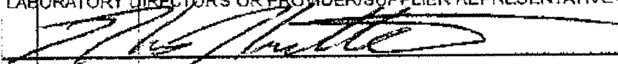
State of Virginia

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495287	A. BUILDING ______ B. WING ______	05/02/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SENTARA NURSING CENTER HAMPTON	2230 EXECUTIVE DRIVE HAMPTON, VA 23666

(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 biennial State Licensure Inspection was conducted 4/26/16 through 4/29/16 and 5/2/16. The facility was not in compliance with the following Virginia Rules and Regulations for licensure of Nursing Facilities. The census in this 86 bed facility was 70 at the time of the survey. The survey sample consisted of 22 residents, 15 current Resident reviews (Residents #1 through 4, #6 through 15 and #22) and 7 closed record reviews (Residents #5 and #16 through 21).	F 000	"Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusion set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of Federal and State law"	
F 001	Non Compliance The facility was out of compliance with the following state licensure requirements: This RULE: is not met as evidenced by: 12 VAC 5-371-220 (C) Nursing Services Please Cross-Reference F 309 12 VAC 5-371-340 (A) Dietary and food service program Please Cross-Reference F 371 12 VAC 5-371-220 (F) Nursing Services Based on resident interview, staff interviews, clinical record reviews the facility staff failed to provide twice weekly showers for 2 of 22 residents in the survey sample, Resident #3, and #12. 1. The facility staff failed to provide showers to Resident #3 who was unable to carry out this activity of daily living without the assistance of staff. 2. The facility staff failed to provide Resident #12	F 001	**12 VAC 5-371-220 (C)** **Cross Reference F-309** Refer to F-Tag 309 of the Plan of Correction. Completion Date: 06/10/16 **12 VAC 5-371-340 (A)** **Cross Reference F-371** Refer to F-Tag 371 of the Plan of Correction. Completion Date: 06/10/16 **12 VAC 5-371-220 (F)** **Cross Reference F-312** Refer to F-Tag 371 of the Plan of Correction. Completion Date: 06/10/16	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE



TITLE: Administrator

(X6) DATE: 05/24/2016

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 001	Continued From Page 1	F 001		

with twice weekly showers per her request from 4/16/16 to 4/28/16.
The findings included:

1. Resident #3 was admitted to the facility on 3/9/16 for rehab services following a hospitalization. The resident's diagnoses included generalized weakness and diabetes.

The admission MDS (Minimum Data Set) with an assessment reference date of 3/16/16 coded the resident as scoring a 15 out of a possible 15 on the Brief Interview for Mental Status (BIMS), indicating the resident's cognition was intact. The resident was dependent on two staff for bed mobility, transfers, and bathing.

On 4/27/16 at 10:30 a.m., the resident was observed in bed. The resident was waiting for physical therapy. The resident was asked if she had received showers since she was admitted to the unit. She stated, "No, I have not received a shower". The resident stated she was given bed baths and would have preferred a shower at least every other day. The resident was asked if she had any restrictions that would have limited her ability to shower, such as a physician order. The resident stated she was not aware of any restrictions. At this time a rehab staff entered the room to take the resident to the rehab department.

Review of the clinical record failed to evidence any limitations for the resident's bathing.

On 4/28/16 at 3:00 p.m., a certified nurse aide (CNA#44) was interviewed. She stated they receive report at the beginning of the shift of resident's who are on the shower list for that day and shift. She stated there is no option on the electronic record to document what type of bath was given, such as either a bed bath or shower.

12 VAC 5-371-150 (A, B)
Cross Reference F-151

Refer to F-Tag 151 of the Plan of Correction.

Completion Date: 06/10/16

12 VAC 5-371-140 (D)
Cross Reference F-241

Refer to F-Tag 241 of the Plan of Correction.

Completion Date: 06/10/16

12 VAC 5-371-280 (A, B1, E)
Cross Reference F-248

Refer to F-Tag 248 of the Plan of Correction.

Completion Date: 06/10/16

12 VAC 5-371-220 (C, 1 D)
Cross Reference F-341

Refer to F-Tag 341 of the Plan of Correction.

Completion Date: 06/10/16

State of Virginia

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F 001	Continued From Page 2	F 001		

Continued From Page 2

The shower log was reviewed and the pages inside were blank. The CNA stated based on the resident's room, that her shower days would have been assigned to the day shift on Wednesday's and Saturday's.

The above findings was shared with the Administrator and the Director of Nursing during a morning meeting conducted on 4/29/16.

No additional information was provided prior to exit.

2. Resident #12 was admitted to the facility on 2/15/16. Diagnoses for Resident #12 included but are not limited to chronic pain and immobility syndrome (paraplegia - paralysis of lower extremities).
Resident #12's Annual Minimum Data Set (MDS) (an assessment protocol) with an Assessment Reference Date (ARD) of 2/22/16 coded Resident #12 with a BIMS (Brief Interview for Mental Status) of 15 of 15 indicating no cognitive impairment. In addition, the MDS coded Resident #12 as being totally dependent with the assistance of one staff person for Bathing. Resident #12 was coded as being totally dependent with transfers with the help of two staff persons for Transfers.
An observation was made of Resident #12 on 4/27/16 at approximately 3:50 p.m. She was observed lying in bed on her back. Resident #12 was well groomed and no odors were noted.
Facility notes documented: Resident #12 was admitted to the hospital on 4/6/16 and returned to the facility on 4/16/16.
The ADL (activity of daily living) Verification Worksheet was reviewed for Resident #12. The log covered dates: 4/1/16 through 4/30/16 with the following dates missing: 4/2/16 through 4/4/16, 4/7/16 through 4/18/16, 4/21/16, and 4/26/16. A notation of "8 8" was noted on the following dates:

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F 001	Continued From Page 3	F 001		

4/1/16, 4/5/16,4/6/16, twice on 4/20/16, 4/23/16, 4/24/16, 4/25/16, 4/29/16, and 4/30/16. The DON (Director of Nursing) stated in an interview on 5/2/16 at approximately 12:45 p.m., "The codes used are the same as used for the MDS."
Resident #12's MDS documents that a (8 8) code indicates that the activity did not occur.
The ADL Verification Worksheet documented the following code (4 2) on the following dates: 4/22/16. The MDS documents that (4 2) indicates that Total dependence with help of one staff member was required. The ADL Verification Worksheet documented the following code (3 2) on 4/28/16. The MDS documents that (3 2) indicates Extensive assistance with one staff person assistance. For the remaining days of April 2016, there was no documentation.
An interview was conducted with Resident #12 on 4/27/16 at approximately 3:50 p.m. Resident #12 stated concerns related to showers. She stated: "No shower for two weeks. I went to the hospital and since I've been back I haven't had any showers. The staff will help me with daily bath and I'd be told not enough help, as reason for no shower." When asked if Resident had filed a grievance, she stated: "No."
An interview was conducted on 4/28/16 at approximately 10:00 a.m. with Resident #12. She stated: "I got a shower last night."
On 4/28/16 at approximately 11:15 a.m. the DON (Director of Nursing) stated: "Staffing has been a challenge. Yes, low staffing can affect the care the residents receive."
An interview was conducted with CNA #40 on 4/29/16 at approximately 9:30 a.m. She stated: "Sometimes, no, can't get showers done. Don't have time to get showers done. Depending on assignment might have 2-3 to do. On Saturday's, not enough help." CNA #40 stated: "On days when not enough help, I get the parts washed that sweat or have odors."

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F 001 Continued From Page 4 F 001

On 5/2/16 at approximately 1:30 p.m., Resident #12 was asked the days she is scheduled for showers. Resident #12 stated: "Wednesday and Saturday are my shower days."
The administration consisting of the Administrator and the DON were briefed of the findings on 4/29/16 at approximately 6:00 p.m. No further information was presented.
No additional information was provided prior to exit.

12VAC5-371-150 (A, B) Please Cross-Reference to F-151
12VAC5-371-140 (D) Please Cross-Reference to F-241
12VAC5-371-280 (A, B(1), E) Please Cross-Reference to F-248 12VAC5-371-220 (C)(1)(D) Please Cross-Reference to F-314
12VAC5-371-220 (A) Please Cross-Reference to F-323

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 (D). Cross Reference to F-241
Nursing Services 12 VAC-371-220 (B). Cross Reference to F-309
Nursing Services 12 VAC-371-220 (D). Cross Reference to F-312
Nursing Services 12 VAC-371-220 (D). Cross Reference to F-323
Administrative Services 12VAC-371-180 (C, 3). Cross Reference to F-441
Resident Services, 12VAC5-371-300 (A). Cross Reference F-425 and F-333

12 VAC 5-371-220 (A)
Cross Reference F-323

Refer to F-Tag 323 of the Plan of Correction.

Completion Date: 06/10/16

12 VAC 5-371-220 (D)
Cross Reference F-241

Refer to F-Tag 241 of the Plan of Correction.

Completion Date: 06/10/16

12 VAC 5-371-220 (B)
Cross Reference F-309

Refer to F-Tag 309 of the Plan of Correction.

Completion Date: 06/10/16

12 VAC 5-371-220 (D)
Cross Reference F-312

Refer to F-Tag 312 of the Plan of Correction.

Completion Date: 06/10/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495287	(X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING ______	(X3) DATE SURVEY COMPLETED 05/02/2016

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12 VAC 5-371-220 (D)

Cross Reference F-323

Refer to F-Tag 323 of the Plan of Correction.

Completion Date: 06/10/16

12 VAC 5-371-180 (C, 3)

Cross Reference F-441

Refer to F-Tag 441 of the Plan of Correction.

Completion Date: 06/10/16

12 VAC 5-371-300 (A)

Cross Reference F-425 and F-333

Refer to F-Tag 425 and 333 of the Plan of Correction.

Completion Date: 06/10/16

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

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F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 04/26/16 through 04/29/16 and 05/02/16. Five complaints were investigated. Significant corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. The census in this 86 certified bed facility was 70 at the time of the survey. The survey sample consisted of 22 residents, 15 current Resident reviews (Residents #1 through 4, #6 through 15 and #22) and 7 closed record reviews (Residents #5 and #16 through 21).	F 000	"Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusion set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of Federal and State law"	
F 151 SS=D	483.10(a)(1)&(2) RIGHT TO EXERCISE RIGHTS - FREE OF REPRISAL The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights. This REQUIREMENT is not met as evidenced by: Based on the Resident Group Interview, facility document review, and staff interviews the facility staff failed to ensure that Residents were afforded the opportunity to exercise their rights as a citizen of the United States to vote in the March 2016 Virginia Primary Presidential Election. The facility staff failed to provide ballot casting options for Residents who desired to vote in the March 2016 Virginia Primary Presidential	F 151	1. Resident council members were impacted. The staff member was educated on resident rights. 2. All residents wishing to vote have the potential to be affected. 3. Activities Director contacted voter registration office to assist in the application process for absentee voting. 4. The Activities Director will audit annually and ID residents' who wish to vote and assist them in obtaining an absentee ballot. Findings will be presented at the QAPI meeting. 5. Completion Date: 06/10/16	

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

Administrator 05/24/2016

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 151	Continued From page 1	F 151		

Election.

The findings included:

On 4/27/16 at 10:00 a.m. a Resident Group Interview was conducted with 11 Residents present. During the group interview the question was posed to the residents if they had been given the opportunity to vote in the March 2016 Virginia Primary Presidential Election and instantly a unanimous " no " was verbalized. The Resident Group was asked if they were aware of the Primary Presidential Candidates running. The Residents began stating Trump and Clinton, no other names were mentioned. The Residents stated that they were not given the opportunity to cast their individual votes.

On 4/27/16 at approximately 11:15 a.m. after the Resident Group Interview had ended the Activities Director was asked if something had been set up to allow the Residents to vote in the March 2016 Virginia Primary Presidential Election. The Activities Director stated, "There were no Absentee Ballots for the Primary for the residents here at the facility in March 2016. But I will make sure they will have them for November."

The facility policy titled "Activity Director's Responsibilities" revised 12/9/14 documented in part, as follows:

The Director of Activities responsibilities include:
*Planning, coordinating, and directing a program of activities that is designed to meet the physical, mental and psychosocial well-being of each resident/participant.

On 4/28/16 at approximately 5:30 p.m. a pre-exit

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 151 Continued From page 2 — F 151

debriefing was held with the Administrator and the Director of Nursing where the above information was shared.

Prior to exit no further information was provided.

F 177 SS=D — 483.10(o) RIGHT TO REFUSE CERTAIN TRANSFERS — F 177

An individual has the right to refuse a transfer to another room within the institution, if the purpose of the transfer is to relocate a resident of a SNF, from the distinct part of the institution that is a SNF to a part of the institution that is not a SNF, or a resident of a NF, from the distinct part of the institution that is a NF to a distinct part of the institution that is a SNF.

A resident's exercise of the right to refuse transfer under paragraph (o)(1) of this section does not affect the individual's eligibility or entitlement to Medicare or Medicaid benefits.

This REQUIREMENT is not met as evidenced by:

Based on resident interview, staff interview, facility documentation review, and in the course of a complaint investigation, the facility staff failed to honor 1 Resident's (Resident #19) refusal of Transfer from a Skilled Nursing bed to a Long Term Care bed within the same facility in a survey sample of 22 residents.

Resident #19 was admitted to the facility on 9/10/15 for skilled nursing services following a hospitalization. Diagnoses on the Admission MDS (Minimum Data Set - an assessment protocol) with an ARD (assessment reference

Provider's Plan of Correction (F 177):

1. Resident #19 was transferred to a dually certified bed and no longer resides at the facility.

2. All residents experiencing a room transfer has the potential to be affected.

3. Social Workers have been in-serviced regarding patient transfer rights.

4. The Social Worker and/or designee will audit 50% of room transfers for 90 days to ensure proper documentation supporting room transfer. Findings will be reported to the QAPI Meeting.

5. Completion Date: 06/10/16

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

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F 177	Continued From page 3	F 177		

date) of 9/17/15, included but were are not limited to Heart Failure, Arthritis, Osteoporosis (a condition makes your bones weak and more likely to break), Cerebrovascular Accident (stroke), and Generalized Muscle Weakness.

The Quarterly MDS with an ARD of 2/26/16, coded Resident #19 as having a 00 of 15 BIMS (Brief Interview for Mental Status) score, indicating severely impaired cognition. In addition, the Quarterly MDS coded Resident #19 as requiring extensive assistance with the assistance of two staff persons for Bed Mobility, Transfers, Toilet Use, and Bathing. The Quarterly MDS coded that Walking in room and corridor did not occur. In addition, Resident #19 was coded as occasionally incontinent of urine. The admission MDS with an ARD of 9/17/15 coded Resident #19 as always incontinent of bowel functioning.

A document was provided on 5/2/16 at approximately 1:43 p.m. by the Rehabilitation Manager, Employee #55. The document stated that therapy services began on 9/11/15 and continued through 11/05/15. The Rehab manager stated that these dates were billed to Resident's private insurance (name of insurance company). Physical Therapy discharge recommendations documented on 11/5/15: "Discharge recommendations: Recommend 24 hour nursing care if patient returns home or Long Term Care. Her husband is not physically capable to provide level of care she requires. Restorative Nursing Program: To facilitate patient maintaining current level of performance and in order to prevent decline, development of and instruction in the following Restorative Nursing Programs has been completed with the

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F 177	Continued From page 4	F 177		

Interdisciplinary team: bed Mobility, ambulation and transfers.

Starting on 1/1/16 Therapy services consisting of Physical Therapy, Occupational Therapy, and Speech Therapy services were reinstated with Medicare Part B being billed. Therapy services billed to Medicare Part B were discontinued on 2/18/16. Therapy services were reinstated on 3/9/16 consisting of Physical Therapy and Occupational Therapy and continued through 3/22/16 and were billed private pay. The Physical Therapy Evaluation and Plan of Treatment documented on 1/1/2016 Assessment Summary documented the following:
"Skilled Justification: Reason for Skilled Services: Patient may benefit from skilled PT (Physical Therapy) to increase strength and activity tolerance to increase independence with gait, transfers, and bed mobility to decrease burden of care for caregivers, to return to PLOF (prior level of function) and to maintain her highest functional level. Focus of POT (Plan of Treatment) Skilled intervention Focus = Restoration. Physical Therapy Discharge Summary dated 2/18/16 documented the following Discharge Recommendations: Recommend patient ambulate with CNAs (certified nursing assistants) attend morning exercise class when available and propel wc (wheel chair) in the facility. Restorative Nursing Program: To facilitate patient maintaining current level of performance and in order to prevent decline, development of and instruction in the following Restorative Nursing Programs has been completed with the Interdisciplinary team: ambulation, bed Mobility and transfers.

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F 177	Continued From page 5	F 177		

Therapy services were reinstated under private pay on 3/9/16. Services consisted of Physical Therapy and Occupational Therapy. The Physical Therapy Evaluation dated 3/9/16 documented the following Skilled Justification: Patient's family requested to resume skilled Physical Therapy. Patient will be seen for a two week trial to increase ambulation. Physical Therapy discharge Summary dated 3/23/16 documented the following discharge Recommendations: Recommend 24 hour care if patient goes home or Long Term Care. Restorative Nursing Program: To facilitate patient maintaining current level of performance and in order to prevent decline, development of and instruction in the following Restorative Nursing Programs has been completed with the Interdisciplinary Team: ambulation, bed Mobility and transfers. Functional Outcomes: Bed Mobility = Minimum Assist; Transfers = Moderate Assist; Level Surfaces = Caregiver Assist

During an interview with Resident #19's spouse on 4/27/16 at approximately 3:55 p.m., her husband stated: "We objected to discharge, without prior notification despite (Doctor #7's) notes of need for skilled care. They removed her over my wife's objection to move."

An interview was conducted with the facility Administrator #1 on 4/29/16 at approximately 8:17 a.m. The administrator did state that Resident #19 was transferred off of the skilled unit to the Long Term Care Unit upon Physical Therapy's 11/06/16 Discharge Summary documenting that Resident #19 was no longer progressing with therapy.

An interview was conducted with the Rehab

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495287	A. BUILDING ______ B. WING ______	C 05/02/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SENTARA NURSING CENTER HAMPTON	2230 EXECUTIVE DRIVE HAMPTON, VA 23666

(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 177	Continued From page 6 Manager on 5/2/16 at approximately 1:45 p.m. She provided dates of service for Rehabilitative Services. She stated: "(Resident #19) was opened to Therapy Services on three different occasions. On each occasion services were stopped as the resident was not longer making progress, therefore no skilled need to continue services. We can not continue even under private pay skilled services of a therapist with a license when a resident no longer makes progression with therapy. The administration consisting of the Administrator and the DON were briefed of the findings on 4/29/16 at approximately 6:00 p.m. No further information was presented.	F 177		
F 241 SS=E	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: 1. Based on observation, resident interviews, facility documentation reviews, clinical record review, and in the course of a complaint investigation, the facility staff failed to maintain and promote dignity for 2 of 22 residents in the survey sample, (Resident #4 and #5). 1. Staff failed to maintain and promote dignity by not knocking on door prior to entrance for Resident #4.	F 241	1. Resident #4 and #5's dignity were not preserved. Resident #4 was not given notification (knocking on door) prior to staff entering room and resident #5 was not taken to the bathroom timely. Staff members were educated on resident rights relating to dignity. 2. All residents have the potential to be affected. 3. Nursing will be in-serviced on dignity. 4. The DON and/or designee will round 5x (times) weekly for 8 weeks to ensure dignity is maintained. Findings will be reported to the QAPI Meeting. 5. Completion Date: 06/10/16	

F 241 Continued From page 7 F 241

2. Staff failed to maintain and promote dignity by not complying with toileting assistance requests in a timely manner to maintain urinary continence for Resident #5.

The Findings included:

1. Resident #4 was originally admitted on 2/17/04 with readmissions on 2/21/14 and 2/24/15. Diagnoses for Resident #4 included but are not limited to Multiple Sclerosis (progressive disease that causes damage to the central nervous system), Diabetes Mellitus (disease where the blood sugars are not controlled), Peripheral Vascular disease (disease affecting blood supply to lower extremities), Pressure Ulcers (bed sores) to sacrum and left heel and Urinary Tract Infection (UTI).

Resident #4's Quarterly Minimum Data Set (MDS - an assessment protocol) with an Assessment Reference Date (ARD) of 1/8/16 coded Resident #4 as having a BIMS (Brief Interview for Mental Status) of 4 out of 15 indicating a severe impairment in cognition. In addition, Resident #4 was coded as being totally dependent with the assistance of two staff persons for bed mobility. Resident #4 was coded as having an indwelling foley catheter and coded as being always incontinent of bowel function.

An observation was made on 4/27/16 at approximately 9:00 a.m. LPN (Licensed Practical Nurse) #39 was observed entering Resident #4's room without knocking on the door prior to entering.

An observation was made on 4/29/16 at approximately 10:30 a.m.. LPN (Licensed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495287	A. BUILDING ______ B. WING ______	C 05/02/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SENTARA NURSING CENTER HAMPTON	2230 EXECUTIVE DRIVE HAMPTON, VA 23666

(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 241	Continued From page 8 Practical Nurse) #39 was observed entering Resident #4's room without knocking on the door prior to entering. In an interview with LPN #39 on 4/29/16 at approximately 10:30 a.m. she/he stated: "I should have knocked. I forget to knock on the doors, especially when I see that the resident sees me coming in." The facility's Policy and Procedure titled "Personal Privacy - Care and Services" with a revision date of 2/10/15 documented the following: "Policy Statement: The privacy and dignity of all residents is maintained. Residents will be examined and treated in a manner that maintains the privacy of their bodies. People not involved in the care of the resident will not be present without the resident's consent while she is being examined or treated." The facility's Policy and Procedure titled "Life Care - Resident Rights and Responsibilities" with a revision date of 11/10/15 documented: "The facility will make every effort to assist the resident in exercising his/her and ensure that the Resident/Patient is always treated with respect, kindness, and dignity." The administration consisting of the Administrator and the DON were briefed of the findings on 4/29/16 at approximately 6:00 p.m. No further information was presented. 2. Resident #5 was a 76 year old admitted to the	F 241		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495287	A. BUILDING ______ B. WING ______	C 05/02/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SENTARA NURSING CENTER HAMPTON	2230 EXECUTIVE DRIVE HAMPTON, VA 23666

(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 241	Continued From page 9	F 241		

facility initially on 6/20/07 and readmitted on 9/1/15 with diagnoses to include. *Diabetes Mellitus, **Chronic Pain, ***Osteoarthritis, ****Depression, and *****Obesity.

The most recent comprehensive Minimum Data Set (MDS) assessment was a Significant Change with an Assessment Reference Date (ARD) of 3/1/16. The Brief Interview for Mental Status (BIMS) was a 15 out of a possible 15 which indicated that Resident #5 was cognitively intact and capable of daily decision making. Under Section G Functional Status the resident was coded extensive two person assist for bed mobility, transfer, dressing, toilet use, and personal hygiene. Under Balance During Transitions and Walking the resident was codes as follows: Moving from seated to standing position=2, not steady, only able to stabilize with staff assistance; Walking, Turning around, Moving on and off toilet=8, Activity did not occur; Surface to surface transfer=2, not steady, only able to stabilize with staff assistance. Under Section H Bladder and Bowel Resident #5 was coded 1= occasionally incontinent (less than 7 episodes of incontinence) for both. The resident was coded under Section K as 63 inches in height and 248 pounds in weight.

Resident #5's Comprehensive Care Plan dated 3/21/16-Present documented in part, as follows:

"Problems: Urinary and Bowel Continence: Resident #5 is frequently incontinent. Intervention: Check for incontinence; change if wet/soiled. Clean skin with mild soap and water. Apply moisture barrier. Check skin for areas of redness. report any changes to the nurse. Use pads/briefs to manage incontinence.

F 241 Continued From page 10 F 241

Problem: Bowel Continence: Resident #5 has occasional incontinent.
Goal: Episodes of bowel incontinence will be eliminated by 5/31/16
Intervention: Document when Resident #5 is incontinent. Perform complete assessment of skin. Note areas of redness. Apply moisture barrier to buttocks.

Problem: Self Care Deficit-assistance required with bathing, hygiene, dressing, tolieting, and grooming r/t (related to) osteoarthritis, decline in function mobility and pain.
Goal: Will be odor free, dressed and out of bed daily over the next 90 days. Resident #5 will assist with ADL's (activities of daily living) to the highest degree possible AEB (as evidenced by) increased ability to perform PLOF (prior level of function).
Intervention: Assist with ADL's (bathing, grooming, tolieting, feeding, ambulating)if Resident #5 unable to complete.
Maintain privacy and dignity during care activity."

On 4/28/16 at 9:00 a.m. an interview was conducted with Resident #5. During the interview Resident #5 stated, "Yesterday afternoon right after shift change around 3:30 p.m. I was in my chair in the hall near the bathroom because I needed to pee. I asked the aide to take me to the bathroom. She said you have to wait, I said I can't wait I gotta pee. I had to pee on myself. When she came back I had been sitting in a wet diaper over an hour at least. It happens all the time. I have to wet and poop on myself too. It makes me feel really bad, because I know when I have to go to the bathroom and I mess up my clothes. I wish I could do it myself, but I can't

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495287	A. BUILDING ______ B. WING ______	C 05/02/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SENTARA NURSING CENTER HAMPTON	2230 EXECUTIVE DRIVE HAMPTON, VA 23666

(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 241	Continued From page 11	F 241		

that's why I'm here. It's very embarrassing, makes you feel like you are being treated like a child or an animal. "

On 3/29/16 at 3:30 p.m. an interview was conducted with CNA #43. CNA #43 was asked if Resident #5 had been incontinent on 4/27/16 during her initial rounds at the beginning of her shift. CNA #43 stated, " I was busy with someone else and I told her I would be back. When I went to change her she was wet. She does know when she has to go." When asked, "Do you feel it is a dignity issue for her to wet on herself? " CNA #43 stated, "Yes I do, it is."

The facility policy titled "Personal Privacy-Care and Services" revised 2/10/15 documented in part:

"Policy Statement: The privacy and dignity of all residents is maintained."

The facility policy titled "Resident Rights and Responsibilities" revised 11/10/15 documented in part:

"Policy Statement: Prior to, upon admission to the facility, the Resident/Patient will be informed of his/her rights, grievance procedures, and the rules and regulations governing his/her conduct and responsibilities while a resident in the facility.

Monitoring:
*The facility will make every effort to assist the resident in exercising his/her and ensure that the Resident/Patient is always treated with respect, kindness, and dignity."

On 4/28/16 at approximately 5:30 p.m. a pre-exit

F 241 Continued From page 12 F 241

debriefing was held with the Administrator and the Director of Nursing where the above information was shared. The Director of Nursing was asked what are her expectations of her staff regarding the toileting of residents. The Director of Nursing stated, "I would expect if a resident was alert and oriented for them to be taken to the bathroom."

Prior to exit no further information was provided.

*Diabetes Mellitus: a complex disorder of carbohydrates, fat, and protein metabolism that is primarily a result of a deficiency or complete lack of insulin secretion by the beta cells of the pancreas or resistance to insulin.

**Chronic Pain: pain that continues or recurs over a prolonged period, caused by various diseases or abnormal conditions.

***Osteoarthritis: a form of arthritis in which one or many joints undergo degenerative changes, including bony sclerosis, loss of cartilage, bone spurs, and cartilage in the joints.

****Depression: a decrease of vital functional activity, a mood disturbance characterized by feelings of sadness, despair, and discouragement resulting from and normally proportionate to some personal loss or tragedy.

*****Obesity: an abnormal increase in the proportion of fat cells, mainly in the viscera and subcutaneous tissues of the body.

The above definitions were derived from Mosby's Dictionary of Medicine, Nursing, and Health Professions 8th Edition.

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
	495287	A. BUILDING ______ B. WING ______	C 05/02/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SENTARA NURSING CENTER HAMPTON	2230 EXECUTIVE DRIVE HAMPTON, VA 23666

(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 246	Continued From page 13	F 246		
F 246 SS=E	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on interviews, clinical record review, facility documentation and in the course of a complaint investigation, facility staff failed to answer call bells in a timely manner for two residents (#16 and # 17) from a survey sample of 22 residents. 1. Resident #16 waited at times 20, 30, and 40 minutes resulting in a delay for assistance with care. 2. Resident #17 waited over 40 and 50 minutes for assistance with care needs. The findings included: 1. In the course of a complaint investigation Resident #16 was placed in the survey sample as a closed record as this resident is no longer at the facility. Resident #16 was admitted to the facility on 5/5/15 and discharged home on 5/23/15. Diagnoses for Resident #16 included but were not limited to End Stage Renal Disease, Atrial Fibrillation, Diabetes, aftercare for traumatic fractured hip, difficulty in walking and muscle	F 246	1. Resident #16 and #17 are no longer at this facility. 2. All residents have the potential to be affected. 3. Nursing will be in-serviced regarding call bell responsiveness. 4. The DON and/or designee will audit 25% of resident call bell responsiveness for 5 weeks. Findings will be reported to the QAPI Meeting. 5. Completion Date: 06/10/16	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495287	A. BUILDING ______ B. WING ______	C 05/02/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SENTARA NURSING CENTER HAMPTON	2230 EXECUTIVE DRIVE HAMPTON, VA 23666

(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 246	Continued From page 14	F 246		

weakness.

Resident #16's Minimum Data Set (an assessment protocol) with an Assessment Reference Date (ARD) of 5/19/2015 coded Resident #16 with a BIMS (Brief Interview Mental Status) score of 15 indicating no cognitive impairment. In addition, the Minimum Data Set coded Resident #16 requiring extensive assistance with one person physical assistance for Activities of Daily Living, specifically toilet use. Also Resident #16 was coded as occasionally incontinent of bladder and always continent of bowel.

In the course of a complaint investigation and record review the call bell logs generated by the facility while Resident #16 was at the facility from 5/5/16 until 5/23/16 (Resident #16's room number during admission) the call bells were consistently answered by staff at times over 20, 30, and 40 minutes:
on 5/6/15 at 10:50 am response time was 23:23 minutes/seconds,
on 5/09/15 at 8:52 pm response time was 27:06 minutes/seconds,
on 5/14/15 at 7:40 pm response time was 37:31 minutes/seconds,
on 5/17/15 at 8:50 am response time was 24:01 minutes/second,
and on 5/23/15 at 8:41 am response time was 23:36 minutes/seconds.

It was noted in the group interview with 11 cognitive residents on 4/27/16 at 10:30 am that it takes staff too long to come and answer the call bells, an hour or more at times.

F 246 Continued From page 15 F 246

According to the care plan under 'continence', Resident #16 is occasionally incontinent... reports pain and had a decline in functional mobility and weakness. The interventions to assist Resident #16 included but are not limited to: Answer call bell quickly ...empty bladder before meals, at bedtime, and before activities.

In an interview with Administration #2 on 4/28/15 at approximately 12:15 pm, it was stated that the expectation for staff to answer call bells was "5 minutes- staff should respond within 5 minutes" and when asked why response time was longer, it was noted as a staffing issue at times which the administrative staff had identified and are in the process of correcting.

According to the facility policy titled, 'Answering Call Light' revised on 4/9/13, the expectation was to "answer call lights promptly" and "make the resident as comfortable as possible and offer further assistance before leaving the room."

2. In the course of a complaint investigation Resident #17 was placed in the survey sample as a closed record as this resident is no longer at the facility. Resident #17 was admitted to the facility on 9/1/15 and discharged home on 9/21/15. Diagnoses for Resident #17 included but were not limited to seizure disorder, enlarged prostate with urinary tract symptoms, constipation, muscle weakness, stroke, and non-Hodgkin lymphoma (a type of blood cancer).

Resident #17's Minimum Data Set (an assessment protocol) with an Assessment Reference Date (ARD) of 9/8/2015 coded Resident #17 with a BIMS (Brief Interview Mental

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495287	A. BUILDING ______ B. WING ______	C 05/02/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SENTARA NURSING CENTER HAMPTON	2230 EXECUTIVE DRIVE HAMPTON, VA 23666

(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 246	Continued From page 16 Status) score of 15 indicating no cognitive impairment. In addition, the Minimum Data Set coded Resident #17 requiring extensive assistance with a two person physical assistance for Activities of Daily Living, specifically toilet use (coded 3 for extensive assistance defined as resident involved in activity, staff provide weight-bearing support and coded 3 for a two person physical assist). Also Resident # 17 was coded as frequently (7 or more episodes) incontinent of bladder and occasionally (one episode) incontinent of bowl. According to the call bell log for Resident #17's room during her stay at the facility from 9/1/15 through 9/21/15 waited consistently over 20 minutes and at times over 40 and 50 minutes for assistance with care needs. According to the call bell logs generated by the facility staff response times recorded: on 9/4/15 at 7:26 pm staff response time was 20:38 minutes/seconds, on 9/5/15 at 5:30 pm the staff response time was 50:31 minutes/seconds, on 9/6/15 at 4:24 pm response time was 28:04 minutes/seconds, on 9/6/15 at 6:01 pm response time was 40:42 minutes/seconds, on 9/7/15 at 6:52 pm response time was 48:22 minutes/seconds, on 9/10/15 at 6:03 pm response time was 22:10 minutes/seconds, on 9/11/15 at 5:52 pm response time was 23:04 minutes/seconds, on 9/13/15 at 12:11 pm response time was 27:46 minutes/seconds, on 9/14/15 at 9:35 pm response time was 40:35 minutes/seconds, on 9/15/15 at 7:12 pm response time was 22:26	F 246		

F 246 Continued From page 17 F 246

minutes/seconds,
on 9/16/15 at 6:32 am response time was 24:20 minutes/seconds,
on 9/19/15 at 5:56 response time was 37:08 minutes/seconds,
on the same evening 9/19/15 at 8:32 pm staff response time was 23:52 and
again on 9/19/15 at 9:42 pm response time was 31:56 minutes/seconds.

According to a clinical note dated 9/8/15 Resident #17 was alert and oriented with a BIMS score of 15 (no cognitive impairment), reported experienced pain in the last 5 days occurring occasionally at a rate of 8/10 moderate in severity, and sometimes made it hard to sleep at night.

According to Resident #17's care plan due to incontinence and risk for falls with a history of falls interventions included but were not limited to: Respond promptly to calls for assist to the toilet. Due to the risk for skin breakdown it was care planned for Resident #17 to be checked for incontinence and changed if wet/soiled; however, the frequency of 3 times a day was not implemented to start until 9/21/15.

In an interview with Resident #17 on 4/28/16 at 10:28 am it was stated that the call bell was used but the response time was long especially after 7 pm and, "one evening I had to wait until the next morning to be changed after I had slept in my urine." She could not recall the date.

It was also noted in the group interview with 11 cognitive residents on 4/27/16 at 10:30 am that it takes staff too long to come and answer the call

F 246 Continued From page 18 — F 246

bells, an hour or more at times.

In an interview with Administration #2 on 4/28/15 at approximately 12:15 pm it was stated that the expectation for staff to answer call bells was: "5 minutes- staff should respond within 5 minutes" and when asked why response time was longer, it was noted as a staffing issue at times which the administrative staff had identified and are in the process of correcting.

According to the facility policy titled, 'Answering Call Light' revised on 4/9/13, the expectation was to, "answer call lights promptly" and "make the resident as comfortable as possible and offer further assistance before leaving the room."

Complaint Deficiency

F 248 SS=E — 483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES — F 248

The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident.

This REQUIREMENT is not met as evidenced by:

Based on the Resident Group Interview, facility document review, and staff interviews the facility staff failed to provide an ongoing program of activities to enhance the highest practicable level of physical, mental, and psychosocial well-being in November 2015, December 2015, January 2016 and February 2016 for all residents in the facility.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495287	A. BUILDING ______ B. WING ______	C 05/02/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SENTARA NURSING CENTER HAMPTON	2230 EXECUTIVE DRIVE HAMPTON, VA 23666

(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 248 Continued From page 19

F 248

The facility staff failed to ensure that a ongoing program of activities was in place in November 2015, December 2015, January 2016, and February 2016 for all facility residents.

The findings included:

On 4/27/16 at 10:00 a.m. a Resident Group Interview was conducted with 11 cognitive Residents present. During the group interview the residents were asked about activities in the building. The following statements were made by the residents in group, "We just started having activities back a month or two ago", "We didn't have anything for about 4 months", "We only played bingo a few times in the 4 months, nothing else". The surveyor asked the group, "What did you do everyday for the 4 months?" The group responded, "Nothing we didn't have a activities person." When the residents in group were asked if this was the consensus of the entire group they all 11 residents agreed.

On 4/27/16 at approximately 11:15 a.m. after the Resident Group Interview had ended an interview was conducted with the Activities director. The Activities Director was made aware that the Residents in group had shared that they had went without activities in the building for about 4 months and was asked if this was correct. The Activities Director stated, "I only started a few months ago on February 22, there wasn't a Activities Director here for a few months before me. I have been working really hard to get the activities back up and going here again. I hired an assistant and we have a full calendar now" Surveyor asked, "How do you track which activities the residents attend?" The Activities

1. Residents received limited activities from November 2015 through February 2016.

2. All residents wishing to participate in activities has the potential to be affected.

3. The facility has hired an Activities Director and Activities Assistant to ensure daily activities are provided for the residents.

4. The Activities Director will provide a monthly activity calendar of events monthly. Findings will be reported to the QAPI Meeting.

5. Completion Date: 06/10/16

(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 248 Continued From page 20 F 248

Director stated, "Each resident has a monthly calendar and I highlight the activity they attend."

The Resident Attended Activity Calendars for March and April 2016 were reviewed and revealed that the residents were having and attending numerous activities. The Activity Director was asked to show the Resident Attended Activity Calendars for November 2015, December 2015, January 2016 and February 2016. According to the Activity Director there were no documentation of activities for the residents for November, January, or February. The Activity Director was able to locate some Resident Attended Activity Calendars for December and was asked to pull the ones for the residents that had attended the Group Interview. Nine Resident Attended Activity Calendars for December were reviewed with from the Group interview. The number of attended activities on the calendars ranged from 0 to 4 for of the 9 residents in the month of December.

On 4/27/16 at approximately 12:30 p.m. the Administrator was made aware that the Residents in group had shared that they had went without activities in the building for about 4 months and was asked if this was correct. The Administrator stated, "We had been without an Activities Director for about 4 months, end of last year and the first part of this year." Surveyor asked, "Who did the activities with the residents when you were without a Activities Director?" The Administrator replied, "Different ones of my staff would go in and do things with them. The Administrator was asked for the dates of the prior Activities Director leaving and the date the new Activity Director started. The prior Activities Director was on an approved leave from November 19, 2015-

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495287	A. BUILDING ______ B. WING ______	C 05/02/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SENTARA NURSING CENTER HAMPTON	2230 EXECUTIVE DRIVE HAMPTON, VA 23666

(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 248	Continued From page 21	F 248		

January 11, 2016, returned January 12, 2016 and left employment with the facility on February 6, 2016. The new Activities Director's hire date at the facility was February 22, 2016.

The facility policy titled "Activity Director's Responsibilities" revised 12/9/14 documented in part, as follows"

Policy Statement: The Activity Director will be a qualified professional who meets federal and state specific requirements. The Director is delegated by the Administrator, the authority, responsibility and accountability to implement established resident/participant Activity Policies and Procedures.

The Director of Activities responsibilities include:

*Planning, coordinating, and directing a program of activities that is designed to meet the physical, mental and psychosocial well-being of each resident/participant.
*Assuring timely completion of resident's/participant's records, and maintaining records necessary for the completion of activity services.

The facility policy titled "Activity Program" revised 12/9/14 documented in part, as follows"

Purpose: The facility will provide for an ongoing program designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident/participant.

Procedure:

(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 248	Continued From page 22 2. Activities are scheduled daily and residents are given the opportunity to assist in planning and critiquing the Activity Programs. 5. The Activity program consists of individual, small and large group activities. 7. Notice of cancellations/changes of scheduled programs will be provided in advance to residents and appropriate personnel. On 4/28/16 at approximately 5:30 p.m. a pre-exit debriefing was held with the Administrator and the Director of Nursing where the above information was shared. Prior to exit no further information was provided.	F 248		
F 309 SS=E	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on staff interviews, clinical record review and during the course of a complaint investigation the facility staff failed to provide services to 2 of 22 residents to maintain their highest practicable physical well-being, Resident #18 and #19. 1. The facility staff failed to follow the physician orders for diabetic management for Resident #18. The nursing staff failed to notify the physician of	F 309		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495287	A. BUILDING ______ B. WING ______	C 05/02/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SENTARA NURSING CENTER HAMPTON	2230 EXECUTIVE DRIVE HAMPTON, VA 23666

(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 309	Continued From page 23 blood sugars outside the ordered parameters; less than 70 or greater than 350. 2. The facility staff failed to follow physician orders for daily showers for Resident #19. The findings included: 1. Resident #18 was originally admitted to the facility on 3/6/15 with a diagnosis of diabetes. The resident expired at the facility on 1/28/16. The last MDS (Minimum Data Set) a quarterly with an assessment reference date of 1/12/16 coded the resident as scoring a 6 out of a possible 15 on the Brief Interview for Mental Status (BIMS), indicating the resident had severely impaired cognition. The resident had received insulin injections each day of 7 day look back/assessment period. The comprehensive plan of care identified the resident had a potential for hypo/hyper (low or high) blood sugars. The goal was that the resident would not have signs or symptoms of a diabetic reaction. Two of the interventions listed to achieve/maintain the goal was to monitor "Accuchecks per MD (physician) order, and notify the MD as needed". An Accucheck is a blood sugar meter. The complainant alleged the resident was sent to the emergency room three times for a blood sugar of 30 or less between 3/6/15 and 6/9/15; normal lab reference for blood glucose/sugar is above 70 mg/dl-milligram per deciliter. A review of the clinical record evidenced the resident was sent to the emergency room on one	F 309	1. Patients #18 and #19 are no longer at this facility. 2. All residents with physician order pertaining to blood sugar and showers have the potential to be affected. 3. All nurses were educated on executing physician orders and when to notify physician and documentation. 4. The DON and/or designee will randomly audit 25% of residents weekly for 8 weeks to ensure diabetic medication and showers as ordered are followed. Findings will be reported to the QAPI Meeting. 5. Completion Date: 06/10/16	

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
	495287	A. BUILDING ______ B. WING ______	C 05/02/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SENTARA NURSING CENTER HAMPTON	2230 EXECUTIVE DRIVE HAMPTON, VA 23666

(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 309	Continued From page 24	F 309		

occasion during that time range; on 4/13/15 for a blood sugar of 29. The resident was treated at the hospital and discharged back to the facility.

Resident #18's diabetic management orders from admission to June 2015 were further reviewed. The physician ordered Accuchecks to be done before meals along with sliding scale insulin coverage from March 2015 through April 2015. In May 2015 the Accucheck was changed to include before meals and before bedtime starting 5/12/15.

The Accucheck sliding scale orders dated 3/6/15 and 5/12/15 read: Humalog insulin-sliding scale: blood sugar < (less than) 70.00 or > (greater) 350.00 Notify MD.

The Medication Administration Record's (MAR's) for March, April, May and June 2015 were reviewed. There were 10 occasions of blood sugars less than 70, and 33 occasions of blood sugars above 350. There was no evidence in the nurses notes or the MAR of notification of the physician for these 43 blood sugars outside the parameters.

In March 2015, there were 11 high blood sugars without notification obtained on: 3/9 at 11:00 am=529, 3/11 at 4:30 pm=406, 3/12 at 11:00 am=389, 3/13 at 11:00 am=376, 3/16 at 11:00 am=367, 3/22 at 11:00 am=353, 3/27 at 11:00 am=407, 3/29 at 6:30 am=367 and 3/30 at 6:30 am=353.

In April 2015, there were 8 high blood sugars without notification obtained on: 4/1 at 6:30 am=383, 4/2 at 4:30 pm=362, 4/3 at 6:30 am=408, 4/4 at 6:30 am=387 and at 11:30

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F 309	Continued From page 25	F 309		

am=446, 4/5 at 4:30 pm=357, 4/14 at 11:30 am=415 and 4/18 at 11:30 am=437. There were 2 low blood sugars without notification obtained on: 4/27 at 9:00 pm=56 and 4/28 at 9:00 pm=64.

In May 2015, there were 7 high blood sugars without notification obtained on: 5/3 at 6:30 am=404, 5/4 at 6:30 am=438, 5/6 at 6:30 am=418 and 11:30 am=508, 5/7 at 11:30 am=395 and on 5/8 at 11:30 am=354. There were 5 low blood sugars without notification obtained on 5/9 at 4:30 pm=68, 5/18 at 11:30=69, 5/21 at 4:30 pm=39, 5/28 at 4:30 pm-47 and 5/29 at 4:30 pm=59. On 5/21 at 4:30 pm, the resident was administered 1 milligram intramuscularly glucagon per physician orders dated 3/8/15.

In June 2015 there were 7 occasions the nurse failed to call on: 6/5/at 4:30 pm=398, 6/5 at 9:00 pm=378, 6/11 at 9:00 pm=388, 6/12 at 11:30 am=418, 6/17 at 11:30 am=358, 6/28 at 4:30 pm=375 and 6/30 at 4:30 pm=358. There were 3 low blood sugars without notification obtained on 6/20 at 4:30 pm-62, 6/21 at 4:30 pm=65, and 6/22 at 4:30 pm=58.

The failure to notify the physician when the blood sugars were outside the parameters was shared with the Administrator and the Director of Nursing during the morning of 4/29/16. The Director of Nursing was afforded the opportunity to provide any additional information to address this.

On 4/29/16 at 2:00 pm, the Director of Nursing stated, "The expectation is that they would follow the physician orders...notification would be found in the nurses notes".

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495287	A. BUILDING ______ B. WING ______	C 05/02/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SENTARA NURSING CENTER HAMPTON	2230 EXECUTIVE DRIVE HAMPTON, VA 23666

(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 309	Continued From page 26	F 309		

2. Resident #19 was admitted to the facility on 9/10/15 for skilled nursing services following a hospitalization. Diagnoses on the Admission MDS (Minimum Data Set - an assessment protocol) with an ARD (assessment reference date) of 9/17/15,included but were are not limited to Heart Failure, Arthritis, Osteoporosis (a condition makes your bones weak and more likely to break, Cerebrovascular Accident (stroke), and Generalized Muscle Weakness.

The Quarterly MDS with an ARD of 2/26/16, coded Resident #19 as having a 00 of 15 BIMS (Brief Interview for Mental Status) score, indicating severely impaired cognition. In addition, the Quarterly MDS coded Resident #19 as requiring extensive assistance with the assistance of two staff persons for Bed Mobility, Transfers, Toilet Use, and Bathing. The Quarterly MDS coded that Walking in room and corridor did not occur. In addition, Resident #19 was coded as occasionally incontinent of urine. Resident was rated as (9) for bowel continence indicating that the resident did not have a bowel movement for the entire 7 days the assessment is based on. The admission MDS with an ARD of 9/17/15 coded Resident #19 as always incontinent of bowel functioning.

A physicians order dated 3/7/16 documented Daily Showers.

On 4/29/16 at approximately 11:10 a.m. CNA #65 provided the surveyor with a Bath List and stated: (Resident #19's) "...shower days were Wednesday and Saturday on day shift."

The ADL (activity of daily living verification worksheet) was reviewed.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495287	A. BUILDING ______ B. WING ______	C 05/02/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SENTARA NURSING CENTER HAMPTON	2230 EXECUTIVE DRIVE HAMPTON, VA 23666

(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 309	Continued From page 27	F 309		

Starting on 3/7/16 when a physician's order was written for daily showers, the log for the remainder of March 2016 documented no bathing for the following dates: 3/8/16 through 3/11/16, 3/16/16 through 3/20/16, 3/23/16, 3/24/16, 3/26/16, 3/29/16, and 3/30/16. The following seven dates were not included in the ADL printout: 3/12/16, 3/13/16, 3/15/16, 3/21/15, 3/21/16, 3/25/16, 3/27/16, and 3/28/16.

An interview was conducted with Resident #19's spouse on 4/27/16 at approximately 3:55 p.m. Resident #19's spouse stated that when Resident #19 was on the skilled unit she received daily showers. He stated that the daily showers stopped upon transfer to Unit 1, the Long Term Care Unit.

An interview was conducted with the Director of Nursing (DON) on 4/27/16 at approximately 9:15 a.m. She stated that the computer system has a glitch that does not allow the printout to differentiate between showers and baths.

An interview was conducted with CNA #40 on 4/29/16 at approximately 9:30 a.m. CNA #40 stated: "Sometimes, no, can't get showers done. Don't have time to get showers done. Depending on assignment might have 2-3 to do. On Saturday's, not enough help." CNA #40 stated: "On days when not enough help, I get the parts washed that sweat or have odors." CNA #40 stated: "She (Resident #19) was my assignment most of the time. When I went part time around February she was (CNA #61's) assignment. She (Resident #19) didn't get daily showers until about the last month."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495287	A. BUILDING ______ B. WING ______	C 05/02/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SENTARA NURSING CENTER HAMPTON	2230 EXECUTIVE DRIVE HAMPTON, VA 23666

(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 309	Continued From page 28 The administration consisting of the Administrator and the DON were briefed of the findings on 4/29/16 at approximately 6:00 p.m. No further information was presented.	F 309		
F 312 SS=E	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interviews, and clinical record reviews the facility staff failed to provide the necessary services to maintain good personal hygiene for 2 of 22 residents in the survey sample, Resident #3 and #12. 1. The facility staff failed to provide showers to Resident #3 who was unable to carry out this activity of daily living without the assistance of staff. 2. The facility staff failed to provide Resident #12 with twice weekly showers per her request from 4/16/16 to 4/28/16. The findings included: 1. Resident #3 was admitted to the facility on 3/9/16 for rehab services following a hospitalization. The resident's diagnoses included generalized weakness and diabetes.	F 312	1. Residents #3 and #12 were provided showers. 2. All residents have the potential to be affected. A 100% review of current residents will be completed to ensure that showers are scheduled for a least twice per week. 3. C.N.A's will be educated on bathing schedule and documentation. 4. Director of Nursing and/or designee will audit 10% of residents weekly for 8 weeks. Findings will be reported to the QAPI Meeting. 5. Completion Date: 06/10/16	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495287	A. BUILDING ______ B. WING ______	C 05/02/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SENTARA NURSING CENTER HAMPTON	2230 EXECUTIVE DRIVE HAMPTON, VA 23666

(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 312	Continued From page 29 The admission MDS (Minimum Data Set) with an assessment reference date of 3/16/16 coded the resident as scoring a 15 out of a possible 15 on the Brief Interview for Mental Status (BIMS), indicating the resident's cognition was intact. The resident was dependent on two staff for bed mobility, transfers, and bathing. On 4/27/16 at 10:30 a.m., the resident was observed in bed. The resident was waiting for physical therapy. The resident was asked if she had received showers since she was admitted to the unit. She stated, "No, I have not received a shower". The resident stated she was given bed baths and would have preferred a shower at least every other day. The resident was asked if she had any restrictions that would have limited her ability to shower, such as a physician order. The resident stated she was not aware of any restrictions. At this time a rehab staff entered the room to take the resident to the rehab department. Review of the clinical record failed to evidence any limitations for the resident's bathing. On 4/28/16 at 3:00 p.m., a certified nurse aide (CNA#44) was interviewed. She stated CNA's receive report at the beginning of their shift of those resident's who are scheduled to receive a shower for that day and shift. She stated there is no option on the electronic record to document what type of bath was given, such as either a bed bath or shower. The shower log was reviewed and the pages inside were blank. The CNA stated based on the resident's room, her shower days were assigned to the day shift on Wednesday's and Saturday's.	F 312		

F 312 Continued From page 30 F 312

The above findings was shared with the Administrator and the Director of Nursing during a morning meeting conducted on 4/29/16.

No additional information was provided prior to exit.

2. Resident #12 was admitted to the facility on 2/15/16. Diagnoses for Resident #12 included but are not limited to chronic pain and immobility syndrome (paraplegia - paralysis of lower extremities).
Resident #12's Annual Minimum Data Set (MDS) (an assessment protocol) with an Assessment Reference Date (ARD) of 2/22/16 coded Resident #12 with a BIMS (Brief Interview for Mental Status) of 15 of 15 indicating no cognitive impairment. In addition, the MDS coded Resident #12 as being totally dependent with the assistance of one staff person for Bathing. Resident #12 was coded as being totally dependent with transfers with the help of two staff persons for Transfers.
An observation was made of Resident #12 on 4/27/16 at approximately 3:50 p.m. She was observed lying in bed on her back. Resident #12 was well groomed and no odors were noted.
Facility notes documented: Resident #12 was admitted to the hospital on 4/6/16 and returned to the facility on 4/16/16.
The ADL (activity of daily living) Verification Worksheet was reviewed for Resident #12. The log covered dates: 4/1/16 through 4/30/16 with the following dates missing: 4/2/16 through 4/4/16, 4/7/16 through 4/18/16, 4/21/16, and 4/26/16. A notation of "8 8" was noted on the following dates: 4/1/16, 4/5/16,4/6/16, twice on 4/20/16, 4/23/16, 4/24/16, 4/25/16, 4/29/16, and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495287	A. BUILDING ______ B. WING ______	C 05/02/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SENTARA NURSING CENTER HAMPTON	2230 EXECUTIVE DRIVE HAMPTON, VA 23666

(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 312	Continued From page 31 4/30/16. The DON (Director of Nursing) stated in an interview on 5/2/16 at approximately 12:45 p.m., "The codes used are the same as used for the MDS." Resident #12's MDS documents that a (8 8) code indicates that the activity did not occur. The ADL Verification Worksheet documented the following code (4 2) on the following dates: 4/22/16. The MDS documents that (4 2) indicates that Total dependence with help of one staff member was required. The ADL Verification Worksheet documented the following code (3 2) on 4/28/16. The MDS documents that (3 2) indicates Extensive assistance with one staff person assistance. For the remaining days of April 2016, there was no documentation. An interview was conducted with Resident #12 on 4/27/16 at approximately 3:50 p.m. Resident #12 stated concerns related to showers. She stated: "No shower for two weeks. I went to the hospital and since I've been back I haven't had any showers. The staff will help me with daily bath and I'd be told not enough help, as reason for no shower." When asked if Resident had filed a grievance, she stated: "No." An interview was conducted on 4/28/16 at approximately 10:00 a.m. with Resident #12. She stated: "I got a shower last night." On 4/28/16 at approximately 11:15 a.m. the DON (Director of Nursing) stated: "Staffing has been a challenge. Yes, low staffing can affect the care the residents receive." An interview was conducted with CNA #40 on 4/29/16 at approximately 9:30 a.m. She stated: "Sometimes, no, can't get showers done. Don't have time to get showers done. Depending on assignment might have 2-3 to do. On Saturday's, not enough help." CNA #40 stated: "On days when not enough help, I get the parts washed	F 312		

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
	495287	A. BUILDING ______ B. WING ______	C 05/02/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SENTARA NURSING CENTER HAMPTON	2230 EXECUTIVE DRIVE HAMPTON, VA 23666

(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 312	Continued From page 32 that sweat or have odors." On 5/2/16 at approximately 1:30 p.m., Resident #12 was asked the days she is scheduled for showers. Resident #12 stated: "Wednesday and Saturday are my shower days." The administration consisting of the Administrator and the DON were briefed of the findings on 4/29/16 at approximately 6:00 p.m. No further information was presented.	F 312		
F 314 SS=G	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observations, clinical record reviews, facility documentation, and staff interviews the facility staff failed to identify facility acquired pressure ulcers prior to them developing to an advanced stage resulting in harm for 2 of 22 residents in the survey sample, Resident #5 and #13. 1. The facility staff failed to identify a Stage III Sacrum Pressure Ulcer prior to it developing to an Advanced Stage on 2/17/16 for Resident #5, which constitutes harm.	F 314	1. Pressure Ulcer for residents #5 and #13 were resolved. 2. All residents identified as high risk have the potential to be affected. Current residents will have pressure ulcer risk assessments completed. 3. All licensed nursing staff will be educated on skin integrity assessments. 4. Director of Nursing and/or designee will randomly audit 25% of Braden scale weekly for 12 weeks. Clinical Manager and/or designee will complete a review of 50% of weekly skin assessments for 8 weeks. Findings will be reported to the QAPI Meeting. 5. Completion Date: 06/10/16	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495287	A. BUILDING ______ B. WING ______	C 05/02/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SENTARA NURSING CENTER HAMPTON	2230 EXECUTIVE DRIVE HAMPTON, VA 23666

(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 314	Continued From page 33	F 314		

2. The facility staff failed to identify a Stage III Left Ankle Pressure Ulcer prior to it developing to an Advanced Stage on 1/13/16 for Resident #13, which constitutes harm.

The findings included:

1. Resident #5 was a 76 year old admitted to the facility initially on 6/20/07 and readmitted on 9/1/15 with diagnoses to include *Stage III Pressure Ulcer, **Diabetes Mellitus, ***Chronic Pain, ****Osteoarthritis, *****Depression, and ******Obesity.

The most recent comprehensive Minimum Data Set (MDS) assessment was a Significant Change with an Assessment Reference Date (ARD) of 3/1/16. The Brief Interview for Mental Status (BIMS) was a 15 out of a possible 15 which indicated that Resident #5 was cognitively intact and capable of daily decision making. Under Section G Functional Status the resident was coded extensive two person assist for bed mobility, transfer, dressing, toilet use, and personal hygiene. Under Balance During Transitions and Walking the resident was coded as follows: Moving from seated to standing position = 2, not steady, only able to stabilize with staff assistance; Walking, Turning around, Moving on and off toilet = 8, Activity did not occur; Surface to surface transfer = 2, not steady, only able to stabilize with staff assistance. Under Section H Bladder and Bowel Resident #5 was coded 1= occasionally incontinent (less than 7 episodes of incontinence) for both. The resident was coded under Section K as 63 inches in height and 248 pounds in weight. Under Weight

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495287	A. BUILDING ______ B. WING ______	C 05/02/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SENTARA NURSING CENTER HAMPTON	2230 EXECUTIVE DRIVE HAMPTON, VA 23666

(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 314	Continued From page 34	F 314		

Loss/Weight Gain the resident was coded 0, indicating that there was no gain or loss of 5% in the last month or 10% in the last 6 months. Under Skin Conditions Resident #5 was coded as having one Stage III pressure ulcer measuring 1.5 cm (centimeters) x 1.0 cm x 0.3 cm. The most severe tissue type for any pressure ulcer being a 4 indicating Eschar-black, brown, or tan tissue that adheres firmly to the wound bed or ulcer edges, may be softer or harder than surrounding skin. Resident was also coded to have pressure reducing devices for her chair and bed, on a turning and repositioning program, pressure ulcer care with application of ointments/medications other than to feet.

Resident #5's Comprehensive Care Plan dated 11/27/15-3/21/16 documented in part, as follows:

"Problems: Resident #5 at risk of pressure ulcer r/t (related to) her decreased mobility and history of incontinence/skin impairment. (9/23/15).
Interventions:
-weekly skin inspections with referrals to wound care specialist/pcp (patient care provider) as indicated.
-Check skin for redness, skin tears, swelling, or pressure areas. Report any signs of skin breakdown.

Problems: Stage 3 pressure ulcer SACRUM onset 2/17/16
Interventions:
-Assess and record the size (L x W x D) (length x width x depth), amount and characteristics of exudates, and pain status. 1 Time Weekly Starting 2/17/16.
-Perform complete skin assessment and record. I Time Weekly Starting 2/17/16.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495287	A. BUILDING ______ B. WING ______	C 05/02/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SENTARA NURSING CENTER HAMPTON	2230 EXECUTIVE DRIVE HAMPTON, VA 23666

(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 314	Continued From page 35	F 314		

-Provided care according to the protocol for Stage 3 Pressure Ulcer.
-ROHO cushion to chair when OOB (out of bed)."

During the survey Resident #5 was observed up in the wheelchair on 4/26/16, 4/27/16, 4/28/16, and 4/29/16 throughout the day with no ROHO cushion (pressure relief cushion) in place for pressure relief.

Resident #5's April 2016 Physician Orders signed 4/1/16 indicated the following order: 2/23/16 ROHO cushion to chair when OOB (out of bed).

The Director of Nursing was asked for all Braden Scales for Predicting Pressure Sore Risk for Resident #5 that had been completed the past year. Only 2 Braden Scales were completed and documented in part, as follows:

"5/13/15
Sensory Perception-No Impairment
Moisture-Rarely Moist
Activity-Chair Fast
Mobility-Slightly Limited
Nutrition-Adequate
Friction and Shear-No Apparent Problem
Braden Score-19=No Risk

9/1/15
Sensory Perception-No Impairment
Moisture-Occasionally Moist
Activity-Chair Fast
Mobility-Slightly Limited
Nutrition-Adequate
Friction and Shear-Potential Problem
Braden Score-17=At Risk"

The Director of Nursing was asked for a copy of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495287	A. BUILDING ______ B. WING ______	C 05/02/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SENTARA NURSING CENTER HAMPTON	2230 EXECUTIVE DRIVE HAMPTON, VA 23666

(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 314 Continued From page 36 F 314

all Weekly Skin Assessments for Resident #5 for February and March 2016. The following Weekly Skin Assessments were reviewed and documented in part, as follows:

"Date Created: 2/9/16 11:02 p.m.
Does this patient have a Pressure Ulcer?-0-No
Completed Signature: (Nurse's Name)
Date/Time Stamped 2/10/16 12:02 a.m.

Date Created: 2/17/16 1:08 a.m.
Does this patient have a Pressure Ulcer?-0-No
Completed Signature: (Nurse's Name)
Date/Time Stamped 2/17/16 2:08 a.m.

Date Created: 3/9/16 5:22 a.m.
Does this patient have a Skin Lesion or an Open Wound?-1-Yes
Does this patient have a Pressure Ulcer?-1-Yes
Completed Signature: (Nurse's Name)
Date/Time Stamped 3/9/16 6:22 a.m."

Weekly Skin Assessments for Resident #5 dated 2/23/15 and 3/2/16 could not be found per the Director of Nursing.

Resident #5's Clinical Note dated 2/17/16 at 12:15 p.m., approximately 10 hours after the Weekly Skin Assessment was signed completed with no identified Pressure Ulcers, documented in part, as follows:

"Writer in with wound MD (Medical Doctor) this am to assess patients sacral wound. Patients sacrum has 50% necrotic tissue and 50% granulation tissue and has moderate amount of serous drainage. We will do santyl daily. Patient refuses debridement and made aware of risks of not having wound debrided. Patient tolerated well

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
	495287	A. BUILDING ______ B. WING ______	C 05/02/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SENTARA NURSING CENTER HAMPTON	2230 EXECUTIVE DRIVE HAMPTON, VA 23666

(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 314	Continued From page 37	F 314		

and denies pain. (Wound Nurse name)"

Resident #5's Weekly Skin Condition Progress Report was reviewed and documented in part, as follows:

"Type of Wound: Pressure Ulcer
Wound Location: sacrum
Date of Onset: 2/17/16
Contributing Factors: Incontinence

Assessment Date: 2/17/16
Stage of Ulcer: Stage III
Wound Size: length (cm) 2.0 Width (cm) 1.0
Depth (cm) 0.3
Tissue Type: Granulating 50%, Necrotic 50%
Exudate: Moderate
Exudate Color: Straw/Red

Assessment Date: 2/24/16
Stage of Ulcer: Stage III
Wound Size: length (cm) 1.5 Width (cm) 1.0
Depth (cm) 0.3
Tissue Type: Granulating 40%, Necrotic 10%
Exudate: Moderate
Exudate Color: Straw/Red

Assessment Date: 3/2/16
Stage of Ulcer: Stage III
Wound Size: length (cm) 1. Width (cm) 0.5 Depth (cm) 0.3
Tissue Type: Granulating 80%, Slough 20%
Exudate: Moderate
Exudate Color: Straw

Assessment Date: 3/9/16
Stage of Ulcer: Stage III
Wound Size: length (cm) 0.5 Width (cm) 0.3
Depth (cm) 0.2

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495287	A. BUILDING ______ B. WING ______	C 05/02/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SENTARA NURSING CENTER HAMPTON	2230 EXECUTIVE DRIVE HAMPTON, VA 23666

(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 314	Continued From page 38	F 314		

Tissue Type: Granulating 95%, Slough 5%
Exudate: Moderate
Exudate Color: Straw/Red"

The Wound Care Specialist Evaluations for Resident #5 were reviewed and documented in part, as follows:

"2/17/16
History of Present Illness:
Chief Complaint: Patient has a wound on their sacrum.
HPI (history of physical illness) Statement: She presents with a stage 3 pressure wound of the sacrum of at least 1 days duration.
Appetite: Good
Focused Wound Exam:
Etiology: Pressure
MDS 3.0 Stage: 3
Duration >1 days
Wound Size: 2.0 x 1.0 x 0.3 cm
Surface Area: 2.00 cm (centimeter) squared
Exudate: Moderate Serous
Yellow Necrotic: 50%
Granulation Tissue: 50%
Dressing: Santyl-Once Daily
Coordination of Care: Data and history pertinent to this patient's care were obtained via Nursing Staff, Patient. This patient's care was discussed with another health care provider Nursing Staff Member during this visit.

3/16/16
History of Present Illness:
Chief Complaint: Patient has a wound on their sacrum.
HPI (history of physical illness) Statement: She presents with a stage 3 pressure wound of the sacrum of at least 25 days duration. Prior healing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495287	A. BUILDING ______ B. WING ______	C 05/02/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SENTARA NURSING CENTER HAMPTON	2230 EXECUTIVE DRIVE HAMPTON, VA 23666

(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 314 Continued From page 39 F 314

wound has improved and required confirmation of current clinical status and evaluation with preventive recommendations to prevent recurrence.
Appetite: Good
Focused Wound Exam:
Etiology: Pressure
MDS 3.0 Stage: 3
Duration >25 days
Objective: Healing
Wound Progress: Resolved 3/16/16
Coordination of Care: Data and history pertinent to this patient's care were obtained via Nursing Staff, Patient. This patient's care was discussed with another health care provider Nursing Staff Member during this visit."

The facility policy titled "Physician Approved Pressure Ulcer-Prevention Orders/Protocol" not dated , documented in part:

"All Residents

3. All Residents are assessed for pressure ulcer risk on admission; weekly times four weeks, then quarterly, with significant change and annually using the Braden scale. Re-evaluate if a pressure ulcer is identified.
6. Weekly skin inspections.
7. Apply Moisture/barrier after incontinence episodes.
8. Develop patient-specific written care plan for pressure ulcer prevention."

The facility policy titled "Pressure Ulcer Prevention" revised 11/12/16 documented in part;

"Policy Statement: To prevent development of pressure ulcers.

F 314 Continued From page 40 F 314

*All Residents are assessed for pressure ulcer risk on admission, every week times 4 after admission, quarterly, with significant change and annually using the Braden scale.
*Weekly skin inspections are conducted and documented on all residents by licensed staff.
*Complete weekly skin inspection form.
*Turning and repositioning frequency is dependent on resident assessment and chart on TAR (Treatment Administration Record).
*Pressure ulcer prevention order set is implemented based on need."

The facility policy titled "Guidelines of Care-Pressure Sores" revised 2/10/15 documented in part:

"Purpose: Residents entering facility without pressure sores do not develop them unless the individual's condition demonstrates that they were unavoidable.

Procedure:
1. Facilities will provide routine preventive and daily care including turning and proper positioning, application of pressure reduction or relief devices, skin care, provision of clean and dry bed linens, and maintenance of adequate nutrition and hydration.
2. A determination that development of a pressure sore was unavoidable may be made only if aggressive routine preventive and daily care, and appropriate preventive measures and care specific to the resident ' s unique risk factors, were provided.
3. Nursing facilities will document interventions, based on each resident ' s risk factors and strengths, on the interdisciplinary plan of care. If

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495287	A. BUILDING ______ B. WING ______	C 05/02/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SENTARA NURSING CENTER HAMPTON	2230 EXECUTIVE DRIVE HAMPTON, VA 23666

(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 314	Continued From page 41	F 314		

objectives are not met, alternative approaches will be developed."

The facility policy titled "Standard and Required Characteristics-Skin Conditions" revised 6/18/15 documented in part:

"Purpose: Resident's are provided with care to prevent and treat skin breakdown.

Procedure:
3. Residents do not develop skin breakdown unless their medical condition makes breakdown unavoidable."

The facility policy titled "Skin Inspection" revised 5/13/14 documented in part:

"1. Weekly skin inspections must be completed on all residents."

On 4/28/16 at approximately 5:30 p.m. a pre-exit debriefing was held with the Administrator and the Director of Nursing and the above information was shared. The Director of Nursing was asked what were her expectations of her staff in regards to pressure ulcers. The Director of Nursing stated, "I expect the nurses to assess the residents and recognize them (pressure ulcers) early on before they get to an advanced stage." When asked what was expected in regards to Resident #5's physician ordered ROHO cushion, the Director of Nursing stated, "I expect the nurses to follow the physician orders."

The following outline document was provided by the Administrator prior to exit documented in part, as follows:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495287	A. BUILDING ______ B. WING ______	C 05/02/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SENTARA NURSING CENTER HAMPTON	2230 EXECUTIVE DRIVE HAMPTON, VA 23666

(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 314	Continued From page 42	F 314		

"Allegation: Facility did not identify pressure ulcer until it reached a Stage III level.

2/16/16
Skin assessment completed indicating no pressure ulcer.
Care Plan meeting with family-no indication of Pressure Ulcer
Discussed with patient diet recommendations and patient agrees to follow.
Patient non-compliant with diet,

2/17/16
Pressure ulcer to sacrum identified as Stage III by Name (Wound Care Physician). This assessment places doubt regarding the accuracy that this was, in fact a Stage III.

3/3/16 Dietary note indicates non-compliant with diet.

3/4/16 Patient non-compliant with care.

3/11/16 Patient continues to be non-compliant with care.

This patient is alert and oriented with a BIMS score of 15."

On 5/2/16 at 11:48 a.m. a phone interview was conducted with the Wound Care Physician. The Wound Care Physician was made aware of the above statement regarding the accuracy of her wound care assessment of Resident #5 on 2/17/16. The Wound Care Physician stated, "That was never brought to my attention that they were questioning my assessments of any resident. I'm visible every week to them if they

(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 314	Continued From page 43	F 314		

have a concern. I touch base with the Director of Nursing and the Clinical Manager weekly of anything new, worse, or changed, I give updates. This was definitely a Stage III pressure ulcer."

On 5/2/16 at approximately 2:00 p.m. after reviewing the above document presented by the Administrator, the Administrator was informed of the Wound Care Physician's comments. The Administrator was also reminded that the skin assessment was not completed until the 11-7 shift on 2/16/16 with it being signed completed on 2/17/16. In regards to the Care Plan meeting with the family on 2/16/16 there was no documentation to show a skin check was completed during this meeting and it is not the family's responsibility to monitor for pressure ulcers. The resident's MDS addressed no significant gains or loss of weight in the past 6 months. The findings dated 3/3/16, 3/4/16, and 3/11/16 regarding non-compliance of the resident were identified 16 days after the facility acquired Stage III sacrum pressure ulcer was identified.

On 5/2/16 at approximately 2:30 p.m. the Administrator and the Director Of Nursing provided documentation indicating on 2/10/16 a Mock Survey Audit was conducted in the facility. The Mock Survey Audit revealed issues with pressure ulcers. On 2/29/16 an Action Plan was developed stating: Problem Pressure Ulcers are at unfavorable targets. The facility plan of correction was reviewed by 2 surveyors, the Administrator, and the Director of Nursing. During the review of the Plan of Correction it was noted under Weekly Skin Assessments audits were only completed for one week in March , and under Braden Scale there were no March audits. Under action, Clinical Manager to audit

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495287	A. BUILDING ______ B. WING ______	C 05/02/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SENTARA NURSING CENTER HAMPTON	2230 EXECUTIVE DRIVE HAMPTON, VA 23666

(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 314 Continued From page 44 F 314

treatments weekly no audits were available. Under action, Assessment of Adequate Surfaces for Treatment Prevention no audits had been completed. Based on the lack of audits to show that a functioning corrective Action Plan was in place and the fact the identified deficient areas had not been corrected prior to the start of the survey Past Non-Compliance was not offered at exit.

Prior to exit no further information was provided.

*Stage III Pressure Ulcer: Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling. Definition derived from the Minimum Data Set (MDS) Assessment-Version 3.0

**Diabetes Mellitus: a complex disorder of carbohydrates, fat, and protein metabolism that is primarily a result of a deficiency or complete lack of insulin secretion by the beta cells of the pancreas or resistance to insulin.

***Chronic Pain: pain that continues or recurs over a prolonged period, caused by various diseases or abnormal conditions.

*****Osteoarthritis: a form of arthritis in which one or many joints undergo degenerative changes, including bony sclerosis, loss of cartilage, bone spurs, and cartilage in the joints.

******Depression: a decrease of vital functional activity, a mood disturbance characterized by feelings of sadness, despair, and discouragement resulting from and normally proportionate to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495287	A. BUILDING ______ B. WING ______	C 05/02/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SENTARA NURSING CENTER HAMPTON	2230 EXECUTIVE DRIVE HAMPTON, VA 23666

(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 314	Continued From page 45	F 314		

some personal loss or tragedy.

*******Obesity: an abnormal increase in the proportion of fat cells, mainly in the viscera and subcutaneous tissues of the body.

The above definitions were derived from Mosby's Dictionary of Medicine, Nursing, and Health Professions 8th Edition.

2. Resident #13 was a 65 year old originally admitted to the facility on 1/1/2000 and readmitted on 9/22/14 with diagnoses to include *Recent History of Stage III Pressure Ulcer,**Hypertension, ***Hemiplegia, and ****Hemiparesis.

The most recent Minimum Data Set (MDS) assessment was a Quarterly with an Assessment Reference Date (ARD) of 3/1/16. The Brief Interview for Mental Status (BIMS) was a 15 out of a possible 15 which indicated that Resident #5 was cognitively intact and capable of daily decision making. Under Section G Functional Status the resident was coded extensive two person assist for bed mobility and total dependence for bathing. Under Functional Limitation in Range of Motion Resident #3 was coded as having Upper and Lower extremity impairment on both sides. The resident was 65 inches in height and 146 pounds in weight. Under Weight Loss/Weight Gain the resident was coded 0, indicating that there was no gain or loss of 5% in the last month or 10% in the last 6 months. Under Skin Conditions the resident was coded as being at risk of developing pressure ulcers.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495287	A. BUILDING ______ B. WING ______	C 05/02/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SENTARA NURSING CENTER HAMPTON	2230 EXECUTIVE DRIVE HAMPTON, VA 23666

(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 314	Continued From page 46	F 314		

Resident #5's Comprehensive Care Plan dated 9/22/14-3/7/16 documented in part, as follows:

"Problems: Resident #13 at risk of pressure ulcer r/t (related to) his being mostly bedfast.
Goal: Resident #13 will remain free of skin breakdown over the next 90 days. Goal date: 3/3/16
Interventions:
*Use pillows, pads, or wedges to reduce pressure on heels and pressure points. Turn/reposition.
*Weekly skin assessments, Check skin for redness, skin tears, swelling, or pressure areas. Report any signs of skin breakdown"

The Director of Nursing was asked for all Braden Scales for Predicting Pressure Sore Risk for Resident #13 that had been completed the past year. Only 1 Braden Scale was completed and documented in part, as follows:

"11/30/15
Sensory Perception-Slightly Limited
Moisture-Occasionally Moist
Activity-Chair Fast
Mobility-Very Limited
Nutrition-Adequate
Friction and Shear-Potential Problem
Braden Score-15=At Risk"

The Director of Nursing was asked for a copy of all Weekly Skin Assessments for Resident #13 for December 2015, January 2016, and February 2016. Based on the surveyor's observation in the electronic medical record for Resident #13, there was no evidence of documented Weekly Skin Assessments for the above months. The Director of Nursing also stated, "We did not find any Weekly Skin Assessments for the time frame you

F 314 Continued From page 47 F 314

requested for the resident."

Resident #13's April Physician Orders signed 4/2/16 indicated the following order: 12/2/15 Weekly Skin Inspections (with shower or bath preferably).

The Wound Care Specialist Evaluations for Resident #13 were reviewed and documented in part, as follows:

"1/13/16
History of Present Illness:
Chief Complaint: Patient has a wound on their ankle.
HPI (history of physical illness) Statement: He presents with a stage 3 pressure wound of the left lateral ankle of at least 1 days duration.
Appetite: Good
Focused Wound Exam:
Etiology: Pressure
MDS 3.0 Stage: 3
Duration >1 days
Wound Size: 0.4 x 0.5 x 0.2 cm (centimeter)
Surface Area: 0.20 cm squared
Exudate: Light Sero-Sanguinous
Yellow Necrotic: 30%
Granulation Tissue: 70%
Dressing: Santyl-Once Daily
Coordination of Care: Data and history pertinent to this patient's care were obtained via Nursing Staff, Patient. This patient's care was discussed with another health care provider Nursing Staff Member during this visit.

1/20/16
History of Present Illness:
Chief Complaint: Patient has a wound on their ankle.

F 314 | F 314

Continued From page 48

HPI (history of physical illness) Statement: He presents with a stage 3 pressure wound of the left , lateral ankle of at least 7 days duration.
Appetite: Good
Focused Wound Exam:
Etiology: Pressure
MDS 3.0 Stage: 3
Duration >7 days
Wound Size: 0.3 x 0.2 x 0.2 cm
Surface Area: 0.06 cm squared
Exudate: Light Sero-Sanguinous
Yellow Necrotic: 15%
Granulation Tissue: 85%
Wound Progress: Improved
Dressing: Santyl-Once Daily
Coordination of Care: Data and history pertinent to this patient' s care were obtained via Nursing Staff, Patient. This patient's care was discussed with another health care provider Nursing Staff Member during this visit.

1/27/16
History of Present Illness:
Chief Complaint: Patient has a wound on their ankle.
HPI (history of physical illness) Statement: He presents with a stage 3 pressure wound of the left lateral ankle of at least 13 days duration.
Appetite: Good
Focused Wound Exam:
Etiology: Pressure
MDS 3.0 Stage: 3
Duration >13 days
Wound Progress: Resolved 1/21/16
Coordination of Care: Data and history pertinent to this patient's care were obtained via Nursing Staff, Patient. This patient's care was discussed with another health care provider Nursing Staff Member during this visit."

F 314 Continued From page 49 F 314

On 4/28/16 at 4:15 p.m. a phone interview was conducted with the Wound Care Physician after Resident #13's Wound Care Specialist Evaluations were reviewed. The Wound Care Physician was asked if Resident #13's pressure ulcer to the left lateral ankle was indeed a pressure area. The Wound Care Physician stated, "If I document pressure, it's pressure. I call it like I see it."

Resident #13's Clinical Notes were reviewed and documented in part, as follows

"1/14/16 at 3:43 p.m. Writer in with wound MD (Medical Doctor) on 1/13/16 to assess area to patients left lateral ankle. Patient in bed at the time and ankle had light amount of sero sangious drainage with no foul odor. Patient has 30% yellow necrotic tissue and 70 % granulation tissue. Patient tolerated well and denied pain and treatment provided as ordered. Wound Nurse

1/19/16 at 9:45 a.m. Discussed in SOC (standards of care) mtg (meeting); new stg (stage) 3 to left ankle rlt (related to) positioning; resident is contracted. Dietary

1/21/16 at 11:14 a.m. Writer in patients room with wound MD on 1/20/16 to see patients left lateral ankle. Patients left ankle has 15% yellow necrotic tissue and 85% granulation tissue with light sero sangious drainage. Patients ankle is improving with decreased surface area and increased granulation. We will continue with santyl daily and patient tolerated well and denied any pain. Patient continues to wear prevalon boots."

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
	495287	A. BUILDING ______ B. WING ______	C 05/02/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SENTARA NURSING CENTER HAMPTON	2230 EXECUTIVE DRIVE HAMPTON, VA 23666

(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 314	Continued From page 50	F 314		

Resident #13's Weekly Skin Condition Progress Report was reviewed and documented in part, as follows:

"Type of Wound: Pressure Ulcer
Wound Location: Left Lat (lateral) Ankle
Date of Onset: NO DATE
Contributing Factors: Immobility

Assessment Date: 1/14/16
Stage of Ulcer: Stage III
Wound Size: length (cm) 0.4 Width (cm) 0.5
Depth (cm) 0.2
Tissue Type: Granulating 70%, Slough 30%
Exudate: Small
Exudate Color: Straw/Red
Odor Present: No

Assessment Date: 1/20/16
Stage of Ulcer: Stage III
Wound Size: length (cm) 0.3 Width (cm) 0.2
Depth (cm) 0.2
Tissue Type: Granulating 85%, Necrotic 15%
Exudate: Small
Exudate Color: Straw/Red
Odor Present: No"

The facility policy titled "Physician Approved Pressure Ulcer-Prevention Orders/Protocol" not dated, documented in part, read as:

"All Residents

3. All Residents are assessed for pressure ulcer risk on admission; weekly times four weeks, then quarterly, with significant change and annually using the Braden scale. Re-evaluate if a pressure ulcer is identified.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495287	A. BUILDING ______ B. WING ______	C 05/02/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SENTARA NURSING CENTER HAMPTON	2230 EXECUTIVE DRIVE HAMPTON, VA 23666

(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 314	Continued From page 51	F 314		

6. Weekly skin inspections.
7. Apply Moisture/barrier after incontinence episodes.
8. Develop patient-specific written care plan for pressure ulcer prevention."

The facility policy titled "Pressure Ulcer Prevention" revised 11/12/16 documented in part, read as;

"Policy Statement: To prevent development of pressure ulcers.

*All Residents are assessed for pressure ulcer risk on admission, every week times 4 after admission, quarterly, with significant change and annually using the Braden scale.
*Weekly skin inspections are conducted and documented on all residents by licensed staff.
*Complete weekly skin inspection form.
*Turning and repositioning frequency is dependent on resident assessment and chart on TAR (Treatment Administration Record).
*Pressure ulcer prevention order set is implemented based on need."

The facility policy titled "Guidelines of Care-Pressure Sores" revised 2/10/15 documented in part:

"Purpose: Residents entering facility without pressure sores do not develop them unless the individual's condition demonstrates that they were unavoidable.

Procedure:
1. Facilities will provide routine preventive and daily care including turning and proper positioning, application of pressure reduction or

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495287	A. BUILDING ______ B. WING ______	C 05/02/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SENTARA NURSING CENTER HAMPTON	2230 EXECUTIVE DRIVE HAMPTON, VA 23666

(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 314	Continued From page 52	F 314		

relief devices, skin care, provision of clean and dry bed linens, and maintenance of adequate nutrition and hydration.
2. A determination that development of a pressure sore was unavoidable may be made only if aggressive routine preventive and daily care, and appropriate preventive measures and care specific to the resident ' s unique risk factors, were provided.
3. Nursing facilities will document interventions, based on each resident ' s risk factors and strengths, on the interdisciplinary plan of care. If objectives are not met, alternative approaches will be develope

The facility policy titled "Standard and Required Characteristics-Skin Conditions" revised 6/18/15 documented in part:

"Purpose: Resident's are provided with care to prevent and treat skin breakdown.

Procedure:
3. Residents do not develop skin breakdown unless their medical condition makes breakdown unavoidable."

The facility policy titled "Skin Inspection" revised 5/13/14 documented in part:

"1. Weekly skin inspections must be completed on all residents."

On 4/28/16 at approximately 5:30 p.m. a pre-exit debriefing was held with the Administrator and the Director of Nursing and the above information was shared. The Director of Nursing was asked what were her expectations of her staff in regards to pressure ulcers. The Director of Nursing

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
	495287	A. BUILDING ______ B. WING ______	C 05/02/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SENTARA NURSING CENTER HAMPTON	2230 EXECUTIVE DRIVE HAMPTON, VA 23666

(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 314	Continued From page 53	F 314		

stated, "I expect the nurses to assess the residents and recognize them (pressure ulcers) early on before they get to an advanced stage."

The following outline document was provided by the Administrator prior to exit documented in part, as follows:

"Allegation: Facility did not identify pressure ulcer until it reached a Stage III level.

1/13/16
Pressure ulcer to left lateral ankle identified as Stage III by (Name Wound Care Physician). Depth of .2 would indicate doubt regarding the accuracy that this was, in fact a Stage III.

1/27/16
Pressure area noted as healed. This short healing time would further lead to doubt that assessment on 1/13/16 was accurately classified as a Stage III."

On 5/2/16 at 11:48 a.m. a phone interview was conducted with the Wound Care Physician. The Wound Care Physician was made aware of the above statement regarding the accuracy of her wound care assessment including depth of pressure area of Resident #13 on 1/13/16 by the facility. The Wound Care Physician stated, "That was never brought to my attention that they were questioning my assessments of any resident. I'm visible every week to them if they have a concern. I touch base with the Director of Nursing and the Clinical Manager weekly of anything new, worse, or changed, I give updates. This was definitely a Stage III pressure ulcer. I also have a problem with that because there is no extra tissue on an ankle, a 0.2 depth can absolutely be a Stage III."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495287	A. BUILDING _____ B. WING _____	C 05/02/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SENTARA NURSING CENTER HAMPTON	2230 EXECUTIVE DRIVE HAMPTON, VA 23666

(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 314	Continued From page 54	F 314		

On 5/2/16 at approximately 2:00 p.m. after reviewing the above document presented by the Administrator, the Administrator was informed of the Wound Care Physician's comments.

On 5/2/16 at approximately 2:30 p.m. the Administrator and the Director Of Nursing provided documentation indicating on 2/10/16 a Mock Survey Audit was conducted in the facility. The Mock Survey Audit revealed issues with pressure ulcers. On 2/29/16 an Action Plan was developed stating: Problem Pressure Ulcers are at unfavorable targets. The facility plan of correction was reviewed by 2 surveyors, the Administrator, and the Director of Nursing. During the review of the Plan of Correction it was noted under "Weekly Skin Assessments" audits were only completed for one week in March. On the "Skin Assessment Audit" dated 4/5/26 for Resident #13, all boxes were unchecked indicating the audit had not been completed. Under "Braden Scale" there were no March audits. Under "Action, Clinical Manager to audit treatments weekly", no audits were available. Under "Action, Assessment of Adequate Surfaces for Treatment Prevention", no audits had been completed. Based on the lack of audits to show that a functioning corrective Action Plan was in place and the fact the identified deficient areas had not been corrected prior to the start of the survey Past Non-Compliance was not offered at exit.

Prior to exit no further information was provided.

*Stage III Pressure Ulcer: Full thickness tissue loss. Subcutaneous fat may be visible but bone,

F 314 Continued From page 55 F 314

tendon or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling. Definition derived from the Minimum Data Set (MDS) Assessment-Version 3.0

**Hypertension: a common disorder that is a known cardiovascular disease risk factor, characterized by elevated blood pressure over normal values of 120/80 mmHg (milligrams of mercury) in an adult.

***Hemiplegia: paralysis of one side of the body.

****Hemiparesis: muscular weakness of one half of the body.

The above definitions were derived from Mosby's Dictionary of Medicine, Nursing, and Health Professions 8th Edition.

F 323 SS=D 483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES F 323

The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.

This REQUIREMENT is not met as evidenced by:
Based on observations, clinical record reviews, facility documentation, and staff interviews the facility staff failed to provide appropriate care and ensure the use of appropriate assistive devices to

F 323 Continued From page 56

prevent avoidable falls resulting in harm for 2 of 22 residents in the survey sample, Resident's #5 and #19.

1. The facility staff failed to use an appropriate assistive device during a toilet transfer on 12/21/15 resulting in a avoidable fall with a fracture for Resident #5, which constitutes harm.

2. The facility staff failed to ensure Resident #19 remained free of accidents related to staff member ambulating the Resident on 9/25/15 when assignment sheet documented "ambulation by PT (Physical Therapy) only".

The findings included:

1. Resident #5 was a 76 year old admitted to the facility initially on 6/20/07 and readmitted on 9/1/15 with diagnoses to include. *Diabetes Mellitus, **Chronic Pain, ***Osteoarthritis, ****Depression, and *****Obesity.

The most recent comprehensive Minimum Data Set (MDS) assessment was a Significant Change with an Assessment Reference Date (ARD) of 3/1/16. The Brief Interview for Mental Status (BIMS) was a 15 out of a possible 15 which indicated that Resident #5 was cognitively intact and capable of daily decision making. Under Section G Functional Status the resident was coded extensive two person assist for bed mobility, transfer, dressing, toilet use, and personal hygiene. Under Balance During Transitions and Walking the resident was coded as follows: Moving from seated to standing position=2, not steady, only able to stabilize with staff assistance; Walking, Turning around, Moving on and off toilet=8, Activity did not occur;

F 323

1. Staff did not utilize appropriate transfer device for resident #5. Staff assisted Resident #19 in ambulation which had no specific physician order relating to PT transfers only.
2. All residents have a potential to be affected.
3. All licensed nursing staff will be in-serviced on proper assistive transfer devices and transferring methods.
4. Clinical Managers and/or designee will verify 25% of resident weekly for appropriate patient application of assistive transfer devices for 8 weeks. Results will be reported to QAPI Meeting.
5. Date of Completion: 06/10/16

F 323 Continued From page 57 F 323

Surface to surface transfer=2, not steady, only able to stabilize with staff assistance. Under Section H Bladder and Bowel Resident #5 was coded 1= occasionally incontinent (less than 7 episodes of incontinence) for both. The resident was coded under Section K as 63 inches in height and 248 pounds in weight.

The prior comprehensive Minimum Data Set (MDS) assessment was a Significant Change with an Assessment Reference Date (ARD) of 9/8/15. The Brief Interview for Mental Status (BIMS) was a 15 out of a possible 15 which indicated that Resident #5 was cognitively intact and capable of daily decision making. Under Section G Functional Status the resident was coded extensive one person assist for bed mobility and personal hygiene. Under Transfers Resident #5 was coded as activity did occur but only once or twice with two person assist. The resident was coded total dependence two person assist for Toilet use. Under Balance During Transitions and Walking the resident was coded as follows: Moving from seated to standing position, Walking, Turning around, Moving on and off toilet=8, Activity did not occur; Surface to surface transfer=2, not steady, only able to stabilize with staff assistance. Under Section H Bladder and Bowel Resident #5 was coded 1= occasionally incontinent for Bowel (less than 7 episodes of incontinence) and 3=always incontinent of Bladder. The resident was coded under Section K as 63 inches in height and 214 pounds in weight.

Resident #5's Comprehensive Care Plan dated 11/27/15-3/21/16 documented in part, as follows:

Problems: Self care deficit-Extensive to total

F 323 Continued From page 58 F 323

assistance required with bathing, hygiene, dressing, tolieting, and grooming.
Interventions: no intervention noted for tolieting.

Problems: At Risk For Falls R/T (related to) decreased mobility/unsteady gait. (toe fx [fracture] post fall 12/21/15)
Interventions: Provide reminders to use ambulation and transfer assist devices.

Problems: Transfers (to/from: bed, chair, wheelchair, standing position)- (Resident #5) requires extensive assistance.
Goal: Resident #5 will complete transfers with the assistance of 1-2 people/lift devices as required.
Interventions: Transfer using board/lift devices-Starting 11/27/15.

Problems: Actual Fall 9/23/15, 12/21/15.
Interventions: Transfer using the mechanical lift.

Resident #5's Physician orders were reviewed and documented in part, as follows: 9/3/15 HIGH RISK for FALLS/ (FACILITY NAME) Fall Prevention Protocol.

A Musculoskeletal Assessment dated 9/3/15 at 6:14 p.m. for Resident #5 documented in part, as follows: Transfer Ability-d. Lifted mechanically-1. YES.

Resident #5's Clinical Notes were reviewed and documented in part, as follows:
9/6/15 at 12:49 a.m. CONTINUES TO REQUIRE EXTENSIVE ASSIST WITH ADLS AND TRANSFERS.

9/6/15 at 2:20 p.m. Resident require assistance x

F 323 Continued From page 59 F 323

2 with ADL's (activities of daily living) very little help from resident during care.

On 4/28/16 at 9:00 a.m. Resident #5 was interviewed regarding a fall with a fracture she had experienced in December 2015. Resident #5 stated, "We were in the big bathroom near the nurse's station because I needed to use the toilet, me and the aide. I said are you going to get the sit to stand lift? She said no, you can do it, grab this rail and pull up. I said I can't do that, she said yes you can, I said no I can't. So she said put your hand on the rail and the other hand on the other rail and pull up. So anyways, I told her again I can't do that and she said I'm here to help you. So I went ahead and pulled but I was scared because I have fallen so many times. I reached over to get the rail and I fell to the floor. When I fell, my right foot went underneath me, because I have a problem turning that foot, so then I fell to the floor. I said oh I'm hurt you gotta help me, I was crying and she got another aide to help get me up. They pulled me up to get me back in the chair, three of them." The surveyor asked Resident #5 if she was lowered to the floor or fell straight to the floor, the resident stated, "I fell to the floor, no one lowered me." The surveyor asked Resident #5 if she was hurting and she stated, "Yes ma'am, really hurting!" Surveyor asked her where she was hurting and the Resident stated, "In my right toe and right leg." Resident #5 stated, "Then they took me to my room and got me to bed. No nurse never came and checked me. My toe kept hurting and I told someone I think I broke my toe and they said how do you know you broke your toe, I said it hurts to move it. I told them my toe was not getting any better, they said you can't do anything for a broken toe. Resident was asked how was she

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495287	A. BUILDING ______ B. WING ______	C 05/02/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SENTARA NURSING CENTER HAMPTON	2230 EXECUTIVE DRIVE HAMPTON, VA 23666

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 60	F 323		

normally transferred on a daily basis to get on the toilet, she stated, "They transfer me with the sit to stand only."

The Fall Investigation Assessment dated 12/28/15 for Resident was reviewed and documented in part, as follows:
(Reports fall 12/21/15)
Time of Fall: 7a-3p Shift
Location of Fall: Bathroom (Big Bathroom near nurse's station)
Witness: CNA (certified nursing assistant) #40 (per pt [patient])
FALL HISTORY:
Is there a history of falls?-Yes
Has the resident fallen within the past 3 month?-Yes
Has the resident sustained injury resulting from the fall?-Yes
If YES describe type of injury-fx (fracture noted 12/26-12/27 p.m. shift by x-ray to right foot.
PHYSICAL/COGNITIVE ASSESSMENT:
Has the resident been assessed as being at high risk for falls?-Yes
If YES, identify reasons for the risk-impulsive, decreased mobility.
Does the resident have unsteady gait?-Yes
Does the resident use an assistive device for mobility?-Yes
If YES, describe the type of device-wheelchair
RESIDENT INTERVIEW/DESCRIPTION OF FALL:
Did you know that you were going to fall?-Yes
Did you have any pain or injury prior to fall?-No
Did you experience any of the following just prior to the fall?-Yes
If YES, describe.-Unusual activity-stand without lift.
FOLLOW-UP ACTION:

F 323 Continued From page 61 F 323

Did the resident require evaluation by physician?-No
Did the resident require x-ray?-Yes

Additional notes observed: CNA#40, CNA #42, CNA #41 oof (off of floor) manually and into chair, normally uses sit to stand.
CNA #40 lowered to the floor, doesn't recall reporting to nurse.
The Fall Investigation was completed by RN (Registered Nurse) Clinical Manager #21

Staff statements obtained during the investigation of the fall were reviewed and documented in part, as follows:

"CNA #40: Dated 12/29/15
On the date in question, Resident #5 had stated that she needed to use the restroom and had been waiting for a while so I offered to assist her. I have not worked with Resident #5 in some time with transfers so I asked her how she had been transferring to the commode or if she had been transferring. She stated to me that she had recently went to the community restroom located in front of the nursing station and used the bars to pull up. I asked her if she was comfortable with using that restroom and she stated that she was. Once in the restroom, I positioned her in front of the commode and assisted her with standing while she used the bars to pull up. As she was turning around to sit down on the commode her leg either locked or gave out and she said that she could not do it. At that time I held on to her and lowered her onto the floor and told her I would go get CNA #42 to help me. CNA #42 and I could not stand her up so we got CNA #41 to help us as well. Once we had her up, we sat her in her wheelchair, changed her pants, and stood

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 62 her up with the stand-up lift to pull up her pants and change her brief. Once we had her sitting back down, we asked her several times if she was fine and also asked if she could move her leg and foot and she could do both. She stated that she was fine and that she wanted to go home for Christmas so she did not want her daughter to know. I do not recall if I told a nurse or even what nurses were on the unit that day. CNA #42 No date. While performing afternoon rounds CNA #40 came out of the bathroom by the nurses station while I was passing with soiled lines bags and asked me for help. I took the bags to the dirty closet and went to the restroom when I saw Resident #5 on the floor sitting up on her bottom. I asked what happened and CNA #40 said she fell while trying to transfer her from the chair to the commode and that she had eased her to the floor. CNA #40 asked CNA #41 to help and we lifted Resident #5 back into her chair. CNA #40 got the sit to stand so we could change her pants because they were wet. Resident #5 said she was fine but her right leg was sore. She bent her knee and moved her toes she said she didn't feel any pain she said everything else was fine. I told CNA #40 that she should tell the nurse what happened. I didn't see her fall, but now I realize I should have told the nurse to cover myself and Resident #5 because she didn't. CNA #41 Dated 12/29/15 I CNA #41 was walking down the hall and CNA #40 and CNA #42 came out the bathroom and told me to get some blue pants out of her closet so she can change her pants. When saw Resident #5 she was NOT on the floor."	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495287	A. BUILDING ______ B. WING ______	C 05/02/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SENTARA NURSING CENTER HAMPTON	2230 EXECUTIVE DRIVE HAMPTON, VA 23666

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323		F 323		

Continued From page 63
RN Clinical Manager #21 interviewed Resident #5 regarding the fall but was unable to provide the surveyor with any documentation of the resident's statement.

Included in the Fall Investigation documentation was a copy of the Radiology Report documented in part, as follows:

"DOS: (date of service) 12/26/15
Examination Foot AP (anterior/posterior) and LAT (lateral) 2V (2 views), RIGHT

Results: 3-view exam; comparison unavailable. Bones are subjectively osteopenic. There is a non displaced right fifth distal metacarpal fracture with minimal angular deformity. There is no joint subluxation or angular malalignment. There is regional soft tissue swelling.

Conclusion: FRACTURE"

On 4/29/16 at approximately 2:15 p.m. an interview was conducted with the RN Clinical Manager #21 who stated, "After I completed the fall investigation on Resident #5, I did provide verbal counseling and education to CNA #40, CNA #41, and CNA #42 about the fall policy, notification of the nurse immediately, assessment to be done by a nurse prior to relocating resident, and to use the mechanical lift with all transfers."

An interview was conducted with CNA #41 and CNA #42 on 4/28/16 at 3:05 p.m.. During the interview both CNAs were asked how they would do a wheelchair to toilet transfer for Resident #5. CNA #41 stated, "I am usually her aide, and that morning when I got her up I used the sit to stand lift. I always do the sit to stand with her, she isn't

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
	495287	A. BUILDING ______ B. WING ______	C 05/02/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SENTARA NURSING CENTER HAMPTON	2230 EXECUTIVE DRIVE HAMPTON, VA 23666

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

F 323 Continued From page 64 F 323

steady." CNA #42 stated, "For bathroom transfers I always use the sit to stand lift."

On 4/29/16 an interview was conducted with CNA #40 at 9:30 a.m. regarding Resident #5's fall on 12/21/15. CNA #40 stated, "Well I didn't have her, but she had been ringing a long time to go the bathroom so I told her I would take her. She said I have been using the walker to get on the toilet, pretty sure. I haven't worked with her in a while I just took resident's word for it. Name (RN Clinical Manager #21) told me I shouldn't do it myself she was lift." When asked what she would do differently now if she was to transfer Resident #5, CNA #40 stated, "Would not take Resident #5's word about how she could transfer and that she was fine. It kinda backfired a week later. I would have used the sit to stand lift. They (management) tried to fuss at me about why I was transferring her by myself, I was nervous so I came in and I took pictures the next day. I looked over her bed and nothing there, no signs about transfers."

On 4/28/16 at 3:00 p.m. Resident #5's communication board above her bed was observed, it was empty; no symbols indicating the appropriate level of transfer assistance, required transfer device, and any required safety devices were posted.

On 4/28/16 at approximately 1:30 p.m. surveyor, Resident #5, Rehabilitation Manager #55, Doctor of Physical Therapy #56, and Certified Occupational Therapy Assistant #52 entered the large bathroom at the nurse's station where Resident #5 fell and injured herself on 12/21/15. Resident #5 was asked to verbally walk us through what happened on the day of the fall.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495287	A. BUILDING ______ B. WING ______	C 05/02/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SENTARA NURSING CENTER HAMPTON	2230 EXECUTIVE DRIVE HAMPTON, VA 23666

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323		F 323		

Continued From page 65
Resident #5 verbatim explained the incident to the rehabilitation staff as she had told the surveyor in her above statement. The rehabilitation staff proceeded to physically act out the incident as described by Resident #5. Resident #5 stated, "That's exactly what happened."

The following note was presented to surveyor on 4/28/16 by the Doctor of Physical Therapy #56, and Certified Occupational Therapy Assistant #52 after meeting with Resident #5, documented in part, as follows:

"We have been asked to assess a situation in which Resident #5 sustained a fall on December 21, 2015, while transferring to a toilet from her wheelchair. Per Resident #5's memory, she was positioned in front of the toilet with her wheelchair at a 45 degree angle (facing the left aspect of the toilet) and was able to pull herself up with the grab bar. Once she was standing, she recalls the CNA removing the wheelchair to allow increased room for the transfer. Resident #5 attempted to pivot in order to sit on the toilet; however, she was unable to lift her right foot and lost her balance and fell.

Resident #5 was discharged from OT (occupational therapy) on October 6th, 2015 at which time Resident #5 was performing slideboard transfers and standing tolerance activities to increase independence in functional mobility. Resident #5's functional progress in OT was minimal secondary to physical limitations (arthritic pain and limited range of motion in arms and legs), pain tolerance, and at times self-limiting behaviors (patient reported that she could not participate in therapy for various reasons). Resident #5 was performing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495287	A. BUILDING ______ B. WING ______	C 05/02/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SENTARA NURSING CENTER HAMPTON	2230 EXECUTIVE DRIVE HAMPTON, VA 23666

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

F 323 Continued From page 66 F 323

slideboard transfers from her bed to her wheelchair with Minimal Assist x2 staff members to Moderate Assist x 1 staff member; however, required significant assistance with perihygiene and clothing management secondary to limited range of motion which impacted her ability to perform such tasks-even after education in compensatory strategies.

Resident #5 was discharged from PT (physical therapy) on October 12th, 2015. She was performing sit to stands in the parallel bars with standby assistance and moderate assistance for transfers using bilateral upper extremity support. She was able to tolerate standing for 1 minute intervals secondary to arthritic pain and her medical status (accumulation of fluid).

Based on her functional status from her October therapy case and the fact that her performance in transfers were impacted depending on which staff member was assisting her, it would not have been recommended at that particular time to utilize one person to stand pivot transfer Resident #5 given her fluctuating performance between disciplines."

The facility policy titled "Transfer/Safety Device Symbols" revised 7/9/13 documented in part, as follows:

"Policy Statement: Identification of transfer devices and safety devices and the level of transfer assistance needed for each resident.

Performed By: RN/LPN/CNA
*Symbols indicating the appropriate level of transfer assistance, required transfer device, and any required safety devices are posted in the room for each resident.
*The following are identified with a symbol at the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495287	A. BUILDING ______ B. WING ______	C 05/02/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SENTARA NURSING CENTER HAMPTON	2230 EXECUTIVE DRIVE HAMPTON, VA 23666

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

F 323 Continued From page 67 F 323

bedside"
-Stand up Lift
-Two Person Assist

Monitoring:
Outcomes Monitoring:-Symbols are placed upon admission and updated as changes occur.
Document Management:-Reviewed quarterly and with any significant change."

On 4/28/16 at approximately 5:30 p.m. a pre-exit debriefing was held with the Administrator and the Director of Nursing and the above information was shared. The Director of Nursing was asked how she would have expected the CNA to transfer Resident #5 during the toilet transfer on 12/21/15. The Director of Nursing stated, "Of course I expect them to transfer with the appropriate device for the resident."

The following outline document was provided by the Administrator prior to exit documented in part:

"Allegation: Lowering of patient to floor during transfer resulting in potential fracture.

Further Investigation of this found the following:
Investigation regarding resident-Resident #5 being lowered to floor on 12/21/15 during 7am-3pm shift.

*12/21/15 On day of alleged injury, resident was seen by attending physician at 3:08 p.m. as noted in Medical Record. Per physician assessment, lower extremities were noted to have edema x2 which is patient's baseline. No cyanosis or clubbing was noted.

*12/22/15 At 8:09 p.m., resident complained of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495287	A. BUILDING ______ B. WING ______	C 05/02/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SENTARA NURSING CENTER HAMPTON	2230 EXECUTIVE DRIVE HAMPTON, VA 23666

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 68 right great toe pain. LPN (Licensed Practical Nurse) assessment revealed no bruising. Resident reported to LPN during this assessment that she was dropped yesterday while in the shower. *12/22/15 At 8:25 p.m., LPN notified physician and family of this reported incident. No new orders from attending physician were given. No further complaints of pain were noted on this day. *12/23/15 Resident complained of pain to right foot. Pain medication given to address this pain. Resident noted to have an enjoyable visit with family during evening. *12/24/15 Resident went home with son as planned for Christmas holiday and returned on same day. *12/26/15 Resident complaining of pain, x-ray ordered. X-ray revealed fracture of right 5th toe. Also noted was that bones were subjectively osteopenic. *12/27/15 Attending physician visited resident following positive x-ray. *12/29/15 Additional investigation was conducted following positive x-ray. *Investigation revealed that resident was lowered to floor during transfer by CNA. This transfer did not represent any deviation from standard practice. Resident was very familiar with this CNA. Resident is alert and oriented as evidenced by her BIMS score of 15. Resident denied further pain during this investigation.	F 323		

F 323 Continued From page 69 F 323

Based on this investigation, there is no evidence of harm related to a deficient practice.

Follow up action as result of investigation: Re-educate staff member regarding CMS (Center Medicare Services) definition falls and reporting requirements."

On 5/2/16 at approximately 2:00 p.m. after reviewing the above document presented by the Administrator, the Administrator was informed that the deficient practice was that Resident #5 was not transferred with the appropriate device on 12/21/15 resulting in an avoidable fall with a major injury of a fracture constituting harm.

Prior to exit no further information was provided.

*Diabetes Mellitus: a complex disorder of carbohydrates, fat, and protein metabolism that is primarily a result of a deficiency or complete lack of insulin secretion by the beta cells of the pancreas or resistance to insulin.

**Chronic Pain: pain that continues or recurs over a prolonged period, caused by various diseases or abnormal conditions.

***Osteoarthritis: a form of arthritis in which one or many joints undergo degenerative changes, including bony sclerosis, loss of cartilage, bone spurs, and cartilage in the joints.

****Depression: a decrease of vital functional activity, a mood disturbance characterized by feelings of sadness, despair, and discouragement resulting from and normally proportionate to some personal loss or tragedy.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495287	A. BUILDING ______ B. WING ______	C 05/02/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SENTARA NURSING CENTER HAMPTON	2230 EXECUTIVE DRIVE HAMPTON, VA 23666

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 70 *****Obesity: an abnormal increase in the proportion of fat cells, mainly in the viscera and subcutaneous tissues of the body. The above definitions were derived from Mosby's Dictionary of Medicine, Nursing, and Health Professions 8th Edition. 2. Resident #19 was admitted to the facility on 9/10/15 for skilled nursing services following a hospitalization. Diagnoses on the Admission MDS (Minimum Data Set - an assessment protocol) with an ARD (assessment reference date) of 9/17/15 included, but are not limited to Heart Failure (condition where heart can't pump the blood the body needs), Arthritis, Osteoporosis (thinning of bone that causes increase risk for fracture), Cerebrovascular Accident (stroke), and Generalized Muscle Weakness. The Resident Care Summary Assessment forms were requested for the following dates: 9/10/15, 9/18/15, and for the date of Resident #19's fall. Three Resident Care Summary Assessments were provided that were printed on 5/2/16 at 11:09 a.m. The forms had no date other than the printed date. The two forms document "Mobility: OT/PT" (Occupational therapy and Physical Therapy) Review of the September 2015 orders documented no specifics of who can ambulate Resident #19. Review of the admission Falls Risk Assessment dated 9/10/15, documented a score of 14. High Risk if score of 10 or above is documented on the form. The Fall Risk Assessment documented	F 323		

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 71	F 323		

Mobility: Gait balance as not able to perform function. In addition, the assessment documented the resident was chair bound.

Review of the Pain Assessment Scale dated 9/10/15 documented that no pain was present.

Review of the current care plan effective dates 3/15/16 to present documented the following problems:

"1. At risk for falls related to communication and impaired balance and shuffling gait.
Interventions included:
Keep areas free of obstructions to reduce the risks of falls or injury.
Remind (Resident #19) to call for assistance before moving from bed to chair and from chair to bed.
Footwear will fit properly and have non-skid soles.
Therapy referrals to evaluate gait/balance/and falls as needed.
2. ADL (activity of daily living) deficit: assistance required with transfers, bed mobility, toileting, bathing, hygiene, dressing, and grooming related to weakness and decline in functional mobility.
Interventions included:
Assist with ADL's (bathing, grooming, toileting, feeding, ambulating) if (Resident #19) unable to complete. Encourage to participate in care at highest level capable.
3. Locomotion on unit and off unit - (Resident #19)
Interventions included:
Assist (Resident) to desired location. Make sure ambulatory assist device remains close to (Resident)
Check location; redirect as needed.

F 323 Continued From page 72 F 323

The Falls Risk Assessment dated 9/25/15 documented a score of 16. High risk if a score of 10 or above is documented on the form. In addition, the form documented Ambulation status as chair bound and Mobility: Gait/balance as not able to perform function.

A Facility Clinical Note dated 9/25/15 at 11:22 p.m. documented the following:
Patient was seen by CNA working with the walker, CNA assisted patient to the bathroom and reported she had to assist patient to the floor because her leg gave up. Patient vital signs stable....Patient denies pain, able to move upper and lower extremities without difficulty, patient reported her husband told her she had to walk, encouraged her to continue using the call light to help her when she needs to walk, Husband called and made him aware.

A Facility Life Care Corporation Fall Investigation Assessment dated 9/26/15 was reviewed. It documented:
Yes Resident assessed as being at high risk for falls
Yes Unsteady gait
Yes Resident demonstrated unsafe mobility habits (explanation documented: "husband encourages aggressive progression. Pt (patient) compliant even when PT (physical therapy states unsafe)
Yes Resident uses assistive device and wheelchair is circled. NOTE: Walker is not circled.

A Facility Clinical Addendum Note dated 9/26/15 at 1:01 a.m. documented the following:
Husband at the bedside, patient started c/o (complain of) hip pain bilaterally, MD (Medical Doctor) made aware and new order received to

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 73	F 323		

send patient to ER (emergency room) to be evaluated. ...
The SBAR (situation, background, assessment, recommendation) Physician/Nurse Communication Tool dated 9/25/15 documented:
Situation: This started 9/25/15 This has gotten: worse
Pertinent History: Atrial Fibrillation (irregular heart beat), benign hypertension (high blood pressure), Chronic diastolic heart failure (condition where the heart can't pump the blood they body needs), Hypoxia (low oxygen levels reaching the body tissues), Hypoxemia (low concentration of oxygen in the blood) Blood Pressure 162/84 chair sitting Right arm
Pulse Oximetry (testing to measure oxygen levels) (Room air 98; Respirations 20 and Temperature 98

The Emergency Room note dated 9/25/15 was reviewed. It documented
"Pt (patient) got out of bed at 11 p.m. with the assistance of her CNA and attempted ambulating to the bathroom with walker. She began to fall, and was eased to the floor. Complains of gradually worsening bilateral hip pain since then, left > (greater than) right, as well as SOB (shortness of breath). No other injuries or pains. Husband endorses history of recurrent UTIs (urinary tract infections). She has no other complaints. Review of Systems:
Musculoskeletal: positive for arthralgias and falls.
Physical Exam: Back: Non tender.
Musculoskeletal: Total Trochar Prosthetic left hip and right hip (artificial hip replacements) on palpation (feel). No peripheral edema or other muscular tenderness.
Chest xray: Preliminary result: Mild haziness c/w (consistent with) CHF (congestive heart failure)

F 323 Continued From page 74 F 323

Hip Complete Bilateral (both sides): No fracture, prosthetic in place
Physician's notes: Patient with fall. No evidence of fracture or dislocation on evaluation. No sign of intracranial (within the skull), chest, or abdominal injury. Will treat for contusions with pain management, ice, elevation and close followup with primary medical doctor. Worrisome symptoms discussed with patient and she agrees to return to Emergency Department for worsening.
Final Diagnosis: Fall, initial encounter; pain of both hip joints; and subtherapeutic international normalized ration (INR)
Discharge Prescriptions: Lidocaine (Lidoderm) 5% (700 milligram patch) apply 1 patch as directed for 12 hours every 24 hours (12 hours on, 12 hours off
Medline Plus documents: "Lidocaine is in a class of medications called local anesthetics. It works by stopping nerves from sending pain signals."

Facility clinical note dated 9/26/15 05:18 a.m. documented: 0435 Patient returned from emergency room via stretcher alert and verbal, no sob (shortness of breath), no resp (respiratory) distress, husband reported no injury was found at the hospital, per husband patient received 5 mg Coumadin* at the hospital for low INR. New order received for Lidoderm patch. Patient assisted to bed, cleaned and dried, appeared comfortable. Vital signs stable BP 126/62; Pulse 63; Temperature 97.2; Pulse oximetry 97% on room air. Call light in reach.
Medline plus documents: 'Coumadin is used to prevent blood clots from forming or growing larger in your blood and blood vessels"

F 323 Continued From page 75 F 323

Facility Clinical Note dated 9/27/15 at 11:53 p.m. documented: Received resident in bed pt (patient) refused to get out of bed this weekend due to the fall pt s/p (patient status post) fall day 3 pt c/o (patient complained of) pain new order for Lidoderm patches which was placed onto bilat (bilateral) hips where pt (patient) stated the pain was....

Facility Clinical Note of the Doctor #7 dated 10/3/15 at 3:23 p.m documented: ...She is scheduled to have a lumbar and pelvis MRI (magnetic resonance imaging to assess for lumbar (relating to the lower part of the back) spinal stenosis (Spinal stenosis is a narrowing of the open spaces within your spine, which can put pressure on your spinal cord and the nerves that travel through the spine to your arms and legs) history and to rule out pelvic fracture given persistent pain symptoms.

MRI Lumbar Spine without contrast report documented the following:
Order date/Time 10/22/15 01:24 p.m.

Indication: ...female with osteoporosis and muscle weakness
Comparison: Correlation made with chest CT (computerized (or computed) tomography(imaging by sections) from 7/14/15 and CT abdomen 3/11/15

Impression:
1. Moderate spinal stenosis at L2 (Lumbar 2) secondary to retropulsion (an abnormal gait in which the body is bent backward) of chronic compression fracture. This abuts but does not compress the conus.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495287	A. BUILDING ______ B. WING ______	C 05/02/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 76 2. Nonacute compression fractures of T12 (12th thoracic vertebra) inferior endplate and L1 (1st Lumbar vertebra)superior endplate appear to have incompletely healed components with edematous fracture clefts. Please correlate with localizing symptoms/any mechanical pain. 3. Fairly large hemangioma in the L1 (1st lumbar) vertebral body, but without aggressive features. 4. Multilevel degenerative disc disease, particularly at L 4-5 (4th and 5th Lumbar vertebra), with broad disc bulge and right eccentric disc protrusion crowding right lateral recess in particular. Multilevel facet (joints between the spine) degenerative changes are also present, particularly at L4-5 and L3-4, and there is mild to moderate central stenosis at these levels secondary to degenerative changes. 5. Lower lumbar dorsal paraspinal muscle atrophy and asymmetric left psoas (large muscles that run from the lumbar spine through the groin) muscle atrophy. Bone Density Study dated 10/22/15 at 12:43 p.m. Impression: 1. Based on the above findings, the patient has low bone mass/osteopenial based on a T-score of 1.9* at the lumbar spine based on WHO (World Health Organization) criteria. No FRAX (WHO - World Health Organization Fracture Risk Assessment Tool) has been given as the patient has been treated for osteoporosis and has expressed a prior osteoporotic fracture. *Addendum: The impression should state: a T score of -1.9 (Negative 1.9) within the lumbar spine indicating low bone mass/osteopenia (reduced bone mass of lesser severity than osteoporosis) WHO definition of osteoporosis and osteopenia on DXA (al-energy X-ray absorptiometry)	F 323		

F 323 Continued From page 77 F 323

(specified for postmenopausal Caucasian females):
(T-score is the relevant measure when screening for osteoporosis)
Normal T score at or above -1 SD
Osteopenia T score between -1 and -2.5 SD
Osteoporosis: T score at or below -2.5 SD
Established osteoporosis T score at or below -2.5 SD plus fragility fracture

An interview was conducted with CNA #66 on 4/27/16 at approximately 6:20 p.m. CNA stated: "She was in bed, I got her up. We walked to bathroom using walker. When got in there, as getting ready to sit on toilet as she (Resident #19) turned, knees buckled. I lowered her to a sitting position." When asked what happened next, CNA #66, stated: "Went out and got help." When asked what time the fall occurred, CNA stated: "happened after dinner after 7:30 about." CNA #66 stated that she left the room once the Resident's husband arrived and began talking with the Nurse. When CNA was asked if she was assigned to walk Resident #19, CNA #66 stated: "No." When asked why she ambulated Resident #19, CNA #66 stated: "She said and insisted I get her up. She was determined to walk. The walker was in the room."

An interview was conducted on 4/27/16 at approximately 6:30 p.m. with the Director of Nursing (DON). The DON was shown the Admission MDS (Minimum Data Set - an assessment protocol) with an ARD (assessment reference date of 9/17/15 and then the DON was asked: How should she be transferred? The MDS documented 2 staff person should transfer.

F 323 | F 323

Continued From page 78
The DON stated: "No, that did not happen." The DON was asked if there is an order that the Resident can ambulate with CNA. The DON stated: "Orders state High Risk for Falls. I'd also have to look more at the chart." The DON was asked how does therapy relay updates so that the Unit nurses and staff know when a resident can begin walking on the unit. She stated: "In management meeting if a change, it would get reported for our therapy patients. The Unit Managers report back to their Unit staff."

An interview was conducted on 4/27/16 at approximately 7:05 p.m., with the Rehab Manager #55. The rehab manager was asked if Resident #19 should have been walking on the Unit on 9/25/15. She stated: "Typically if a walker in room there'd be a verbal communication. I'd have to look at other notes. The Nurses on the Unit base verbal communications on their clinical background and knowledge of the patient would determine if a Resident should be walked based on the activities with her therapist."

A phone interview was conducted with Doctor (Dr.) #7 on 4/28/16 at approximately 11:05 a.m. The Dr. stated that the Resident fell on 9/25/15 and was sent to the Emergency Room for evaluation. When asked if the Dr. felt that the Resident's progress declined in Physical Therapy after the fall, he stated: "no decline in PT (physical therapy. Let me say this, (the Resident) is now in the hospital for evaluation of chest pain. Cardiology, Pulmonary, and Nephrology colleagues are asking why are they being consulted. She (Resident #19) is medically optimized. The family have unrealistic expectations. She is from the medical end, she's

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 79 improved as much as expected. I would anticipate further decline." When asked the Dr's professional opinion if the non acute Fracture noted on the MRI was related to the fall of 9/25/15, he stated: "No. Non acute means more that 8 weeks old. Osteoporosis played into the fracture. She had increased pain the first week after the fall." The Dr. was asked if the Resident should have been walking on the Units with non therapy staff. He stated: "No." An interview was conducted with LPN #35 on 4/29/16 at approximately 12:30 p.m. When asked if Resident #19 was to be walking on the unit, LPN #35 stated: "She is non ambulatory. She is wheel chair bound." An interview was conducted with the Unit Manager RN #22 on 4/29/16 at approximately 12:33 p.m. When asked how information is relayed from therapy, to the Units, she stated: "Therapy lets us know and we pass on the the CNAs." A policy and procedure entitled "Fall Prevention Program - Post Fall Program with a revision date of 10/4/13 was reviewed. It documented the following policy statement: "A resident will receive the appropriate assessment, care and follow- up after a fall." The administration consisting of the Administrator and the DON were briefed of the findings on 4/29/16 at approximately 6:00 p.m. No further information was presented.	F 323		
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE	F 332		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495287	A. BUILDING _____ B. WING _____	C 05/02/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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 332 Continued From page 80

The facility must ensure that it is free of medication error rates of five percent or greater.

This REQUIREMENT is not met as evidenced by:

Based on medication pass observation, staff interviews, facility document review and clinical record review the facility staff failed to ensure they were free from a medication error rate of 5% or greater. There were 36 observed medication opportunities with 2 errors, resulting in a 5.55% medication error rate. The resident involved in the medication errors was Resident # 22.

The findings included:

Resident #22 was admitted to the facility on 4/18/2016. Diagnoses included but were not limited to Hypertension, muscle weakness, aftercare following joint replacement, anemia and seizures.

Review of Resident #22's clinical record revealed an Admission Comprehensive MDS (minimum data set-an assessment protocol) with an ARD (assessment reference date) of 4/25/16. The resident's BIMS (brief interview for mental status) score was coded as a 15 which indicated no cognitive impairment. The resident was further coded as requiring limited assistance by one to two staff members to complete her ADLs and was continent of both bladder and bowel.

On 4/27/16, during the morning medication pass at approximately 10:00 a.m., RN (registered nurse) #23 administered the following

F 332

1. Resident #22 did not received all medications per medication administration record. Nurse was educated on medication administration procedures.

2. All residents receiving medication have the potential to be affected.

3. All licensed nursing staff will be educated regarding medication administration.

4. Director of Nursing and/or designee will conduct medication observation audits 3x (times) week for 8 weeks. Audit results will be reported at QAPI Meeting.

5. Completion Date: 06/10/16

F 332 Continued From page 81
medications to Resident #22:

Furosemide 20 MG (milligrams)-diuretic to treat HTN (Hypertension)
Calcium 600 MG supplement with 400 IUs (International Units) of vitamin D3
Aspirin 325 MG- pain/fever relief
Gabapentin 300 MG- anti seizure
Pantoprazole Sodium 20 MG- reduces stomach acid
Celecoxib 100 MG- anti-inflammatory, treats arthritis
Carvedilol 12.5 MG-used to treat HTN and heart failure
Oxycodone 5 MG (2 Tablets)-pain reliever often used with aspirin

During the reconciliation process of the medications given and the physician orders the following errors were revealed:

1.The physician's order sheet noted - "Miralax for 14 days 17 gram/dose (17 grams) powder (gram), two times daily (9:00 am and 9:00 pm) starting 4/18/2016 ".

Review of the April 2016 MAR (medication administration record) noted the medication dose was to be for 14 days at 17 gram/dose (17 grams) powder (gram), two times daily (9:00 am and 9:00 pm). RN #23 neglected to give Miralax to Resident #22 during the 9:00 am medication administration observation.

2. The physician's order sheet noted - "Colace 100 MG (2 capsules), two times daily (9:00 am and 9:00 pm) starting 4/19/2016".

Review of the April 2016 MAR (medication

F 332

(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 332	Continued From page 82 administration record) noted: "Colace 100 MG (2 capsules), two times daily (9:00 am and 9:00 pm) starting 4/19/2016". RN #23 neglected to give Resident #22 Colace during the 9:00 am medication administration observation. An interview was conducted on 4/27/16 at approximately 5:00 pm with RN #23 who revealed that Resident #22 received Colace with her last dose of medication in the afternoon after therapy around 12:30 pm. RN #23 s stated: "I did not have Colace on my cart for the 9:00 am medication pass and had to obtain from another cart but waited until resident returned from therapy" and "we did not have Miralax in the facility today...I did not give Miralax." According to the Medication Administration Facility Policy last revised on 3/12/2013, Medications must be given within one (1) hour prior to or within one (1) hour after scheduled time of administration unless specific orders are given. The Administrator and DON (director of nursing) were informed of the findings at a briefing on 4/28/16 at approximately 5:38 pm. No other information was submitted by the facility.	F 332		
F 333 SS=E	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review the facility staff failed to ensure 1 of 22 residents in the survey sample were free from a	F 333		

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
	495287	A. BUILDING ______ B. WING ______	C 05/02/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SENTARA NURSING CENTER HAMPTON	2230 EXECUTIVE DRIVE HAMPTON, VA 23666

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 333	Continued From page 83 significant medication error, Resident #17. The facility staff did not administer the physician's ordered Primidone (an anticonvulsant) 250 MG (milligrams) used to treat seizures to Resident # 17 from 9/7/15 through 9/21/15. The findings included: In the course of a complaint investigation Resident #17 was placed in the survey sample as a closed record as this resident was no longer at the facility. Resident #17 was admitted to the facility on 9/1/15 and discharged home on 9/21/15. Diagnoses for Resident #17 included but not limited to seizure disorder, enlarged prostate with urinary tract symptoms, constipation, muscle weakness, stroke, and non-Hodgkin lymphoma (a type of blood cancer). Resident #17's Minimum Data Set (an assessment protocol) with an Assessment Reference Date of 9/8/2015 coded Resident #17 with a BIMS (Brief Interview Mental Status) score of 15 indicating no cognitive impairment. In addition, the Minimum Data Set coded Resident #17 requiring extensive assistance with a two person physical assistance for Activities of Daily Living. Also Resident # 17 was coded as frequently incontinent of bladder and occasionally Incontinent of bowl. Per physicians orders Primidone 250 MG (2 Tablets) was ordered on 9/1/15 two times daily for Resident #17 and discontinued on 9/4/15. Another order was started on 9/7/15 for Primidone 250 MG two times a day and discontinued on 9/21/15	F 333	1. Resident #17 is no longer at this facility. 2. All residents receiving medication have the potential to be affected. 3. All licensed nursing staff will be educated regarding medication administration. 4. Director of Nursing and/or designee will conduct medication observation audits 3x's (times) weekly for 6 weeks. Audit results will be reported at QAPI Meeting. 5. Completion Date: 06/10/16	

F 333 Continued From page 84 F 333

Review of the clinical record nursing note dated 9/4/15 noted resident' inquires about why ...Primidone (seizure medication) has been discontinued last evening per doctor...resident was taking it for treatment of seizures. A clinical nursing note dated 9/21/15 noted resident "complained of not getting Primidone medication, advised patient that the medication was not available explained that it was not in stat box either, called pharmacy to refill..said that they did not have an order and that the order was discontinued, advised the pharmacy that the order was rewritten in computer, and said that it was acknowledged, re-entered the order awaiting delivery."

According to the Pharmacy History for Order Identification sheet the pharmacy received a new order for Primidone 250 MG for Resident #17 on 9/7/15 at 12:10 pm and again on 9/21/15 at 1:22 pm to discontinue, showing that the order was active from 9/7/15 until 9/21/15.

In an interview with the Pharmacy Technician (Others #56) on 4/29/16 at approximately 6:00 pm it was noted that Resident #17 did not receive Primidone from 9/7/15 until 9/21/15. It was confirmed by Others #56 that the order was submitted to the pharmacy but not delivered and they would usually deliver this within 24 hours but not in this situation; it was not delivered. Others #56 stated, "I don't know why the new order on 9/7/15 was refused...and we have no notes that facility called until the next order came in on 9/21/15."

Complaint Deficiency

F 356 483.30(e) POSTED NURSE STAFFING F 356

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495287	A. BUILDING ______ B. WING ______	C 05/02/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SENTARA NURSING CENTER HAMPTON	2230 EXECUTIVE DRIVE HAMPTON, VA 23666

(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 356 SS=C

Continued From page 85

INFORMATION

The facility must post the following information on a daily basis:
o Facility name.
o The current date.
o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift:
- Registered nurses.
- Licensed practical nurses or licensed vocational nurses (as defined under State law).
- Certified nurse aides.
o Resident census.

The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows:
o Clear and readable format.
o In a prominent place readily accessible to residents and visitors.

The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.

The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.

This REQUIREMENT is not met as evidenced by:
The facility staff failed to ensure nurse staffing was posted on a daily basis, and specified data was included.

F 356

1. The staffing data was immediately posted at each unit.

2. Any person desiring to review staffing data has the potential to be affected.

3. Licensed RN's were in-serviced regarding regulation requirement.

4. Administrator and/or designee will verify posted staffing pattern 5x's (times) weekly for 5 weeks. Findings will be reported at the monthly QAPI Meeting.

5. Completion Date: 06/10/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495287	A. BUILDING ______ B. WING ______	C 05/02/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SENTARA NURSING CENTER HAMPTON	2230 EXECUTIVE DRIVE HAMPTON, VA 23666

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F 356	Continued From page 86 The findings included: On 5/2/16 at 10:00 a.m., the nurse staffing information was observed posted on both nursing units. Both of these posts were dated 4/29/16. The posts included only the total numbers of each category, it did not include the actual hours worked by each category to include the registered nurses, licensed practical nurses and certified nurse aides. On 5/2/16 at 10:30 a.m., the Director of Nursing was interviewed. The above findings was shared. She was in the process of completing the nurse posting information for that day. She stated she was responsible for the posting of the staffing Monday through Friday. She stated it is not always posted on the weekends as she does not have a full-time weekend supervisor.	F 356		
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: The facility staff failed to store food under sanitary conditions.	F 371		

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
	495287	A. BUILDING ______ B. WING ______	C 05/02/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SENTARA NURSING CENTER HAMPTON	2230 EXECUTIVE DRIVE HAMPTON, VA 23666

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F 371	Continued From page 87 The facility kitchen staff failed to ensure outdated refrigerated foods were not stored inside the kitchen walk-in and reach-in refrigerators. The findings included: On 4/26/16 at 12:50 a.m., an inspection of the kitchen was done. The Food Service Director accompanied the inspector. The following was observed: 1. Two pre-packaged trays of 2-3 pound diced tomatoes were stored inside the walk-in refrigerator. Both trays were dated with a use by date of 4/12/16. 2. A clear plastic container of cranberry sauce, that had been used and out of the original container, was found stored inside the walk-in refrigerator. The cranberry sauce was dated as opened on 4/21/16. 3. Caramel sauce, not in its original container was found stored inside a reach-in refrigerator. The label read use by date 4/22/16. The Food Service Director discarded each of the above food items when discovered by the inspector during the tour. On 4/29/16 at 12:03 p.m., the Registered Dietician (RD) was interviewed. The above findings were shared. The RD stated refrigerated foods that are not stored in their original containers should be discarded within 72 hours. The facility policy titled Food Production Policies and Procedures dated 11/18/15 read, in part:...If a product is removed from the original container, label with a use by date not to exceed 72 hours.	F 371	1. Outdated refrigerated food was immediately removed and discarded. 2. All residents have the potential to be affected. 3. Dining Services staff educated on appropriate date labeling and discarding of food. 4. The Dining Services Director and/or designee will inspect the walk in refrigerator 3 times per week for 60 days. Findings will be reported at the QAPI Meeting. 5. Completion Date: 06/10/16	
F 425	483.60(a),(b) PHARMACEUTICAL SVC -	F 425		

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
	495287	A. BUILDING ______ B. WING ______	C 05/02/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SENTARA NURSING CENTER HAMPTON	2230 EXECUTIVE DRIVE HAMPTON, VA 23666

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F 425 SS=E	Continued From page 88 ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on medication pass observation, staff interviews, clinical record review, facility documentation, and in the course of a complaint investigation, facility staff failed to provide routine medications for two residents (#17 and #22) from a survey sample of 22. 1. Facility staff failed to provide seizure medication (Primidone) from 9/7/15 through 9/21/15 twice a day as ordered by the physician for Resident #17. 2. During Medication Administration Observation	F 425	1. The facility failed to properly ensure medications were available for patient #17 who no longer resides at the facility and resident #22 medication was ordered immediately and delivered. 2. All residents have the potential to be affected. 3. All licensed LPN's and RN's were educated on the policy for reordering medication. 4. The Clinical Manager and/or designee will verify that medications are ordered and available 3x (times) weekly for 6 weeks. Audit findings will be reported to the QAPI Meeting. 5. Completion Date: 06/10/16	

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
	495287	A. BUILDING ______ B. WING ______	C 05/02/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 425	Continued From page 89	F 425		

a routine medication (Miralax-used to relieve constipation) was not available and not administered twice a day on 4/27/16 per physician's orders for Resident #22.

The findings included:

1. In the course of a complaint investigation Resident #17 was placed in the survey sample as a closed record as this resident is no longer at the facility. Resident #17 was admitted to the facility on 9/1/15 and discharged home on 9/21/15. Diagnoses for Resident #17 included but not limited to seizure disorder, enlarged prostate with urinary tract symptoms, constipation, muscle weakness, stroke, and non-Hodgkin lymphoma (a type of blood cancer).

Resident #17's Minimum Data Set (an assessment protocol) with an Assessment Reference Date of 9/8/2015 coded Resident #17 with a BIMS (Brief Interview Mental Status) score of 15 indicating no cognitive impairment. In addition, the Minimum Data Set coded Resident #17 requiring extensive assistance with a two person physical assistance for Activities of Daily Living. Also Resident # 17 was coded as frequently incontinent of bladder and occasionally incontinent of bowel.

Per physicians orders Primidone 250 MG (2 Tablets) was ordered two times daily on 9/1/15 for Resident #17 and discontinued on 9/4/15. Another order was started on 9/7/15 for Primidone 250 MG two times a day and discontinued on 9/21/15.

Review of the clinical record nursing notes dated 9/4/16 read resident inquires about why

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495287	A. BUILDING ________ B. WING ________	C 05/02/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SENTARA NURSING CENTER HAMPTON	2230 EXECUTIVE DRIVE HAMPTON, VA 23666

(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 425	Continued From page 90	F 425		

...Primidone (seizure medication) had been discontinued last evening per doctor...resident was taking it for treatment of seizures. In a clinical nursing note dated 9/21/15 Resident #17..."complained of not getting Primidone medication, advised patient that the medication was not available explained that it was not in stat box either, called pharmacy to refill..said that they did not have an order and that the order was discontinued, advised the pharmacy that the order was rewritten in computer, and said that it was acknowledged, re-entered the order awaiting delivery."

According to the Pharmacy History for Order Identification sheet the pharmacy received a new order for Primidone 250 MG for Resident #17 on 9/7/15 at 12:10 pm and again on 9/21/15 at 1:22 pm to discontinue, showing that the order was active from 9/7/15 until 9/21/15.

In an interview with the Pharmacy Technician (Others #56) on 4/29/16 at approximately 6:00 pm it was noted that Resident #17 did not receive Primidone from 9/7/15 until 9/21/15. It was confirmed by Others #56 that the order was submitted to the pharmacy but not delivered... it was for Primidone 250 MG two times a day and we would usually deliver this daily but not in this situation it was not delivered. Others #56 stated, "I don't know why the new order on 9/7/15 was refused...and we have no notes that facility called until the next order came in on 9/21/15."

2. Resident #22 was admitted to the facility on 4/18/2016. Diagnoses included but were not limited to hypertension, muscle weakness, aftercare following joint replacement, anemia,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495287	A. BUILDING ______ B. WING ______	C 05/02/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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 425	Continued From page 91	F 425		

and seizures. Review of Resident # 22's clinical record revealed an Admission Comprehensive MDS (minimum data set-an assessment protocol) with an ARD (assessment reference date) of 4/25/16. The resident's BIMS (brief interview for mental status) score was coded as a 15 indicated no cognitive impairment. The resident was further coded as requiring limited assistance by one to two staff members to complete her ADLs and was continent of both bladder and bowel.

On 4/27/16, during the morning medication pass at approximately 10:00 a.m., RN (registered nurse) # 23 administered the following medications to Resident # 22:

Furosemide 20 MG (milligrams)-diuretic to treat HTN (Hypertension)
Calcium 600 MG supplement with 400 IUs (International Units) of vitamin D3
Aspirin 325 MG- pain/fever relief
Gabapentin 300 MG- anti seizure
Pantoprazole Sodium 20 MG- reduces stomach acid
Celecoxib 100 MG- anti-inflammatory, treats arthritis
Carvedilol 12.5 MG-used to treat HTN and heart failure
Oxycodone 5 MG (2 Tablets)-pain reliever often used with aspirin

During the reconciliation process of the medications given and the physician orders the following error was revealed:

Miralax (relieves constipation) for 14 day 17 gram/dose (17 grams) powder (gram) was not administered to Resident #22. The physician's order sheet noted - "Miralax 14 day 17 gram/dose

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495287	A. BUILDING ______ B. WING ______	C 05/02/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SENTARA NURSING CENTER HAMPTON	2230 EXECUTIVE DRIVE HAMPTON, VA 23666

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F 425	Continued From page 92 (17 grams) powder (gram) two times daily (9:00 am and 9:00 pm) starting 4/18/2016 ". Review of the April 2016 MAR (medication administration record) noted the medication dose was to be for 14 day 17 gram/dose (17 grams) powder (gram) two times daily (9:00 am and 9:00 pm). RN #23 neglected to give Resident #22 Miralax during the 9:00 am medication administration observation. An interview was conducted on 4/27/16 at approximately 5:00 pm with RN #23 who revealed that Resident #22 had not received her Miralax dose this am. When this error was pointed out RN #23 stated: "we did not have Miralax in the facility today...I did not give Miralax." In an interview with Administration #2 on 4/27/16 at 11:00 am it was noted that a problem exists with availability of house stock (over the counter) medications such as Miralax...in the last 3-4 weeks nursing staff alerted me about stock concerns...there is no formal process to ensure supplies are available on each cart/unit...when a medication is not available the nursing staff verbally alerts me to order more...I will designate a locked area on the unit to change this process of storing medications..and RN #21 will continue to observe medication audits weekly and I will look every other day. According to the Medication Administration Policy revised on 3/12/2013 Medications must be given within one (1) hour prior to or within one (1) hour after scheduled time of administration unless specific orders are given. The Administrator and DON (director of nursing) were informed of the findings at a briefing on 4/28/16 at approximately	F 425		

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F 425	Continued From page 93 5:38 pm. No other information was submitted by the facility. Complaint deficiency	F 425		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens	F 441	1. Nurses caring for Resident #4 did not follow proper hand washing technique as well as proper anchoring of urinary tubing. Nurses were immediately educated on proper hand washing and anchoring techniques. 2. All residents with wounds or urinary tubing have the potential to be affected. 3. Licensed staff will be in-serviced on proper hand washing procedures and techniques. Licensed LPN's and RN's will be educated on proper anchoring of urinary tubing. 4. The Clinical Manager and/or designee will complete 10 handwashing observations weekly for 8 weeks. Clinical Manager and/or designee will observe 50% of patients for 8 weeks for proper anchoring of urinary tubing. All audit findings will be reported at the QAPI Meeting. 5. Completion Date: 06/10/16	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495287	A. BUILDING ______ B. WING ______	C 05/02/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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 441		F 441		

Continued From page 94
Personnel must handle, store, process and transport linens so as to prevent the spread of infection.

This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview, facility documentation review, clinical record review, and in the course of a complaint investigation, the facility staff failed for 1 resident, Resident #4, in the survey sample of 22 residents to maintain infection control practices.

A. Facility satff failed to follow proper handwashing practices during wound care

B. proper positioning of urinary drainage bag and correct anchoring of urinary tubing to help prvent the spread of infection.

The findings included:

Resident #4 was originally admitted on 2/17/04 with readmissions on 2/21/14 and 2/24/15. Diagnoses for Resident #4 included but are not limited to Multiple Sclerosis, Diabetes Mellitus, Urinary Tract Infection, Peripheral Vascular disease and Pressure Ulcers (bed sores) to sacrum and left heel.

Resident #4's Quarterly Minimum Data Set (MDS) (an assessment protocol) with an Assessment Reference Date (ARD) of 1/8/16 coded Resident #4 as having a BIMS (Brief Interview for Mental Status) of 4 out of 15 indicating a severe impairment in cognition. In addition, Resident #4 was coded as being totally

F 441 Continued From page 95 F 441

dependent with the assistance of two staff persons for bed mobility. Resident #4 was coded as having an indwelling foley catheter and coded as being always incontinent of bowel function.

A. An observation of Resident #4's wound care by Doctor (Dr) #8 and Wound Care Nurse LPN (Licenced Practical Nurse) #34 was observed on 4/27/16 at approximately 9:30 a.m.. Both staff members washed hands prior to care initation. Initially LPN #34 cleansed the bedside table and proceeded to place wound care supplies onto the table. No barrier was used underneath the supplies. Resident #4 was turned from her back position onto her right side. Dr. #8 took the foley drainage bag out of it's cover and tossed it on the window side of the bed. After washing hands, LPN #34 removed the dressing from the sacral area. When asked to decribe the wound LPN #34 stated: "granulation with some slough". Dr.#8 stated the measurements of sacral cluster to be 4 centimenters (cm) by 8 cm by 0.9 cm. Handwashing was observed by both Dr.#8 and LPN #34. The LPN cleansed one sacral wound and then proceeded to cleanse the other sacral wound without washing hands in between each wound. Santyl oinment was applied to both sacral wounds. Alginate dressing was applied to both sacral wounds and then covered with dressing. Dr. #8 then washed her hands and stated: "The sacral cluster used to be one wound."

Dr. #8 was asked by the LPN #34 to get the scizzors from the wound treatment cart. Dr. #8 gave the scissors to the LPN #34. LPN #3, without wiping the scissors off, began to cut the UNNA (medicated dressing wrap) boot off of the resident's leg. The scissors were then placed on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495287	A. BUILDING ______ B. WING ______	C 05/02/2016

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SENTARA NURSING CENTER HAMPTON	2230 EXECUTIVE DRIVE HAMPTON, VA 23666

(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 441 Continued From page 96 F 441

the table. LPN #34 cleansed vascular wounds of the leg and then proceeded to cleanse the ankle wound with normal saline. Alginate dressing was applied, and then LPN #34 opened the UNNA boot without washing hands. At this time LPN #34 washed hands and proceeded to wrap the left foot and leg. After completing this LPN #34 placed the scissors in a box of unopened dressings. At this time the two staff members were asked if they were done. They responded: "Yes." At that time, the surveyor asked about linear open wounds noted at the upper end of the boot. Dr. #8 stated: "I have not seen those." Dr. #8 washed her hands and began to assess the linear wounds. Dr. #8 measured them at 0.3 cm by 5 cm by 0.1 cm. She stated it was probably due the UNNA boot. Dr. #8 asked for alginate dressing, which she applied after cleaning the wound with normal saline and then the UNNA boot was applied over the area. A Coban dressing was then applied over the UNNA boot. During wound care observation, Dr.#8 stated that the heel and sacral wounds were pressure ulcers and the leg were vascular ulcers.

At this time, after washing hands, Dr. #8 left the room. The LPN #34 cleansed up supplies from the table and cleaned the table with sanitizer.

An interview was conducted with the Wound Care Nurse, LPN #34 on 4/28/16 at approximately 2:45 p.m. The LPN stated: "We are not allowed to bring into the room the disinfectant. That is why I didn't wipe the sissors off after I finished with them in the room. I didn't realize I didn't wash my hands after opening the UNNA boot. I thought I washed my hands when doing each of the sacral wounds. ...Yes, I would agree now that the sacral cluster has two separate wounds."

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F 441	Continued From page 97	F 441		

B. An observation was made on 4/26/16 at approximately 2:55 p.m. Resident was observed lying in bed on her back. CNA (Certified Nursing Assistant) #62 was asked to pull down the cover so that I could observed foley catheter tubing. An anchor was observed to be placed on thigh; however, the foley tubing was not correctly secured in the tubing. CNA #62 was asked to slide the foley tubing a little bit either way which she did. The CNA did not comment that the tubing was not secured properly in the anchor.

An observation was made of Resident #4's routine urinary catheter care being performed by CNA (Certified Nursing Assistant) #61. When CNA #61 came into the room she was observed explaining to Resident #4 what she would be doing. The CNA then proceeded to wash her hands and look in the Foley bag cover for the Urinary Drainage Bag. She stated at that time: "Where's the bag? I want to empty it before I do foley care." The CNA located the urinary drainage bag on the floor between the Resident's bed and the window. The CNA stated: "This shouldn't be on the floor." The CNA emptied the bag, measured the amount of urine and placed the bag in it's cover. The CNA then washed her hands. The CNA obtained a basin of water, and allowed the resident to test the temperature of the water, which the resident stated: "it's fine." The CNA proceeded to perform foley catheter care by following the facility's Policy and Procedure entitled Perineal Care of Resident with a Foley". The CNA was asked who changes the anchors. The CNA stated: "The nurses change them when they need it."

On 4/29/16 at approximately 10:30 a.m., LPN #39

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495287	A. BUILDING ______ B. WING ______	C 05/02/2016

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F 441	Continued From page 98	F 441		

was asked to lower covers of Resident #4 so that I could observe the foley catheter. The catheter tubing was observed to not be properly secured in the anchor. When this was mentioned by the surveyor, LPN #39 stated: "The aide do foley catheter care." LPN #39, when asked to properly secure the catheter in the anchor, did not know how.

Resident #4's current careplan with an effective date of 4/19/16 to present, documented Problem of:

1. At risk for infection R/T (related to) indwelling catheter. Interventions included but were not limited to: Clean around catheter with soap and water, Keep tubing below level of bladder and free of kinks or twists, Report any sign of infection.

2. Impaired skin integrity related to venous ulcer to left leg. The goal included: "Resident will not have complications from impairment of skin integrity for next 90 days." The surveyor did not observe any specific interventions related to infection control related to wound other than the intervention of "keep it clean and dry."

The policy and procedure entitled: "Handwashing/Hand Hygiene/Fingernail Hygiene - Infection Prevention and Control #204 with a revision date of 5/2014 was reviewed. It documented the following:
"Wash hands with liquid soap for routine handwashing when hands have been contaminated with potentially infectious materials, before doing invasive procedures, before and after contact with an infected and or isolated patient."

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F 441 Continued From page 99 F 441

The policy and procedure titled: "Wound Care" with a revision date of 10/14/14 documented the following:

"Purpose: To provide aseptic wound care in accordance with Physician's orders."

"Required Action Steps"
4. Set up clean area with supplies.
5. Wash hands thoroughly and put on gloves."

According to the CDC (Center for Disease Control) Healthcare providers should practice hand hygiene at key points in time to disrupt the transmission of microorganisms to patients including: before patient contact; after contact with blood, body fluids, or contaminated surfaces (even if gloves are worn); before invasive procedures; and after removing gloves (wearing gloves is not enough to prevent the transmission of pathogens in healthcare settings). Specifically, the CDC (Center for Disease Control) Guideline for Hand Hygiene in Health-care Setting. Morbidity and Mortality Weekly Report (MMWR), 2002 Volume 51: Hand washing:
1. Wet hands with water, apply soap, rub hands together for at least 15 seconds
2. Rinse and dry with disposable towel
3. Use another towel to turn off faucet.
Duration of entire procedure for Hand washing: 40-60 seconds.

Unused supplies and medications should be maintained in clean areas separate from used supplies and equipment (e.g., glucose meters). Do not carry supplies and medications in pockets. www.cdc.gov

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F 441	Continued From page 100	F 441		

According to the eighth edition of Fundamentals of Nursing written by Potter and Perry: "anchoring catheter to inner tigh reduces pressure on urethra, thus reducing possibility of tissue injury." It "also minimizes risk for bleeding, trauma, meatal necrosis, and bladder spasms from pressure and traction."

The Center of Disease Control (CDC) Guideline for Prevention of Catheter associated Urinary Tract Infections, 2009 documents that a foley urinary drainage bag is to be secured below the bladder to allow proper drainage, but off the floor to reduce infection.

An update was provided to the Director of Nursing (DON) on 4/27/16 at approximately 11:30 a.m. When the DON was informed that the wound care nurse did not wash her hands between certain aspects of wound care, no verbal comment was given. At this time a copy of Infection Control policy related to handwashing was requested.

The administration consisting of the Administrator and the DON were briefed of the findings on 4/29/16 at approximately 6:00 p.m. No further information was presented.