PRINTED: 07/06/2017
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495086	A. BUILDING _____ B. WING _____	R 06/22/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED TCC AND REHABILITATION-BAY POINTE	1148 FIRST COLONIAL RD VIRGINIA BEACH, VA 23454

(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	{F 000}		

An unannounced Medicare/Medicaid revisit to a Federal Comparative Survey conducted May 8, 2017 through May 12, 2017 was conducted 6/20/17 through 6/22/17. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care Requirements. Uncorrected deficiencies are identified within this report. Corrected deficiencies are identified on the CMS 2567-B. Two complaints were investigated during the survey.

The census in this 112 certified bed facility was 79 at the time of the survey. The survey sample consisted of 10 current Resident reviews (Residents #101 through #109 and Resident #111) and 1 closed record reviews (Residents #110).

{F 323} SS=D	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES	{F 323}	

(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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Nicole Gilley	Executive Director	7/7/2017

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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from bed rails prior to installation.

(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain 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 observation, resident interview, staff interview, facility documentation review, clinical record review, and in the course of a complaint investigation, the facility staff failed to provide adequate supervision to prevent an injury that required an Emergency Room visit related to an elopement for 1 Resident of 11 Residents in the survey sample (Resident #110).

Resident #110 exited the facility and was located 19 hours later by the police and required an Emergency Room Evaluation.

The findings included:

Resident #110 was admitted to the facility on 11/15/14. Diagnoses for Resident #110 included but are not limited to Alzheimer's Disease*, Schizophrenia*, and Vision Loss.

Resident #110's Quarterly Minimum Data Set (MDS - an assessment protocol) with an Assessment Reference Date of 4/24/17 coded Resident #110's BIMS (Brief Interview for Mental Status) score of 13 out of 15 indicating no cognitive impairment.

In addition, the Quarterly MDS coded Resident

Past noncompliance: no plan of correction required.

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#110 as being independent in walking and as requiring supervision and set up help for Locomotion off the unit. Resident #110 required Supervision with one staff person assist for Toilet use.

A 4/24/17 Unsafe Wandering Risk Evaluation documented Resident #110 not to be at risk for wandering.
Upon Resident #110's return from leaving the facility and Emergency Room evaluation and treatment, a 5/4/17 Unsafe Wandering Risk Evaluation form found Resident #110 to be at Risk for Elopement. The Facility Placed a Wander Guard on Resident #110 in addition to one to one supervision.

Resident #110's 11/8/16 Care Plan documented a focus area of Dementia in Alzheimer's Disease with early onset without behavior disturbance. Interventions included but not limited to: reorient him from time to time. In addition the Care Plan also documented another focus of Resistive to Care related to cognitive deficit. Interventions included: Administer and monitor the effectiveness and side effects of medications as ordered, Educate of possible outcomes of not complying with treatment of care.

Review of the Facility Reported Incident form and attached Timeline, documented Resident #110 on 5/3/17 was identified as missing from the facility at approximately 7:00 p.m. After an unsuccessful search of the Facility and Grounds, Police were called to continue search for the missing Resident. In a joint meeting and phone calls of Facility Administration and the Police, the Resident's Physician and Responsible Party were

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notified.

Review of the Facility Camera indicated Resident #110 was last seen by staff at 18:29 (6:29 p.m.) and exited the building at 18:36 (6:36 p.m.)

Continued review of the Facility Reported Incident and attached timeline documented that Resident #110 was not located until the following day 5/4/17 by the Police at 1:48 p.m. (approximately 19 hours from when the Resident left the Facility unsupervised).

Review of 5/4/17 Emergency Room Records documented the following:
58 year old male with history of dementia found wandering, small laceration of forearm.
Patient unable to tell how his forearm was injured.
Wound oozing despite pressure.
One suture place for hemeostasis with success.
Tetanus updated.
Laceration Left forearm, length 2 millimeters long
Oriented to self only
Resident was discharged home to the Nursing Facility. (Timeline documented that the Facility Social Worker accompanied the Resident back to the Facility).

A Google map check of location of the Nursing Facility and intersection of roads that Resident #110 was located documented the distance to be approximately 7.7 miles. It is not known how Resident #110 traveled this area.

An interview on 6/22/17 at approximately 1:25 p.m., with the Social Worker who accompanied the Resident from the Emergency Room to the facility was conducted. She stated the Resident said he just went for a walk and got turned

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around.

Resident #110's guardian was called and interviewed on 6/22/17 at approximately 3:30 p.m. The Guardian stated the story of Resident #110's elopement essentially as documented above. The Surveyor was unable to interview Resident #110 as the Guardian reported that he died 6/20/17 in the group home.

During an interview with the Facility Administrator, Director of Nursing and Corporate RN, on 6/22/17 at approximately 4:00 p.m., an Action Plan was presented and discussed.
The Action Plan's date of correction was 5/4/17: Resident #110 placed on 1:1 supervision, then q 2 hour (every 2 hour) checks, elopement assessment completed, wanderguard in place, care plan updated, observe for changes in behavior, staff education on missing residents, resident picture book added to elopement book, discharge process explained to resident

All residents with identified exit seeking/wandering behavior have potential to be affected; all resident at time of admission and when identified with significant change in condition will be assessed for risk of elopement/wandering; Identified residents will have code alert bracelet applied, picture will be in wan/elopement risk binders, resident's care plan updated to reflect potential

Systemic changes; any resident identified exit seeking behavior or attempts of elopement will be reported to DNS (Director Nursing Services) and ED (Executive Director), Observe for exit seeking behaviors, Resident will be located on 2nd floor, Resident will be placed on 1:1 supervision for 48

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hours or as determined by physician, resident will be on 24 hour shift report for 72 hours, new behavior assessment will be completed by Social Worker, care plan will be reviewed and revised as indicated. resident will be assessed to determine need for further health care needs or memory unit for exit seeking behaviors.

Monitoring of the change to sustain system compliance ongoing: Monthly QAPI meeting will review elopements, if any occurred and make recommendations to assure compliance to maintain ongoing. QAPI Committee will determine need for further intervention and monitoring beyond 3 months to assure compliance is sustained ongoing.

The survey team reviewed this plan of action, as well as the credible evidence documenting the implementation of this plan. The survey team identified no concerns related to this implementation. Additionally, no concerns were identified related to any further elopements in the facility

This citation is cited as past noncompliance.

The facility administration was informed of the findings during a briefing on 6/22/17 at approximately 4:45 p.m. The facility did not present any further information about the findings.

COMPLAINT DEFICIENCY PAST NON COMPLIANCE

(F 371) 483.60(i)(1)-(3) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY
SS=D

(F 323)

(F 371)

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1. All sandwiches were discarded in the garbage receptacle. Date removed from tray and discarded. 6/23/17
2. All residents have the potential to be affected. 6/23/17
3. Dietary staff in-serviced and competency evaluation completed by Registered Dietitian regarding labeling, dating, and use by date of foods. Registered Dietitian or designee will audit prepared resident lunches 3X/week for 12 weeks. Results of audit will be reviewed by Quality Assurance committee for recommendations. 6/23/17
4. Results of audits will be presented to QAPI committee for review and recommendations of changes and further need for auditing beyond the 12 weeks to assure compliance ongoing. 6/23/17

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(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities.

(i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.

(ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices.

(iii) This provision does not preclude residents from consuming foods not procured by the facility.

(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.

(i)(3) Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption.
This REQUIREMENT is not met as evidenced by:
Based on observations, staff interviews, and facility document review it was determined that the facility staff failed to ensure that food was stored, dated and discarded in a sanitary manner as evidenced by four prepared resident lunches not dated and one prepared resident lunch out of date in the walk-in refrigerator on 6/20/17 during a revisit survey.

The findings included:

On 6/20/17 at 12:25 p.m. a kitchen inspection was completed with the Dietary Manager. In the

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walk-in refrigerator to the left near the doorway a tray on a cart was observed with a yellow sticky note attached with the following date range noted in black bold ink, 6/12/17 - 7/12/17. On top of the tray were 5 small brown paper prepared lunch bags. The surveyor asked what were the prepared lunch bags. The Dietary Manager stated, "They are lunches made up for the residents who go out to appointments and dialysis." The five lunch bags were inspected: bag number 1 had an egg salad sandwich, 2 juices, and a cookie. The bag was not dated but the egg salad sandwich revealed the following date range, 6/12/17-6/13/17. The 4 other prepared lunch bags contained a bologna and ham sandwich, 2 juices and a cookie. There was no date on the outside or on the inside on the sandwiches of the 4 prepared brown bag lunches. The Dietary Manager called the Dietary Aide over and asked her if she made the sandwiches. The Dietary Aide stated, "Yes, I made them." The surveyor asked which lunches did you make? The Dietary Aide stated, "I made the ham and bologna ones." The surveyor then asked, "What about the lunch with the egg salad sandwich?" The Dietary Aide stated, "No, that one was already in here; I didn't make that one. Surveyor asked the Dietary Aide when had she made the 4 prepared lunches and if she had put the yellow sticky note with the date range of 6/12/17-7/12/17. The Dietary Aide stated, "I made them a few days ago, I don't remember the exact day but it was a few days ago. No, the sticker was already there I guess I should have change it or maybe wrote the date on the sandwiches." The surveyor asked the Dietary Manager if sandwiches are good for a month. The Dietary Manager stated, "I wouldn't think so, I should have labeled the sandwiches themselves."

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On 6/20/17 at 5:45 p.m. an interview was conducted with the facility Dietician and she was asked how long sandwiches where good for after prepared. The Dietician stated, "Sandwiches are good for three days."

The facility policy titled, "Food Storage Guidelines" initial date 9/4/12 is documented in part, as follows:

This document provides guidelines for best product quality and assumes proper food handling.

The time limits for refrigeration will keep refrigerated foods from spoiling or becoming dangerous to eat.

Page 8:

Deli Salads: Store-prepared (or homemade) egg, chicken, ham, tuna, macaroni salads=3 to 5 days.

Luncheon meats: opened package 3 to 5 days.

Prior to exit the above information was shared with the Administrator and the Director of Nursing no further documentation was provided by the facility.

(F 372) 483.60(i)(4) DISPOSE GARBAGE & REFUSE PROPERLY
SS=F

(i)(4)- Dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by:
Based on observations, staff interviews, and facility document review it was determined that

(F 371)

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1. Identified trash picked up and discarded in garbage receptacle. 6/23/17
2. All residents have the potential to be affected. 6/23/17
3. (A)Facility removed overgrown bushes, shrubbery, tree limbs and branches that would contain or trap debris on the grounds. (B)Facility posted the following signs for staff, vendors, and visitors "Do not litter" and, "No smoking on property". Staff educated about the Proper disposal of garbage and refuse; that all employees are responsible for keeping facility grounds trash free, not to litter, and not to smoke on facility property or leave cigarette butts on center grounds. (C) Commercial outdoor trash receptacles on order for entrance points of facility to provide a place to properly dispose of trash. (D) Maintenance Director or designees will audit facility grounds for trash and dispose of it appropriately 5 times per week for 12 weeks for 12 weeks. Results of audit will be reviewed by Quality Assurance Committee for recommendations. 6/23/17
4. Results of audits will be presented to the QAPI committee for review and recommendations of any changes and further need for auditing beyond the 12 weeks to assure compliance ongoing. 6/23/17

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the facility staff failed to ensure garbage and refuse was stored properly on 6/20/17 during a revisit survey.

The findings included:

On 6/20/17 at 2:15 p.m. this surveyor made rounds of the facility grounds and the following observations were made.

1. Ten (10) cigarette butts were observed on the ground at the corner of the food service entrance.

2. Four (4) cigarette butts were observed on the ground at the light green facility dumpster.

3. At the ambulance entrance walkway a purple glove was observed on the cement near a table. A 2 inch shard of dark brown glass was observed at the edge of the walkway. One empty plastic Albuterol Sulfate Inhalation Solution ampule and one (1) 30 milliliter medicine cup in mulch along walkway.

4. On the left side of the building near the facility entrance an empty 24 ounce can of beer was lying in the grass.

5. On the left side of the building from the door to the resident garden area four (4) small white plastic trash bags and a large white piece of paper was noted on the facility grounds.

On 6/20/17 at 2:40 p.m. the facility Director of Maintenance was made aware of the garbage and refuse observed by the surveyor during the outside grounds observation. The Director of Maintenance stated, "The lawn maintenance crew comes weekly and are supposed to pick up any

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debris. Dietary is responsible daily for any debris at the dumpsters, and Housekeeping is responsible daily to check the exterior of the building for any debris. I also make rounds."

The facility policy titled "General Environmental Condition" released 2/1/17 is documented in part, as follows:

Policy: A safe, functional, sanitary, and comfortable environment is provided for patients, staff, and the public.

Procedure: 7. Plant operation or maintenance services are provided to maintain the inside and outside of the building, as necessary.

Prior to exit the above information was shared with the Administrator and the Director of Nursing no further documentation was provided by the facility.