ate of Virginia

TEMENT OF DEFICIENCIES PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495395	A. BUILDING _____ B. WING _____	02/04/2016

AME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBOR'S EDGE	ONE COLLEY AVENUE NORFOLK, VA 23510

(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) COMPLETE DATE
F 000	Initial Comments An unannounced Medicare/Medicaid standard survey and biennial State Licensure Inspection was conducted 02/02/16 through 02/04/16. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements and Virginia Rules and Regulations for the Licensure of Nursing Facilities. The Life Safety Code survey/report will follow. No complaints were investigated during the survey. The census in this 33 certified bed facility was 33 at the time of the survey. The survey sample consisted of 9 current Resident reviews (Residents #1 through #9) and 1 closed record review (Resident #10).	F 000		
F 001	Non Compliance The facility was out of compliance with the following state licensure requirements: This RULE: is not met as evidenced by: The facility was not in compliance with the following Virginia Rules and Regulations for the Licensure of Nursing Facilities: Nursing Services 12 VAC 5-371-220 (A). Cross-Reference to F-329. Dietary and food service program 12 VAC 5-371-340 (A). Cross-Reference to F-371. Pharmaceutical Services 12 VAC 5-371-300 (H). Cross-Reference to F-428.	F 001	See POC under F-329 See POC under F-371 See POC under F-428	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Colleen M O'Malley	Administrator	2-25-16

ate of Virginia

TEMENT OF DEFICIENCIES PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495395	A. BUILDING _____ B. WING _____	02/04/2016

AME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBOR'S EDGE	ONE COLLEY AVENUE NORFOLK, VA 23510

(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) COMPLETE DATE
F 001	Continued From Page 1 Pharmaceutical Services 12 VAC 5-371-300 (B). Cross-Reference to F-431.	F 001	See POC under F-431	

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
	495395	A. BUILDING _____ B. WING _____	02/04/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARBOR'S EDGE	ONE COLLEY AVENUE NORFOLK, VA 23510

(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 standard survey was conducted 02/02/16 through 02/04/16. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. No complaints were investigated during the survey.

The census in this 33 certified bed facility was 33 at the time of the survey. The survey sample consisted of 9 current Resident reviews (Residents #1 through #9) and 1closed record review (Resident #10).

F 329 SS=E 483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS

Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.

Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.

F 329

1.No resident was adversely affected from the deficient practice. Resident #3 – Physician made aware of the deficient practice and instructed on the necessity of starting a Gradual Dose Reduction for this resident. Resident #1 – Order obtained and Ativan was discontinued.
2.Current residents with orders for psychotropic medications audited to determine how long order has been in place, to identify if there have been any behaviors, and to identify the frequency of its usage.
3.psychoactive medications will be identified through monthly pharmacy reports. A psychoactive drug report will be obtained weekly for the next five weeks and each resident will be reviewed for possible dose reduction or discontinuation of the medication. These residents will be reviewed for any behaviors, frequency of the use of the medication, and to ensure that there are non-pharmacological interventions are in place. Care plans will also be audited to identify non-pharmacological interventions are documented.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	Administrator	2-25-16

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
	495395	A. BUILDING _____ B. WING _____	02/04/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARBOR'S EDGE	ONE COLLEY AVENUE NORFOLK, VA 23510

(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 329	Continued From page 1	F 329		

This REQUIREMENT is not met as evidenced by:
Based on observation, clinical record review and staff interview it was determined for two of ten residents in the survey sample that facility staff failed to assure Resident #3 had target behaviors warranting use of an antipsychotic and for Resident #1 failed to assure non pharmalogical interventions were tried prior to the use of an antianxiety medication.

1. Resident #3 did not have documented target behaviors warranting the use of the antipsychotic Zyprexa.

2. Resident #1 did not have non-pharmacological (non-drug) interventions prior to the administration of an antianxiety medication (Ativan).

The findings included:

1. Resident #3 was originally admitted to the facility on 7/2/10. Resident #3 was 89 years old at the time of the survey and had diagnoses that included malnutrition, weight loss, "weakness", history of a fractured arm and knee, macular degeneration (eye disease), chronic obstructive pulmonary disease (COPD) and dementia. The quarterly 9/16/15 Minimum Data Set evidenced a Brief Interview for Mental Status (BIMS) evidenced a score of 8 of 15 indicating moderate cognitive impairment. The 12/10/15 comprehensive MDS evidenced the resident's

. Physicians will be educated on the importance of GDRs and that supporting documentation/diagnoses are in place that warrant the use of these medications. Nurses will also be educated on the importance of documenting behaviors as they occur.
4.A psychoactive drug report will be obtained weekly for the next five weeks and each resident will be reviewed for possible dose reduction or discontinuation of the medication. These residents will also be reviewed for any behaviors, frequency of the use of the medication, and to ensure that there are non-pharmacological interventions are in place.
5.Date of Compliance: 3/10/2016

EPARTMENT OF HEALTH AND HUMAN SERVICES
ENTERS FOR MEDICARE & MEDICAID SERVICES

ITEMENT OF DEFICIENCIES D PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495395	A. BUILDING _____ B. WING _____	02/04/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARBOR'S EDGE	ONE COLLEY AVENUE NORFOLK, VA 23510

(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 329	Continued From page 2	F 329		

cognitive status had declined to 6 of 15 indicating severe impairment. The MDS evidence that the resident had verbal behaviors directed toward others four to six days of the seven day assessment period. Review of the 3/28/15 significant change MDS evidenced that she had the same verbal behaviors directed toward others.

The resident's functional status (assistance with activities of daily living) has remained static (assistance of one person) except for dressing now requiring extensive assistance of one person.

The resident was admitted to the hospital in January 2016 for exacerbation of her COPD.

During the initial tour (noon on 2/2/16) the resident was seated in the restorative dining room. Resident #3 called out to the surveyor stating that we had met and she knew the surveyor. Within minutes of talking, the resident asked who the surveyor was and stated that we had not met. Her lunch was untouched except for the pudding and ice tea.

Later that day (2:30 pm) the resident was observed across from the nursing station her confusion was obvious as she was asking where she should go and what she should do. The resident however knew she did not have her glasses on and requested that the staff get them for her. Resident #3 appeared eager for conversation and would engage anyone who passed by her.

On the afternoons of 2/3 and 2/4/16 the resident was observed in the same spot in front of the

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
	495395	A. BUILDING _____ B. WING _____	02/04/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARBOR'S EDGE	ONE COLLEY AVENUE NORFOLK, VA 23510

(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 329	Continued From page 3	F 329		

nursing station and across from the elevators. This appeared to be her "spot" and there was almost constant staff and visitors to occupy Resident #3's attention. The resident's preference for this spot is part of her current care plan.

Review of the clinical record evidenced that the resident was receiving 2.5 mg (milligrams) of Zyprexa. The same dose of Zyprexa was discontinued in March of 2015 and restarted 4/27/15.

Review of nursing notes evidenced that on several occasions (4/9 and 4/22/15) the resident insulted visitors. On 4/20/15 the attending physician documented, "approached by staff due to pt's (patient's) agitation related to interaction with visitors to facility. On multiple occasions has insulted and degraded. Unable to redirect - worse as the day progresses.....will start low dose of Zyprexa to attempt to control agitation to improve QDL (quality of life) of patient and community."

On 4/28/15 the pharmacist in his monthly review documented, "Resumed Zyprexa 2.5 mg hs (bedtime). Insulted visitors on several occasions. Refer to guidelines for use of antipsychotic." The pharmacist was referring to the Centers for Medicare and Medicaid's (CMS) guidelines for the use of antipsychotic medications in persons with the diagnoses of dementia.

Behavioral or Psychological Symptoms of Dementia (BPSD) Antipsychotic medications are only appropriate for elderly residents in a small minority of circumstances (unless the antipsychotic is prescribed to treat previously

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
	495395	A. BUILDING _____ B. WING _____	02/04/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARBOR'S EDGE	ONE COLLEY AVENUE NORFOLK, VA 23510

(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 329	Continued From page 4	F 329		

diagnosed mental illness such as schizophrenia or possibly other conditions listed above). All antipsychotic medications carry a Food and Drug Administration (FDA) Black Box Warning. Since June 16, 2008, FDA warned healthcare professionals that both conventional and atypical antipsychotics are associated with an increased risk of death in elderly patients treated for dementia-related psychosis. Addition information is available at: http://www.fda.gov/Drugs/default.htm. (A black box warning means that medical studies indicate that the drug carries a significant risk of serious or even life-threatening adverse effects. It is the strongest warning that the U.S. Food and Drug Administration can require a pharmaceutical company to offer.)

The guidelines continue that the use of antipsychotic medications should be used to address specific behaviors or target behaviors (biting, kicking, scratching) which cause residents to present a danger to themselves or others, or interfere with the staff's ability to provide care. The behaviors cause an impairment in the resident's functional capacity.

In May and September 2015 the pharmacist requested the physician to provide a diagnosis for the use of the Zyprexa. In response to the September 2015 request the Nurse Practitioner documented behavioral or psychological symptoms of dementia. No additional information such as the target behavior, or goal was provided.

Review of the care plan evidenced a problem of "MOOD", with restlessness, anxiety and repetitive

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
	495395	A. BUILDING _____ B. WING _____	02/04/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARBOR'S EDGE	ONE COLLEY AVENUE NORFOLK, VA 23510

(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 329	Continued From page 5	F 329		

statements. The goal was to have a decrease in the next 90 days. The goal was continued on 7/13/15, 9/23/15, 12/21/15 and in place until 3/9/16. The staff was to determine additional causes of mood disorder, consult Psych resources for recommendations or obtain a referral to Psychiatric services as needed. An additional problem of behaviors was included, the care plan was reviewed at the intervals above but the behaviors were not documented. Another problem was her psychoactive medication (Zyprexa) because of a history of aggression and agitation. One approach was to assess for appropriateness of non pharmalogical interventions for behavior symptom relief and administer all medications per physician orders.

During an interview with the Administrator and the Director of Nurses on 2/4/16 (4 pm) the DON was asked if there was documentation that any of the above had been completed, if the target behavior had been identified and the effectiveness of the drug assessed, no information could be provided.

2. For Resident #1 the facility staff failed to implement non-pharmacological interventions prior to administering a PRN (as needed) antianxiety medication-Ativan.

Resident #1 was originally admitted to the facility on 01/10/14 and the most recent re-admission was 05/17/14. Diagnoses included but were not limited to Multiple Sclerosis (an unpredictable, degenerative often disabling disease of the central nervous system that disrupts the flow of information within the brain), Hypertension, Anxiety, Depression and Dementia.

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
	495395	A. BUILDING _____ B. WING _____	02/04/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARBOR'S EDGE	ONE COLLEY AVENUE NORFOLK, VA 23510

(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 329	Continued From page 6	F 329		

Review of the resident's clinical record revealed a Comprehensive Significant Change MDS (minimum data set-an assessment protocol) with an ARD (assessment reference date) of 06/10/15. The most recent MDS was a Quarterly with an ARD of 12/03/15. The resident's BIMS (brief interview for mental status) score was a 9 out of possible 15 which indicated the resident was moderately cognitively impaired resulting in poor safety decisions. Further review noted the resident was totally dependent on one staff member for bed mobility, transferring to different surfaces toileting and bathing. It was further noted the resident did not walk or self propel a wheelchair for locomotion throughout her room and the unit. The resident was coded as requiring extensive assistance to perform personal hygiene and required supervision and set up for eating. Due to the diagnosis of neurogenic bladder the resident required a foley catheter to control urine and was occasionally incontinent of bowel.

Review of Resident #1's POS (physician order sheet) revealed a physician validated order dated 07/31/15, for Lorazepam (Ativan-a sedative, hypnotic antianxiety medication) 1 mg (milligram) tablet. The order noted: "One tablet by mouth every 6 hours as needed."

Review of the resident's MAR (medication administration record) from 11/2015 to current noted the resident received the aforementioned medication on the following dates:
11/12/15 at 10:40 p.m.-anxiety. No non-pharmacological interventions attempted prior to administration-no results noted.
11/14/15 at 10:45 p.m.-increased anxiety. No non-pharmacological interventions attempted

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
	495395	A. BUILDING _____ B. WING _____	02/04/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARBOR'S EDGE	ONE COLLEY AVENUE NORFOLK, VA 23510

(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 329	Continued From page 7	F 329		

prior to administration-no results noted.
12/16/15 at 9:16 p.m.-increased anxiety. No non-pharmacological interventions attempted prior to administration.
12/27/15 at 9:40 a.m.-increased anxiety. No non-pharmalogical interventions attempted prior to administration.
01/01/16 at 11:30 p.m.-increased anxiety. No non-pharmalogical interventions attempted prior to administration.
01/13/16 at 4:15 p.m.-increased anxiety. No non-pharmalogical interventions attempted prior to administration.
01/13/16 at 11:00 p.m.-increased anxiety. No non-pharmalogical interventions attempted prior to administration.
01/24/16 at 9:30 a.m.-increased anxiety. No non-pharmalogical interventions attempted prior to administration.
01/24/16 at 9:00 p.m.-increased anxiety. No non-pharmalogical interventions attempted prior to administration.
01/31/16 at 11:00 p.m.-increased anxiety. No non-pharmalogical interventions attempted prior to administration.

Review of the resident's care plan noted the following:
Problem: Resident has episodes of anxiety and receives prn (as needed) medication as ordered 06/11/15.
Goals: Episodes of anxiety will decrease and resident will be free from side effects of med thru the next review. Goal date: 9/16/15; 12/07/15; 03/07/16.
Approaches: Attempt to calm resident when agitated and allow her to vent her feelings. Provide a calm quiet environment. Administer med as ordered. Monitor the effectiveness of

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
	495395	A. BUILDING _____ B. WING _____	02/04/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARBOR'S EDGE	ONE COLLEY AVENUE NORFOLK, VA 23510

(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 329	Continued From page 8 med and notify MD (doctor) of any noted side effects. Review of nursing notes for the dates of the aforementioned administered medication did not document if any non-pharmacological interventions had been attempted prior to the resident receiving the antianxiety as needed medication Ativan. An interview was conducted on 02/04/16 at approximately 9:45 a.m., with the ADON (assistant director of nursing). When asked about the non-pharmological interventions used prior to the administration of the PRN (as needed) Ativan she stated: "If any non-pharmacological interventions had been tried prior to giving the medication it should have been documented in the nursing notes or on the MAR (medication administration record) if anything has been tried. When the ADON was informed that no documentation could be found regarding the non-pharmacological interventions prior to administering the PRN Ativan she stated: "Oh. I will also review the record and see if I can find any documentation." Administration which consisted of the Administrator and the DON were informed of the findings at a briefing on 02/04/16 at approximately 5:09 p.m. No additional information was submitted for consideration.	F 329		
F 365 SS=D	483.35(d)(3) FOOD IN FORM TO MEET INDIVIDUAL NEEDS Each resident receives and the facility provides food prepared in a form designed to meet individual needs.	F 365	1.No resident was adversely affected from the deficient practice. Resident # 4 pureed meals were prepared to pudding consistency as per our policy. Resident was assessed for weight loss and his weight was maintained.	

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
	495395	A. BUILDING _____ B. WING _____	02/04/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARBOR'S EDGE	ONE COLLEY AVENUE NORFOLK, VA 23510

(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 365	Continued From page 9	F 365		

This REQUIREMENT is not met as evidenced by:
Based on observation and staff interview it was determined food was not prepared in a form to meet the needs of Resident #4. The dietary staff were unable to provide a recipe for pureed diets and the dietary aide pureed the food in the pantry kitchen without direction.

The findings included:

Resident #4 was a 93 year old male who was originally admitted to the facility on 07/07/2011. Diagnoses included but were not limited to Dementia, Asbestosis, a history of a CVA (stroke) resulting in Dysphagia (difficulty in swallowing), Hypertension and CAD (coronary artery disease).

Review of the resident ' s clinical record revealed a Significant Change Comprehensive MDS (minimum data set-an assessment protocol) with an ARD (assessment reference date) of 01/15/16. The resident was coded as having short and long-term memory loss and rarely or ever made decisions regarding his ADLs (activities of daily living). Further review noted the resident was totally dependent on one staff member for bed mobility, locomotion, dressing, eating, personal hygiene and bathing. Further review noted the resident was also incontinent of bladder and bowel. The resident required the use of a mechanical lift with two staff members for transferring to and from different surfaces. The resident was also coded as requiring a pureed diet with nectar thick liquids.

In an interview with the dietary manager on 2/3/16

Dietary staff have been in-serviced on proper consistency for pureed foods, as well as where to find recipes and directions for pureed diets. This in-service will be added into the rotation of periodic in-services for dietary staff.
2.An audit of all residents receiving pureed diets was conducted to ensure meals were being prepared to pudding thick as per our policy.
3.Dietary staff has been in-serviced on proper consistency for pureed foods, as well as where to find recipes and directions for pureed diets and our policies and procedures on diet textures.
4.Dietary Manager or designee will conduct audits 3 times a week for the next 4 weeks and then randomly for the next 2 months to verify the consistency of food.
5.Compliance date 3/15/16

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
	495395	A. BUILDING _____ B. WING _____	02/04/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARBOR'S EDGE	ONE COLLEY AVENUE NORFOLK, VA 23510

(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 365	Continued From page 10	F 365		

at approximately 5:00 pm evidenced that there was only one resident on a pureed diet.

The preparation of the puree meal was observed on the evening of 2/3/16. The mashed potatoes being served were used for the pureed starch and placed in a divided plate. The mashed potatoes retained the scoop shape when plated. The dietary aide then placed several pieces of chicken fried steak into the Ninja blender added hot water and thickener. When asked how he knew how much water and thickener to add, he pointed to a line on the blender and stated, " if I am making one portion I fill to here (pointing again)- is two servings." When placed in the divided plate the mixture was soupy and filled the divided section.

The vegetable being served was a spinach souffle and the same process was followed with adding hot water and thickener. However, the dietary aide was not satisfied with the consistency and went back and added more thickener. The spinach was also soupy and spread out to the limits of the divided section. The plate was then covered and placed in the warmer.

The surveyor then observed as the residents in the dining area were served and several plates were prepared for delivery to resident rooms. The dietary manager (DM) was asked if he had a "spread sheet" or amounts to use for speech diets. The DM did not know if one was available. The dietary aide knew that the spread sheet was available in the kitchen. The spread sheet details the amount for regular diets or therapeutic diet the amount to be provided such as a half a cup, 2 ounces, or one slice/serving (bread/biscuit).

During an interview with the Administrator and the

ATEMENT OF DEFICIENCIES D PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495395	A. BUILDING _____ B. WING _____	02/04/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARBOR'S EDGE	ONE COLLEY AVENUE NORFOLK, VA 23510

(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 365 Continued From page 11

DON on 2/4/16 at 4 pm, the Administrator provided the survey team with information regarding purred diets and stated that unless specified by the physician (Resident #4's was not) the texture should be provided as a pudding consistency.

F 371 SS=F 483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY

The facility must -
(1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and
(2) Store, prepare, distribute and serve food under sanitary conditions

This REQUIREMENT is not met as evidenced by:
Based on observation and staff interview it was determined facility staff failed to prepare and serve food under sanitary conditions. The pantry and steam table area on the Health Care Unit were noted with areas needing cleaning and or replacing.

The findings included:

The evening meal on 2/3/16 was observed by the surveyor. The following sanitation issues were observed:

While the food trays were being transferred to the steam table, three of the four steam wells were noted to be discolored. The Dietary Manager

F 365

F 371

1.The following actions were taken immediately:
a. Deep cleaning of the entire kitchen to include… steam table, blinds, ice cream freezer fan and windows.
b. Removal from service of the griddle and Ninja blender. Replacement items arrived on 2/10/16 and 2/11/2016 respectively.
c. Confirmed the replacement of cabinets at beverage station with Director of Plant Operations.

2.All SNF residents are served food from the pantry; therefore all residents have the potential to be affected by the deficient practices. No food borne illnesses or sanitation issues have affected the health of our residents.

3.The following systemic changes will be implemented to prevent the recurrence of deficient practices:
a. Cleaning task lists will be updated to include the following:
i. Proper cleaning of kitchen equipment (steam table, blender, griddle, etc.)
ii. Proper cleaning of ice cream freezer to include the fan
iii. Proper cleaning of blinds
iv. In-service the Dietary Staff to
b. Dietary Staff will be in-serviced on the following:
i. Proper cleaning of equipment, all areas of kitchen, and beverage station
ii. How to identify equipment that needs replacement and how to continue daily operations when equipment needs replacement
c. Cabinets at beverage station will be replaced.

ATEMENT OF DEFICIENCIES D PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495395	A. BUILDING _____ B. WING _____	02/04/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARBOR'S EDGE	ONE COLLEY AVENUE NORFOLK, VA 23510

(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 371 Continued From page 12

(DM) stated that it was a build up of minerals from the water being heated and reheated. Since the DM took over in October he is now having the staff deep clean the wells on a monthly basis. The wells were so discolored that the water in the wells appeared brown.

The top to the Ninja blender did not fit securely and the window blinds behind the blender were splattered with food partials. The electric frying skillet was located near the window; the blinds behind the skillet were splattered with grease. The underside of the skillet had a greasy build up that came off on the surveyor's hand. The surface of the skillet was marred making sanitizing difficult. The skillet is used at breakfast and to make grilled cheese sandwiches.

The fan cover on the ice cream freezer had a greasy build up.

The cabinets at the drink preparation area appeared to have water damage.

The above concerns were discussed with the Administrator and Dietary Manager on 2/4/16 at 4:15 pm. The DM stated that the blinds were due to be removed and a plexi glass shield placed behind the blender and skillet. The skillet itself is to be replaced with a stainless steel model. The Administrator stated that the drinking prep area cabinets were due to be replaced.

F 428 SS=D 483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON

The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.

F 371

4. The following will be implemented to monitor and ensure sustained performance:

a. Weekly inspections of kitchen equipment will be conducted by the Dietary Manager or his designee to ensure items are in proper working order

b. Weekly inspections of kitchen sanitation will be conducted by Dietary Manager or his designee.

5.Completion date 3/10/16.

F 428

1. Resident #1 Medication Regimen Review was corrected to ensure the medical record remained accurate.

2. All Residents Medication Regimen Reviews were audited to ensure accuracy and any discrepancies were corrected.

EPARTMENT OF HEALTH AND HUMAN SERVICES
ENTERS FOR MEDICARE & MEDICAID SERVICES

ATEMENT OF DEFICIENCIES D PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495395	A. BUILDING _____ B. WING _____	02/04/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARBOR'S EDGE	ONE COLLEY AVENUE NORFOLK, VA 23510

(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 428	Continued From page 13 The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on clinical record reviews and staff interviews the facility staff failed to ensure the Pharmacy Record was accurate for one resident (Resident #1) in a 10 resident survey sample. The findings included: Resident #1 was originally admitted to the facility on 01/10/14 and the most recent re-admission was 05/17/14. Diagnoses included but were not limited to Multiple Sclerosis (an unpredictable, degenerative often disabling disease of the central nervous system that disrupts the flow of information within the brain), Hypertension, Anxiety, Depression and Dementia. Review of the resident's clinical record revealed a Comprehensive Significant Change MDS (minimum data set-an assessment protocol) with an ARD (assessment reference date) of 06/10/15. The most recent MDS was a Quarterly with an ARD of 12/03/15. The resident's BIMS (brief interview for mental status) score was a 9 out of possible 15 which indicated the resident was moderately cognitively impaired resulting in poor safety decisions. Further review noted the resident was totally dependent on one staff member for bed mobility, transferring to different surfaces toileting and bathing. It was further noted the resident did not walk or self propel a	F 428	3. Nursing management staff was educated on the importance of an accurate medical record and how to monitor the Medication Regimen Review for accuracy prior to scanning recommendations into the Medical Record. 4.The DON or designee will review the Medication Regimen Review monthly upon receipt from the pharmacist. 5. Compliance date 3/10/2016	

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
	495395	A. BUILDING _____ B. WING _____	02/04/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARBOR'S EDGE	ONE COLLEY AVENUE NORFOLK, VA 23510

(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 428	Continued From page 14	F 428		

wheelchair for locomotion throughout her room and the unit. The resident was coded as requiring extensive assistance to perform personal hygiene and required supervision and set up for eating. Due to the diagnosis of neurogenic bladder the resident required a foley catheter to control urine and was occasionally incontinent of bowel.

During the clinical record review for Resident #1the Pharmacy Medication Regimen Review record was noted and signed on 05/28/15 by the registered pharmacist. The notation by the registered pharmacist noted: "Hospice Level of Care."

Further review of the Pharmacy Medication Regimen Review record revealed the following documentation: "10/29/15-Not on Hospice now" which had been signed by the registered pharmacist.

An interview was conducted on 02/04/16 at approximately 9:55 a.m., with the Administrator and DON (director of nursing) regarding the actual date of when Resident #4 was no longer on Hospice Services. The DON was able to produce documentation that Resident #4 had been discharged from Hospice Services on 05/05/15, and continued to remain off of the Hospice Services up to current date of 02/04/16. The Pharmacy Medication Regimen Review form was then submitted to the Administrator and DON for review. They both agreed that the documentation by the registered pharmacist was inaccurate regarding Resident #4's Hospice Service dates. The Administrator stated: "It is up to the reviewing nurses to check the pharmacy documentation form every month and to notify the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495395	A. BUILDING _____ B. WING _____	02/04/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARBOR'S EDGE	ONE COLLEY AVENUE NORFOLK, VA 23510

(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 428	Continued From page 15 doctor of any recommended changes or any requests for labs. They are also to ensure the documentation is accurate and bring it to the DON when an inaccurate entry is found." Administration which consisted of the Administrator and the DON were informed of the findings at a briefing on 02/04/16 at approximately 5:09 p.m. No additional information was submitted for consideration.	F 428		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS 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 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	F 431	1. A cabinet was installed in the high end medication room to store the tackle boxes, which contains controlled drugs. The tackle box was secured (permanently affixed) to the cabinet with a lock and chain. The cabinet was also secured with a lock on the outside of the cabinet door. 2. No resident was adversely affected by this practice. 3. All licensed nursing staff has been educated on the importance of ensuring the controlled drug box is permanently affixed to the cabinet. 4.DON or designees will monitor 3 times a week for 5 weeks that the control drug box remains permanently affixed to the cabinet which is locked at all times, with the exception of when the cabinet and box are opened at the direction of the pharmacy to administer medications to our residents. 5. Compliance date is 3/10/2016	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495395	A. BUILDING _____ B. WING _____	02/04/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARBOR'S EDGE	ONE COLLEY AVENUE NORFOLK, VA 23510

(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 431	Continued From page 16	F 431		

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 and staff interview it was determined facility staff failed to secure the emergency controlled substances (narcotics) properly. The narcotic/controlled substance box was in a locked room and had a pad lock on the box, the box itself was small enough to be carries out of the locked room. The box was not permanently affixed.

The findings included:

During the 2/4/16 at 1:50 pm inspection of the one medication room, the emergency controlled substance container including Vicodin, Morphine, Tramadol for pain and Ativan for anxiety was observed on top of the counter in the locked room. The plastic container, about the size of a bread box, did have a independent lock. However: the box had a handle and was light enough to pick up and carry out of the room.

RN #12 accompanying the surveyor stated that the narcotic box remained locked and when an emergency drug was required the pharmacy had to be contacted for the code to the pad lock.

Following the inspection of the medication room the facility Administrator was interviewed

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
	495395	A. BUILDING _____ B. WING _____	02/04/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARBOR'S EDGE	ONE COLLEY AVENUE NORFOLK, VA 23510

(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 431	Continued From page 17 regarding the portability of the narcotic box. The Administrator was not aware that the storage of controlled drugs required a permanently affixed compartments.	F 431		