nursing stated the expectation was that the Physicians would sign Physicians Order sheets at least every 60 days.

On 10/20/2016 at approximately 9:30 AM, an interview was conducted with RN A who stated the physician should sign Physicians Order

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 10/20/2016

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F 386	Continued From page 90 Sheets after they have been sent by the nursing staff. On 10/20/2016 at 5:30 PM, the facility staff (RN F) presented a copy of the last signed Physician Order Sheet dated 5/11/2016. No further information was provided.	F 386		
F 387 SS=D	FREQUENCY & TIMELINESS OF PHYSICIAN VISIT CFR(s): 483.40(c)(1)-(2) The resident must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 days thereafter. A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to ensure timely physician visits for one resident (Resident # 9) in a survey sample of 23 residents. For Resident # 9, the facility staff failed to ensure physicians visits were completed in a timely manner. The last progress note was written on 7/31/2016. Findings included: Resident # 9, a male, was admitted to the facility on 7/31/2015. His diagnoses included but were	F 387	1. Resident #9 has been seen by his physician. 2. All residents have the potential to be affected. 3. Physicians have received written notification of guidelines regarding progress note and visitation requirements. 4. Medical records clerk will monitor 10% of each physicians current progress notes weekly for the next 60 days. Findings will be reported to QAPI for the next 60 days.	12/1/16

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 10/20/2016

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F 387	Continued From page 91	F 387		

not limited to:Dementia, Heart Failure, Chronic Obstructive Pulmonary Disease, Hyperlipidemia, Hypertension, Urinary Tract Infection, Thrombocytopenia and Polyarthritis.

Resident # 9's most recent MDS (minimum data set) was coded as a Quarterly Assessment with an ARD (assessment reference date) of 7/26/2016. . He was coded as having a BIMS (Brief Interview for Mental Status) of 9/15 indicating moderate cognitive impairment. Resident #9 was coded as requiring extensive to total assistance of one staff member for his activities of daily living except eating. For eating, Resident # 9 was coded as requiring supervision and set up only. Resident #9 was also coded as frequently incontinent of bowel and bladder.

Review of Resident # 9's electronic clinical record was conducted on 10/19/2016. Review of Physicians Progress Notes revealed no Progress Notes written between May 2016 - October 2016.

An interview was conducted with the Clinical Manager, Registered Nurse A (RN A) who stated Progress Notes had been written because the Physician did visit Resident # 9 during that period of time. RN A stated Progress Notes were available in the computer. The Information Technology Consultant (Employee D) was asked by the surveyor to retrieve any Progress Notes from the computer.

On 10/20/206 at 5:15 PM, Employee D presented four pages of Progress Notes dated 5/1/2016, 5/29/2016, 6/30/2016 and 7/31/2016. Employee D stated she was unsure of why the Progress Notes could not be seen in the computer earlier but the Progress Notes were

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 10/20/2016

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F 387	Continued From page 92 found in the electronic record. Employee D stated no other Progress Notes were found in the electronic record after 7/31/2016. Resident #9 had not been assessed by his physician between 7/31/2016 and the time of survey 10/20/2016. A thorough review of the clinical record revealed no progress notes had been written by the physician during that time frame. At the time of the end of survey, it had been 81 days since the last Progress Note was written. When interviewed , the DON stated the expectation was that physicians would write progress notes at least every 60 days. The administrator and DON were informed of the failure of the staff to ensure Resident #9 was seen by his physician and a progress note written in a timely manner on 10/20/2016 at 5:25 PM during the end of day debriefing. No further information was provided.	F 387		
F 431 SS=D	DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS CFR(s): 483.60(b), (d), (e) The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be	F 431		12/1/16

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 10/20/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 431

Continued From page 93

labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.

In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.

The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.

This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview, and facility documentation review ,the facility staff failed to ensure expired medications were not available for use in one of two medication rooms and on one of three medication carts.

For the Medication Room on the Oak Grove Unit, the facility staff failed to ensure that expired medication Ranitidine 75 milligrams was not available for use.
And on Cart 3, one opened bottle of expired medication, Ranitidine 75 milligrams, was found in the top drawer where stock medications were

F 431

1. All expired Ranitidine medication has been removed and returned to the pharmacy.

2. All residents with orders for Ranitidine 75 mg have the potential to be affected.

3. Licensed nurses educated regarding monitoring expiration dates on medications.

4. Clinical Manager and/or designee will audit over-the-counter medications for

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 10/20/2016

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F 431 Continued From page 94
stored

Findings included:

On 10/19/2016 at 8:55 AM, an inspection of the Medication Room on the Oak Grove Unit was conducted with Clinical Manager, Registered Nurse A (RN A). There was a cabinet with several over the counter medications stored in the cabinet. RN A stated stock medications come from the Pharmacy and were kept in the cabinet. RN A stated the stock medications were available for use.

Five bottles of expired medications were observed in the medicine cabinet. Ranitidine 75 milligrams 30 tablets in each bottle expiration date 7/20/2016- Batch 14CT033D.

On 10/19/2016 at 9:00 AM, an interview was conducted in the Medication Room with RN A who stated "normally the nurses check the dates. We missed that." RN A stated expired medications should not be available for use. RN A also stated all medications should be checked prior to administering to residents. RN A removed the expired medications and placed them in a large box with other medications that RN A stated were scheduled to be returned to the Pharmacy.

On 10/19/2016 at 9:08 AM, after leaving the medication room, the three medication carts on Oak Grove unit were inspected. LPN C (Licensed Practical Nurse C) was administering medications from Cart 3. At 9:10 AM, LPN C stopped between residents and allowed the surveyor to inspect the cart. LPN C stated the medications in the top drawer were available for

F 431

current dates weekly for the next 60 days. Findings will be reported to QAPI for the next 60 days.

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 10/20/2016

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SENTARA REHABILITATION & CARE RESIDENCE-CHESAPEAKE	776 OAK GROVE RD PO BOX 1277 CHESAPEAKE, VA 23320

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F 431	Continued From page 95 use. On Cart 3, one opened bottle of expired medication, Ranitidine 75 milligrams, was found in the top drawer where stock medications were stored. The bottle had the same expiration date 7/20/2016- Batch 14CT033D. There were 12 pills remaining in the bottle packaged as 30 tablets per bottle. LPN C stated "we should check the expiration date along with the right medication and right dose." On 10/19/2016 at 5:00 PM during the end of day debriefing, the facility administrator, Director of Nursing, Corporate Consultants and other facility staff were informed of the findings. On 10/20/2016 at approximately 2 PM, the Director of Nursing (DON) stated the Pharmacy had run scan of existing prescriptions for Ranitidine 75 milligrams and found no current orders. The DON stated there were 9 residents with current orders for Ranitidine 150 milligrams but that the Pharmacy sent those prescriptions in individual packets for those residents. The DON stated she did not know how long the expired open bottle of medication had been on Cart 3 but that "it could have been there for a long time." The Director of Nursing stated the expectation was that expired medications would not be administered to residents and that the expired bottles of medication should not have been available for use. The facility staff did not present any further information regarding the findings.	F 431		
F 514 SS=E	RES RECORDS-COMPLETE/ACCURATE/ACCESSIB LE CFR(s): 483.75(l)(1)	F 514		12/1/16

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 10/20/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 514	Continued From page 96 The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility documentation review, and clinical record review, the facility staff failed to ensure an accurate and complete clinical record for 6 residents (#17, #2, #11, #16, #15 and #7) of 23 residents in the sample. 1. The Medical Director included an assessment for a different resident in Resident #17 's clinical record. 2. Resident #2's TAR (Treatment Administration Record) was inaccurately completed. 3. Resident #11's October MAR (Medication Administration Record) was inaccurately completed. There were times and dates on the MAR that contained incorrect data. 4. Resident #16's Hospice Note was found in Resident #11's electronic clinical record. 5. For Resident #15, medications were documented as having been administered by the wrong nurse. 6. For Resident #7, medications were	F 514	1. The clinical record for Resident #17 has been corrected. Resident #2's order for input/output measurement has been discontinued. The October 2016 medication administration record for Resident #11 is incomplete. The hospice note for Resident #16 has been moved to the correct clinical record. Resident #7 and #15 had medications that were documented as having been administered by the wrong nurse. 2. All residents have the potential to be affected. 3. Licensed nurses educated on documentation accuracy and the importance of logging off computers used for electronic medical record documentation. 4. Medical records clerk will audit 10% of	

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 10/20/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 514	Continued From page 97 documented as having been administered by the wrong nurse. The findings were as follows: 1. The Medical Director included an assessment for a different resident in Resident #17's clinical record. Resident #17, a 66 year old female was admitted to the facility on 7/9/2013. Her diagnoses included Alzheimer's, dementia, hypertension, high cholesterol, depression, reflux, hypothyroidism, and anxiety. Resident #17's most recent MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 9/14/2016 was coded as a quarterly assessment. Resident #17 was coded as having severe cognitive impairment via a staff assessment. She was coded as needing extensive assistance of one person for her activities of daily living and was always incontinent of bowel and bladder. She ambulated freely around the facility and was nonverbal A clinical record review was conducted on 10/20/2016 at 10:45 AM and it revealed an assessment dated 1/22/2016 by Administration C, Medical Director. This assessment was seen to be inconsistent with Resident #17's clinical diagnoses. It stated that Resident #17's medical history included congestive heart failure, achalasia (difficulty swallowing), pneumonia, organic brain syndrome, and degenerative joint disease. Resident #17's mental status was described as "alert". An interview was conducted with Administration B, Director of Nursing on 10/19/2016 at 11:00 AM. She stated that the assessment of 1/22/2016 "looked incorrect". Administration A, Facility Administrator suggested that the Medical Director be contacted to clarify	F 514	clinical records weekly for the next 60 days for accuracy. Clinical Manager and/or designee will monitor computer login identification practices by licensed nurses three times per week for the next 60 days. Findings will be reported to QAPI for the next 60 days. *************** Preparation and/or execution of this plan of correction does not constitute 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 10/20/2016

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

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F 514	Continued From page 98	F 514		

this assessment.
On 10/19/2016 at 2:00 PM a telephone interview was conducted with Administration C, facility Medical Director. When questioned about this discrepancy, he stated that the assessment of 1/22/2016 was "incorrect and probably described another resident".
The administration was informed of the findings on 10/13/2016 at 5:00 PM.

2. Resident #2's TAR (Treatment Administration Record) was inaccurately completed.

Resident #2's most recent MDS (minimum data set) with an ARD (assessment reference date) of 9/19/16 was coded as a significant change in status assessment. Resident #2 was coded as having short and long term memory problems and as having modified independence in making decisions regarding tasks of daily life. Resident #2 was also coded as requiring extensive to total assistance of one to two staff members to perform activities of daily living. Resident #2 was coded for an indwelling catheter.

On 10/18/16 at 6:40 p.m., Resident #2 was observed in his room, sitting in his wheelchair. A Foley catheter bag was covered and visibly attached to the wheel chair.

On 10/19/16 at 8:30 a.m., a review of Resident #2's electronic clinical record was conducted and revealed the following:

a. A physician order dated 6/25/16, "Intake and Output (I&O) by shift."

b. Review of the October TAR (Treatment Administration Record) revealed no

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 10/20/2016

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

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F 514	Continued From page 99	F 514		

measurements of I&Os on day shift of 10/7, 10/10, 10/14, 10/15. And there were no measurements of I&O on the night shift 10/6 and 10/8. On these dates the area's designated for I&O measurements contained '=' signs or a nurse's initials.

On 10/19/16 at 4:00 p.m., the nurse supervisor, RN (Registered Nurse) D, was interviewed. After reviewing the TAR, RN D said she could not explain the inaccurate documentation of the I&O measurements.

On 10/20/16 at 6:00 p.m., the Administrator and the DON were informed of the inaccurate documentation on Resident #2's October TAR.

3. Resident #11's October MAR (Medication Administration Record) was inaccurately completed. There were times and dates on the MAR that contained incorrect data.

Resident #11 was admitted to the facility on 12/28/15. Diagnoses included stroke, heart failure, renal insufficiency and diabetes.

Resident #11's most recent MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 7/30/16 was coded as a quarterly assessment. Resident #11 was coded as having a BIMS (brief interview of mental status) of "15" out of a possible 15, or cognitively intact. Resident #11 was also coded as requiring extensive assistance of one to two staff members to perform activities of daily living, such as bed mobility and transfer.

On 10/20/16 at 08:30AM , a review of Resident #11's electronic clinical record was conducted.

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 10/20/2016

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 514	Continued From page 100	F 514		

Review of the October MAR revealed the following:

a. Catapril 12.5 mg - Evening dose on 10/9 -the blood pressure reading read 'AB'.

b. Ferrous Sulfate 325 mg - Late Afternoon on 10/5 and 10/9 - administration read '='.

c. Humalog 100 Sliding Scale Insulin - Late Afternoon on 10/5 and 10/9 Blood Sugar read '='.

On 10/20/16 at 2:00 p.m., the Director of Nursing (DON) was informed. After reviewing the clinical record, the DON said, "I'm not sure what happened."

On 10/20/16 at 6:00 p.m., the Administrator and the DON were informed of the inaccurate documentation on Resident #11's MAR. No additional information was provided.

4. Resident #16's Hospice Note was found in Resident #11's electronic clinical record.

Resident #11 was admitted to the facility on 12/28/15. Diagnoses included stroke, heart failure, renal insufficiency and diabetes.

Resident #11's most recent MDS (minimum data set) with an ARD (assessment reference date) of 7/30/16 was coded as a quarterly assessment. Resident #11 was coded as having a BIMS (brief interview of mental status) score of "15" out of a possible 15, or cognitively intact. Resident #11 was also coded as requiring extensive assistance of one to two staff members to perform activities of daily living, such as bed mobility and transfer.

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F 514	Continued From page 101	F 514		

Resident #16 was admitted to the facility on 3/19/15 and readmitted after hospitalization on 5/20/16. Diagnoses included dementia, heart failure, chronic obstructive pulmonary disease, and hypertension.

Resident #16's most recent MDS with an ARD of 8/8/16 was coded as a quarterly assessment. Resident #16 was coded as having short and long term memory problems and as having severely impaired cognitive skills for making daily decisions. Resident #16 was also coded as requiring extensive to total assistance of one staff member to perform activities of daily living, such as bed mobility. Resident #16 was coded for Hospice Care.

On 10/20/16 at 9:00 a.m., a review of Resident #11's electronic clinical record was conducted and revealed a scanned form entitled, SPIRITUAL CARE CLINICAL NOTE. Resident # 16's name was hand written under Patient Name.

On 10/20/16 at 9:35 a.m., the Director of Nursing (DON) was informed of Resident #16's Hospice Note being in Resident #11's electronic clinical record. The DON provided a copy of the Hospice Note. No comment or explanation was provided.

On 10/20/16 at 6:00 p.m., the Administrator and the DON were informed that Resident #16's Hospice Note was in Resident #11's electronic clinical record.

5. For Resident #15, medications were documented as having been administered by the wrong nurse.

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F 514	Continued From page 102 Resident #15, a 74 year old, was admitted to the facility on 10/10/16. Diagnoses included seizures, hypertension, depression and dementia. A Minimum Data Set assessment has not been completed for the resident. It was in progress. On 10/19/16 at 8:30 a.m., Resident #15 was included in the medication pour and pass observation with Licensed Practical Nurse C (LPN C). After the medications were administered, the medications passed were compared to the physician orders and the October 2016 Medication Administration Record (MAR). It was observed that the initials in the boxes on the MAR corresponding to the medications LPN C was observed to administer were not her initials. On 10/19/16, late morning, the MAR was reviewed with LPN C. She was asked to verify her initials. She stated that the initials on the MAR for 10/19/16 were not her initials. When asked if this was an issue she had seen before, LPN C stated that it happened sometimes. After talking with LPN C, the MAR documentation issue was reviewed with Employee D, Information Technology staff. Employee D talked with LPN C at the medication cart where LPN C was assigned. It was determined that the nurse who had worked the medication cart prior to LPN C had not logged out of the system. The screen he had used was minimized (still active). LPN C was able to login to the system also using her own credentials, allowing for the system to be open twice. At some point, LPN C unknowingly began using the screen of the previous nurse while administering the morning medications. All the	F 514		

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F 514	Continued From page 103	F 514		

medications LPN C documented and all the notes she documented while using the other nurse's screen are inaccurate and do not reflect the signature of the actual nurse who completed the work.

The Administrator was informed of the issue at the end of day meeting on 10/19/16.

6. For Resident #7, medications were documented as having been administered by the wrong nurse.

Resident #7, a 96 year old, was admitted to the facility on 9/29/14. Her diagnoses included diabetes, hypertension, reflux and dementia.

Her most recent Minimum Data Set assessment was a quarterly assessment with an assessment reference date of 8/15/16. She had a Brief Interview of Mental Status score of 9 indicating moderate cognitive impairment. She required assistance with her activities of daily living.

On 10/19/16 at 8:30 a.m., Resident #7 was included in the medication pour and pass observation with Licensed Practical Nurse C (LPN C). After the medications were administered, the medications passed were compared to the physician orders and the October 2016 Medication Administration Record (MAR). It was observed that the initials in the boxes on the MAR corresponding to the medications LPN C was observed to administer were not her initials.

On 10/19/16, late morning, the MAR was reviewed with LPN C. She was asked to verify her initials. She stated that the initials on the

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F 514	Continued From page 104	F 514		

MAR for 10/19/16 were not her initials. When asked if this was an issue she had seen before, LPN C stated that it happened sometimes.

After talking with LPN C, the MAR documentation issue was reviewed with Employee D, Information Technology staff. Employee D talked with LPN C at the medication cart where LPN C was assigned. It was determined that the nurse who had worked the medication cart prior to LPN C had not logged out of the system. The screen he had used was minimized (still active). LPN C was able to login to the system also using her own credentials, allowing for the system to be open twice. At some point, LPN C unknowingly began using the screen of the previous nurse while administering the morning medications. All the medications LPN C documented and all the notes she documented while using the other nurse's screen are inaccurate and do not reflect the signature of the actual nurse who completed the work.

The Administrator was informed of the issue at the end of day meeting on 10/19/16.