STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495213	A. BUILDING _____ B. WING _____	C 05/25/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAYSIDE HEALTH & REHABILITATION CENTER	1004 INDEPENDENCE BLVD VIRGINIA BEACH, VA 23455

(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 05/23/17 through 05/25/17. Significant corrections are required for compliance with the following 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. The census in this 60 certified bed facility was 49 at the time of the survey. The survey sample consisted of 17 residents, 11 current Resident reviews (Resident #1 through 11) and 6 closed record reviews (Resident #12 through 17).	F 000		
F 323 SS=G	FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES CFR(s): 483.25(d)(1)(2)(n)(1)-(3) (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain	F 323		6/6/17

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

Electronically Signed | 06/06/2017

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495213	A. BUILDING _____ B. WING _____	C 05/25/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAYSIDE HEALTH & REHABILITATION CENTER	1004 INDEPENDENCE BLVD VIRGINIA BEACH, VA 23455

(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 323	Continued From page 1 informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on staff interviews, clinical record review and facility document review the facility staff failed to implement interventions consistent with the residents needs, goals and person-centered care plan to reduce an avoidable accident for 1 of 17 residents in the survey sample, Resident #4, resulting in a fall and fracture resulting in harm. On 4/6/17 Resident #4 fell off the bed, landed on the floor and sustained a right hip fracture during the provision of care by one staff. The resident's person-centered care plan indicated the resident was at risk for falls and the resident's needs required two person assist with ADL's (Activities of Daily Living) to prevent falls. The findings included: Resident #4 was admitted to the facility on 4/3/09 with history of a stroke with left sided hemiparesis (1) and left sided contractures (2). The MDS (Minimum Data Set) a quarterly with an assessment reference date of 2/2/17 coded the resident as scoring a 15 out of a possible 15 on the Brief Interview for Mental Status (BIMS), indicating the resident's cognition was intact. The resident was coded as requiring two person physical assistance with bed mobility, dressing, toileting, and personal hygiene. The resident was coded as totally dependent on one staff for bathing. The resident had impairment to both upper and lower extremities on one side (left) and	F 323	Past noncompliance: no plan of correction required.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495213	A. BUILDING _____ B. WING _____	C 05/25/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAYSIDE HEALTH & REHABILITATION CENTER	1004 INDEPENDENCE BLVD VIRGINIA BEACH, VA 23455

(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 323	Continued From page 2	F 323		

was bed bound.

The comprehensive person-centered care plan created on 8/2/15 identified the resident was risk for falls related to hemiparesis. The goal was that the resident would remain free of falls and free of minor and major injury. Interventions listed to achieve and maintain the goals were to anticipate and meet the resident's needs, 2 person assist with ADL's, transfer and bed mobility.

During the initial tour of the nursing unit by surveyor #2 on 5/23/17, it was reported that Resident #4 had a recent fall with a fracture.

Further investigation of the fall evidenced a progress note dated 4/6/17 that read, in part: "The patient fell out of bed while receiving ADL care. The patient was on her left side; the aide was pulling the brief from under the patient and the patient fell out of the bed. The patient c/o (complaint) to the right side of her head and right leg, right knee and right thigh...".

Resident #4 was sent to the Emergency Room for evaluation. An X-ray was obtained. The X-ray report from ER on 4/6/17-Lucent line across the right trochanter, highly concerning for nondisplaced intratrochanteric fracture ...discharge diagnosis-hip fracture, right, closed. The fracture did not require surgical intervention. The resident was sent back to the facility with an order for a follow up with an orthopedic physician.

The nurse assigned to care for the resident (Licensed Practical Nurse #1) on the morning of the fall was interviewed on 5/24/17 at 11:30 am. She stated the CNA #1(Certified Nurse Aide)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495213	A. BUILDING _____ B. WING _____	C 05/25/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAYSIDE HEALTH & REHABILITATION CENTER	1004 INDEPENDENCE BLVD VIRGINIA BEACH, VA 23455

(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 323	Continued From page 3	F 323		

came to her that day and stated, "... Ms. (resident name) is on the floor". The nurse then went to get the Director of Nursing (DON) and both entered the resident's room. The resident was observed on the floor between the two resident beds, the resident's head was half way under a chair and the resident was on her right side. The resident was assessed and then placed back into the bed by way of a mechanical lift. The resident stated her right leg was hurting. The LPN stated she asked the CNA what happened. The CNA stated the resident was laying on her left side she was going to pull the resident's brief off and the resident fell off the bed. The nurse stated, "She (the resident) had to have flipped", as the resident was found facing the bed frame. The nurse stated the CNA should have had another staff with her during all ADL care to include, brief changing, bed repositioning, bed mobility and bathing.

On 5/24/17 at 11:45 am, the DON was interviewed. She stated she was in her office when LPN #1 came to get her. She stated she went to the resident's room and found the resident on the floor. After assessing and placing the resident back to bed she questioned the CNA as to what happened. The CNA stated she was "providing care, was busy, in a hurry". The DON stated the CNA knew the resident required two staff for all ADLS and expected the CNA to have asked for help. She stated the resident had a sign above the head of the bed that indicated the resident required two staff. The DON stated in response to the fall an Action Plan was developed, the CNA was given an Employee Corrective Action, suspended for three days and subsequently terminated.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495213	A. BUILDING _____ B. WING _____	C 05/25/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAYSIDE HEALTH & REHABILITATION CENTER	1004 INDEPENDENCE BLVD VIRGINIA BEACH, VA 23455

(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 323	Continued From page 4	F 323		

The Employee Corrective Action dated 4/10/17 read, in part: On 4/6/17 employee (name) CNA failed to get assistance while providing ADL care to resident in room (#) Resident had a fall and sustained a fracture to the right hip.

On 5/25/17 at 12:30 pm, CNA #2 assigned to care for the resident was interviewed. She stated the resident, "has always required two staff for all ADL's to include personal care".

The resident had been observed several times during the survey in bed with her eyes closed. On 5/25/17 at 12:45 pm, the resident was observed awake. The resident was asked about the fall and stated that she had fallen off the bed. When questioned further the resident was not able to provide any additional details. A posting of a sign that indicated the resident required two staff for assistance was above the resident's bed.

The Corrective Action Plan dated 4/6/17 included the following with a corrective action completion date of 4/9/17 read as follows:
"Issue-Fall with Injury.
Comments-Resident sustained a fall during ADL care.
Action:
-Resident evaluated at ER with a fracture to R (right) hip. Completed-4/6/17
-Reviewed list of resident(s) requiring two-person assist for bed, and ensure that sign is posted to indicate this need. Completed-4/6/17.
-Educate CNA staff on proper positioning of resident during provision of care. Completed 4-9-17.
-Review fall(s) every weekday to identify trends, review appropriate interventions. On going.
-Review resident(s) upon admission or with

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495213	A. BUILDING _____ B. WING _____	C 05/25/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAYSIDE HEALTH & REHABILITATION CENTER	1004 INDEPENDENCE BLVD VIRGINIA BEACH, VA 23455

(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 323	Continued From page 5 change of condition for fall interventions. On going. -Monitor provision of ADL care to ensure that two-person assist is used as indicated. Corrective action process will follow as indicated. On going. -Present findings to QA (Quality Assurance) meetings for review and recommendations. On going." Based on the aforementioned interviews with facility staff, review of the corrective action plan and that the deficient practice did not reoccur after 4/9/17 or exist during the current survey, it was determined the facility met Past Non Compliance for this specific regulatory requirement. The following medical Definitions were obtained from Taber's Cyclopedic Medical Dictionary Edition #20: (1) Hemiparesis-Paralysis of one side of the body. (2) Contracture-Fibrosis of connective tissue in skin, fascia, muscle, or a joint that prevents normal mobility of the related tissue or joint.	F 323		
F 333 SS=G	RESIDENTS FREE OF SIGNIFICANT MED ERRORS CFR(s): 483.45(f)(2) 483.45(f) Medication Errors. The facility must ensure that its- (f)(2) Residents are free of any significant medication errors.	F 333		6/6/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495213	A. BUILDING _____ B. WING _____	C 05/25/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAYSIDE HEALTH & REHABILITATION CENTER	1004 INDEPENDENCE BLVD VIRGINIA BEACH, VA 23455

(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 333	Continued From page 6 This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff interviews and facility documentation review, the facility staff failed to ensure residents were free of significant medication errors for 2 of 17 residents (Resident #12 and #13) in the survey sample. 1. Resident #12 was administered medications that were ordered for his roommate which resulted in altered mental status and confusion and consequences that lead to hospitalization resulting in harm. 2. Resident #13 was administered medications that were ordered for his roommate. The resident required medical intervention at a local hospital emergency department. The findings include: 1. Resident #12 was admitted to the nursing facility on 1/24/17 with diagnoses that included stroke, syncope, orthostatic hypotension, muscle weakness, and Alzheimer's disease. The Admission Minimal Data Set (MDS) assessment dated 1/31/17 coded the resident with a score of 7 out of a possible score of 15 on the Brief Interview for Mental Status which indicated he was severely impaired in the skills required for daily decision making. He required extensive assistance of two staff for transfers, bed mobility, extensive assistance of 1 staff for locomotion on and off the unit and used a walker, as well as a wheelchair. The resident was coded not able to independently walk. The resident was not coded with diabetes or depression. He was assessed with high blood pressure (controlled),	F 333	Past noncompliance: no plan of correction required.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495213	A. BUILDING _____ B. WING _____	C 05/25/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAYSIDE HEALTH & REHABILITATION CENTER	1004 INDEPENDENCE BLVD VIRGINIA BEACH, VA 23455

(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 333	Continued From page 7	F 333		

but also had orthostatic blood pressure.

The care plan dated 1/24/17 identified the resident was at risk for falls related to gait/balance problems, had a recent hemorrhagic stroke, a pacemaker for irregular heart rhythms. The goal set for the resident by the staff was that he would be free of falls and injuries.

Resident #12 had physician orders dated 1/24/17 for *Amiodarone HCL (to treat irregular heart rhythms) tablet 200 milligrams (mg) and *Fludrocortisone Acetate (to increase blood pressure) tablet 0.1 mg tablet to be administered every day at 9:00 a.m.

*Amiodarone HCL is used to treat life threatening heart arrhythmia problems called ventricular arrhythmias (www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0000087/).

*Fludrocortisone is used to increase blood pressure(www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0000087/).

On 2/11/17 during the morning medication pass at 9:00 a.m., Resident #12 was not administered Amiodarone and Fludrocortisone Acetate morning medications at 9:00 a.m. on 2/11/17, but instead was administered his roommate's 9:00 a.m. medications: *Acarbose 50 milligram (mg) one tablet for diabetes mellitus to lower blood sugar, *Capecitabine 500 mg three tablets to treat cancer, *Carvedilol 3.125 mg one tablet to treat high blood pressure, *Lexapro 20 mg to treat depression, *Lisinopril 2.5 mg to treat high blood pressure and *Mobic 7.5 mg to treat arthritis.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495213	A. BUILDING _____ B. WING _____	C 05/25/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAYSIDE HEALTH & REHABILITATION CENTER	1004 INDEPENDENCE BLVD VIRGINIA BEACH, VA 23455

(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 333	Continued From page 8	F 333		

*Acarbose is used (with diet only or diet and other medications) to treat type 2 diabetes (condition in which the body does not use insulin normally and therefore cannot control the amount of sugar in the blood) (https://medlineplus.gov/druginfo/meds/a696015.html).

*Capecitabine is in a class of medications called anti-metabolites. It works by stopping or slowing the growth of cancer cells (https://medlineplus.gov/druginfo/meds/a699003.html).

*Carvedilol is used to treat high blood pressure and heart failure (https://medlineplus.gov/druginfo/meds/a697042.html).

*Lexapro is used to treat depression and anxiety (https://medlineplus.gov/druginfo/meds/a603005.html).

*Lisinopril is used to treat high blood pressure (https://medlineplus.gov/druginfo/meds/a692051.html).

*Mobic is used to treat arthritis. It reduces pain, swelling, and stiffness of the joints. Mobic/Meloxicam is known as a nonsteroidal anti-inflammatory drug (NSAID) (http://www.webmd.com/drugs/2/drug-18173/mobic-oral/details). https://medlineplus.gov/druginfo/meds/a601242.html

The Nurse's Notes dated 2/11/14 at 12:44 p.m. indicated the following:
"The signs/symptoms of the changes of condition:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495213	A. BUILDING _____ B. WING _____	C 05/25/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAYSIDE HEALTH & REHABILITATION CENTER	1004 INDEPENDENCE BLVD VIRGINIA BEACH, VA 23455

(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 333	Continued From page 9	F 333		

Abnormal vital signs, functional decline, loss of consciousness. Other change in condition. This started on 2/11/17 during the morning...Assessment (RN)/Appearance (LPN): Vital signs: BP (blood pressure) 116/67-2/11/17 12:48 p.m.-position lying L/arm, P (pulse) 62, R (respiratory) 18.0, T (temperature) 97.1, pulse oximetry 96.0 (95-100=normal-measures arterial oxygen-mayoclinic.org)." The SBAR dated 2/11/17 further indicated: "...Decreased level of consciousness compared to baseline (sleepy/lethargic), increased confusion/disorientation..." The nurse's note and the SBAR (Situation/Situation/Appearance/Review) indicated the physician was called 2/11/17 at 10:00 a.m. and the Resident Representative was notified on 2/11/17 at 10:00 a.m. The physician ordered to monitor the resident's BP every 2 hours times 12 hours, but the physician also ordered the resident be sent to the Emergency Department per request of the family.

The Licensed Practical Nurse (LPN) #2 who wrote the aforementioned nurse's note and completed the SBAR was interviewed on 5/25/17 at 11:20 a.m. The LPN stated on 2/11/17 between 9:30 a.m. and 10:00 a.m., she was approached by LPN #3 (no longer employed by nursing facility) who told her she may have switched the resident's morning medications that resided in the same room. LPN #2 said she confirmed that LPN #3 switched the morning medications for both residents. LPN #2 stated she and another licensed nurse assessed Resident #12 and roommate Resident #13. The LPN stated she called both resident's attending physician, who happened to be the same physician and was given orders to take vital signs every two hours

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495213	A. BUILDING _____ B. WING _____	C 05/25/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAYSIDE HEALTH & REHABILITATION CENTER	1004 INDEPENDENCE BLVD VIRGINIA BEACH, VA 23455

(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 333	Continued From page 10	F 333		

for 12 hours and continue to monitor. According to the LPN, Resident #12 was hypotensive and had a decreased level of consciousness that was different from his baseline compared to previous nurse's notes and staff comments. She said Resident #12 refused his breakfast that morning, which he never did, and heavily slurred his words.

During the above interview, LPN #2 stated she proceeded to call the Director of Nursing (DON) to inform her and make sure she covered all resident needs. She said both of the resident's families were present and Resident #12's family wanted him sent out to the hospital, followed by Resident #13's family also wanting him sent out. According to LPN #2, Resident #12 was sent out via 911. The LPN said she called the ED (Emergency Department), to follow up on Resident #12's condition, and was informed he was admitted to the hospital, but was not told his admitting diagnosis.

Review of the hospital records revealed Resident #12 was seen in the ED on 2/11/17 at 3:57 p.m. The resident was assessed to be lethargic, but could open eyes to verbal/tactile stimuli. The family was at the bedside and stated the resident's lethargy was sudden and not his usual presentation. It was reported from the nursing facility that the resident had received his roommate's medications. The resident's blood pressure was 117/65, pulse 60 and oxygen saturation was 94%. The resident was assessed as confused, with malaise and fatigue. The primary diagnoses was Altered Mental Status with confusion, malaise, fatigue and lethargy secondary to ingesting medications not prescribed for him by a physician. In light of receiving oral anti-hyperglycemic medications, the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495213	A. BUILDING _____ B. WING _____	C 05/25/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAYSIDE HEALTH & REHABILITATION CENTER	1004 INDEPENDENCE BLVD VIRGINIA BEACH, VA 23455

(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 333	Continued From page 11	F 333		

resident's serum glucose level was stable at 104. A routine urinalysis was positive for white blood cells and subsequent urine culture resulted e-coli and the resident was started on antibiotics. The resident was discharged in the care of his family with home health services on 2/14/17.

On 5/24/17 at 4:45 p.m., an interview was conducted with the Administrator, DON (Director of Nursing) and Corporate Nurse. They stated LPN #3 immediately recognized she had switched up both Resident's #12 and #13's morning medications. The DON stated LPN #2 adequately assessed both residents, called physician, obtained orders for each resident and respected the wishes of the families by sending the residents to be evaluated at local EDs. The DON said LPN #3 was suspended pending investigation of the incident, neurological checks were initiated for both residents. LPN #3 was suspended pending full investigation, but independently tendered her resignation. This surveyor asked would a Urinary Tract Infection (UTI) cause the sudden change the staff recognized within the hour of administering the incorrect medications to Resident #12 (hypotension, lethargy, malaise, slurred speech) the Corporate Nurse said, "Not likely."

During the above interview, they further presented their corrective action plan that included the following with a corrective action completion date of 2/22/17:
-100% audit of arm bands, room names and identifying pictures were completed.
-Licensed nurses completed medication pass observations.
-All medication errors for the past year were reviewed to identify any concerns and no trends

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495213	A. BUILDING _____ B. WING _____	C 05/25/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAYSIDE HEALTH & REHABILITATION CENTER	1004 INDEPENDENCE BLVD VIRGINIA BEACH, VA 23455

(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 333	Continued From page 12	F 333		

were noted.
-Education was provided to all licensed nurses on the five rights of medication administration, replacing missing arm band as indicated. (The education was reviewed with original staff sign in sheets).
-Continue medication pass observations on an annual basis and as a part of orientation (must pass prior to working alone on the floor).
-Any nurse who has not had a successful medication pass observation completed within the past year would have the observation done on their next shift worked. (The medication pass observation sheets were reviewed for the five rights, techniques and all medication routes).
-Medication pass observations would be monitored on a random weekly basis to ensure that medications are administered to the correct person.
-Results of the observations and medication error reports would be reviewed by the Physician and the Quality Assurance committee for review and recommendation (ongoing).

Based on the aforementioned interviews with facility staff, review of the corrective action plan and that the deficient practice did not reoccur after 2/22/17 or exist during the current survey, it was determined the facility met Past Non Compliance for this specific regulatory requirement.

The facility's policy and procedures titled "General Dose Preparation and Medication Administration" revised 1/1/13 indicated "...Facility staff should verify that the medication name and dose are correct...identify the resident per facility policy...Verify each time a medication is administered that it is the correct medication, at

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495213	A. BUILDING _____ B. WING _____	C 05/25/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAYSIDE HEALTH & REHABILITATION CENTER	1004 INDEPENDENCE BLVD VIRGINIA BEACH, VA 23455

(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 333	Continued From page 13	F 333		

the correct dose, at the correct route, at the correct rate, at the correct time, for the correct resident..."

2. Resident #13 was administered medications that were ordered for his roommate. The resident required medical intervention at a local hospital emergency department.

Resident #13 was admitted to the nursing facility on 1/24/17 with diagnoses that included but not limited to pneumonia and high blood pressure.

The Admission Minimum Data Set Assessment (MDS) dated 1/31/17 coded Resident #13 with a score of 8 out of a possible score of 15 on the Brief Interview for Mental Status (BIMS) which indicated the resident was moderately impaired in the skills needed for daily decision making. The resident was assessed to require extensive assistance from two staff for be mobility; one staff for toilet use, personal hygiene, dressing and one staff for locomotion on and off the unit with the wheelchair as her primary mode of locomotion. He was totally dependent on one staff for bathing.

The care plan dated 2/1/17 identified limited physical mobility due to decline in Activities of Daily Living (ADL), diabetes mellitus, risk for falls, depression, actively receiving chemotherapy (rectal and renal cancer). The staff were to monitor the resident for episodes of fear, distress, hopelessness and anxiety. They were to administer all medications per physician orders and monitor/document side effects and effectiveness.

Resident #13 had physician orders dated 1/24/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495213	A. BUILDING _____ B. WING _____	C 05/25/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAYSIDE HEALTH & REHABILITATION CENTER	1004 INDEPENDENCE BLVD VIRGINIA BEACH, VA 23455

(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 333	Continued From page 14	F 333		

for *Acarbose 50 milligram (mg) one tablet for diabetes mellitus to lower blood sugar, *Capecitabine 500 mg three tablets to treat cancer, *Carvedilol 3.125 mg one tablet to treat high blood pressure, *Lexapro 20 mg to treat depression, *Lisinopril 2.5 mg to treat high blood pressure and *Mobic 7.5 mg to treat arthritis.

*Acarbose is used (with diet only or diet and other medications) to treat type 2 diabetes (condition in which the body does not use insulin normally and therefore cannot control the amount of sugar in the blood) (https://medlineplus.gov/druginfo/meds/a696015.html).

*Capecitabine is in a class of medications called anti-metabolites. It works by stopping or slowing the growth of cancer cells (https://medlineplus.gov/druginfo/meds/a699003.html).

*Carvedilol is used to treat high blood pressure and heart failure (https://medlineplus.gov/druginfo/meds/a697042.html.)

*Lexapro is used to treat depression and anxiety (https://medlineplus.gov/druginfo/meds/a603005.html).

*Lisinopril is used to treat high blood pressure (https://medlineplus.gov/druginfo/meds/a692051.html).

*Mobic is used to treat arthritis. It reduces pain, swelling, and stiffness of the joints. Mobic/Meloxicam is known as a nonsteroidal anti-inflammatory drug (NSAID)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495213	A. BUILDING _____ B. WING _____	C 05/25/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAYSIDE HEALTH & REHABILITATION CENTER	1004 INDEPENDENCE BLVD VIRGINIA BEACH, VA 23455

(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 333	Continued From page 15	F 333		

(http://www.webmd.com/drugs/2/drug-18173/mobic-oral/details). https://medlineplus.gov/druginfo/meds/a601242.html

On 2/11/17 during the morning medication pass at 9:00 a.m., Resident #13 was not administered the physician ordered morning medications Acarbose, Capecitabine, Carvedilol, Lexapro, Lisinopril and Mobic at 9:00 a.m. on 2/11/17, but instead was administered his roommate's 9:00 a.m. medications: *Amiodarone HCL (to treat irregular heart rhythms) tablet 200 milligrams (mg) and *Fludrocortisone Acetate (to increase blood pressure) tablet 0.1 mg tablet to be administered every day at 9:00 a.m.

*Amiodarone HCL is used to treat life threatening heart arrhythmia problems called ventricular arrhythmias (www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0000087/).

*Fludrocortisone is used to increase blood pressure(www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0000087/).

The Nurse's Notes dated 2/11/14 at 1:18 p.m. indicated the physician was called because Resident #13 did not receive his ordered morning medications, but medications that were ordered for his roommate. The licensed nurse also completed a SBAR (Situation/Situation/Appearance/Review) because of the medication error. The resident's vital signs were: BP 108/67, P 59, R 18, the resident already had oxygen at 2 liters/minute via nasal cannula for the treatment of pneumonia. The physician was called on 2/11/17 at 10:00 a.m. and no

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495213	A. BUILDING _____ B. WING _____	C 05/25/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAYSIDE HEALTH & REHABILITATION CENTER	1004 INDEPENDENCE BLVD VIRGINIA BEACH, VA 23455

(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 333	Continued From page 16	F 333		

further orders were given at the time.

The Licensed Practical Nurse (LPN) #2 who wrote the aforementioned nurse's note and completed the SBAR was interviewed on 5/25/17 at 11:20 a.m. The LPN stated on 2/11/17 at between 9:30 a.m. and 10:00 a.m., she was approached by LPN #3 (no longer employed by nursing facility) who told her she may have switched the resident's morning medications that resided in the same room. LPN #2 said she confirmed that LPN #3 switched the morning medications for both residents. LPN #2 stated she and another licensed nurse assessed Resident #13 and roommate Resident #12. The LPN stated she called both resident's attending physician, who happened to be the same physician, and no further orders were given for Resident #13. She stated the staff continued to monitor the resident's vital signs and mental status.

During the above interview, LPN #2 stated she proceeded to call the Director of Nursing (DON) to inform her and make sure she covered all resident needs. She said both of the resident's families were present and Resident #12's family wanted him sent out to the hospital, followed by Resident #13's family also wanting him sent out. According to LPN #2, Resident #13 was sent out via non-emergent medical transport. The LPN said she called the ED, to follow up on Resident #13's condition, and was informed he was evaluated, treated and after monitoring in the ED was discharged home with family and home health.

Review of the hospital records revealed Resident #13 was seen in the ED on 2/11/17 at 3:09 p.m.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495213	A. BUILDING _____ B. WING _____	C 05/25/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAYSIDE HEALTH & REHABILITATION CENTER	1004 INDEPENDENCE BLVD VIRGINIA BEACH, VA 23455

(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 333	Continued From page 17	F 333		

The resident was assessed with nausea, dry heaving and vomiting, as well as a preexisting condition of shortness of breath and pneumonia which was his diagnosis upon admission to nursing facility. The ED diagnosed Resident #13 with accidental medication error with nausea and vomiting. The resident's condition did not require admission to the hospital. The resident received intravenous fluids, was treated for the nausea and vomiting and discharged with family and home health. The ED notes indicated the resident required more skilled care, but the family refused to send the resident back to the nursing facility and opted for rehabilitation via home health.

On 5/24/17 at 4:45 p.m., an interview was conducted with the Administrator, DON and Corporate Nurse. They stated LPN #3 immediately recognized she had switched up both Resident's #12 and #13's morning medications. The DON stated LPN #2 adequately assessed both residents, called physician, obtained orders for each resident and respected the wishes of the families by sending the resident's to be evaluated at local EDs. The DON said LPN #3 was suspended pending investigation of the incident, neurological checks were initiated for both residents. LPN #3 was suspended pending full investigation, but independently tendered her resignation.

During the above interview, they further presented their corrective action plan that included the following with a corrective action completion date of 2/22/17:
-100% audit of arm bands, room names and identifying pictures were completed.
-Licensed nurses completed medication pass observations.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495213	A. BUILDING _____ B. WING _____	C 05/25/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAYSIDE HEALTH & REHABILITATION CENTER	1004 INDEPENDENCE BLVD VIRGINIA BEACH, VA 23455

(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 333	Continued From page 18 -All medication errors for the past year were reviewed to identify any concerns and no trends were noted. -Education was provided to all licensed nurses on the five rights of medication administration, replacing missing arm band as indicated. (The education was reviewed with original staff sign in sheets). -Continue medication pass observations on an annual basis and as a part of orientation (must pass prior to working alone on the floor). -Any nurse who has not had a successful medication pass observation completed within the past year would have the observation done on their next shift worked. (The medication pass observation sheets were reviewed for the five rights, techniques and all medication routes) -Medication pass observations would be monitored on a random weekly basis to ensure that medications are administered to the correct person. -Results of the observations and medication error reports would be reviewed by the Physician and the Quality Assurance committee for review and recommendation (ongoing). Based on the aforementioned interviews with facility staff, review of the corrective action plan and that the deficient practice did not reoccur after 2/22/17 or exist during the current survey, it was determined the facility met Past Non Compliance for this specific regulatory requirement.	F 333		