PRINTED: 08/30/2016
FORM APPROVED

State of Virginia

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495324	A. BUILDING _____ B. WING _____	08/19/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEASIDE HHC @ ATLANTIC SHORE	1200 ATLANTIC SHORES DRIVE 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) COMPLETE DATE
F 000	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).	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: 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 F279.	F 001	RECEIVED SEP 02 2016 VDH/OLC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Lori Miller L.N.H.A. TITLE: Supt. (X6) DATE: Sept. 01, 2016

State of Virginia

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

PRINTED: 08/30/2016
FORM APPROVED
OMB NO. 0938-0391

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F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted on 8/17/16 through 8/19/16. Corrections are required for compliance with the following 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. The census in this 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).	F 000		
F 276 SS=D	483.20(c) QUARTERLY ASSESSMENT AT LEAST EVERY 3 MONTHS A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review the facility staff failed to assure each resident was assessed at least quarterly utilizing the Minimum Data Set (MDS) for 3 of 18 residents (Residents #7, 12, and 15), in the survey sample. The findings included: 1. Resident #7 was originally admitted to the facility 2/27/16 and has never been discharged from the facility. The current diagnoses include	F 276		

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

LNHA Sept. 01, 2016

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

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F 276	Continued From page 1 hyperlipidemia, multiple sclerosis, hypertension, dysphagia (difficulty swallowing), hypothyroidism, dementia, urinary retention and a vitamin deficiency. The admission MDS (minimum data set) with an assessment reference date (ARD) of 3/5/16 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 12 out of a possible 15. This indicated Resident #7's cognitive abilities for daily decision making were intact. The 3/5/16 MDS assessment also coded the resident as requiring extensive assistance of 1 person with bed mobility, transfers, locomotion, dressing, and toileting, limited assistance with personal hygiene and total care with bathing. On 8/18/16, Resident #7 did not have a comparative quarterly, significant change or other OBRA MDS assessment completed for review. The last OBRA assessment to be transmitted and accepted into the Centers for Medicare/Medicaid Services (CMS) was dated 3/5/16 per the facility's Casper Report MDS 3.0 Missing OBRA Assessment Report. An interview was conducted with the Director of Nursing on 8/19/16 at approximately 1:25 p.m., the Director of Nursing stated the quarterly MDS assessment was not located in the systems; therefore, the conclusion was it was missed. 2. Resident #12 was originally admitted to the facility 9/17/14 and the resident expired 8/2/16. The diagnoses at the time of death included metastatic breast cancer with hospice services, COPD (chronic obstructive pulmonary disease), hypertension, heart failure, dementia, peripheral	F 276		

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F 276	Continued From page 2 vascular disease and stroke. The quarterly MDS (minimum data set) with an assessment reference date (ARD) of 3/16/16 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 7 out of a possible 15. This indicated Resident #12's cognitive abilities for daily decision making severely impaired. The 3/16/16 MDS assessment also coded the resident as requiring extensive assistance of 1 person with bed mobility, dressing, toileting, and personal hygiene and total care of 1 with bathing and locomotion and total care of 2 with transfers. On 8/18/16, Resident #12 did not have a comparative quarterly, significant change or other OBRA MDS assessment completed for review. The last OBRA assessment to be transmitted and accepted into the Centers for Medicare/Medicaid Services (CMS) was dated 3/16/16 per the facility's Casper Report MDS 3.0 Missing OBRA Assessment Report. An interview was conducted with the Director of Nursing on 8/19/16 at approximately 1:25 p.m., the Director of Nursing stated the resident was due for a quarterly MDS assessment June 2016 but it could not located in the systems therefore; the conclusion was it was missed. The Director of Nursing also stated the 8/2/16 discharge MDS assessment was completed on 8/5/16 but had not been submitted on 8/18/16. Transmission of a death in the facility MDS assessment should equal date of death plus (+) 14 days. (RAI manual, MDS 3.0 chapter 2 page 2-16).	F 276		

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F 276	Continued From page 3 3. Resident #15 was originally admitted to the facility 1/22/16 and discharged from the facility return not anticipated on 7/19/16. The diagnoses at the time of discharge include hypertension. The admission MDS (minimum data set) assessment with an assessment reference date (ARD) of 1/29/16 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 15 out of a possible 15. This indicated Resident #15's cognitive abilities for daily decision making were intact. The 1/29/16 MDS assessment also revealed the resident was coded as requiring limited assistance with eating, extensive assistance of 1 person with locomotion, dressing, toileting, and personal hygiene, extensive assistance of 2 persons with bed mobility and transfers and total total care of 1 with bathing. On 8/18/16, Resident #15 did not have a comparative quarterly, significant change or other OBRA MDS assessment completed for review. The last OBRA assessment to be transmitted and accepted into the Centers for Medicare/Medicaid Services (CMS) was dated 1/29/16 per the facility's Casper Report MDS 3.0 Missing OBRA Assessment Report. An interview was conducted with the Director of Nursing on 8/19/16 at approximately 1:25 p.m., the Director of Nursing stated the quarterly MDS assessment was not located in the systems; therefore, the conclusion was it was missed and the 7/19/16 discharge assessment had not been transmitted to CMS. The Director of Nursing stated there was no	F 276		

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F 276	Continued From page 4 facility policy on completing the MDS assessment because they followed the Resident Assessment Instrument's guidelines. Review of the facility's Casper Report MDS 3.0 Missing OBRA Assessment Report revealed the facility had 18 residents with missing OBRA assessments. The Director of Nursing stated this was the first time the report had been obtained for the facility and the listed residents assessment history would be reviewed and the appropriate assessments would be completed to clear up all delinquencies. The Omnibus Budget Reconciliation Act (OBRA) of 1987 requires long term care facilities to complete an ongoing OBRA assessments for each resident within 92 days of the ARD of the most recent MDS assessment. (RAI manual, MDS 3.0 chapter 2 pages 2-16). 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 276	F278: I. 1. Reviewed submission report and validation process with the new MDS Coordinator and the importance of pulling submission report to ensure timely submission. 2. For Resident #4 a corrected MDS assessment was updated to include Hospice services. II. 1. A validation report was completed and any negative variance addressed. 2. Identified all Hospice residents and validated per census data. All Hospice resident MDS assessments were reviewed to ensure the box identifying them as a hospice patient was checked. III. 1a. A transmission report binder has been created for the MDS Coordinator; D.O.N. and/or designee will review the binder weekly to ensure compliance. 1b. MDS Coordinator will create a weekly flow sheet identifying all new residents and when assessments are due. A copy will be given to the D.O.N. 2.a. MDS Assessment accuracy will be validated during IDT and Hospice Team care plan meeting by D.O.N. or designee.	
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the	F 278		

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F 278	Continued From page 5 assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review the facility staff failed to ensure timely completion and accuracy of Minimum Data Set (MDS) assessment for 1 of 18 residents (Resident #4), in the survey sample. 1. The facility staff failed to complete the admission Minimum Data Set (MDS) assessment on or before day 14. 2. The facility staff failed to accurately code section "O100K" Hospice Care on the 8/2/16 MDS assessment. The findings included: Resident #4 was originally admitted to the facility 7/22/16 and has never been discharged from the	F 278	F278 Continued: III. 2b. When a residents converts from an ICF/SNF level of care to hospice the MDS Coordinator will add the patient to the weekly flow sheet for an updated assessment to be completed that week. Hospice conversions are discussed at daily Stand-Up and Stand-Down. IV. The Transmission Binder, flow-sheets and IDT/Hospice Reviews will be reviewed by the QA committee for fours months to ensure sustainable compliance. V. Date of Completion: Sept. 21, 2016	

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F 278	Continued From page 6 facility. The current diagnoses included; heart failure, dementia with behavioral disturbances, and adult failure to thrive. The admission Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 8/2/16 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 5 out of a possible 15. This indicated Resident #4's cognitive abilities for daily decision making were severely impaired. In section "D" the resident was coded for feeling, down, depressed or hopeless and feeling tired or having little energy two to six days out of fourteen days. No behaviors were coded in section "E". In section "G" (Physical functioning) the resident was coded as requiring set-up and supervision with eating, extensive assistance of 2 persons with transfers, extensive assistance of 1 person with bed mobility, locomotion, personal hygiene, dressing, and toileting, total care of 1 with bathing. In section "H" the resident was coded as incontinent of bowels and bladder. Section "O" included special treatments, procedures and programs including Hospice at O100K, but it was not coded as a service received within the 14 day period (7/20/16 - 8/2/16). 1. In section "Z0500B" of the admission Minimum Data Set (MDS) assessment the date of completion was coded as 8/13/16. The Resident Assessment Instrument (RAI) manual states section "Z0500B"of the admission Minimum Data Set (MDS) assessment can be no later than the 14th calendar day of the resident's admission. (admission + 13 calendar days). (RAI manual, MDS 3.0 chapter 2 page 2-15)	F 278		

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F 278	Continued From page 7 Resident #4 with an admission date 7/22/16 + 13 calendar days is 8/4/16. Resident #4's admission Minimum Data Set (MDS) assessment should have had a completion date on or before 8/4/16. The facility staff was 9 days late completing the admission Minimum Data Set (MDS) assessment. An interview was conducted with the Director of Nursing on 8/19/16 at approximately 1:25 p.m. The Director of Nursing stated there was no facility policy on completing the MDS assessment because they followed the Resident Assessment Instrument's guidelines which stated the facility had 14 days to complete an admission MDS assessment. 2. In section "O100K" (Hospice Care) the admission Minimum Data Set (MDS) assessment for Resident #4 was not coded. The clinical record revealed a physician's authorization for Hospice dated 7/22/16 and a document dated and signed on 7/22/16, by the physician, power of attorney and the Hospice agency for an election of medicare Hospice benefits. Hospice services initially ordered on 7/22/16 included nursing, aide and medical social worker services. An interview was conducted with the Director of Nursing on 8/19/16 at approximately 1:25 p.m. The Director of Nursing stated Hospice Care at section "O100K" should have been coded on the 8/2/16 MDS assessment because the resident was enrolled in the Hospice Care program on or before 8/2/16 therefore; a modification would be made to the admission MDS assessment. The	F 278		

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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 278	F279: I. 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 creating the care plans for residents converting to Hospice services and for updating the Hospice section of the care plan. b. 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. Date of Completion: Sept. 21, 2016	
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP 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 must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record	F 279		

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F 279	Continued From page 9 review, the facility staff failed to develop a comprehensive care which included Hospice services for 1 of 18 residents (Resident #4), in the survey sample. The findings included: Resident #4 was originally admitted to the facility 7/22/16 and has never been discharged from the facility. The current diagnoses included: heart failure, dementia with behavioral disturbances, and adult failure to thrive. The admission Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 8/2/16 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 5 out of a possible 15. This indicated Resident #4 cognitive abilities for daily decision making were severely impaired. In section "D" the resident was coded for feeling, down, depressed or hopeless and feeling tired or having little energy two to six days out of fourteen days. No behaviors were coded in section "E". In section "G" (Physical functioning) the resident was coded as requiring set-up and supervision with eating, extensive assistance of 2 persons with transfers, extensive assistance of 1 person with bed mobility, locomotion, personal hygiene, dressing, and toileting, total care of 1 with bathing. In section "H" the resident was coded as incontinent of bowels and bladder. Section "O" included special treatments, procedures and programs including Hospice at O100K, but it was not coded as a service received within the 14 day period (7/20/16 - 8/2/16). The clinical record revealed a physician's authorization for Hospice dated 7/22/16 and a	F 279		

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F 279	Continued From page 10 document dated and signed on 7/22/16, by the physician, power of attorney and the Hospice agency for an election of medicare Hospice benefits. Hospice services initially ordered on 7/22/16 included nursing, aide and medical social worker services. An interview was conducted with the Director of Nursing on 8/19/16 at approximately 1:25 p.m. The Director of Nursing stated the care plan was due to be completed on 8/13/16 but it was still not finished. The Director of Nursing provided the completed care plans but it did not include a care plan for Hospice services. The Director of Nursing also stated there was no facility's policy on care plan development because they followed the Resident Assessment Instrument's guidelines which stated the facility had 21 days to develop an comprehensive care plan. The Resident Assessment Instrument (RAI) manual reads regulations require facilities to complete at a minimum, at regular intervals, a comprehensive standardized assessment of each resident's functional capacity and needs... The results of the assessment... are to be used to develop, review, or revise, each resident's comprehensive plan of care. (RAI manual, MDS 3.0 chapter 4 page 4-1) 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	F287: I. Resident #14 is no longer at the facility. II. a. The D.O.N. will review the validation report to identify any other variances to electronic data submission requirements The D.O.N. will create a time schedule for corrections to be completed and transmitted by the MDS Coordinator. b.The MDS Coordinator will pull the Validation Report to verify submissions and compare to weekly flow sheet to avoid recurrence. III. a. The MDS Coordinator will pull the Validation Report bi-weekly with any negative variances corrected at the time of observation. Copies will be provided to the D.O.N. for review. b. The MDS Coordinator will utilize the new EMR system to generate a a weekly assessment schedule to ensure timely completion of quarterly assessments. IV. A summary report of any negative variance will be provided to the QA committee for review times four months or until sustained compliance is achieved. V. Date of Completion: Sept. 21, 2016	
F 287 SS=D	483.20(f) ENCODING/TRANSMITTING RESIDENT ASSESSMENT (1) Encoding Data. Within 7 days after a facility	F 287		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495324	A. BUILDING _____ B. WING _____	08/19/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 287	Continued From page 11 completes a resident's assessment, a facility must encode the following information for each resident in the facility: (i) Admission assessment. (ii) Annual assessment updates. (iii) Significant change in status assessments. (iv) Quarterly review assessments. (v) A subset of items upon a resident's transfer, reentry, discharge, and death. (vi) Background (face-sheet) information, if there is no admission assessment. (2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State. (3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following: (i) Admission assessment. (ii) Annual assessment. (iii) Significant change in status assessment. (iv) Significant correction of prior full assessment. (v) Significant correction of prior quarterly assessment. (vi) Quarterly review. (vii) A subset of items upon a resident's transfer, reentry, discharge, and death. (viii) Background (face-sheet) information, for an initial transmission of MDS data on a resident that does not have an admission assessment.	F 287		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 287	Continued From page 12 (4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review the facility staff failed to assure within 14 days after completion of a resident's Minimum Data Set (MDS) assessment, the assessments were electronically transmitted to the Centers for Medicare and Medicaid Service (CMS) for 1 of 18 residents (Residents #14), in the survey sample. The findings included: 1. Resident #14 was originally admitted to the facility 2/26/16 and readmitted 4/3/16. The diagnoses at the discharge included dysphagia (difficulty swallowing), urinary retention, chronic pain, an anxiety disorder and peripheral vascular disease. The admission MDS (minimum data set) with an assessment reference date (ARD) of 3/10/16 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 11 out of a possible 15. This indicated Resident #14's cognitive abilities for daily decision making were moderately impaired. The 3/10/16 MDS assessment also revealed Resident #14 required total care with eating, extensive assistance of 2 with bed mobility and dressing, extensive assistance of 1 with transfers, locomotion, and toileting, limited assistance with personal hygiene and total care of 2 with bathing.	F 287		

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F 287	Continued From page 13 An interview was conducted with the Director of Nursing on 8/19/16 at approximately 1:25 p.m., the Director of Nursing stated the resident was discharged home on 6/9/16 and a discharge MDS assessment was presented as completed on 7/19/16 but had not been submitted on 8/18/16.	F 287		