PRINTED: 08/30/2016 FORM APPROVED

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TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU!	R/CLIA MBER:	1''			
	495324		B. WING		08/1	9/2016
PROVIDER OR SUPPLIER		STREET ADI	DRESS, CITY, S	TATE, ZIP CODE		
EHHC @ ATLANTIC S	HORE					
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Initial Comments			F 000			
conducted 8/17/16 was not in compliar	through 8/19/16. The nce with the Virginia I	facility Rules and				
at the time of the su consisted of 18 Res resident reviews (R	urvey. The survey sat sident reviews: 11 cu esidents #1 through:	mple rrent #11) and 7				
Non Compliance			F 001			
The facility was out following state licen	of compliance with the sure requirements:	he	***************************************			
The facility was not following Virginia Ru	in compliance with thules and Regulations	ne				
conduct an initial an resident's needs. T accurately describe perform daily life fur impairments in func	d periodic assessme he assessment shall the resident's capab actions and significar tional capacity. Cro	ent of each ility to				
care shall be developlan shall include metimetables to meet the nutritional, and psychological the comprehensive also describe the se to maintain or impromental, and psychological shall be a second or impromental.	ped for each resident easurable objectives the resident's medical hological needs identified in the plantices that are to be the resident's physical needs in the resident's physical for the resident for	and I, nursing, tified in an shall furnished		- Company of the Comp		
	PROVIDER OR SUPPLIER E HHC & ATLANTIC S SUMMARY STA (EACH DEFICIENCY REGULATORY OR L Initial Comments An unannounced S conducted 8/17/16 was not in complian Regulations for the The census in this at the time of the st consisted of 18 Regulations for the The census in this at the time of the st consisted of 18 Regulations for the The facility was out following state licent reviews (R closed record reviews) Non Compliance The facility was out following state licent The facility was not following Virginia Rule: is not refollowing Virginia Rule: is not resident's needs. The facility was not following Virginia Rule: is not resident's needs. The facility was not following Virginia Rule: is not resident's needs. The facility was not following Virginia Rule: is not resident's needs. The facility was not following Virginia Rule: is not resident's needs. The facility was not following Virginia Rule: is not resident's needs. The facility was not following Virginia Rule: is not resident's needs. 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The survey sa consisted of 18 Residents #11 through closed record reviews (Residents #12 through state licensure requirements: This RULE: is not met as evidenced by The facility was not in compliance with the Virginian closed record reviews (Residents #12 through state licensure requirements: This RULE: is not met as evidenced by The facility was not in compliance with the following state licensure requirements: This RULE: is not met as evidenced by The facility was not in compliance with the following Virginian Rules and Regulations Licensure of Nursing Facilities: 12 VAC 5-371 250 A. The nursing facility conduct an initial and periodic assessment shall accurately describe the resident's capab perform daily life functional capacity. Croreference F276 and F278. 12 VAC 5-371 250 G. A comprehensive care shall be developed for each resident plan shall include measurable objectives timetables to meet the resident's medica nutritional, and psychological needs iden the comprehensive assessment. The plans of the plans of the provided resident is represented to the resident's medical nutritional, and psychological needs iden the comprehensive assessment. The plans of the p	APSOUDER OR SUPPLIER E HHC & ATLANTIC SHORE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Initial Comments An unannounced State Licensure inspection was conducted 8/17/16 through 8/19/16. The facility was not in compliance with the Virginia Rules and Regulations for the Licensure of Nursing Facilities. The census in this 50 certified bed facility was 41 at the time of the survey. The survey sample consisted of 18 Resident reviews: 11 current resident reviews (Residents #1 through #11) and 7 closed record reviews (Residents #12 through 18). 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: 12 VAC 5-371 250 A. The nursing facility shall conduct an initial and periodic assessment of each resident's needs. The assessment shall accurately describe the resident's capability to perform daily life functions and significant impairments in functional capacity. Cross reference F276 and F278. 12 VAC 5-371 250 G. A comprehensive plan of care shall be developed for each resident. The plan shall include measurable objectives and timetables to meet the resident's medical, nursing, nutritional, and psychological needs identified in the comprehensive assessment. The plan shall also describe the services that are to be furnished to maintain or improve the resident's physical, mental, and psychosocial status. Cross reference	TOF DEFICENCIES DE CORRECTION A95324 ABUILDING AB	TOT DEPICENCIES FOORECTION A 95324 PROVIDER OR SUPPLIER E HHC & ATLANTIC SHORE SUMMARY STATEMENT OF DEFICIENCIES (SEAH DEFICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION) AN unannounced State Licensure inspection was conducted 8/17/16 through 8/19/16. The facility was not in compliance with the Vignian Rules and Regulations for the Licensure of Nursing Facilities. The census in this 50 certified bed facility was 41 at the time of the survey. The survey sample consisted of 18 Residents #1 through #11) and 7 closed record reviews (Residents #1 through #11) and 7 closed record reviews (Residents #12 through #18) Non Compliance The facility was not in 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: 12 VAC 5-371 250 A. The nursing facility shall conduct an initial and periodic assessment of each resident's needs. The assessment shall conduct an initial and periodic assessment shall include measurable objectives and timetables to meet the resident's medical, nursing nutritional, and psychological needs identified in the comprehensive assessment. The plan shall include measurable objectives and timetables to meet the resident's medical, nursing nutritional, and psychological needs identified in the comprehensive assessment. The plan shall also describe the services that are to be furnished to maintain or improve the resident's physical, mental, and psychosocial status. Cross reference	The cansus in this 50 certified bed facility was 41 at the time of the survey. The survey sample consisted of 18 Resident reviews: 11 current resident's recision's requirements: This RULE: is not met as evidenced by: The facility was not in compliance with the following state licensure requirements: This RULE: is not met as evidenced by: The facility was not in compliance with the following state licensure requirements: This RULE: is not met as evidenced by: The facility was not in compliance with the following state licensure requirements: This RULE: is not met as evidenced by: The facility was not in compliance with the following state licensure requirements: The census in this 50 certified bed facility was 41 at the time of the survey. The survey sample consisted of 18 Resident reviews: 11 current resident reviews (Residents #11 torugh #11) and 7 closed record reviews (Residents #1 through #11) and 7 closed record reviews (Residents #20 through #12) and 7 closed record reviews (Residents #20 through #13) and 7 closed record reviews (Residents #20 through #13) and 7 closed record reviews (Residents #20 through #13) and 7 closed record reviews (Residents #20 through #13) and 7 closed record reviews (Residents #20 through #13) and 7 closed record reviews (Residents #20 through #13) and 7 closed record reviews (Residents #20 through #13) and 7 closed record reviews (Residents #20 through #20 thr

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F 000	INITIAL COMMENT	rs	F	000			
F 276 SS=D	survey was conduct 8/19/16. Correction with the following 4/2 Term Care required. The Life Safety Coordinary The Life Safety Coordinary The census in this 6/2 at the time of the succonsisted of 18 Respected for the succonsisted for the successive for the successi	de survey/report will follow. 50 certified bed facility was 41 property. The survey sample sident reviews: 11 current esidents #1 through #11) and lews (Residents #12 through RLY ASSESSMENT AT ONTHS 65 a resident using the grument specified by the State AS not less frequently than	F 2	276			
f	by: Based on staff inter review the facility sta resident was assess the Minimum Data S residents (Residents survey sample. The findings included 1. Resident #7 was c acility 2/27/16 and h	view and clinical record aff failed to assure each ed at least quarterly utilizing let (MDS) for 3 of 18 if #7, 12, and 15), in the d: originally admitted to the as never been discharged current diagnoses include			RECEIV SEP 82/2	ED 0016 LC	
ABORATÓRYE	IRECTOR'S OR PROVIDE	R/SUPPLIER(REPRESENTATIVE'S SIGN	ATUDE		/ TITLE 7		(X6) DATE

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

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F 276	dysphagia (difficult dementia, urinary r deficiency. The admission MD	ultiple sclerosis, hypertension, y swallowing), hypothyroidism, etention and a vitamin S (minimum data set) with an	Fá	276			
	coded the resident Interview for Menta out of a possible 18 cognitive abilities for intact. The 3/5/16 M the resident as req 1 person with bed in dressing, and toilet	nce date (ARD) of 3/5/16 as completing the Brief al Status (BIMS) and scoring 12 5. This indicated Resident #7's or daily decision making were MDS assessment also coded uiring extensive assistance of mobility, transfers, locomotion, ing, limited assistance with nd total care with bathing.					
	comparative quarter OBRA MDS assess The last OBRA ass accepted into the C Services (CMS) was	ent #7 did not have a brly, significant change or other sment completed for review. essment to be transmitted and centers for Medicare/Medicaid is dated 3/5/16 per the facility's S 3.0 Missing OBRA t.					
THE PROPERTY AND ADDRESS AND A	Nursing on 8/19/16 the Director of Nurs assessment was no	onducted with the Director of at approximately 1:25 p.m., sing stated the quarterly MDS of located in the systems; usion was it was missed.		ed ausa agasti édekérépéssékésékésékésékésékessen asusana anados astrákásásásásás a sa ya ezere			ACTION AND AND AND AND AND AND AND AND AND AN
	facility 9/17/14 and The diagnoses at the metastatic breast ca COPD (chronic obs	s originally admitted to the the resident expired 8/2/16. ne time of death included ancer with hospice services, tructive pulmonary disease), failure, dementia, peripheral		VACATALISSA ALAKAMA AA-p-ji defensiversings anamasis ang-usa sistema sistema sistema sistema sistema sistema a			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILDI		CONSTRUCTION		E SURVEY IPLETED
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F 276	The quarterly MDS assessment referenceded the resident Interview for Menta out of a possible 15 #12's cognitive abiliseverely impaired. The 3/16/16 MDS aresident as requiringerson with bed may personal hygiene at and locomotion and On 8/18/16, Reside comparative quarter OBRA MDS assess The last OBRA assessment Report An interview was concepted into the C Services (CMS) was facility's Casper Re Assessment Report An interview was conclusing on 8/19/16 the Director of Nursing on 8/19/16 the conclusion was Nursing also stated assessment was concepted into the conclusion was Nursing also stated assessment was concepted into the conclusion was Nursing also stated assessment was concepted into the conclusion was Nursing also stated assessment was concepted into the conclusion was Nursing also stated assessment was concepted into the conclusion was Nursing also stated assessment was concepted into the conclusion was Nursing also stated assessment was concepted into the conclusion of a dassessment should	(minimum data set) with an ince date (ARD) of 3/16/16 as completing the Brief I Status (BIMS) and scoring 7 is. This indicated Resident ities for daily decision making assessment also coded the gextensive assistance of 1 obility, dressing, toileting, and not total care of 1 with bathing I total care of 2 with transfers. Int #12 did not have a rry, significant change or other ament completed for review. The essment to be transmitted and enters for Medicare/Medicaid so dated 3/16/16 per the port MDS 3.0 Missing OBRA to a conducted with the Director of at approximately 1:25 p.m., sing stated the resident was MDS assessment June 2016 ted in the systems therefore; it was missed. The Director of the 8/2/16 discharge MDS ampleted on 8/5/16 but had not a complete in the systems therefore.	F 2	76			

STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPL.	E CONSTRUCTION	(X3) DAT	E SURVEY
AND PLAN C	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILD			СОМ	PLETED
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/ h.d. a.k. a.km	CHABADVCTA	TEMENT OF DEFICIENCIES	1.070	-	vi V prividas securum ikini virti kuntuutuutuun suurum suurum ka kasaan ka	mendelentrische der einstelle speliege.	
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F 276	Continued From pa	ge 3	Fá	276			
	facility 1/22/16 and return not anticipate at the time of discha	s originally admitted to the discharged from the facility ad on 7/19/16. The diagnoses arge include hypertension.					
	assessment with an (ARD) of 1/29/16 co completing the Brie (BIMS) and scoring	S (minimum data set) a assessment reference date oded the resident as f Interview for Mental Status 15 out of a possible 15. This #15's cognitive abilities for					
	daily decision making MDS assessment a coded as requiring lextensive assistance dressing, toileting, extensive assistance.	ng were intact. The 1/29/16 Iso revealed the resident was imited assistance with eating, e of 1 person with locomotion, and personal hygiene, e of 2 persons with bed rs and total total care of 1					
	comparative quarter OBRA MDS assess The last OBRA asses accepted into the Co Services (CMS) was	nt #15 did not have a rely, significant change or other ment completed for review. essment to be transmitted and enters for Medicare/Medicaid added 1/29/16 per the port MDS 3.0 Missing OBRA		OOR HEAD OF THE PROPERTY OF TH			
** Production of the Productio	Nursing on 8/19/16 at the Director of Nursi assessment was no therefore, the conclu	nducted with the Director of at approximately 1:25 p.m., ing stated the quarterly MDS t located in the systems; usion was it was missed and ge assessment had not been		тей, потит то того попровенения в потавления выполняем регулярую подобления выполняем выполняем выполняем выпол			
-	The Director of Nurs	ing stated there was no		a distribution and the second			

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F 276	facility policy on corbecause they follow Instrument's guideli Casper Report MD: Assessment Repor residents with miss Director of Nursing the report had beer the listed residents reviewed and the abe completed to clearly the Complete an ongoine each resident within	mpleting the MDS assessment yed the Resident Assessment ines. Review of the facility's S 3.0 Missing OBRA trevealed the facility had 18 ing OBRA assessments. The stated this was the first time to obtained for the facility and assessment history would be appropriate assessments would har up all delinquencies. The stated this was the first time to obtained for the facility and assessment history would be appropriate assessments would har up all delinquencies. The stated the facility had 18 and	F 2	F278: I. 1. Reviewed submission report validation process with the Coordinator and the importance pulling submission report to timely submission. 2. For Resident #4 a correct assessment was updated to Hospice services. II. 1. A validation report was contained any negative variance addressed. 2. Identified all Hospice resident I assessments were reviewed ensure the box identifying the ahospice patient was checkled.	new MDS ince of ensure ed MDS include mpleted idents and MDS I to	
F 278 SS=D	Administrator and Dat approximately 2:: information was pro 483.20(g) - (j) ASSE ACCURACY/COOF. The assessment meresident's status. A registered nurse reach assessment was participation of heal	ESSMENT RDINATION/CERTIFIED ust accurately reflect the must conduct or coordinate ith the appropriate	F 2	III. 1a. A transmission report bi been created for the MDS Coordinator; D.O.N. and/or will review the binder weekly ensure compliance. 1b. MDS Coordinator will oweekly flow sheet identifying residents and when assess due. A copy will be given to 2.a. MDS Assessment accube validated during IDT an Team care plan meeting by or designee.	designee to reate a g all new ments are the D.O.N. racy will d Hospice	

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TAG		SC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPROPE DEFICIENCY)		DATE
F 278	assessment must see that portion of the an uniform Medicare and willfully and knowing false statement in a subject to a civil most \$1,000 for each assemilifully and knowing to certify a material resident assessment penalty of not more assessment. Clinical disagreement material and false see the facility state of the facility st	pleted. completes a portion of the ign and certify the accuracy of ssessment. d Medicaid, an individual who gly certifies a material and resident assessment is eney penalty of not more than sessment; or an individual who gly causes another individual and false statement in a not is subject to a civil money than \$5,000 for each ent does not constitute a tatement. IT is not met as evidenced review and clinical record aff failed to ensure timely uracy of Minimum Data Set for 1 of 18 residents a survey sample. alled to complete the Data Set (MDS) assessment	F	278	F278 Continued: III. 2b. When a residents converts from an ICF/SNF level of care hospice the MDS Coordinator wand the patient to the weekly flusheet for an updated assessment to be completed that week. Hose conversions are discussed at distand-Up and Stand-Down. IV. The Transmission Binder, flow sheets and IDT/Hospice Review will be reviewed by the QA committee for fours months to ensure sustainable compliance. V. Date of Completion: Sept. 21, 2	to will ow ent spice aily ws	
		spice Care on the 8/2/16				de de la Colonia	Milmulandiliseconnasious conn
	The findings include	d:		Links the same of		an i wanishi umpungapinga	ошенатонирива
		ginally admitted to the facility ver been discharged from the		PERSONAL PROPERTY OF THE PERSONAL PROPERTY OF		ная принавод Фалайадосу	docal-ample desirán des secuelos de secuel

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F 278	failure, dementia wi and adult failure to an adult failure to a seessment with ar (ARD) of 8/2/16 cook the Brief Interview of scoring 5 out of a property of a prop	diagnoses included; heart th behavioral disturbances, thrive. mum Data Set (MDS) hassessment reference date led the resident as completing or Mental Status (BIMS) and ossible 15. This indicated tive abilities for daily decision ely impaired. In section "D" the for feeling, down, depressed eling tired or having little lays out of fourteen days. No ed in section "E". In section ioning) the resident was coded and supervision with eating, e of 2 persons with transfers, e of 1 person with bed, personal hygiene, dressing, are of 1 with bathing. In dent was coded as incontinent ler. Section "O" included procedures and programs t O100K, but it was not coded d within the 14 day period B" of the admission Minimum essment the date of	F	278			

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F 278	Resident #4 with an calendar days is 8/Minimum Data Set have had a comple The facility staff wa admission Minimum assessment. An interview was conversely and the Director of Nurfacility policy on conversely policy poli	n admission date 7/22/16 + 13 4/16. Resident #4's admission (MDS) assessment should tion date on or before 8/4/16. Is 9 days late completing the In Data Set (MDS) Inducted with the Director of Interest at approximately 1:25 p.m. It is sing stated there was no Impleting the MDS assessment Interest wed the Resident Assessment Interest which stated the facility Inplete an admission MDS K" (Hospice Care) the In Data Set (MDS) assessment		278			
		fore; a modification would be sion MDS assessment. The				and the Control of th	

AMME OF PROVIDER OR SUPPLIER SEASIDE HIRC @ ATLANTIC SHORE STREET ADDRESS, CITY, STATE, ZIP CODE 1200 ATLANTIC SHORES DRIVE VRGINA BEACH, VA 23454 VRGINA BEACH, VA 23454 F278 Continued From page 8 Director of Nursing also stated there was no facility policy on completing the MDS assessment lost cause they followed the Resident Assessment Instrument's guidelines. The above findings were shared with the Administrator and Director of Nursing on 8/19/16 at approximately 2:30 p.m. No additional information was provided. A facility must use the results of the assessment to develop, review and revise the resident's comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial meeds that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under \$483.25 (and any services this would otherwise be required under \$483.25 (and any services this power of the provided due to the resident's exercise of rights under \$483.10 (b)(4).		OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	£ ' '	TIPLE CONSTRUCTION NG		E SURVEY IPLETED
STREET ADDRESS, CITY, STATE, DORE SEASIDE HIC @ ATLANTIC SHORE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST SE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 278 Continued From page 8 Director of Nursing also stated there was no facility policy on completing the MDS assessment because they followed the Resident Assessment instrument's guidelines. The above findings were shared with the Administrator and Director of Nursing on 8/19/16 at approximately 2:30 p.m. No additional information was provided. F 279 SS=D COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and finetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25, and any services that would otherwise be required under §483.25 but are not provided due to the resident's services of rights under §483.10, including the right to refuse treatment			495324	B. WING_		08/	19/2016
F 278 Continued From page 8 Director of Nursing also stated there was no facility policy on completing the MDS assessment because they followed the Resident Assessment Instrument's guidelines. F 278 The above findings were shared with the Administrator and Director of Nursing on 8/19/16 at approximately 2:30 p.m. No additional information was provided. F 279 SS=D COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan first Resident #4 was revised to include Hospice services. II. A 100% audit was conducted of all Hospice resident care plans, with any negative variances corrected at the time of observation. III. a. The MDS Coordinator will be accountable for creating the care plans for residents converting to Hospice services and for updating the Hospice services and for updating the Hospice services and for updating the Hospice services and for each resident shat includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan for Resident #4 was revised to include Hospice services. II. A 100% audit was conducted of all Hospice resident care plans, for resident care plans, for resident care plans, for resident was prevised to include Hospice services. III. A 100% audit was conducted of all Hospice resident services of the time of observation. IV. The D.O.N will complete a 100% bi-weekly audit to ensure compliance; any negative variances will be corrected at the time of observation. IV. The D.O.N. will report audit outcomes to the QA committee for four months for review and recommendation to ensure sustainable compliance. V. Date of Com			HORE		1200 ATLANTIC SHORES DRIVE	tau atau pangangan mengelah dikantah kembanya kembanya kembangan kembanya kembanya kembanya kembanya kembanya	от под него на под него на Него него на под
Director of Nursing also stated there was no facility policy on completing the MDS assessment because they followed the Resident Assessment Instrument's guidelines. The above findings were shared with the Administrator and Director of Nursing on 8/19/16 at approximately 2:30 p.m. No additional information was provided. F 279 483.20(d), 483.20(k)(1) DEVELOP SS=D COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan for Resident #4 was revised to include Hospice services. II. A 100% audit was conducted of all Hospice resident care plans, with any negative variances corrected at the time of observation. III. a. The MDS Coordinator will be accountable for residents converting to Hospice services and for updating the Hospice section of the care plan. MDS Coordinator will be accountable for residents converting to Hospice services and for updating the Hospice section of the care plan. MDS Coordinator will create a binder for non-skilled residents and hospice residents to be audited weekly to ensure compliance. C. The D.O.N will complete a 100% bi-weekly audit to ensure compliance: any negative variances will be corrected at the time of observation. IV. The D.O.N. will report audit outcomes to the QA committee for four months for review and recommendation to ensure sustainable compliance. V. The D.O.N. will report audit outcomes to the QA committee for four months for review and recommendation to ensure sustainable compliance. V. Date of Completion: Sept. 21, 2016	PREFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPL	ULD BE	COMPLETION
This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record	F 279	Director of Nursing facility policy on corbecause they follow Instrument's guideling The above findings Administrator and Eat approximately 2: information was provided as 20(d), 483.20(k) COMPREHENSIVE A facility must use to develop, review a comprehensive plant The facility must deplan for each reside objectives and time medical, nursing, an needs that are identiassessment. The care plan must to be furnished to at highest practicable psychosocial well-be §483.25; and any se be required under § due to the resident's §483.10, including the under §483.10(b)(4) This REQUIREMENT.	also stated there was no impleting the MDS assessment yed the Resident Assessment yed the Resident Assessment nes. Were shared with the Director of Nursing on 8/19/16 30 p.m. No additional yided. ((1) DEVELOP: CARE PLANS The results of the assessment and revise the resident's in of care. Welop a comprehensive care and that includes measurable tables to meet a resident's indirect mental and psychosocial diffied in the comprehensive describe the services that are stain or maintain the resident's physical, mental, and eing as required under ervices that would otherwise 483.25 but are not provided as exercise of rights under the right to refuse treatment.		I. The care plan for Resident #4 revised to include Hospice set II. A 100% audit was conducted Hospice resident care plans, any negative variances corre the time of observation. III. a. The MDS Coordinator will accountable for creating the for residents converting to Ho services and for updating the section of the care plan. b. MDS Coordinator will crea for non-skilled residents and residents to be audited week ensure compliance. c. The D.O.N will complete a bi-weekly audit to ensure cor any negative variances will b corrected at the time of obse IV. The D.O.N. will report audit outcomes to the QA committe four months for review and recommendation to ensure sustainable compliance.	ervices. of all with cted at be care plans espice Hospice te a binder hospice by to 100% espication. ee for	

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F 279	review, the facility secomprehensive car services for 1 of 18 the survey sample. The findings includ Resident #4 was or 7/22/16 and has ne facility. The current failure, dementia wand adult failure to The admission Min assessment with an (ARD) of 8/2/16 couthe Brief Interview scoring 5 out of a president #4 cognition making were sever resident was coded or hopeless and fee energy two to six dispensive assistance extensive assistance extensive assistance mobility, locomotion and toileting, total of section "H" the resident was coded as a service receive (7/20/16 - 8/2/16). The clinical record in the service receive (7/20/16 - 8/2/16).	staff failed to develop a re which included Hospice i residents (Resident #4), in red: riginally admitted to the facility over been discharged from the adiagnoses included: heart ith behavioral disturbances,	F	279			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495324	B. WING		08/	19/2016	
NAME OF PROVIDER OR SUPPLIER SEASIDE HHC @ ATLANTIC SHORE				STREET ADDRESS, CITY, STATE, ZIP CODE 1200 ATLANTIC SHORES DRIVE VIRGINIA BEACH, VA 23454		en e	
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F 287 SS=D	document dated ar physician, power or agency for an elect benefits. Hospice s 7/22/16 included now orker services. An interview was concerning on 8/19/16 The Director of Nurdue to be complete finished. The Director of Nurdue to be completed care plan for Hospice send Nursing also stated on care plan develothe Resident Assess which stated the factor and comprehensive the Resident Assess which stated the factor complete at a minicomprehensive staresident's functionare sults of the assess develop, review, or comprehensive pla 3.0 chapter 4 page. The above findings Administrator and I at approximately 2: information was predessed to the complete stares of the same and I at approximately 2: information was predessed to the complete stares of the same and I at approximately 2: information was predessed to the complete stares of the same and I at approximately 2: information was predessed to the complete stares of the same and I at approximately 2: information was predessed to the complete stares of the complete starts of t	and signed on 7/22/16, by the fattorney and the Hospice services initially ordered on ursing, aide and medical social conducted with the Director of at approximately 1:25 p.m. rsing stated the care plan was ed on 8/13/16 but it was still not stor of Nursing provided the services. The Director of there was no facility's policy opment because they followed esment Instrument's guidelines cility had 21 days to develop care plan. In the services of the services of the services of the services of the services. The Director of the services of	F 2	F287: I. Resident #14 is no longer at the facility. II. a. The D.O.N. will review the report to identify any other variance a time for corrections to be completed transmitted by the MDS Coordinator will provided to the p	validation riances to quirements schedule d and dinator. ull the omissions heet to oull the oted opies for utilize the e a lie to ative he QA ur opliance		
	(1) Encoding Data.	Within 7 days after a facility					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1) MULTIPLE CONSTRUCTION BUILDING		(X3) DATE SURVEY COMPLETED	
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F 287	must encode the foresident in the facili (i) Admission asses (ii) Annual assessm (iii) Significant chan (iv) Quarterly review (v) A subset of item reentry, discharge, (vi) Background (facility is no admission ass (2) Transmitting dat completes a resider must be capable of System information the MDS in a format record layouts and of passes standardized the State. (3) Transmittal requ a facility completes facility must electror accurate, and comp System, including th (i) Admission assess (ii) Annual assessm (iii) Significant correct (v) Significant correct assessment. (vi) Quarterly review (vii) A subset of item reentry, discharge, a (viii) Background (fa initial transmission of	nt's assessment, a facility illowing information for each ty: sment. Item updates. Ige in status assessments. It assessments. It assessments is upon a resident's transfer, and death. Item assessment. Item assessment. Item assessment, a facility int's assessment, a facility itransmitting to the CMS for each resident contained in a that conforms to standard item and death defined by CMS and irements. Within 14 days after a resident's assessment, a inically transmit encoded, lete MDS data to the CMS item following: sment. Item is status assessment. Item of prior full assessment. Item of prior quarterly Item updates. Item It	F 28				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
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F 287	the format specified has an alternate R/	ge 12 e facility must transmit data in d by CMS or, for a State which Al approved by CMS, in the the State and approved by	Fá	287		ndalaya asaada aa aa daaba aa	
	by: Based on staff intereview the facility stays after complete Data Set (MDS) as were electronically Medicare and Mediresidents (Resident The findings included Resident #14 was facility 2/26/16 and diagnoses at the diagnoses a	rview and clinical record raff failed to assure within 14 on of a resident's Minimum sessment, the assessments transmitted to the Centers for caid Service (CMS) for 1 of 18 is #14), in the survey sample. ed: as originally admitted to the readmitted 4/3/16. The scharge included dysphagia g), urinary retention, chronic order and peripheral vascular					
	assessment referer coded the resident Interview for Mental out of a possible 15 #14's cognitive ability were moderately im assessment also retotal care with eatin with bed mobility an assistance of 1 with	S (minimum data set) with an ance date (ARD) of 3/10/16 as completing the Brief that Status (BIMS) and scoring 11 is. This indicated Resident ties for daily decision making apaired. The 3/10/16 MDS avealed Resident #14 required g, extensive assistance of 2 and dressing, extensive a transfers, locomotion, and distance with personal hygiene with bathing.					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495324	B. WING		80	19/2016	
	PROVIDER OR SUPPLIER HHC @ ATLANTIC S	SHORE		STREET ADDRESS, CITY, STATE, ZIP 1200 ATLANTIC SHORES DRIVE VIRGINIA BEACH, VA 23454		* In Tagle 2 dags tag 5 dags 2	
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F 287	Nursing on 8/19/16 the Director of Nurs discharged home of assessment was pr	onducted with the Director of at approximately 1:25 p.m., sing stated the resident was n 6/9/16 and a discharge MDS resented as completed on been submitted on 8/18/16.	F 2	87			