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STA	TEMENT C	FOEFICIENCIES	(X1) PROVIDER/SUPPL		(X2) MULTIF	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
ANU	PLANOF	CORRECTION	IDENTIFICATION N	OMBEK!	A. BUILDING	·	
			49528	7	B. WING		05/02/2016
N/	ME OF PF	OVIDER OR SUPPLIER			DDRESS, CITY, S	TATE, ZIP CODE	
		NURSING CENTER	HAMPTON	1	ECUTIVE DRI		
				HAMPTO	ON, VA 23666		
	X4) ID REFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCE Y MUST BE PRECEDED B .SC IDENTIFYING INFORM	YFULL	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE COMPLETE TE APPROPRIATE DATE
panagingpros	F 000	Initial Comments			F 000		
		Inspection was cor and 5/2/16. The fac with the following V for licensure of Nul The census in this time of the survey. of 22 residents, 18 (Residents #1 thro and 7 closed recor #16 through 21). Non Compliance The facility was ou	siennial State Licens inducted 4/26/16 thro cility was not in con /irginia Rules and R rsing Facilities.  86 bed facility was The survey sample 5 current Resident re ugh 4, #6 through 1 d reviews (Resident t of compliance with	ough 4/29/2 repliance egulations  70 at the consisted eviews 5 and #22 rs #5 and		"Preparation and/or ex of correction does not admission or agreemed of the truth of the facts conclusion set forth in deficiencies. The plar prepared and/or executive is required by the prand State law."  12 VAC 5-371-220 (C)  Cross Reference	constitute  It by the provider  It alleged or  It is statement of  It of correction is  It is stated to be a consistent of the solely because  It is ovisions of Federal
		This RULE: is not	met as evidenced b	ıy:		Refer to F-Tag 3	e09 of the Plan of Correction.
		∵ ≮2 V∆∩ 5-371-340	(A) Dietary and foo	d service			
		program Please Cross-Refe				12 VAC 5-371-340 (A) Cross Reference	e F- <b>371</b>
			(F) Nursing Service interview, staff Inter			Refer to F-Tag	371 of the Plan of Correction.
		dinical record revided twice week	ews the facility staff (ly showers for 2 of	failed to 22 residen	ts	Completion Da	te: 06/10/16
			ole, Resident #3, and			12 VAC 5-371-220 (F) Cross Reference	e F-312
		Resident #3 who wactivity of daily living	vas unable to carry ong without the assist	out this		Refer to F-Tag	371 of the Plan of Correction.
		staff.  2. The facility staff failed to provide Resident #12			! ·	Completion Da	te: 06/10/16
1 45	OBATOR	HIRECTOR'S OR PROM	DER/SUPPLIER REPRESI	ENTATIVE'S S	IGNATURE	TITLE	(X6) DATE
LAE	ORATOR!		SELOGI TELEVICE INCO				10/10/20
	<u> </u>	15/mes	ue			Administrator	If continuation sheet 1 of 6
ST	ATE FOR	Λ		021199		485 <b>K</b> 11	management and the second of the

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		DEFICIENCIES ORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU			CONSTRUCTION	(X3) DATE SURVEY COMPLETED
* despression may			495287		B. WING	annajanningsynn najytyn delemateksiaksia saassa – sa. – s. 24. – s. 27. –	05/02/2016
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P	X4) ID REFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE  MUST BE PRECEDED BY  SC IDENTIFYING INFORMA	FULL.	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION: CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE COMPLETE
	F 001 C	ontinued From Pa	ige 1		F 001		
	4.	ith twice weekly si 16/16 to 4/28/16. he findings include	howers per her reque ed:	est from		12 VAC 5-371-150 (A, B) Cross Reference F	-151
		Resident #3 was 9/16 for rehab ser	admitted to the facili	ity on		Refer to F-Tag 151	of the Plan of Correction.
	h		e resident's diagnose	s included		Completion Date: (	06/10/16
	a: re	ssessment referer sident as scoring	S (Minimum Data Se ace date of 3/16/16 c a 15 out of a possible or Mental Status (BIM	oded the e 15 on		12 VAC 5-371-140 (D) Cross Reference F-	241
	in	dicating the reside	ent's cognition was in dent on two staff for	tact. The		Refer to F-Tag 241	of the Plan of Correction.
		obility, transfers, a	-			Completion Date: 0	06/10/16
	of pt he	oserved in bed. Th hysical therapy. The ad received showe	a.m., the resident w ne resident was waiti ne resident was aske rs since she was adi	ng for ed if she mitted to		12 VAC 5-371-280 (A, B1, E) Cross Reference F-	
	sh	lower". The reside	, "No, I have not rece ent stated she was gi ve preferred a showe	iven bed		Refer to F-Tag 248	of the Plan of Correction.
	ev ha	ery other day. The day identifies the any restrictions	e resident was asker that would have limit ch as a physician ord	d if she ted her		Completion Date: 0	06/10/16
	re re	sident stated she s strictions. At this ti	was not aware of any me a rehab staff ent ident to the rehab de	/ ered the		12 VAC 5-371-220 (C, 1 D) Cross Reference F-	341
	R		l record failed to evid			Refer to F-Tag 341 (	of the Plan of Correction.
	O) (C) res an an els	n 4/28/16 at 3:00 p NA#44) was interviceive report at the sident's who are or d shift. She stated ectronic record to c	.m., a certified nursiviewed. She stated to beginning of the shift the shower list for the there is no option of locument what type wither a bed bath or s	hey ft of that day on the of bath		Completion Date: 0	6/10/16

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State of Virginia STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY ND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING 495287 B. WING 05/02/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2230 EXECUTIVE DRIVE SENTARA NURSING CENTER HAMPTON HAMPTON, VA 23666 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5)(EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PRÉFIX PREFIX COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DATE DEFICIENCY) F 001 Continued From Page 2 F 001 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 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:

State of Virginia (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION ND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING \_ B. WING 05/02/2016 495287 VAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE SENTARA NURSING CENTER HAMPTON 2230 EXECUTIVE DRIVE HAMPTON, VA 23666 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL IEACH CORRECTIVE ACTION SHOULD BE COMPLETE <sup>≒</sup>REFIX PREFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) DATE TAG TAG DEFICIENCY) 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.

\$tate of Virginia (X3) DATE SURVEY STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING B. WING 05/02/2016 495287 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2230 EXECUTIVE DRIVE SENTARA NURSING CENTER HAMPTON HAMPTON, VA 23666 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) (D PREFIX (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) Continued From Page 4 F 001 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 12 VAC 5-371-220 (A) Saturday are my shower days." Cross Reference F-323 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 Refer to F-Tag 323 of the Plan of Correction. information was presented. No additional information was provided prior to Completion Date: 06/10/16 exit. 12 VAC 5-371-220 (D) 12VAC5-371-150 (A, B) Please Cross-Reference Cross Reference F-241 to F-151 12VAC5-371-140 (D) Please Cross-Reference to Refer to F-Tag 241 of the Plan of Correction. 12VAC5-371-280 (A, B(1), E) Please Cross-Reference to F-248 12VAC5-371-220 (C) Completion Date: 06/10/16 (1)(D) Please Cross-Reference to F-314 12VAC5-371-220 (A) Please Cross-Reference to F-323 12 VAC 5-371-220 (B) **Cross Reference F-309** Refer to F-Tag 309 of the Plan of Correction. The facility was not in compliance with the following Virginia Rules and Regulations for the Completion Date: 06/10/16 Licensure of Nursing Facilities. Nursing Services 12 VAC-5-371-220 (D). Cross 12 VAC 5-371-220 (D) Reference to F-241 Cross Reference F-312 Nursing Services 12 VAC-371-220 (B). Cross Reference to F-309 Refer to F-Tag 312 of the Plan of Correction. Nursing Services 12 VAC-371-220 (D). Cross Reference to F-312 Nursing Services 12 VAC-371-220 (D). Cross Completion Date: 06/10/16 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

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	TEMENT OF PLAN OF C	DEFICIENCIES ORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NUI			PLÉ CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED
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						371-220 (D) Cross Reference F-323	
						Refer to F-Tag 323 of the Plan of Co	orrecti <b>o</b> n.
					(	Completion Date: 06/10/16	
						-371-180 (C, 3)	
					(	Cross Reference F-441	
					ſ	Refer to F-Tag 441 of the Plan of C	orrection.
					(	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 Correction.	Plan of
						Completion Date: 06/10/16	
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### PRINTED: 05/16/2016 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 495287 B. WING 05/02/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2230 EXECUTIVE DRIVE SENTARA NURSING CENTER HAMPTON HAMPTON, VA 23666 (k4) ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID PREFIX (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TEACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE ľAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) 000 INITIAL COMMENTS F 000 "Preparation and/or execution of this plan Ah unannounced Medicare/Medicaid standard of correction does not constitute survey was conducted 04/26/16 through admission or agreement by the provider 04/29/16 and 05/02/16. Five complaints were of the truth of the facts alleged or Investigated. Significant corrections are required conclusion set forth in the statement of for compliance with 42 CFR Part 483 Federal deficiencies. The plan of correction is Long Term Care requirements. The Life Safety prepared and/or executed solely because Code survey/report will follow. it is required by the provisions of Federal and State law" 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 #\$ and #16 through 21). F 151 483.10(a)(1)&(2) RIGHT TO EXERCISE RIGHTS F 151 1. Resident council members were SS=D - FREE OF REPRISAL impacted. The staff member was The resident has the right to exercise his or her educated on resident rights. rights as a resident of the facility and as a citizen of resident of the United States. All residents wishing to vote have the potential to be affected. The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights. 3. Activities Director contacted voter registration office to assist in the This REQUIREMENT Is not met as evidenced application process for absentee voting. by:

Based on the Resident Group Interview, facility

document review, and staff interviews the facility staff falled 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

annually and iD residents' who wish to vote and assist them in obtaining an

absentee ballot. Findings will be presented at the QAPI meeting.

4. The Activities Director will audit

5. Completion Date: 06/10/16

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

TITLE

(X6) DATE

Administrator 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

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: HE9D11

Facility ID: VA0216

if continuation sheet Page 1 of 101

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	PE DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 '	LTIPLE CONSTRUCTION DING		(X3) DATE SURVEY COMPLETED
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	Interview was condupresent. During the was posed to the rethe opportunity to vorting the was posed to the rethe opportunity to vortinary Presidential unanimous "no "was Group was asked if Primary Presidential Residents began strother names were notated that they were ast their individual On 4/27/16 at appropriate their individual On 4/27/16 at appropriate Primary President Group Interestor was asked to allow the Resident Virginia Primary President Ballots for the primary President they will have the sure they will have the facility in the facility policy titted and policy titted and policy titted and policy that is definental and psychosic esident/participant.	ed:  a.m. a Resident Group ucted with 11 Residents a group interview the question sidents if they had been given be in the March 2016 Virginia I Election and instantly a less verbalized. The Resident they were aware of the I Candidates running. The lating Trump and Clinton, no mentioned. The Residents e not given the opportunity to	F	151		

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ST/	TEMENT DPLANC	OF DE F COR	FICIENCIES RECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		ISTRUCTION	(X3) DATE SURVE COMPLETED	Υ
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្ន	ENIAR	4 NUH	ISING CENTER	HAMPTON	1	HAMP'	TON, VA 23666		
<del></del>	ka 10		STRALADV STA	TEMENT OF DEFICIENCIES		····		K.: /kers	
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	F 151	Cont	inued From pa	ge 2	F 1	51			
		1		_	• •	01			
				with the Administrator and the					
:			stor of Nursing shared.	where the above information					
		Prior	to exit no furth	er information was provided.					
	F 177			O REFUSE CERTAIN	F 1	77			
			NSFERS	OTTER OOL OLIVINIA	, .	, ,			
		An in	dividual has th	e right to refuse a transfer to		1	Resident #19 was transferred t	o a	
				the institution, if the purpose		d	lually certified bed and no longer		
				relocate a resident of a SNF,		r	esides at the facility.		
				t of the institution that is a			,		
				institution that is not a SNF,		2	. All residents experiencing a roo	nm.	ļ
				f, from the distinct part of the					į
			ution that is a N ution that is a S	IF to a distinct part of the INF.		U	ransfer has the potential to be af	rected.	
						3	. Social Workers have been in-se	rviced	
		under	r paragraph (o)	e of the right to refuse transfer (1) of this section does not		re	egarding patient transfer rights.		
		affect	the individual	s eligibility or entitlement to		А	The Cooled Markov and for Josia	mea	1
		Medic	are or Medica	id benefits.			. The Social Worker and/or design		
		:					ill audit 50% of room transfers fo		
		med	ng pangang a pagamanan a a aman n				ays to ensure proper documenta		Ì
			REQUIREMEN	T is not met as evidenced		St	upporting room transfer. Finding	s will	l
ĺ		by:		and a series of the series of		b	e reported to the QAPI Meeting.		
				nterview, staff interview, in review, and in the course					-
ı				tigation, the facility staff failed		5	. Completion Date: 06/10/16		- 1
				s (Resident #19) refusal of					
l				ed Nursing bed to a Long					
				л the same facility in a survey					
l		samp	le of 22 resider	nts.					-
		Resid	ent #19 was a	dmitted to the facility on					
1				irsing services following a					
				gnoses on the Admission					1
				Set - an assessment					
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	CENTER	S FOR MEDICARE	& MEDICAID SERVICES			<u> </u>	<u>MB MO. 0930-039 I</u>
S	ATEMENT C	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	TIPLE CONSTRUCTION ING	-	(X3) DATE SURVEY COMPLETED C
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		to Heart Failure, Ar condition makes yo to break), Cerebroy Generalized Muscle The Quarterly MDS coded Resident #1: (Brief Interview for indicating severely addition, the Quarte as requiring extens assistance of two s Transfers, Toilet Us MDS coded that W not occur. In additions occasionally income to be a soccasionally income to be	cluded but were are not limited thritis, Osteoporosis (a our bones weak and more likely vascular Accident (stroke), and	F 1	77		
Westerning the state of the sta		functioning.  A document was prapproximately 1:43 Manager, Employe that therapy service continued through manager stated that Resident's private is company). Physica recommendations is "Discharge recommendations is "Discharge recommendations are in Term Care. Her hucapable to provide Restorative Nursing maintaining current order to prevent definition in the fo	rovided on 5/2/16 at p.m. by the Rehabilitation e #55. The document stated es began on 9/11/15 and 11/05/15. The Rehab at these dates were billed to insurance (name of insurance documented on 11/5/15; mendations: Recommend 24 f patient returns home or Long usband is not physically level of care she requires. g Program: To facilitate patient tevel of performance and intelliowing Restorative Nursing in completed with the				

	CENTER	S FUN MEDICANE	& MEDICAID SELVICES	···			<del>11 </del>
		OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' ''		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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			495287	B. WING			05/02/2016
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-merci	F 177	Continued From pa	ge 4	F	177	•	
		Interdisciplinary tea and transfers.	m: bed Mobility, ambulation				
		Starting on 1/1/16	Therapy services consisting of Occupational Therapy, and				
		Speech Therapy se	ervices were reinstated with				,
		Medicare Part B be billed to Medicare F	ing billed. Therapy services Part B were discontinued on				
			ervices were reinstated on				
			Physical Therapy and				
			apy and continued through				
			illed private pay. The Physical and Plan of Treatment				
			/2016 Assessment Summary				
		documented the fol					
П	-		n: Reason for Skilled				
			nay benefit from skilled PT				
	:	(Physical Therapy)	to increase strength and				
			increase independence with				
		gait, transfers, and	bed mobility to decrease				!
П			caregivers, to return to PLOF				
		(prior level of functional to	on) and to maintain her evel. Focus of POT (Plan of				
			intervention Focus =				
			cal Therapy Discharge				
			18/16 documented the				
Ш		following Discharge	Recommendations:				
Ш		Recommend patier	nt ambulate with CNAs				
Ш	1	(certified nursing as	ssistants) attend morning				
	;	exercise class when	n avallable and propel wc facility. Restorative Nursing				
	į	(witeer criair) in the Drogram: To facility	ate patient maintaining current				
i		level of performance	e and in order to prevent				
H			ent of and instruction in the				
			e Nursing Programs has been				
Ш		completed with the	Interdisciplinary team:				
П			obility and transfers.				

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S	TATEMENT	F DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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			495287	B. WING		05/02/2016
, and		ROVIDER OR SUPPLIER NURSING CENTER	HAMPTON		STREET ADDRESS, CITY, STATE, ZIP CODE 2230 EXECUTIVE DRIVE HAMPTON, VA 23666	
	(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		DBE COMPLETION
		pay on 3/9/16. Sen Therapy and Occup Therapy Evaluation following Skilled Jurequested to resum Patient will be seen increase ambulation Summary dated 3/2 following discharge Recommend 24 ho Long Term Care. For facilitate patient performance and in development of and Restorative Nursing completed with the ambulation, bed McFunctional Outcompassist; Transfers = Surfaces = Caregiv During an interview on 4/27/16 at approhusband stated: "V without prior notification of need for slover my wife's object An interview was conditional outcomes of need for slover my wife's object An interview was conditional outcomes and the solution of the	ere reinstated under private vices consisted of Physical pational Therapy. The Physical dated 3/9/16 documented the stification: Patient's family e skilled Physical Therapy. for a two week trial to n. Physical Therapy discharge 3/16 documented the Recommendations: ur care if patient goes home or restorative Nursing Program: maintaining current level of a order to prevent decline, if instruction in the following programs has been Interdisciplinary Team: obility and transfers. The maintaining current level of a order to prevent decline, if instruction in the following programs has been Interdisciplinary Team: obility and transfers. The maintaining current level of the skilled care. They removed her objected to discharge, ation despite (Doctor #7's) called care. They removed her orducted with the facility of 4/29/16 at approximately sinistrator did state that transferred off of the skilled m Care Unit upon Physical Discharge Summary tesident #19 was no longer	£.	177	

An interview was conducted with the Rehab

(	CENTERS	S FOR MEDICARE	& MEDICAID SERVICES			JIMID IAO. DAJO-	
Sī	ATEMENT C	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	} · · ′	TIPLE CONSTRUCTION ING	(X3) DATE SURVE COMPLETED	
			495287	B. WING	Andrew Control of the	C 05/02/201	6
		OVIDER OR SUPPLIER NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2230 EXECUTIVE DRIVE HAMPTON, VA 23666		
to Pine	(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORRECT X (EACH CORRECTIVE ACTION SHOU	DBE COMPL	ETION
	F 241 - 4 SS=E	he provided dates services. She status pened to Therapy occasions. On each topped as the resistences, therefore services. We can revivate pay skilled scense when a resistence with the administration and the DON were 129/16 at approxination was presidence and the DON were 183.15(a) DIGNITY NDIVIDUALITY	at approximately 1:45 p.m. of service for Rehabilitative ed: "(Resident #19) was Services on three different the occasion services were dent was not longer making no skilled need to continue not continue even under services of a therapist with a dent no longer makes erapy.  consisting of the Administrator briefed of the findings on nately 6:00 p.m. No further		1. Resident #4 and #5's dignity preserved. Resident #4 was not notification (knocking on door) staff entering room and resider not taken to the bathroom time members were educated on resights relating to dignity.	given prior to t #5 was ly. Staff	
	1 1 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	ty:  1. Based on obser acility documentati eview, and in the of hvestigation, the fa and promote dignity survey sample, (Re	NT is not met as evidenced reation, resident interviews, on reviews, clinical record course of a complaint icility staff failed to maintain y for 2 of 22 residents in the esident #4 and #5).		<ol> <li>All residents have the poten affected.</li> <li>Nursing will be in-serviced of the DON and/or designee who so the Sx (times) weekly for 8 weeks the dignity is maintained. Findings reported to the QAPI Meeting.</li> </ol>	n dignity. Il round o ensure	
		Resident #4.	and government of the second s		5 Completion Date: 06/10/16		

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	TATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	) ` .	TIPLE CONSTRUCTION ING	(X3) DATE SURVEY COMPLETED
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			495287	B. WING		05/02/2016
mika.	NAME OF P	ROVIDER OR SUPPLIER	Date to Character and Characte		STREET ADDRESS, CITY, STATE, ZIP CODE	
			// NAME TO A		2230 EXECUTIVE DRIVE	
	SENTARA	NURSING CENTER	HAMPIUN		HAMPTON, VA 23666	<del>and and special and a familiar</del> to the first of the second secon
cetro	(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIV  (EACH CORRECTIVE ACTION SHOULD  CROSS-REFERENCED TO THE APPRODEFICIENCY)	DBE COMPLETION
-	r" 0 44		7	F 2	44	
		Continued From pa		r Z	41	
		not complying with t	intain and promote dignity by toileting assistance requests in maintain urinary continence			
		The Findings includ	led:			
		with readmissions of Diagnoses for Residential to Multiple S that causes damage system), Diabetes Molood sugars are not Vascular disease (of to lower extremities to sacrum and left hole of the Infection (UTI).  Resident #4's Quartern and assessment president president president president resident president resident president resident resident president resident	s originally admitted on 2/17/04 on 2/21/14 and 2/24/15. dent #4 included but are not iclerosis (progressive disease e to the central nervous Mellitus (disease where the ot controlled), Peripheral disease affecting blood supply solds), Pressure Ulcers (bed sores) heel and Urinary Tract terly Minimum Data Set (MDS totocol) with an Assessment			
	1 to 10 to 1	Reference Date (AF #4 as having a BIM Status) of 4 out of 1 impairment in cogni was coded as being	RD) of 1/8/16 coded Resident S (Brief Interview for Mental I5 indicating a severe ition. In addition, Resident #4 totally dependent with the			-
		Resident #4 was co	taff persons for bed mobility.  bded as having an indwelling boded as being always of function.			
		approximately 9:00 Nurse) #39 was obs	a made on 4/27/16 at a.m. LPN (Licensed Practical served entering Resident #4's ting on the door prior to			
		An observation was	s made on 4/29/16 at			

approximately 10:30 a.m.. LPN (Licensed

### PRINTED: 05/16/2016 FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTER'S FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED DENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING 05/02/2016 B. WING 495287 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2230 EXECUTIVE DRIVE SENTARA NURSING CENTER HAMPTON HAMPTON, VA 23666 (X5) COMPLETION DATE PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES ID (X4) ID PREFIX (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 241 Continued From page 8 F 241 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

information was presented.

4/29/16 at approximately 6:00 p.m. No further

Resident #5 was a 76 year old admitted to the

### PRINTED: 05/16/2016 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 CENTER'S FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION A. BUILDING. 05/02/2016 B. WING 495287 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2230 EXECUTIVE DRIVE SENTARA NURSING CENTER HAMPTON HAMPTON, VA 23666 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION DATE SUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECTIVE ACTION SHOULD BE (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) 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.

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			495287	B. WING		05/02/2016
		ROVIDER OR SUPPLIER NURSING CENTER	HAMPTON		STREET ADDRESS, CITY, STATE, ZIP 2238 EXECUTIVE DRIVE HAMPTON, VA 23666	COOE
number of the second	(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		N SHOULD BE COMPLETION E APPROPRIATE DATE
bund	F 241	Continued From pa	ge 10	F 2	241	
		occasional incontin Goai: Episodes of eliminated by 5/31/Intervention: Docuincontinent. Perfor skin. Note areas obarrier to buttocks.  Problem: Self Carewith bathing, hygies grooming r/t (relate function mobility and Goai: Will be odor daily over the next assist with ADL's (ahighest degree posincreased ability to function). Intervention: Assis grooming, tolieting, Resident #5 unable Maintain privacy ar On 4/28/16 at 9:00 conducted with Resident #5 stated	bowel incontinence will be 16 ment when Resident #5 is m complete assessment of f redness. Apply moisture  e Deficit-assistance required ne, dressing, tolleting, and d to) osteoarthritis, decline in id pain. free, dressed and out of bed 90 days. Resident #5 will activities of daily living) to the isible AEB (as evidenced by) perform PLOF (prior level of t with ADL's (bathing, feeding, ambulating)if			
		chair in the hall nea needed to pee. I a bathroom. She sai can't wait I gotta pe When she came be diaper over an hou time. I have to wel makes me feel rea have to go to the b	ar the bathroom because I sked the aide to take me to the d you have to wait, I said I se. I had to pee on myself, ack I had been sitting in a wet r at least. It happens all the and poop on myself too. It lly bad, because I know when I athroom and I mess up my buld do it myself, but I can't			

NAME OF PROVIDER OR SUPPLIER  SENTARA NURSING CENTER HAMPTON  (X4) ID PROVIDER OR SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REQUILATORY OR LSC IDENTIFYING INFORMATION)  F 241  Continued From page 11  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 if 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."	C 05/02/2016
STREET ADDRESS, CITY, STATE, ZIP COL  SENTARA NURSING CENTER HAMPTON  (X4) ID PREFIX TAG  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  F 241  Continued From page 11 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 fold 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	05/02/2016
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"Policy Statement: The privacy and dignity of all	
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."	

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			495287	B, WING		***	05/02/2016
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	SENTARA	NURSING CENTER	HAMPTON		HAI	MPTON, VA 23666	
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		Continued From pa	200 12	E	241		
	F 241		with the Administrator and the				
		Director of Nursing	where the above information				
		was shared. The I	Director of Nursing was asked				
		what are her exped	ctations of her staff regarding				
		the tolieting of resid	dents. The Director of Nursing				
		stated, "I would ex	pect if a resident was alert and be taken to the bathroom."				
		oriented for them u	De taken to me bannoom.				
		Prior to exit no furt	her information was provided.				
		*Diabetes Mellitus:	a complex disorder of				
		carhohydrates, fat,	and protein metabolism that is				
		primarily a result of	f a deficiency or complete lack				
		of insulin secretion pancreas or resista	by the beta cells of the ance to insulin.				
		**Chronic Pain: pa over a prolonged p diseases or abnorr	ain that continues or recurs period, caused by various mal conditions.				
		***Octooarthritis: a	form of arthritis in which one				
		or many joints und	ergo degenerative changes,				
		including bony scle	erosis, loss of cartilage, bone				
		spurs, and cartilag	e in the joints.				
		activity a mood dis	decrease of vital functional sturbance characterized by				
		resulting from and some personal los	s, despair, and discouragement normally proportionate to s or tragedy.				
		*****Obesity: an a proportion of fat ce subcutaneous tiss	bnormal increase in the alls, mainly in the viscera and ues of the body.				
		The above definition Dictionary of Media Professions 8th Economics	ons were derived from Mosby's cine, Nursing, and Health dition.				

FORM CMS-2567(02-99) Previous Versions Obsolete

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		495287	B. WING			05/02	2/2016
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F 246	Continued From pa 483.15(e)(1) REAS OF NEEDS/PREFE	ONABLE ACCOMMODATION		246 246			
	services in the facili accommodations of preferences, except	ight to reside and receive ty with reasonable individual needs and t when the health or safety of er residents would be			<ol> <li>Resident #16 and #17 are no lothis facility.</li> <li>All residents have the potential affected.</li> </ol>	J	
	oy: Based on interview facility documentation complaint investigate answer call bells in	IT is not met as evidenced s, clinical record review, on and in the course of a ion, facility staff falled to a timely manner for two # 17) from a survey sample of			<ol> <li>Nursing will be in-serviced regacall bell responsiveness.</li> <li>The DON and/or designee will a 25% of resident call bell responsive for 5 weeks. Findings will be report the QAPI Meeting.</li> <li>Completion Date: 06/10/16</li> </ol>	udīt eness	
The second secon	minutes resulting in care.  2. Resident #17 wai for assistance with of the findings include  1. In the course of a Resident #16 was parallely. Resident #1	complaint investigation laced in the survey sample as his resident is no longer at the 6 was admitted to the facility					
] [ ]	Diagnoses for Resid not limited to End St Fibriliation, Diabetes	arged home on 5/23/15. fent #16 included but were lage Renal Disease, Atrial s, aftercare for traumatic lty in walking and muscle					

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		ENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
		MENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLW IDENTIFICATION NUMBER:		; · ·			COMPLETED		
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			495287	B, WING			05/02/2016		
	VAME OF PR	ROVIDER OR SUPPLIER				ET ADDRESS, CITY, STATE, ZIP CODE			
	SENTARA	NURSING CENTER	HAMPTON	2230 EXECUTIVE DRIVE					
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	F 246	Continued From pa	ge 14	F:	246				
		weakness.	9						
			imum Data Set (an						
			ol) with an Assessment RD) of 5/19/2015 coded						
			BIMS (Brief Interview Mental						
-		Status) score of 15	indicating no cognitive						
		impairment. In addi	tion, the Minimum Data Set 3 requiring extensive						
		assistance with one	person physical assistance						
		for Activities of Daily	y Living, specifically toilet use.						
			was coded as occasionally ler and always continent of						
		bowel.							
		In the course of a c	omplaint investigation and						
	ĺ	record review the c	all bell logs generated by the						
	į	facility while Reside	nt #16 was at the facility from (Resident #16's room number						
	E E	during admission) tl	he call bells were consistently						
	ľ	answered by staff a	t times over 20, 30, and 40						
		minutes:	am response time was 23:23						
		minutes/seconds,	atti respunse titte was 20.20						
		on 5/09/15 at 8:52	pm response time was 27:06						
		minutes/seconds,	om response time was 37:31						
	i	minutes/seconds,							
			am response time was 24:01						
	į	minutes/second, and on 5/23/15 at 8	:41 am response time was						
		23:36 minutes/seco							
		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						
-1	غ اغ	bells, an hour or mo	ore at times.				i		

 A PARTY OF THE PROPERTY OF THE PARTY OF THE	S FOR MEDICARE OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	1	TIPLE CONSTRUCTION		E SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	DING		С
		495287	B. WING			02/2016
	NURSING CENTER	HAMPTON		STREET ADDRESS, CITY, STATE, 2230 EXECUTIVE DRIVE HAMPTON, VA 23666		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		THE APPROPRIATE	(X5) COMPLETION DATE
	Resident #16 is occupain and had a deweakness. The intermediate weakness. The intermediate process of correction and when asked weakness of correction and when asked and weakness of correction and weakness of	are plan under 'continence', casionally incontinent reports cline in functional mobility and erventions to assist Resident re not limited to: Answer call y bladder before meals, at e activities.  In Administration #2 on 4/28/15 2:15 pm, it was stated that the ff to answer call bells was "5 all respond within 5 minutes" thy response time was longer, it ffing issue at times which the report had identified and are in the report of the first policy titled, 'Answering on 4/9/13, the expectation was to promptly" and "make the table as possible and offer before leaving the room."  a complaint investigation placed in the survey sample as this resident is no longer at the first resident is no longer at the first resident is no longer at the first resident in the survey sample as this resident is no longer at the first resident in the survey sample as the first resident in the first resident in the survey sample as the first resident in the first residen		246		
	assessment protoc	inimum Data Set (an col) with an Assessment IRD) of 9/8/2015 coded a BIMS (Brief Interview Mental				

PRINTED: 05/16/2016 FORM APPROVED OMB NO. 0938-0391 DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '		ONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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			495287	B. WING		The state of the s	05/02/2016	
	NAME OF PI	OVIDER OR SUPPLIER	Metados de com cominha Meson principal de como de comunicación que como como de como como como como como como como com		STRE	ET ADDRESS, CITY, STATE, ZIP CODE		
					2230	EXECUTIVE DRIVE		
	SENTARA	NURSING CENTER	HAMPTON		HAN	1PTON, VA 23666		
							X1 (2/5)	
	(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL BC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETION	
desired do	F 246	Continued From pa	ge 16	F	246			
		-	<del>-</del>	•	- 10			
		Status) score of 15	indicating no cognitive					
		impairment. In addi	tion, the Minimum Data Set					
		coded Resident #1	requiring extensive					
		assistance with a tv	yo person physical assistance					
		for Activities of Daily	Living, specifically toilet use					
			ive assistance defined as					
		resident involved in	activity, staff provide					
		weight-bearing sup	port and coded 3 for a two					
		person physical ass	ist). Also Resident # 17 was					
		coded as frequently	(7 or more episodes)					
	1	incontinent of bladd	er and occasionally (one					
		episode) incontinen	t of bowl.					
		6	Il hall has for Decident #17's					
		According to the ca	II bell log for Resident #17's ay at the facility from 9/1/15					
		room ouring her si	aited consistently over 20					
		inrough 9/21/10 Wa	es over 40 and 50 minutes for					
		minutes and at time	e needs. According to the call					
		assistance with car	buths facility stoff response					
			by the facility staff response					
		times recorded:	t-ff -nanagea tima was					
			n staff response time was					
		20:38 minutes/seco	HUA,					
			n the staff response time was					
		50:31 minutes/seco	mus,					
			n response time was 28:04					
		minutes/seconds,	m response time was 40:42					
		on 9/6/15 at 6:01 pr minutes/seconds,	il teshouse time was total					
			n response time was 48:22					
		minutes/seconds,	waspranted and a transfer to the					
	1	on 9/10/15 at 6:03 :	om response time was 22:10					
		minutes/seconds,						
		on 9/11/15 at 5:52 r	om response time was 23:04					
		minutes/seconds,						
	5	on 9/13/15 at 12:11	pm response time was 27:46					
		minutes/seconds,	print a supportion with the state of the					
	!	nn 9/14/15 at 0:35 :	om response time was 40:35					
		on ar 14/10 at a.00 ; minutes/seconds	siii ooponoo amo moo isioo					

on 9/15/15 at 7:12 pm response time was 22:26

-paragraphic and the same	ERS FOR		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUI	TIPLE CO	INSTRUCTION		E SURVEY IPLETED
AND PLA	NOFCORRE	CTION	IDENTIFICATION NUMBER:	A, BUILE	ING	the state of the s		С
	ngunika ayan are		495287	B. WING				02/2016
		R OR SUPPLIER	HAMPTON		2230	ETADDRESS, CITY, STATE, ZIP CODI EXECUTIVE DRIVE PTON, VA 23666		
(X4) II PREFI TAG	X (E.	ACH DEFICIENC!	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	IO PREF TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
F 2	minute on 9/1 minute on 9/1 minute on 9/1 minute on the responsa sain 31:56  According to the first occas sever night.  According the first occas sever night.  In ar 10:28 but it pm a morn urine	es/seconds, 19/15 at 5:56 es/seconds, es/seconds, es ame eveninse time was on 9/19/15 at minutes/seconding to a clinivas alert and o cognitive imiterced pain it sionally at a miterventions and promptly to the risk for ned for Residutinence and requency of 3 emented to standing to be characteristically and some energy of 3 emented to standing to be characteristically one evening to be characteristically one evening to be characteristically one evening to be characteristically one to detail the residential as also noted diffuse residen	am response time was 24:20 response time was 37:08 rng 9/19/15 at 8:32 pm staff s 23:52 and tt 9:42 pm response time was	t di	246			

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S	TATEMENT (	F DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	1 ' '		NSTRUCTION		TE SURVEY MPLETED
A	ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A, BUIL	JING			С
			495287	B. WING	i	n deletitiske for an en	05	/02/2016
		ROVIDER OR SUPPLIER NURSING CENTER			2230 E	T ADDRESS, CITY, STATE, ZIP COI EXECUTIVE DRIVE PTON, VA 23666	DE	
	(X4) ID PREFIX TAG	SUMMARY STA	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	IO PREF TAG	ix	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULDBE	(X5) COMPLETION DATE
		Continued From pa bells, an hour or m	ore at times.	F	246			
		at approximately 1: expectation for star minutes- staff shou and when asked w was noted as a sta	h Administration #2 on 4/28/15 2:15 pm it was stated that the ff to answer call bells was: "5 uld respond within 5 minutes" hy response time was longer, it ffing issue at times which the had identified and are in the ng.	t				
		Call Light' revised to, "answer call light resident as comfor	cility policy titled, 'Answering on 4/9/13, the expectation was nts promptly" and "make the table as possible and offer before leaving the room."					
	F 248	Complaint Deficier 483.15(f)(1) ACTIV INTERESTS/NEEI	icy /ITIES MEET DS OF EACH RES	F	248			
		of activities design	rovide for an ongoing program ed to meet, in accordance with e assessment, the interests and al, and psychosocial well-being	į (				
		by: Based on the Residocument review, staff failed to provinctivities to enhance of physical, mentain November 2015	NT is not met as evidenced sident Group Interview, facility and staff interviews the facility de an ongoing program of ce the highest practicable level I, and psychosocial well-being December 2015, January y 2016 for all residents in the					

Event ID: HE9011

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		F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	TIPLE CONSTRUCTION DING	(X3) DATE SURVEY COMPLETED
				M. GOICE		С
			495287	B, WING		05/02/2016
	SENTARA (X4) ID		TEMENT OF DEFICIENCIES	(D	STREET ADDRESS, CITY, STATE, ZIP CODE  2230 EXECUTIVE DRIVE  HAMPTON, VA 23666  PROVIDERS PLAN OF CORRECTION SHOULD	
	PREFIX TAG		MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG		
		orogram of activities 2015, December 20 February 2016 for a The findings include On 4/27/16 at 10:00	ed to ensure that a ongoing s was in place in November 115, January 2016, and all facility residents.	F2	<ol> <li>Residents received limited at from November 2015 through F 2016.</li> <li>All residents wishing to partiactivities has the potential to be affected.</li> </ol>	ebruary cipate in
The second state of the se		nterview was conducted and the residents present. The following. The following the residents in group activities back a months and was anything for allowing else". The "What did you do extivities person." I were asked if this wenter group they allow as conducted with Activities Director was conducted with Activities Director was asked in the group without activities in months and was asked in the group without activities in months and was asked in the group without activities in months and was asked in the group without activities in months ago on Feb Activities Director here.	During the group interview asked about activities in the ving statements were made by up, "We just started having inth or two ago", "We didn't bout 4 months", "We only times in the 4 months, surveyor asked the group, veryday for the 4 months?" ed, "Nothing we didn't have a When the residents in group ras the consensus of the 11 residents agreed.  Example 11:15 a.m. after the erview had ended an interview the Activities director. The ras made aware that the had shared that they had went the building for about 4 ked if this was correct. The tated, "I only started a few ruary 22, there wasn't a ere for a few months before orking really hard to get the		<ol> <li>The facility has hired an Activ Director and Activities Assistant ensure daily activities are provide the residents.</li> <li>The Activities Director will premonthly activity calendar of every monthly. Findings will be report the QAPI Meeting.</li> <li>Completion Date: 06/10/16</li> </ol>	to led for ovide a nts
		an assistant and we Surveyor asked, "H	nd going here again. I hired have a full calendar now" ow do you track which nts attend?" The Activities			

S	TATEMENT (	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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			495287	B. WING		05/02/2016
		NURSING CENTER	HAMPTON		STREET ADDRESS, CITY, STATE, ZIP CODE 2230 EXECUTIVE DRIVE HAMPTON, VA 23666	
	(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL BC IDENTIFYING INFORMATION)	ID PREF TAG		JLD BE COMPLETION
		calendar and I highlical process of the calendar and I highlical process of the calendar and I highlical process of the calendar and a calend	ch resident has a monthly light the activity they attend."  ded Activity Calendars for 16 were reviewed and sidents were having and activities. The Activity to show the Resident alendars for November 2015, anuary 2016 and February the Activity Director there attended to locate some Activity Calendars for asked to pull the ones for the attended the Group Interview. Indeed Activity Calendars for asked with from the Group attended activities on the offer of attended activities on the offer of the 9		248	

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			A MILDIOAID SERVICES	77/20 8 8 8 8	TIDLEA	Chicy Cit (CTICA)	(X3) DATE SURVEY		
		DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		COMPLETED			
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			495287	B. WING	***************************************		05/02/2016		
-	NAME OF P	ROVIDER OR SUPPLIER	La constant of the constant of			ET ADDRESS, CITY, STATE, ZIP CODE			
	SENTARA	NURSING CENTER	HAMPTON	2230 EXECUTIVE DRIVE					
	SE14173141		and the second s	HAMPTON, VA 23666					
	(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SCIDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETION		
	F 248	Continued From pa	rge 21	F 2	248				
	,	•	eturned January 12, 2016 and						
		left employment wit	h the facility on February 6,						
			ivities Director's hire date at						
		the facility was Feb	ruary 22, 2010.						
		The facility policy tit	tled "Activity Director's						
		Responsibilities" re part, as follows"	vised 12/9/14 documented in						
		•							
		Policy Statement:	The Activity Director will be a						
		qualmed profession state specific requir	al who meets federal and rements. The Director is						
		delegated by the Ac	Iministrator, the authority,						
		responsibility and a	ccountability to implement it/participant Activity Policies						
		and Procedures.	apartolpartriolitis r ollows						
			vities responsibilities include:						
		*Planning, coordina	iting, and directing a program						
		or activities that is o	designed to meet the physical, social well-being of each						
		resident/participant	•						
		*Assuring timely co	mpletion of nt's records, and maintaining						
		records necessary	for the completion of activity						
		services.							
	:								
		The facility policy til 12/9/14 documente	tled "Activity Program" revised ed in part, as follows"						
		Purpose: The facili	ity will provide for an ongoing						
		program designed	to meet, in accordance with assessment, the interests and						
		the ohysical menta	assessment, the interests and it, and psychosocial well-being						
		of each resident/pa	rticlpant.						
Ì									

Procedure:

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '				
		495287	B. WING		MOCH MODIFIES CO.	-	2/2016
				2230 E	XECUTIVE DRIVE TON, VA 23666	A 44	
(X4) ID PREFIX TAG	(FACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFI) TAG	<	JEACH CORRECTIVE ACTION SHOUL	D BE	(X5) COMPLETION DATE
F 309	2. Activities are so are given the oppo critiquing the Activity prosmall and large grows. Notice of cance programs will be pland appropriate per consultation of Nursing was shared.  Prior to exit no furt 483.25 PROVIDE HIGHEST WELL Each resident mus provide the necessor maintain the higmental, and psych	heduled daily and residents runity to assist in planning and ty Programs. gram consists of individual, bup activities. Illations/changes of scheduled rovided in advance to residents insonnel.  Toximately 5:30 p.m. a pre-exited with the Administrator and the where the above information ther information was provided. CARE/SERVICES FOR SEING at receive and the facility must sary care and services to attain thest practicable physical, osocial well-being, in					
	by: Based on staff int and during the couthe facility staff fail 22 residents to maphysical well-being  1. The facility staff	erviews, clinical record review irse of a complaint investigation led to provide services to 2 of aintain their highest practicable g, Resident #18 and #19.					
	NAME OF PI SENTARA (X4) ID PREFIX TAG	F 248 Continued From page 2. Activities are so are given the opporting or critiquing the Activity. The Activity programs will be pland appropriate per company of the provide the necess or maintain the high mental, and psych accordance with the and plan of care.  This REQUIREME by:  Based on staff int and during the couther facility staff fail 22 residents to maphysical well-being or design or design or design or design.	NAME OF PROVIDER OR SUPPLIER  SENTARA NURSING CENTER HAMPTON  (X4) ID PREFIX TAG  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 309  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.	NAME OF PROVIDER OR SUPPLIER  SENTARA NURSING CENTER HAMPTON  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  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.  F 309 A83.25 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.	NAME OF PROVIDER OR SUPPLIER  SENTARA NURSING CENTER HAMPTON  (X4) ID FREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  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 309 483.25 PROVIDE CARE/SERVICES FOR  F 309  SS=E 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.	MAME OF PROVIDER OR SUPPLIER  SENTARA NURSING CENTER HAMPTON  SENTARA NURSING CENTER HAMPTON  (A4) ID SUMMARY STATEMENT OF CERCENCIES (EACH DEVISION WILL BE RECEDED BY PULL PREER REGULATORY OR LSC IDENTIFYING INFORMATION)  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.  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MAME OF PROVIDER OR SUPPLIER  495287  SENTARA NURSING CENTER HAMPTON  SIMMARY STATEMENT OF DEFICIENCIES EACH DEFIDIORY MUST BE PRECEDED BY FULL EACH DEFIDIORY FOR BROWN A PRECEDED BY FULL EACH DEFIDIORY OF THE APPREPRIATE  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.  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C	FNTERS	FOR MEDICARE	& MEDICAID SERVICES			OMB NO	<u>, 0938-0391</u>
STA	TEMENT OF	DEFICIENCIES ORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TIPLE CONSTRUCTION	(X3) DAT COM	TE SURVEY MPLETED
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		VIDER OR SUPPLIER	HAMPTON		STREET ADDRESS, CITY, STATE, ZIP CO 2230 EXECUTIVE DRIVE HAMPTON, VA 23666	DDE	
*	(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC (DENTIFYING INFORMATION)	ID PREF TAG	PROVIDER'S PLAN OF COR	SHOULD BE	(X5) COMPLETION DATE
	the 20 Table Two ps substitutes Table to the table to table to the table to table t	The facility staff rders for daily shown in the findings included the resident expired the fact MDS (Minimal of the fact MDS (Minimal of the fact MDS), individed the resident expired the resident expired the fact (BIMS), individed the resident expired the fact (BIMS), individed the resident expired the fact (BIMS), individed the fact (BIMS), i	de the ordered parameters; ater than 350.  failed to follow physician owers for Resident #19.  ed:  is originally admitted to the that diagnosis of diabetes. In the facility on 1/28/16.  Immum Data Set) a quarterly the reference date of 1/12/16 as scoring a 6 out of a Brief Interview for Mental cating the resident had cognition. The resident had cognition. The resident had cognition. The resident had cognition. The goal was that the have signs or symptoms of a two of the interventions listed in the goal was to monitor ID (physician) order, and notify and Accucheck is a blood leged the resident was sent to monitor three times for a blood		1. Patients #18 and #19 are this facility.  2. All residents with physici pertaining to blood sugar as have the potential to be affi.  3. All nurses were educated executing physician orders a notify physician and docum.  4. The DON and/or designer andomly audit 25% of resident for 8 weeks to ensure diable medication and showers as followed. Findings will be rethe QAPI Meeting.  5. Completion Date: 06/10	ian order nd showers fected. d on and when to mentation. de will dents weekly etic ordered are eported to	
	r	ormat lab reference	between 3/6/15 and 6/9/15; be for blood glucose/sugar is ligram per deciliter.				

A review of the clinical record evidenced the resident was sent to the emergency room on one

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m		1	& MEDICAID SERVICES	T		ONSTRUCTION	(X3) DATE SURVEY	
3	TATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 .		COMPLETED		
	ND LEWIN OI	CONTROLION		M. DUILL		nggar ya manifektirin kilaki kilaki kilaki kilaki kilaki na tari ngaya ya nga na nangan na di dilipanin kilaki	С	
-			495287	B. WING	***************************************		05/02/2016	
-	NAME OF P	ROVIDER OR SUPPLIER	The state of the s	1	STRE	ET ADDRESS, CITY, STATE, ZIP CODE		
			ELA MOTONI		l	EXECUTIVE DRIVE		
	SENTARA	NURSING CENTER	HAMPION		HAM	IPTON, VA 23666		
	(X4) ID PREFIX TAG	(FACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	O BE COMPLETIO	
	F 309	Continued From pa	nge 24	F	309			
	, 500		at time range; on 4/13/15 for a					
		blood sugar of 29.	The resident was treated at scharged back to the facility.					
		Resident #18's dia	betic management orders from					
		admission to June	2015 were further reviewed.					
		The physician order	ered Accuchecks to be done g with sliding scale insulin					
		coverage from Mar	rch 2015 through April 2015. In					
		May 2015 the Accu	icheck was changed to include					
			pefore bedtime starting					
		5/12/15.						
		The Accucheck slie	ding scale orders dated 3/6/15					
		and 5/12/15 read:	Humalog insulin-sliding scale: s than) 70.00 or > (greater)					
		350.00 Notify MD.	s than i thou or . (Breator)					
			Control Control Control Control					
		The Medication Ad	Iministration Record's (MAR's) ay and June 2015 were					
		reviewed. There w	ere 10 occasions of blood					
		sugars less than 7	0, and 33 occasions of blood					
		sugars above 350	There was no evidence in the MAR of notification of the					
		physician for these	2 43 blood sugars outside the					
		parameters.	-					
		In March 2015, the	ere were 11 high blood sugars					
		i without antification	obtained on: 3/9 at 11:00	_				
		am=529, 3/11 at 4	:30 pm=406, 3/12 at 11:00 am= am=376, 3/16 at 11:00	•				
		am=367, 3/22 at 1	1:00 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	e were 8 high blood sugars					
		without notification	obtained on: 4/1 at 6:30					
١	I	1 nm-202 1/2 of 1.1	30 nm=362 4/3 at 6:30					

am=408, 4/4 at 6:30 am=387 and at 11:30

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	CENTER	S FOR MEDICARE	& MEDICAID SERVICES				1	
		OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
			495287	B. WING			05/02	2/2016
	Lucia or pr	ANUNCO AR SURRIUS			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
	NAME OF P	ROVIDER OR SUPPLIER			i	230 EXECUTIVE DRIVE		
	CENTADA	A NURSING CENTER HAMPTON						
	DENIAINA				n	AMPTON, VA 23666		
na.w.	(X4) ID PREFIX TAG	JEACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
Section 1. Control of the section 1. Control		am=415 and 4/18 a low blood sugars w 4/27 at 9:00 pm=56 In May 2015, there without notification am=404, 5/4 at 6:3 and 11:30 am=508 5/8 at 11:30 am=35 sugars without noti pm=68, 5/18 at 11: 5/28 at 4:30 pm-47 5/21 at 4:30 pm, th milligram intramuse orders dated 3/8/15 In June 2015 there	0 pm=357, 4/14 at 11:30 at 11:30 at 11:30 am=437. There were 2 ithout notification obtained on: 6 and 4/28 at 9:00 pm=64.  were 7 high blood sugars obtained on: 5/3 at 6:30 0 am=438, 5/6 at 6:30 am=418, 5/7 at 11:30 am=395 and on 64. There were 5 low blood fication obtained on 5/9 at 4:30 am=39, and 5/29 at 4:30 pm=39, and 5/29 at 4:30 pm=59. One resident was administered 1 cularly glucagon per physician		3309			
		pm=378, 6/11 at 9: am=418, 6/17 at 1° pm=375 and 6/30 at 10 blood sugars w 6/20 at 4:30 pm-62 at 4:30 pm=58.  The failure to notify sugars were outsid with the Administration of the morning Nursing was afford any additional infor- on 4/29/16 at 2:00 stated. "The expect	00 pm=388, 6/12 at 11:30 I:30 am=358, 6/28 at 4:30 at 4:30 pm=358. There were 3 vithout notification obtained on 2, 6/21 at 4:30 pm=65, and 6/22 vithe physician when the blood le the parameters was shared ator and the Director of Nursing of 4/29/16. The Director of led the opportunity to provide remation to address this.  I pm, the Director of Nursing station is that they would follow rsnotification would be found					

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1	CENTER	S FUR MEDICARE	A MEDICAID SERVICES	Γ		to the state of th	MAN BASE OF ENERGY
		OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		NOTRUCTION	(X3) DATE SURVEY COMPLETED
			10.400.00	D WINC			C 05/09/35/45
			495287	B. WING	Table 1 to 1 t	A DESCRIPTION OF THE PROPERTY	05/02/2016
	NAME OF P	ROVIDER OR SUPPLIER				ET ADDRESS, CITY, STATE, ZIP CODE	
	CENTAR A	NURSING CENTER	HAMPTON			EXECUTIVE DRIVE	
	Wall A To St. A.	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			HAW	IPTON, VA 23666	
	(X4) ID PREFIX TAG	(FACH DEFICIENC)	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SCIDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETION
-	F 309	Continued From pa	ige 26	F:	30 <b>9</b>		
			as admitted to the facility on	,			
		2. Resident #13 W	nursing services following a				
		haenitalization Dis	ignoses on the Admission				
		MDS (Minimum Da	ta Set - an assessment				
		protocol) with an Af	RD (assessment reference				
		date) of 9/17/15,inc	duded but were are not limited	•			
		to Heart Failure, Ar	thritis, Osteoporosis (a				
		condition makes yo	our bones weak and more likely				
		to break, Cerebrovascular Accident (stroke), and Generalized Muscle Weakness.					
		Generalized Musci	S VV GGRI 1000.				
		The Quarterly MDS	with an ARD of 2/26/16,				
		coded Resident #1	9 as having a 00 of 15 BIMS				
		(Brief Interview for	Mental Status) score,				
		indicating severely	impaired cognition. In erly MDS coded Resident #19				
		acollion, the Qualit	ive assistance with the				
		as requiring extens	taff persons for Bed Mobility,				
		Transfers, Toilet Us	se, and Bathing. The Quarterly				
		MDS coded that W	alking in room and corridor did				
		not occur. In additi	ion, Resident #19 was coded				
		as occasionally inc	ontinent of urine. Resident				
		was rated as (9) to	r bowel continence indicating do not have a bowel movement				
		for the entire 7 day	s the assessment is based on.				
l		The admission MD	S with an ARD of 9/17/15				
		coded Resident #1	9 as always incontinent of				
		bowel functioning.					
		A physicians order	dated 3/7/16 documented				
		Daily Showers.					
		On 4/29/16 at appr	oximately 11:10 a.m. CNA #65				
		orovided the surve	yor with a Bath List and stated:	•			
		(Resident #19's) ".	shower days were				
		Wednesday and S	aturday on day shift."				
		The ADL (activity o	f daily living verification				

worksheet) was reviewed.

			& WILDIO/AID OLI (VIOLO	11401 441 11	TINE CONSTITUTION		(X3) DATE SURVEY				
		DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A BUILDING			COMPLETED				
***				A. BUILDING			C				
			495287	B. WING	- A special production of the state of the s		05/02/2016				
ei erma	NAME OF P	ROVIDER OR SUPPLIER	ary y y		STREET ADDRESS, CITY, STATE, ZIP COD	E					
	CENTARA	ARA NURSING CENTER HAMPTON			2230 EXECUTIVE DRIVE						
	SILIVITATO				HAMPTON, VA 23666		hi suca				
	(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREF TAG		<b>IOULD</b>	BE COMPLETION				
2.64	F 309	Continued From pa	ge 27	F:	309						
		written for daily sho remainder of March for the following dat 3/16/16 through 3/2 3/26/16, 3/29/16, ar seven dates were n printout: 3/12/16, 3/ 3/21/16, 3/25/16, 3/ An interview was co spouse on 4/27/16; Resident #19's spo #19 was on the skil showers. He stated	when a physician's order was wers, the log for the 2016 documented no bathing tes: 3/8/16 through 3/11/16, 20/16, 3/23/16, 3/24/16, ad 3/30/16. The following tot included in the ADL 3/13/16, 3/15/16, 3/21/15, 27/16, and 3/28/16.  Inducted with Resident #19's at approximately 3:55 p.m. use stated that when Resident led unit she received daily d that the daily showers fer to Unit 1, the Long Term								
		Nursing (DON) on 4 a.m. She stated the glitch that does not	onducted with the Director of 4/27/16 at approximately 9:15 at the computer system has a allow the printout to en showers and baths.								
		4/29/16 at approxin stated: "Sometime Don't have time to gon assignment migi Saturday's, not eno "On days when not washed that sweat stated: "She (Residual) February she was (	onducted with CNA #40 on hately 9:30 a.m. CNA #40 s, no, can't get showers done. get showers done. Depending ht have 2-3 to do. On hugh help." CNA #40 stated: enough help, I get the parts or have odors." CNA #40 dent #19) was my assignment When I went part time around CNA #61's) assignment. She it get daily showers until about								

the special section of	TO THE PROPERTY AND ADDRESS OF THE PARTY OF	FUR WEDICARE F DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE CO	ONSTRUCTION	(X3) DATE SURVEY
S I. AN	DPLANOF	CORRECTION	IDENTIFICATION NUMBER:				COMPLETED
							C .
			495287	B, WING	A1000000000000000000000000000000000000		05/02/2016
1	AME OF PR	OVIDER OR SUPPLIER				ET ADDRESS, CITY, STATE, ZIP CODE	
5	FNTARA	TARA NURSING CENTER HAMPTON				EXECUTIVE DRIVE	
					NAIVI	PTON, VA 23666  PROVIDER'S PLAN OF CORRECTIO	N (X5)
	(X4) ID PREFIX TAG	IFACH DEFICIENCY	(TEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETION
	F 309 (	Continued From pa	age 28	F;	309		
	1	1	consisting of the Administrator				
	,	nd the DON were	briefed of the findings on				
	4	/29/16 at approxir	nately 6:00 p.m. No further				
	l ross	nformation was pro	esented. NADE DROVIDED EOR	F	312		
	F 312 6	183.25(a)(3) ADL ( DEPENDENT RES	CARE PROVIDED FOR		J 1 L	1. Residents #3 and #12 were pr	rovided
	-					showers.	
	/	resident who is u	nable to carry out activities of			m att the state of the management	nl to bo
		daily living receives	s the necessary services to ition, grooming, and personal			2. All residents have the potenti affected. A 100% review of curro	
		and oral hygiene.	more, grooming, zero para			residents will be completed to en	
						that showers are scheduled for a	
						twice per week.	
		this REQUIREME	NT is not met as evidenced			a Chi Manifestanian h	athing
		by:	the state of intensions and			<ol> <li>C.N.A's will be educated on be schedule and documentation.</li> </ol>	atimig
		Based on resident	t interview, staff interviews, and ews the facility staff failed to			Schedule and documentation.	
		provide the necess	sary services to maintain good			4. Director of Nursing and/or de	
		personal hygiene f	or 2 of 22 residents in the			will audit 10% of residents week	
		survey sample, Re	sident #3 and #12.			weeks. Findings will be reported	to the
		1. The facility staff	failed to provide showers to			QAPI Meeting.	
		Resident #3 who v	vas unable to carry out this			5. Completion Date: 06/10/16	
			ng without the assistance of			3. Completion Date: 00/10/20	
		staff.					
		2. The facility staff	failed to provide Resident #12		,		•
		with twice weekly: 4/16/16 to 4/28/16	showers per her request from				
İ		4/10/10 (0 4/20/10	<b>4</b>		; ;		
		The findings include	ded:				
		Resident #3 wa	s admitted to the facility on				
		3/9/16 for rehab se	ervices following a		*		
		hospitalization. The	ne resident's diagnoses				
		included generaliz	ed weakness and diabetes.				

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Ì	CENTER	S FOR MEDICARE	& MEDICAID SERVICES				The same of the same	1
s	ATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED C	
			495287	B. WING	201111111111111111111111111111111111111		1	02/2016
7	VAME OF PE	OVIDER OR SUPPLIER			STRE	ET ADDRESS, CITY, STATE, ZIP CODE		1
	<b>4</b> 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4				2230	EXECUTIVE DRIVE		1
	SENTARA	<b>NURSING CENTER</b>	HAMPTON			PTON, VA 23666		
				1 17-(19)		4.1		
	(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	3BE	(X5) COMPLETION DATE
-	F 312	Continued From pa	ae 29	F:	312			
			S (Minimum Data Set) with an					
		The admission MD	5 (Willimfull) Data Set) with an					
		assessment reteret	nce date of 3/16/16 coded the					
-			a 15 out of a possible 15 on					
		the Brief Interview for Mental Status (BIMS), indicating the resident's cognition was intact. The						
		morcaung me reside	ident on two staff for bed					
		resident was deper mobility, transfers, :	and hathing					
		mounty, transiers,	and batting,					
		On 4/27/16 at 10:30	a.m., the resident was					
		oheaniad in had. T	he resident was waiting for					
		physical therapy. The resident was asked if she						
		had received show	ers since she was admitted to					
		the unit. She state	d, "No, I have not received a					
		shower". The resid	lent stated she was given bed					
		baths and would ha	ave preferred a shower at least					
		every other day. Ti	he resident was asked if she					
		had any restrictions	s that would have limited her					
		ability to shower, su	uch as a physician order. The					
		resident stated she	was not aware of any					
		restrictions. At this	time a rehab staff entered the					
			sident to the rehab					
		department.						
	,							
		Review of the clinic	al record failed to evidence					
		any limitations for t	he resident's bathing.					
1		On 4/28/16 at 3:00	p.m., a certified nurse aide					
		(UNA#44) Was inte	rviewed. She stated CNA's					
		receive report at th	e beginning of their shift of no are scheduled to receive a					
		mose resident's Wr	and shift. She stated there is					
		snower for that day	ectronic record to document					
		no option on the en	vas given, such as either a bed					
1		hath or chower Th	e shower log was reviewed					
		and the page incident	de were blank. The CNA					
		and the pages make	e resident's room, her shower		•			
	!	dove were accident	d to the day shift on					
-		Wednesday's and	овиниву з.					

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

~~		OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	TIPLE C	ONSTRUCTION		TE SURVEY VPLETED
		CORRECTION	IDENTIFICATION NUMBER:	A. BUILC	ING			
			495287	B. WING	j	a planta communication account of the communication and the communication accounts of the commun	1	C / <b>02/2016</b>
	NAME OF P	ROVIDER OR SUPPLIER		L	STRE	EET ADDRESS, CITY, STATE, ZIP CODE		
-			LIANADTONI			EXECUTIVE DRIVE		
	SENTARA	NURSING CENTER	HAMFION		HAN	MPTON, VA 23666		
	(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
1444	F 312	Continued From pa	ice 30	F	312			
		The above findings Administrator and t	was shared with the he Director of Nursing during a bonducted on 4/29/16.					
		No additional informexit.	nation was provided prior to					
		2/15/16. Diagnose but are not limited I syndrome (paraple extremities). Resident #12's Anr (an assessment pn Reference Date (A #12 with a BIMS (E Status) of 15 of 15 impairment. In add #12 as being totally assistance of one s Resident #12 was dependent with tra persons for Transfe An observation wa 4/27/16 at approximate observed lying in b was well groomed Facility notes docu admitted to the hos the facility on 4/16/17 The ADL (activity of Worksheet was reversed was revented to the parameters.)	s made of Resident #12 on nately 3:50 p.m. She was ed on her back. Resident #12 and no odors were noted. mented: Resident #12 was spital on 4/6/16 and returned to	:				
	Berger and State of S	the following dates 4/4/16, 4/7/16 throid 4/26/16. A notation following dates: 4/26/16 throid	missing: 4/2/16 through ugh 4/18/16, 4/21/16, and n of "8 8" was noted on the 1/16, 4/5/16,4/6/16, twice on 1/24/16, 4/25/16, 4/29/16, and					

e.	TATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA			ONSTRUCTION	(X3) DATE	E SURVEY PLETED
Á	NO PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUIL!	ING			3
			495287	B. WING	<b>9</b>		05/0	02/2016
en-et-		ROVIDER OR SUPPLIER	A 1000		2230	ET ADDRESS, CITY, STATE, ZIP CODE EXECUTIVE DRIVE IPTON, VA 23686		
	(X4) ID PREFIX TAG	(EACH DEFICIENC)	ITEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAC		PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD GROSS-REFERENCED TO THE APPROVIDERICENCY)	DBE	(X5) COMPLETION DATE
		an interview on 5/2 p.m., "The codes us the MDS." Reside a (8 8) code indicatoccur. The ADL Verification following code (4 2 4/22/16. The MDS indicates that Total staff member was Worksheet documon 4/28/16. The Mindicates Extensive person assistance April 2016, there was an interview was a 4/27/16 at approximated concerns re "No shower for two and since I've been showers. The staff and I'd be told not shower." When as grievance, she staff an interview was a approximately 10:0 stated: "I got a shown of Nursin challenge. Yes, to the residents received the shower of Nursin challenge. Yes, to the residents received the staff approximately 10:0 stated: "I got a shown of Nursin challenge. Yes, to the residents received the staff approximately 10:0 stated: "I got a shown of Nursin challenge. Yes, to the residents received the staff approximately 10:0 stated: "I got a shown of Nursin challenge, yes, to the residents received the staff approximately 10:0 staff appro	(Director of Nursing) stated in /16 at approximately 12:45 sed are the same as used for ant #12's MDS documents that tes that the activity did not tes that the activity did not on Worksheet documented the on the following dates: documents that (4.2) dependence with help of one required. The ADL Verification ented the following code (3.2) IDS documents that (3.2) assistance with one staff. For the remaining days of as no documentation. Onducted with Resident #12 on mately 3:50 p.m. Resident #12 on mately 3:50 p.m. Resident #12 on mately 3:50 p.m. Resident #12 on sked if Resident had any will help me with daily bath enough help, as reason for no sked if Resident had filed a ted: "No." conducted on 4/28/16 at conducted on 4/28/16 at conducted on 4/28/16 at conducted in Staffing has been a w staffing can affect the care		312			

SENTERENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER OR SUPPLIER  SENTARA NURSING CENTER HAMPTON  (X4) ID PRETIX TAG  (X4) ID PRETIX TAG  (X4) ID PRETIX TAG  (X4) ID PRETIX TAG  (X5) MARRY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG  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 314 SS=G 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	CI	ENTERS	S FOR MEDICARE	& MEDICAID SERVICES			0	<u>MB NO. 0</u>	938-0391
NAME OF PROVIDER OR SUPPLIER  SENTARA NURSING CENTER HAMPTON  SUMMARY STATEMENT OF DEPICIENCIES (EACH CORRECTION MUST BE PRECEDED BY FULL TAG (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION)  F 312 Continued From page 32	STA	TEMENT O	F DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	' '				
SENTARA NURSING CENTER HAMPTON  (K4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION)  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 314 483.25(c) TREATMENT/SVCS TO  SS=G 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				495287	B. WING			1	2/2016
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  F 312 Continued From page 32 F 312 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 314 483.25(c) TREATMENT/SVCS TO F 314  SS=G 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 inflividual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and				HAMPTON	Annual Control of the	22	230 EXECUTIVE DRIVE		
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 314 483.25(c) TREATMENT/SVCS TO FREVENT/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		REFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREF	IX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	BE	(X5) COMPLETION DATE
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 4 8 S = G	hat sweat or have on 5/2/16 at approxif12 was asked the showers. Resident the administration and the DON were 4/29/16 at approximormation was proposed to the services to promote they were unavoidable of the sort of advanced stage residents in the surfacility documentating they staff failed to pressure ulcers proposed to the surfacility of the surfacility staff failed to pressure ulcers proposed to the surfacility of the surfacility staff failed to pressure ulcers proposed to the surfacility of the surfacility and the surfacility and the surfacility staff failed to pressure ulcers proposed to the surfacility and the surfacility staff failed to pressure ulcers proposed to the surfacility staff failed to pressure ulcers proposed to the surfacility staff failed to pressure ulcers proposed to the surfacility staff failed to pressure ulcers proposed to the surfacility staff failed to pressure ulcers proposed to the surfacility staff failed to pressure ulcers proposed to the surfacility staff failed to pressure ulcers proposed to the surfacility staff failed to pressure ulcers proposed to the surfacility staff failed to pressure ulcers proposed to the surfacility staff failed to pressure ulcers proposed to the surfacility staff failed to pressure ulcers proposed to the surfacility staff failed to pressure ulcers proposed to the surfacility staff failed to pressure ulcers proposed to the surfacility staff failed to pressure ulcers proposed to the surfacility staff failed to pressure ulcers proposed to the surfacility staff failed to pressure ulcers proposed to the surfacility staff failed to pressure ulcers proposed to the surfacility staff failed to pressure ulcers proposed to the surfacility staff failed to pressure ulcers proposed to the surfacility staff failed to pressure ulcers proposed to the surfacility staff failed to pressure ulcers proposed to the surfacility staff failed to pressure ulcers proposed to the surfacility staff failed to pressure ulcers proposed to the surfacility staff failed to pressure ulcers	odors."  ximately 1:30 p.m., Resident days she is scheduled for the flat that a stated: "Wednesday and nower days."  consisting of the Administrator briefed of the findings on mately 6:00 p.m. No further essented.  MENT/SVCS TO PRESSURE SORES  prehensive assessment of a must ensure that a resident lity without pressure sores unless the condition demonstrates that able; and a resident having eives necessary treatment and e healing, prevent infection and from developing.  NT is not met as evidenced tions, clinical record reviews, ion, and staff interviews the original in harm for 2 of 22 rvey sample, Resident #5 and failed to identify a Stage III Dicer prior to it developing to e on 2/17/16 for Resident #5,	F		<ol> <li>Pressure Ulcer for residents ### #13 were resolved.</li> <li>All residents identified as high have the potential to be affected Current residents will have pressurer risk assessments completed.</li> <li>All licensed nursing staff will be educated on skin integrity assess.</li> <li>Director of Nursing and/or dewill randomly audit 25% of Brade weekly for 12 weeks. Clinical Maand/or designee will complete a of 50% of weekly skin assessmen weeks. Findings will be reported QAPI Meeting.</li> </ol>	n risk I. ure d. d. esignee en scale anager review ts for 8	

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

S	TATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		ONSTRUCTION		SURVEY PLETED
A	ND PLAN OF	CORRECTION	(DE)41)FIGATION NOTICE.	A. BUILD	ING	The same and the s		2
			495287	B. WING			05/	02/2016
		ROVIDER OR SUPPLIER NURSING CENTER	HAMPTON		2230	ET ADDRESS, CITY, STATE, ZIP CODE EXECUTIVE DRIVE MPTON, VA 23666		
	(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
	F 314	Left Ankle Pressure	failed to identify a Stage III be Ulcer prior to it developing to c on 1/13/16 for Resident #13,	F;	314			
		facility initially on 6/ 9/1/15 with diagnos Pressure Ulcer. **E	ed: s a 76 year old admitted to the 20/07 and readmitted on ses to include *Stage III Diabetes Mellitus, ****Chronic aritis, ******Depression, and					
And the second s		Set (MDS) assessing with an Assessmer 3/1/16. The Brief I (BIMS) was a 15 or indicated that Resigned capable of dail Section G Function coded extensive two mobility, transfer, or personal hygiene. Transitions and Was follows: Moving position = 2, not st staff assistance; Very Moving on and off Surface to surface able to stabilize with Section H Bladder coded 1= occasion episodes of incontinuas coded under Section H Bladder section of the	omprehensive Minimum Datament was a Significant Change at Reference Date (ARD) of Interview for Mental Status ut of a possible 15 which dent #5 was cognitively intact by decision making. Under hal Status the resident was to person assist for bed by Jalance During alking the resident was coded of from seated to standing eady, only able to stabilize with Valking, Turning around, toilet = 8, Activity did not occur; transfer = 2, not steady, only the staff assistance. Under and Bowel Resident #5 was hally incontinent (less than 7 linence) for both. The resident Section K as 63 inches in unds in weight. Under Weight					

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

	IATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
1	ND PLAN OF	CORRECTION	INCHARACTION HOMOGRA	A, BUILE	DING	С
			495287	B, WING		05/02/2016
		ROVIDER OR SUPPLIER NURSING CENTER	HAMPTON		STREET ADDRESS, CITY, STATE, 2 2230 EXECUTIVE DRIVE HAMPTON, VA 23666	IP CODE
-	(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES ( MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		TION SHOULD BE COMPLETION THE APPROPRIATE DATE
	F 314	indicating that there the last month or 1 Under Skin Conditionaving one Stage I 1.5 cm (centimeter most severe tissue being a 4 indicating tissue that adheres ulcer edges, may be surrounding skin. In have pressure reduced, on a turning a pressure ulcer care cointments/medicationationational skin. In the second stage of the second stage of the second stage of the second skin in the second skin for record special stage of the skin for record skin for record skin in the second skin for record ski	he resident was coded 0, a was no gain or loss of 5% in 0% in the last 6 months. Ons Resident #5 was coded as II pressure ulcer measuring s) x 1.0 cm x 0.3 cm. The type for any pressure ulcer geschar-black, brown, or tan firmly to the wound bed or e softer or harder than Resident was also coded to ucing devices for her chair and not repositioning program, a with application of ons other than to feet.  The prehensive Care Plan dated ocumented in part, as follows:  and #5 at risk of pressure ulcer decreased mobility and history in impairment. (9/23/15).  The pressure ulcer sacreting, or eport any signs of skin.  By pressure ulcer SACRUM  of the size (L x W x D) (length x ount and characteristics of a status. 1 Time Weekly		314	

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

S	TATEMENT ND PLAN OI	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •	CONSTRUCTION	COMPLETED
			495287	B. WING		05/02/2016
		ROVIDER OR SUPPLIER NURSING CENTER		22	REET ADDRESS, CITY, STATE, ZIP CODE 30 EXECUTIVE DRIVE AMPTON, VA 23666	
****	(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	DBE COMPLETION
A CONTRACTOR OF THE PROPERTY O	F 314	3 Pressure UlcerROHO cushion to During the survey in the wheelchair of and 4/29/16 throug cushion (pressure pressure relief.  Resident #5's Apri 4/1/16 indicated th ROHO cushion to The Director of Nu Scales for Predicti Resident #5 that h year. Only 2 Brad documented in pa "5/13/15	cording to the protocol for Stage of chair when OOB (out of bed)."  Resident #5 was observed up on 4/26/16, 4/27/16, 4/28/16, ghout the day with no ROHO relief cushion) in place for 12016 Physician Orders signed be following order: 2/23/16 chair when OOB (out of bed).  It is given as asked for all Bradening Pressure Sore Risk for the past en Scales were completed and rt, as follows:	F 314		
		Sensory Perceptic Moisture-Rarely M Activity-Chair Fast Mobility-Slightly Li Nutrition-Adequate Friction and Shear Braden Score-19= 9/1/15 Sensory Perceptic Moisture-Occasion Activity-Chair Fast Mobility-Slightly Li Nutrition-Adequate Friction and Shear Braden Score-17=	loist t mited e r-No Apparent Problem eNo Risk on-No Impairment hally Moist t mited e r-Potential Problem			

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

S	TATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONS	TRUCTION	(X3) DATE COMP	SURVEY LETED
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ine.	44. 5 · 4 · 10 · 10 · 10 · 10 · 10 · 10 · 10		495287	B. WING	140000000000000000000000000000000000000	ADDRESS, CITY, STATE, ZIP CODE	05/0	2/2016
		ROVIDER OR SUPPLIER NURSING CENTER	HAMPTON		2230 EX	ECUTIVE DRIVE ON, VA 23666		or and a second
	(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE ROSS-REFERENCED TO THE APPROP DEFICIENCY)	9E	(X5) COMPLETION DATE
		February and Marc Skin Assessments of documented in part documented in part "Date Created: 2/9/Does this patient has Completed Signatu Date/Time Stamped Date Created: 2/17/Does this patient has Completed Signatu Date/Time Stamped Date Created: 3/9/10/Does this patient has Wound?-1-Yes Does this patient has Completed Signatu Date/Time Stamped Weekly Skin Asses 2/23/15 and 3/2/16/Director of Nursing Resident #5's Clinical Director #5's Cl	sessments for Resident #5 for h 2016. The following Weekly were reviewed and t, as follows:  16 11:02 p.m. ave a Pressure Ulcer?-0-No re: (Nurse's Name) d 2/10/16 12:02 a.m.  16 1:08 a.m. ave a Pressure Ulcer?-0-No re: (Nurse's Name) d 2/17/16 2:08 a.m.  16 5:22 a.m. ave a Skin Lesion or an Open ave a Pressure Ulcer?-1-Yes re: (Nurse's Name) d 3/9/16 6:22 a.m."  ssments for Resident #5 dated could not be found per the		314			

CENTERS FOR MEDICARE & MEDICAID SERVICES

		OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 '		ONSTRUCTION		TE SURVEY MPLETED
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e in		and the state of t	495287	B. WING		EET ADDRESS, CITY, STATE, ZIP CODE	05	/02/2016
		ROVIDER OR SUPPLIER  NURSING CENTER	HAMPTON		2230	EXECUTIVE DRIVE MPTON, VA 23666		
-	(X4) ID PREFIX TAG	(EACH DEFICIENCY	ITEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(XS) COMPLETION DATE
	F 314	Resident #5's Wee Report was reviewed follows:  "Type of Wound: Pi Wound Location: Si Date of Onset: 2/17 Contributing Factor Assessment Date: Stage of Ulcer: Sta Wound Size: length Depth (cm) 0.3 Tissue Type: Grant Exudate: Moderate Exudate Color: Strawound Size: length Depth (cm) 0.3 Tissue Type: Grant Exudate: Moderate Exudate Color: Strawound Size: length Depth (cm) 0.3 Tissue Type: Grant Exudate: Moderate Exudate Color: Strawound Size: length (cm) 0.3 Tissue Type: Grant Exudate: Moderate Exudate Color: Strawound Size: Grant Exudate: Moderate Exudate Color: Strawound Size: Grant Exudate: Moderate Exudate Color: Strawound Size: Strawound Size: Grant Exudate: Moderate Exudate Color: Strawound Size: Strawound Size: Grant Exudate Color: Strawound Size: Grant Exudate Color: Strawound Size: Strawound Size: Grant Exudate Color: Strawo	Vound Nurse name)"  kly Skin Condition Progress ed and documented in part, as ressure Ulcer acrum 7/16 rs: Incontinence 2/17/16 ge III n (cm) 2.0 Width (cm) 1.0 ulating 50%, Necrotic 50% aw/Red 2/24/16 ge III n (cm) 1.5 Width (cm) 1.0 ulating 40%, Necrotic 10% aw/Red 3/2/16 ge III n (cm) 1.5 Width (cm) 0.5 Depth ulating 80%, Slough 20% aw 3/9/16		314			
	addinglife was at	Stage of Ulcer: Sta Wound Size: length	ge iii n (cm) 0.5 Width (cm) 0.3					

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

	TATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		ONSTRUCTION	(X3) DATE SURVEY COMPLETED
,	IND PLAN O	CONTECTION		A, BUILL		minimum and an annual survivors of the Arman Artist Park (A.S. N.) (Sign Companies)	С
			495287	B. WING	:		05/02/2016
		ROVIDER OR SUPPLIER A NURSING CENTER	HAMPTON		2230	EET ADDRESS, CITY, STATE, ZIP CODE DEXECUTIVE DRIVE MPTON, VA 23666	
	(X4) ID PREFIX FAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION
		Exudate: Moderate Exudate Color: Strate Exudate: Moderate Strate Exudate: Moderate Yellow Necrotic: 50° Granulation of Carto this patient. This with another health Member during this 3/16/16 History of Present II Chief Complaint: Paccum. HPI (history of physics) 18/16/16 History of Present II Chief Complaint: Paccum. HPI (history of physics) 18/16/16 Presents with a state Exudate: Works of Present II Chief Complaint: Paccum.	illating 95%, Slough 5%  aw/Red"  pecialist Evaluations for eviewed and documented in attent has a wound on their dical illness) Statement: She ge 3 pressure wound of the days duration.  am:  1.0 x 0.3 cm  cm (centimeter) squared Serous  50%  noe Daily  e: Data and history pertinent a were obtained via Nursing patient's care was discussed care provider Nursing Staff visit.		314		

PRINTED: 05/16/2016 FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTER'S FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION COMPLETED **IDENTIFICATION NUMBER:** A. BUILDING 05/02/2016 495287 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2230 EXECUTIVE DRIVE SENTARA NURSING CENTER HAMPTON HAMPTON, VA 23666 (X5) COMPLETION DATE PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PREFIX TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG DEFICIENCY) F 314 Continued From page 39 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

#### PRINTED: 05/16/2016 **FORM APPROVED** DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING \_ 05/02/2016 495287 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2230 EXECUTIVE DRIVE SENTARA NURSING CENTER HAMPTON HAMPTON, VA 23666 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PREFIX EACH CORRECTIVE ACTION SHOULD BE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) 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

nutrition and hydration.

factors, were provided.

dry bed linens, and maintenance of adequate

3. Nursing facilities will document interventions, based on each resident 's risk factors and strengths, on the interdisciplinary plan of care. If

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

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

PRINTED: 05/16/2016 FORM APPROVED OMB NO. 0938-0391

ATEMENT C	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			ONSTRUCTION		TE SURVEY MPLETED
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	OVIDER OR SUPPLIER	495287 HAMPTON	B. WING	STRE 2230	EET ADDRESS, CITY, STATE, ZIP CODE EXECUTIVE DRIVE MPTON, VA 23666	05	/02/2016
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	will be developed." The facility policy til Characteristics-Skil documented in part 'Purpose: Residen prevent and treat sil Procedure: 3. Residents do nounless their medical unavoidable." The facility policy til 5/13/14 documente "1. Weekly skin inson all residents." On 4/28/16 at approcedure for Nursing was shared. The Director of Nursing was shared. The Director sand recogearly on before they when asked what weekly when asked what weekly on before they when asked what we sident #5's physithe Director of Nursenurses to follow the The following outling outling the part of the side	net, alternative approaches lied "Standard and Required in Conditions" revised 6/18/15 :: t's are provided with care to kin breakdown.  It develop skin breakdown il condition makes breakdown		314:			

Facility ID: VA0216

	CENTER	S FOR MEDICARE	& MEDICAID SEKVICES	-			1010 140, 0000 000 1
		OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		DNSTRUCTION	(X3) DATE SURVEY COMPLETED
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			495287	B. WING			05/02/2016
-	NAME OF PI	ROVIDER OR SUPPLIER			STRE	ET ADDRESS, CITY, STATE, ZIP CODE	
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	SENTARA	NURSING CENTER	HAMPTON	l	HAM	PTON, VA 23666	
				,L		PROVIDER'S PLAN OF CORRECTIO	N (X5)
	(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SCIDENTIFYING INFORMATION)	ID PREFI TAG	×	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETION
- Joseph	F 314	Continued From pa	ge 42	F 3	14		
		"Allegation: Facility until it reached a St	did not identify pressure ulcer age III level.				
		pressure ulcer.	ompleted indicating no with family-no indication of				
	an a (Amount), Mandada	Pressure Ulcer	ent diet recommendations and flow.				
	e principal de la companya de la com	Name (Wound Card assessment places that this was, in fac	doubt regarding the accuracy				
		diet.					
I	:	3/4/10 Patient non-	compliant with care.				
		3/11/16 Patient con with care.	tinues to be non-compliant				
	:	This patient is alert score of 15."	and oriented with a BIMS				
	4	conducted with the Wound Care Physic above statement re wound care assess 2/17/16. The Wour That was never browere questioning m	a.m. a phone interview was Wound Care Physician. The cian was made aware of the garding the accuracy of her ment of Resident #5 on a Care Physician stated, bught to my attention that they y assessments of any e every week to them if they				

ST/		F DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	FIPLE CONSTRUCTION	(X3) DATE SURVEY
-	U I'UNN UP	CORRECTION I	IDENTIFICATION NUMBER:	•	NG	COMPLETED
1		CONTROLL	495287	B, WING		C 05/02/2 <b>01</b> 6
- 1		OVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COL 2230 EXECUTIVE DRIVE HAMPTON, VA 23666	PE
	(X4) ID PREFIX TAG	SUMMARY STA	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	PROVIDER'S PLAN OF CORR  X (EACH CORRECTIVE ACTION SI	HOOFD BE SOWILLTER SOM
-	F 314	Continued From pa	age 43	F	314	
		Nursing and the Cl	touch base with the Director of inical Manager weekly of se, or changed, I give updates. a Stage III pressure ulcer."			
		reviewing the abov Administrator, the the Wound Care P Administrator was assessment was n shift on 2/16/16 wi	eximately 2:00 p.m. after be document presented by the Administrator was informed of thysician's comments. The also reminded that the skin to completed until the 11-7 th it being signed completed on s to the Care Plan meeting with			
		the family on 2/16/documentation to completed during family's responsibulcers. The reside significant gains of months. The finding 2/11/16 regarding	there was no show a skin check was this meeting and it is not the lility to monitor for pressure ent's MDS addressed no r loss of weight in the past 6 ngs dated 3/3/16, 3/4/16, and non-compilance of the resident days after the facility acquired			
The second secon		On 5/2/16 at appr Administrator and provided docume Mock Survey Aud The Mock Survey	oximately 2:30 p.m. the the Director Of Nursing ntation indicating on 2/10/16 a it was conducted in the facility. Audit revealed issues with On 2/29/16 an Action Plan was			
		developed stating at unfavorable tar correction was re Administrator, an During the review noted under Wee were only completed and a Raden Sc	p: Problem Pressure Ulcers are regets. The facility plan of viewed by 2 surveyors, the dithe Director of Nursing. For the Plan of Correction it was allowed for one week in March, and alle there were no March audits.	<b>.</b>		

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICARD SERVICES

PRINTED: 05/16/2016 FORM APPROVED OMB NO. 0938-0391

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		OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		NSTRUCTION	(X3) DATE SURVEY COMPLETED
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			495287	B. WING			05/02/2016
	NAME OF P	ROVIDER OR SUPPLIER			STREET	TADDRESS, CITY, STATE, ZIP CODE	
	SENTAR	A NURSING CENTER	намртом			XECUTIVE DRIVE	
	W. 1417-11-17	A HOROMO OCH TER	TOTAL TOTAL		HAMP	TON, VA 23666	
	(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETION
-	F 314	Continued From pa	ge 44	F 3	314		
		-	no audits were available.				
			ssment of Adequate Surfaces				
		for Treatment Preve	ention no audits had been				
			on the lack of audits to show				
			prrective Action Plan was in the identified deficient areas				
			cted prior to the start of the				
	1	_	ompliance was not offered at				
	:	exit.					
		Prior to exit no furth	er information was provided.				
		loss. Subcutaneous tendon or muscle is present but does no loss. May include u	Ulcer: Full thickness tissue is fat may be visible but bone, not exposed. Slough may be at abscure the depth of tissue indermining and tunneling, om the Minimum Data Set -Version 3.0				
		carbohydrates, fat, a primarily a result of	a complex disorder of and protein metabolism that is a deficiency or complete lack by the beta cells of the nee to insulin.				
			in that continues or recurs griod, caused by various al conditions.				
	approprie	or many joints unde	a form of arthritis in which one rgo degenerative changes, osis, loss of cartilage, bone in the joints.				
		activity, a mood dist	decrease of vital functional urbance characterized by despair, and discouragement				

resulting from and normally proportionate to

PRINTED: 05/16/2016

			AND HUMAN SERVICES					NO. 0938-0391
	1	1	& MEDICAID SERVICES	1	75.673.07	A Challer of Lory I Chall		DATE SURVEY
		OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1. '		CONSTRUCTION		COMPLETED
			495287	B. WING				C 05/02/2016
-	NAME OF P	ROVIDER OR SUPPLIER			•	REET ADDRESS, CITY, STATE, ZIP CODE		
					22	30 EXECUTIVE DRIVE		
	SENTARA	NURSING CENTER	HAMPION		HA	MPTON, VA 23666		
	(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO GROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X6) COMPLETION DATE
~	F 314	Continued From pa	ae 45	F	314			
		some personal loss	-					
		********Obesity: an a proportion of fat ce subcutaneous tissu	abnormal increase in the ils, mainly in the viscera and les of the body.					
		The above definition Dictionary of Medic Professions 8th Ed	ns were derived from Mosby's ine, Nursing, and Health itlon.					
		admitted to the faci readmitted on 9/22, *Recent History of	as a 65 year old originally lity on 1/1/2000 and /14 with diagnoses to include Stage III Pressure on, ***Hemiplegia, and					
Marie Charles Control of the Control		assessment was a Reference Date (Al Interview for Menta of a possible 15 wh was cognitively inta decision making. It is status the resident person assist for be dependence for ba Limitation in Range coded as having U impairment on both inches in height an Under Weight Loss coded 0, indicating of 5% in the last months. Under Sk	Quarterly with an Assessment RD) of 3/1/16. The Brief I Status (BIMS) was a 15 out sich indicated that Resident #5 act and capable of daily Under Section G Functional was coded extensive two ed mobility and total thing. Under Functional of Motion Resident #3 was pper and Lower extremity a sides. The resident was 65 d 146 pounds in weight. Weight Gain the resident was that there was no gain or loss onth or 10% in the last 6 in Conditions the resident was risk of developing pressure					

Facility ID: VA0216

ulcers.

FORM CMS-2567(02-99) Previous Versions Obsolete

CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/16/2016 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495287	B. WING	A CONTRACTOR OF THE PROPERTY O	C 05/02/2016
	OVIDER OR SUPPLIER		2	STREET ADDRESS, CITY, STATE, ZIP CODE 1230 EXECUTIVE DRIVE HAMPTON, VA 23666	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE COMPLETION
	9/22/14-3/7/16 do "Problems: Resident # breakdown over the state of th	mprehensive Care Plan dated cumented in part, as follows:  lent #13 at risk of pressure ulcer being mostly bedfast.  13 will remain free of skin me next 90 days. Goal date:  s, or wedges to reduce pressure issure points. Turn/reposition. essments, Check skin for s, swelling, or pressure areas. of skin breakdown"  ursing was asked for all Braden ing Pressure Sore Risk for had been completed the past len Scale was completed and art, as follows:  on-Slightly Limited nally Moist to ted eer-Potential Problem			

Facility ID: VA0216

#### **FORM APPROVED** DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA COMPLETED IDENTIFICATION NUMBER: A, BUILDING 05/02/2016 495287 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2230 EXECUTIVE DRIVE SENTARA NURSING CENTER HAMPTON HAMPTON, VA 23666 (X5) COMPLETION DATE PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES ID (X4) ID PREFIX FACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) **PREFIX** CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 314 F 314 Continued From page 47 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: 11/13/16 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.

FORM CMS-2567(02-99) Previous Versions Obsolete

Facility ID: VA0216

PRINTED: 05/16/2016

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

s	TATEMENT C	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	3	LTIPLE CONSTRUCTION	(>	(3) DATE SURVEY COMPLETED
A	ND PLAN OH	CORRECTION	(DEM HEIGHT INTRODUCE)	A. BUILL	DING		С
			495287	B. WING			05/02/2016
		ROVIDER OR SUPPLIER NURSING CENTER	HAMPTON		STREET ADDRESS, CITY, STATE, ZIP CO 2230 EXECUTIVE DRIVE HAMPTON, VA 23666		
•	(X4) ID PREFIX TAG	(FACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		SHOULD B	E COMPLETION ATE DATE
		presents with a sta, lateral ankle of at Appetite: Good Focused Wound E Etiology: Pressure MDS 3.0 Stage: 3 Duration >7 days Wound Size: 0.3 x Surface Area: 0.06 Exudate: Light Ser Yellow Necrotic: 15 Granulation Tissue Wound Progress: Dressing: Santyl-O Coordination of Ca to this patient' s ca Staff, Patient. This with another health Member during this 1/27/16 History of Present Chief Complaint: Fankle. HPI (history of phy presents with a stallateral ankle of at I-Appetite: Good Focused Wound Etiology: Pressure MDS 3.0 Stage: 3 Duration >13 days Wound Progress: Coordination of Cato this patient's car Staff, Patient. This	sical illness) Statement: He ge 3 pressure wound of the left least 7 days duration.  xam:  0.2 x 0.2 cm cm squared o-Sanguinous i% less with limproved less and history pertinent re were obtained via Nursing spatient's care was discussed in care provider Nursing Staff is visit.  Illness: Patient has a wound on their sical illness) Statement: He ge 3 pressure wound of the left least 13 days duration.  Exam:  Resolved 1/21/16 lere: Data and history pertinent re were obtained via Nursing is patient's care was discussed in care provider Nursing Staff least care provider Nursing Staff least care provider Nursing Staff		314		

PRINTED: 05/16/2016 FORM APPROVED OMB NO. 0938-0391

k	CENTER	S FOR MEDICARE	& MEDICAID SERVICES	4	and the second		<u> </u>
Si	ATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	TIPLE CONSTRUCTION		ATE SURVEY DMPLETED
-			495287	B. WING			C 5/02/2016
1	VAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	E	
	SENTARA	NURSING CENTER	HAMPTON		2230 EXECUTIVE DRIVE HAMPTON, VA 23666		
_[					PROVIDER'S PLAN OF CORRE	CTION	(X5)
	(X4) ID PREFIX TAG	(FACH DEFICIENC)	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG	(EACH CORRECTIVE ACTION SH	HOULD BE	COMPLETION
1	F 314	Continued From pa	ge 49	F3	314		
		conducted with the Resident #13's Wo	p.m. a phone interview was Wound Care Physician after und Care Specialist				
		Physician was askeulcer to the left late	eviewed. The Wound Care ed if Resident #13's pressure ral ankle was indeed a				
		pressure area. The stated, "If I docume call it like I see it."	e Wound Care Physician ent pressure, it's pressure. I				
	;	Resident #13's Clir documented in par	ical Notes were reviewed and ;, as follows				
		(Medical Doctor) or patients left lateral time and ankle had drainage with no fo yellow necrotic tiss tissue. Patient tole	n. Writer in with wound MD n 1/13/16 to assess area to ankle. Patient in bed at the light amount of sero sangious of the light amount of sero sangious of the light amount of sero sangious and 70 % granulation rated well and denied pain and as ordered. Wound Nurse				
		1/19/16 at 9:45 a.m (standards of care)	i. Discussed in SOC mtg (meeting); new stg kle rlt (related to) positioning;				
	To the second se	with wound MD on lateral ankle. Patie necrotic tissue and light sero sangious improving with dec	m. Writer in patients room 1/20/16 to see patients left ints left ankle has 15% yellow 85% granulation tissue with drainage. Patients ankle is reased surface area and ion. We will continue with	1			
	enter to	santyl daily and pai	ient tolerated well and denied ontinues to wear prevalon				

Facility ID: VA0216

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S	TATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			495287	B. WING			C 05/02/2016
004		a warn on el maillea	70001	<b>!</b>	STR	EET ADDRESS, CITY, STATE, ZIP CODE	
	NAME O⊩ PI	ROVIDER OR SUPPLIER				EXECUTIVE DRIVE	
	SENTARA	NURSING CENTER	HAMPTON	,		WPTON, VA 23666	
er e	(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETION
-	F 314	Continued From pa	ige 50	F	314		
		Resident #13's We	ekly Skin Condition Progress				
		Report was reviewe follows:	ed and documented in part, as				
		"Type of Wound: P: Wound Location: L	ressure Uicer eft Lat (lateral) Ankle				
		Date of Onset: NO Contributing Factor	DATE				
		Assessment Date: Stage of Ulcer: Sta	ge III				
			(cm) 0.4 Width (cm) 0.5				
		Depth (cm) 0.2 Tissue Type: Grant	ulating 70%, Slough 30%			•	
		Exudate: Small					
		Exudate Color: Stra Odor Present: No	aw/Red				
		Assessment Date:					
		Stage of Ulcer: Sta Wound Size: length	n (cm) 0.3 Width (cm) 0.2				
		Depth (cm) 0.2					
		Tissue Type: Grani Exudate: Small	ulating 85%, Necrotic 15%				
		Exudate Color: Str	aw/Red				
		Odor Present: No	•				
		The facility policy to	itled "Physician Approved evention Orders/Protocol" not				
		dated, documented	d in part, read as:				
		"All Residents					
	, n	risk on admission; quarterly, with sign	re assessed for pressure ulcer weekly times four weeks, then difficant change and annually				
		using the Braden s pressure ulcer is it	scale. Re-evaluate if a dentified.				

~~†	-	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUI	TIPLE C	CONSTRUCTION		E SURVEY PLETED
		CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	DING	Manual Casalida Andrewson Way April Casalina Andrewson Casalina Ca		2
			495287	B. WING	i		1	02/2016
		ROVIDER OR SUPPLIER NURSING CENTER	ALL PAR	.,	2236	EET ADDRESS, CITY, STATE, ZIP CODE D EXECUTIVE DRIVE MPTON, VA 23666		
	(X4) ID PREFIX TAG	(EACH DEFICIENC)	ITEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERÊNCED TO THE APPROF DEPICIENCY)	DBE	(X5) COMPLETION DATE
		episodes. 8. Develop patients pressure ulcer prev The facility policy ti Prevention" revised read as; "Policy Statement: pressure ulcers.  *All Residents are a risk on admission, admission, quarter annually using the *Weekly skin inspect documented on all *Complete weekly *Turning and repost dependent on resident TAR (Treatment Act *Pressure ulcer pre implemented bases The facility policy ti Care-Pressure Sort documented in par "Purpose: Resider pressure sores do individual's condition unavoidable.  Procedure: 1. Facilities will pre delity care including	pections. parrier after incontinence repectific written care plan for rention."  Itled "Pressure Ulcer I 11/12/16 documented in part,  To prevent development of  assessed for pressure ulcer every week times 4 after ly, with significant change and Braden scale. Intions are conducted and residents by licensed staff. Iskin inspection form. Islicitioning frequency is Ident assessment and chart on Imministration Record). Intervention order set is Ident and "Guidelines of Iteled "Guide		314			

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

s	TATEMENT (	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• ,		ONSTRUCTION		TE SURVEY MPLETED
A	ND PLAN OF	CORRECTION	EXTERIOR FOR FOREST	A" RAILE	IING			С
			495287	B. WING			05	/02/2016
		ROVIDER OR SUPPLIER	HAMPTON		2230	ET ADDRESS, CITY, STATE, ZIP CODE EXECUTIVE DRIVE IPTON, VA 23666		
*****	(X4) ID PREFIX TAG	(FACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIVE (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D8E	(X5) COMPLETION DATE
The state of the s		dry bed linens, and nutrition and hydrat 2. A determination pressure sore was only if aggressive recare, and appropriacare specific to the factors, were provid 3. Nursing facilities based on each resistrengths, on the inobjectives are not rewill be develope.  The facility policy ti Characteristics-Ski documented in part. "Purpose: Resider prevent and treat survival and tr	care, provision of clean and maintenance of adequate fion. Ithat development of a unavoidable may be made outine preventive and daily ate preventive measures and resident 's unique risk ded. It is will document interventions, ident 's risk factors and iterdisciplinary plan of care. If met, alternative approaches the "Standard and Required in Conditions" revised 6/18/15 it:  In this are provided with care to kin breakdown.  In develop skin breakdown all condition makes breakdown.		314			

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

ww		OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	1	TIPLE CONSTRUCTION		TE SURVEY MPLETED
		CORRECTION	IDENTIFICATION NUMBER:	A BUILE	DING		С
-			495287	B. WING		The second secon	/02/2016
		NURSING CENTER	HAMPTON		STREET ADDRESS, CITY, STATE, ZIP CO 2230 EXECUTIVE DRIVE HAMPTON, VA 23666	ODE	
	(X4) ID PREFIX TAG	(FACH DESIGIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		SHOULD BE	(X5) COMPLETION DATE
		residents and recorearly on before the early on before the The following outling the Administrator plass follows:  "Allegation: Facility until it reached a Sign of the Stage III by (Name Depth of .2 would it accuracy that this work as a Stage III."  On 5/2/16 at 11:48 conducted with the Wound Care Physiabove statement rewound care assess pressure area of Facility. The Wound was never brought questioning my as visible every week I touch base with the Clinical Manager wor changed, I give Stage III pressure with that because	ne nurses to assess the gnize them (pressure ulcers) y get to an advanced stage." ne document was provided by rior to exit documented in part, y did not identify pressure ulcer	t	314		

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S	TATEMENT (	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1''		CONSTRUCTION	(X3) DATE SU COMPLE	
			495287	B. WING	l		05/02/2	2016
	Sandard State of the State of t		457501	L		REET ADDRESS, CITY, STATE, ZIP CODE		
	NAME OF PE	ROVIDER OR SUPPLIER			l	80 EXECUTIVE DRIVE		
	SENTARA	NURSING CENTER	HAMPTON		1	MPTON, VA 23666		
						PROVIDER'S PLAN OF CORRECTION	NI -	(X5)
	(X4) ID PREFIX TAG	JEACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	PREF TAG		(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	DBE CO	MPLETION DATE
<b>6</b> 08814	F 314	Continued From pa	nge 54	F	314			
		reviewing the above Administrator, the Athe Wound Care Pithe Wound Care Pithe Wound Care Pithe Would at approvided document Mock Survey Audit The Mock Survey Administrators. Odeveloped stating: at unfavorable targicorrection was revi	eximately 2:00 p.m. after be document presented by the administrator was informed of hysician's comments.  Eximately 2:30 p.m. the she Director Of Nursing tation indicating on 2/10/16 a was conducted in the facility. Audit revealed issues with an 2/29/16 an Action Plan was Problem Pressure Ulcers are ets. The facility plan of sewed by 2 surveyors, the the Director of Nursing.			-		
		During the review of noted under "Weel were only complete the "Skin Assessm Resident #13, all b Indicating the audit	of the Plan of Correction it was kly Skin Assessments" audits ed for one week in March. On ent Audit" dated 4/5/26 for oxes were unchecked had not been completed.					
		audits. Under "Act treatments weekly" Under "Action, Ass for Treatment Previously completed. Based that a functioning of place and the fact had not been corre- survey Past Non-C exit.	ale" there were no March tion, Clinical Manager to audit ", no audits were available. sessment of Adequate Surfaces rention", no audits had been I on the lack of audits to show corrective Action Plan was in the identified deficient areas acted prior to the start of the compliance was not offered at	6				
-		Prior to exit no furt	her information was provided.					
		*Stage III Pressure	e Ulcer: Full thickness tissue us fat may be visible but bone,				and the second s	_ 1.X.4.F., \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \

CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/16/2016 FORM APPROVED OMB NO. 0938-0391 (x3) DATE SURVEY

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION ING	COMPLETED
		495287	B. WING	and a similar interference or an appropriate the same demanderate interference or an inches de la terre	05/02/2016
	ROVIDER OR SUPPLIER NURSING CENTER	HAMPTON		STREET ADDRESS, CITY, STATE, ZIP CODE 2230 EXECUTIVE DRIVE HAMPTON, VA 23666	
(X4) ID PREFIX TAG	(FACH DEFICIENC)	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFII TAG		LD BE COMPLETION
F 323 SS=D	present but does no loss. May include to Definition derived from (MDS) Assessment "Hypertension: a control known cardiovascu characterized by elementary) in an adult "Hemiplegia: partimeter body.  The above definition Dictionary of Medic Professions 8th Ed 483.25(h) FREE OHAZARDS/SUPER The facility must erenvironment remail as is possible; and	s not exposed. Slough may be of obscure the depth of tissue undermining and tunneling. From the Minimum Data Set to-Version 3.0 common disorder that is a lar disease risk factor, evated blood pressure over 20/80 mmHg (milligrams of lit.  The large of the body. In the large of the body. In the large of t	F3	323	
	by: Based on observa facility documentat facility staff failed to	NT is not met as evidenced tions, clinical record reviews, ion, and staff interviews the provide appropriate care and appropriate assistive devices to			

OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION (DENTIFICATION NUMBER: A. BUILDING \_ C 495287 05/02/2016 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2230 EXECUTIVE DRIVE SENTARA NURSING CENTER HAMPTON HAMPTON, VA 23666 (X5) COMPLETION DATE PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES ID X4) IO (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX REFIX CROSS-REFERENCED TO THE APPROPRIATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) F 323 F 323 Continued From page 56 prevent avoidable falls resulting in harm for 2 of 1. Staff did not utilize appropriate 22 residents in the survey sample, Resident's #5 transfer device for resident #5. and #19. Staff assisted Resident #19 in 1 The facility staff failed to use an appropriate ambulation which had no specific assistive device during a toilet transfer on physician order relating to PT 12/21/15 resulting in a avoidable fall with a transfers only. fracture for Resident #5, which constitutes harm. 2. All residents have a potential to be 2 The facility staff failed to ensure Resident #19 affected. remained free of accidents related to staff member ambulating the Resident on 9/25/15 3. All licensed nursing staff will be inwhen assignment sheet documented "ambulation serviced on proper assistive transfer by PT (Physical Therapy) only". devices and transferring methods. The findings included: 4. Clinical Managers and/or designee 1. Resident #5 was a 76 year old admitted to the will verify 25% of resident weekly facility initially on 6/20/07 and readmitted on for appropriate patient application 9/1/15 with diagnoses to include. \*Diabetes of assistive transfer devices for 8 Mellitus, \*\*Chronic Pain, \*\*\*Osteoarthritis, \*\*\*\*Depression, and \*\*\*\*\*Obesity. weeks. Results will be reported to QAPI Meeting. The most recent comprehensive Minimum Data Set (MDS) assessment was a Significant Change 5. Date of Completion: 06/10/16 with an Assessment Reference Date (ARD) of

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, tollet 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; PRINTED: 05/16/2016 FORM APPROVED

PRINTED: 05/16/2016 FORM APPROVED OMB NO. 0938-0391

-	CENTER	S FOR MEDICARE	& MEDICAID SERVICES				1010	
		OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, , ,		E CONSTRUCTION	COM	E SURVEY IPLETED
			495287	B. WING			1	C 02/2016
	NAME ()E D	OVIDER OR SUPPLIER	Control of the Contro	<u></u>	\$1	REET ADDRESS, CITY, STATE, ZIP CODE		
	NAME OF F	CONDEN ON SUCH CICK			22	30 EXECUTIVE DRIVE		
	SENTARA	NURSING CENTER	HAMPTON		н	AMPTON, VA 23666		
							NI .	(X5)
4070	(X4) ID PREFIX TAG	(EACH DESIGNENC)	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	COMPLETION DATE
	F 323	able to stabilize with Section H Bladder and Section H Bladder and Section H Bladder and Section H Bladder and Section H Brief Indicated that Resigned and capable of dail Section G Function Coded extensive or mobility and person Resident #5 was conly once or twice resident was coded assist for Toilet use Transitions and Was follows: Moving position, Walking, off toilet=8, Activity surface transfer=2 stabilize with staff Bladder and Bowe occasionally incontinent of Bladder and Bladd	transfer=2, not steady, only in staff assistance. Under and Bowel Resident #5 was ally incontinent (less than 7 nence) for both. The resident section K as 63 inches in		323			
		pounds in weight.  Resident #5's Con 11/27/15-3/21/16 of	nprehensive Care Plan dated locumented in part, as follows:					

Problems: Self care deficit-Extensive to total

			(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUI	TIPLE CONSTRUCT	TON		E SURVEY
STATEME! AND PLAN	NT OF DEFICIENT OF CORRECTION	)N	IDENTIFICATION NUMBER:		ING			MPLETED C
			495287	B. WING			•	/02/2016
	F PROVIDER OR		1000					
(X4) ID PREFIX TAG	SU	MMARY ST	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAC	PRC IX (EACH	DVIDER'S PLAN OF COP I CORRECTIVE ACTION REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE
F 32	assistance dressing, Intervention Problems decrease [fracture] intervention ambulation Problems wheelchas requires (Goal: Resident and documer 1/6/15 at 1/6	e require tolieting, ons: no in the tolieting, ons: no in the tolieting, ons: no in the tolieting in the tol	d with bathing, hygiene, and grooming. Intervention noted for tolieting. Intervention of Falls R/T (related to) y/unsteady gait. (toe fx 12/21/15) ovide reminders to use ansfer assist devices.  It is toliform: bed, chair, fing position)- (Resident #5) is assistance.  It is will complete transfers with 1-2 people/lift devices as ansfer using board/lift 11/27/15.  It is fall 9/23/15, 12/21/15. It is ansfer using the mechanical lift y/sician orders were reviewed in part, as follows: 9/3/15 HiG (FACILITY NAME) Fall	H Is	323			
	9/6/15 a	t 2:20 p.r	n. Resident require assistance	x			-antiquetion shor	t Bana 50 of 40

í	CENTER	S FOR MEDICARE	& MEDICAID SERVICES			U	MD NO. 0930-0391
S	TATEMENT C		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	- Constitution of the Cons	And the state of t	495287	B. WING		**************************************	C 05/02/2016
-	NAME OF PE	ROVIDER OR SUPPLIER	2 de		\$1	REET ADDRESS, CITY, STATE, ZIP CODE	
				1	22	30 EXECUTIVE DRIVE	
	SENTARA	NURSING CENTER	HAMPTON		Н	AMPTON, VA 23666	
	(X4) ID PREFIX TAG	/EACH DESIGNOY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETION
	F 323	Continued From pa	ge 59	F 3	123		
-				. •			
			ities of daily living) very little				
		help from resident o	during care,				
		Do 1100116 -1 0-00	a.m. Resident #5 was				
		intensioued records	ng 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 beca	ause I needed to use the toilet,				
		me and the aide. I	said are you going to get the				
		sit to stand lift? She	e said no, you can do it, grab				
		this rail and puil up.	. I said I can't do that, she said				
		ves vou can, I said	no I can't. So she said put				
		your hand on the ra	ail and the other hand on the				
		other rail and pull u	p. So anyways, I told her				
		again I can't do thai	t and she said I'm here to help				
		you. So I went ahe	ad and pulled but I was scared				
		pecause I have fall	en so many times. I reached				
		pver to get the rail a	and I fell to the floor. When I ent underneath me, because I				
		reii, my right foot Wi	ning that foot, so then I fell to				
		the floor I sold of	I'm hurt you gotta help me, I				
		use mous. I salu oil	got another aide to help get				
		me un They nuller	d me up to get me back in the				
		chair, three of them	n." The surveyor asked				
		Resident #5 if she v	was lowered to the floor or fell				
		straight to the floor,	, the resident stated, "I fell to				
		the floor, no one lov	wered me." The surveyor				
		asked Resident #5	if she was hurting and she				
		stated, "Yes ma'am	n, really hurting!" Surveyor				
		asked her where s	she was hurting and the				
		Resident stated, "Ir	my right toe and right leg."				
		Resident #5 stated	, "Then they took me to my bed. No nurse never came				
		room and got me to	My toe kept hurting and I told				
		ianu Checkeu Ine. 1	proke my toe and they said how				
		SOMEONE LANGE FOR	roke your toe, I said it hurts to				
		move it. I told them	n my toe was not getting any				
		hetter they said vo	u can't do anything for a				
		broken toe. Reside	ent was asked how was she				

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

91	ATEMENT C	F DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C		(X3) DATE SURVEY COMPLETED
Αľ	ID PLAN <b>O</b> F	CORRECTION	IDENTIFICATION NOWDER	A. BUILDING	4	С
			495287	B. WING		05/02/2016
		OVIDER OR SUPPLIER NURSING CENTER	HAMPTON	2230	EET ADDRESS, CITY, STATE, ZIP CODE EXECUTIVE DRIVE JIPTON, VA 23666	
****	(X4) ID PREFIX TAG	(FACH DESIGIENC)	TEMENT OF DEFICIENCIES ' MUST BE PRECÉDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE COMPLETION
		toilet, she stated, "Testand only."  The Fall Investigation 12/28/15 for Reside documented in particle (Reports fall 12/21/Time of Fall: 7a-3p Location of Fall: 8a hurse's station)  Witness: CNA (cer (per pt [patient])  FALL HISTORY: Is there a history of Has the resident fall famonth?-Yes Has the resident state fall?-Yes If YES describe typ 12/26-12/27 p.m. s PHYSICAL/COGN: Has the resident be fisk for falls?-Yes If YES, identify read decreased mobility?-Yes If YES, describe the mobility?-Yes If YES, describe the RESIDENT INTER FALL: Did you know that Did you experience to the fall?-Yes	d on a daily basis to get on the They transfer me with the sit to on Assessment dated ent was reviewed and it, as follows:  15) Shift athroom (Big Bathroom near tified nursing assistant) #40  If falls?-Yes llen within the past 3  Istained injury resulting from the of injury-fx (fracture noted thift by x-ray to right foot. ITIVE ASSESSMENT: the assessed as being at high sons for the risk-impulsive, the unsteady gait?-Yes use an assistive device for the type of device-wheelchair type of device-wheelchair type of device-wheelchair type of device for the type of device for the type of device wheelchair type of device for the type of device wheelchair type of device for the type of device type of device wheelchair type of device for the type of device type of device wheelchair type of device type of the following just prior to fall?-No eany of the following just prior	1.		
		If YES, describeUlift. FOLLOW-UP ACT	Inusual activity-stand without ION:			

CENTERS FOR MEDICARE & MEDICAID SERVICES

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	i ico	ME SURVEY IMPLETED C 5/02/2016
	ROVIDER OR SUPPLIER	495287	B. WING	STREET ADDRESS, CITY, STATE, ZIP CODE 2230 EXECUTIVE DRIVE HAMPTON, VA 23666		
 (X4) ID PREFIX TAG	VEACH DEFICIENCY	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		IOULD BE	(X5) COMPLETION DATE
	CNA #41 oof (off on normally uses sit to CNA #40 lowered reporting to nurse. The Fall Investigat (Registered Nurse Staff statements of the fall were revas follows:  "CNA #40: Dated On the date in questiat she needed to been waiting for a I have not worked with transferring to the transferring to the transferring. She recently went to the in front of the nurse pull up. I asked husing that restroom Once in the restroom once in	quire evaluation by quire x-ray?-Yes pserved: CNA#40, CNA #42, of floor) manually and into chair, o stand. to the floor, doesn't recall ion was completed by RN ) Clinical Manager #21 btained during the investigation flewed and documented in part,	•	323		

	CENTER	S FOR MEDICARE	& MEDICAID SERVICES				), 0938-0391
S	TATEMENT	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LTIPLE CONSTRUCTION DING		TE SURVEY
			495287	B. WING			C 5/02/2016
-	NAME OF PI	ROVIDER OR SUPPLIER	A Section of the Sect		STREET ADDRESS, CITY, STATE, ZIP CO 2230 EXECUTIVE DRIVE	DDE	
	SENTARA	NURSING CENTER	HAMPTON		HAMPTON, VA 23666		
~_,-	(X4) ID PREFIX TAG	(FACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX (EACH CORRECTIVE ACTION	SHOULD BE	(X5) COMPLETION DATE
		and change her brichback down, we ask was fine and also a leg and foot and shifted she was fine and for Christmas so shifted kneed and the backed what happed fell while trying to the commode and floor. CNA #40 asl lifted Resident #5 to stand because they were was fine but her rig kneed and moved happened. I didn't should have told the Resident #5 because they were was fine but her rig kneed what happened. I didn't should have told the Resident #5 because they were was fine but her rig kneed was fine but her rig kneed was fine but her rig kneed was fine but her rig kneed. I didn't should have told the Resident #5 because they was fine but har should have told the Resident #5 because they was fine but har should have told the Resident #5 because they was fine but har should have told the Resident #5 because they was fine but har should have told the Resident #5 because they was fine but har should have told the Resident #5 because they was fine but har should have told the Resident #5 because they was fine but har should have told the Resident #5 because they was fine but har should have told the Resident #5 because they was fine but har should have told the Resident #5 because they was fine but har should have told the Resident #5 because they was fine but har should have told the Resident #5 because they was fine but har should have told the Resident #5 because they was fine but har should have told the Resident #5 because they was fine but har should have told the Resident #5 because they was fine but har should have told the Resident #5 because they was fine but har should have told the Resident #5 because they was fine but har should have told the fine fine fine fine fine fine fine fin	and-up lift to pull up her pants ef. Once we had her sitting ed her several times if she sked if she could move her e could do both. She stated and that she wanted to go home he did not want her daughter to all if I told a nurse or even what unit that day.  It took the bags to the dirty the restroom when I saw floor sitting up on her bottom. Hend and CNA #40 said she cansfer her from the chair to that she had eased her to the ked CNA #41 to help and we so we could change her pants were toes she said she didn't fee everything else was fine. I told should tell the nurse what see her fall, but now I realize the nurse to cover myself and the was she didn't.		323		
***************************************		I CNA #41 was wa #40 and CNA #42 told me to get som so she can change	Iking down the hall and CNA came out the bathroom and e blue pants out of her closet her pants. When saw as NOT on the floor."				

Ì	TATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	' '		ONSTRUCTION		E SURVEY
1	nd Plan <b>o</b> f	CORRECTION	IDENTIFICATION NUMBER:				1	C / <b>02/2016</b>
1		ROVIDER OR SUPPLIER	495287 HAMPTON	B. WING	\$TRE 2230	ET ADDRESS, CITY, STATE, ZIP CODE EXECUTIVE DRIVE APTON, VA 23666	) UO.	02/2010
	(X4) ID PREFIX TAG	SUMMARY STA	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	I IX	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETION DATE
	F 323	regarding the fall b surveyor with any oresident's statement the fall was a copy of the lin part, as follows:  "DOS: (date of ser Examination Foot (lateral) 2V (2 view Results: 3-view examination Foot of the lin part, as follows:  "DOS: (date of ser Examination Foot of the line of	er #21 interviewed Resident #5 ut was unable to provide the documentation of the nt.  I Investigation documentation Radiology Report documented  vice) 12/26/15 AP (anterior/posterior) and LAT vs), RIGHT  kam; comparison unavailable, ively osteopenic. There is a t fifth distal metacarpal fracture lar deformity. There is no joint pular malalignment. There is e swelling.		323			

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

PRINTED: 05/16/2016 FORM APPROVED OMB NO. 0936-0391

pintos	CENTED	O LOIL MICDICALL	O MEDICAID SCITTIOLS	r			
		OF DEFICIENCIES FOORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	LTIPLE CONSTRUCTION DING		E SURVEY APLETED
			495287	B. WING	;	1	C / <b>02/2016</b>
_		maliform am alimation	427501	1	STREET ADDRESS, CITY, STATE, ZIP CO		, J. 2. 2. 2. 2. 2. 2. 2. 2. 2. 2. 2. 2. 2.
	NAME OF P	ROVIDER OR SUPPLIER			2230 EXECUTIVE DRIVE		
	SENTARA	NURSING CENTER	HAMPTON		HAMPTON, VA 23666		
					PROVIDER'S PLAN OF COR	DECTION	(X5)
	(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREF TAG	IX (EACH CORRECTIVE ACTION	SHOULD BE	COMPLETION
	F 323	Continued From pa	ae 64	F	323		
ĺ	,		stated, "For bathroom				
			se the sit to stand lift."				
		and to to to all to a					
			view was conducted with CNA				
		#40 at 9:30 a.m. re	garding Resident #5's fall on				
		12/21/15. CNA #40	stated, "Well I didn't have				
		ner, but she had be	en ringing a long time to go old her I would take her. She				
			sing the walker to get on the				
			haven't worked with her in a				
			ident's word for it. Name (RN				
			21) told me I shouldn't do it				
			" When asked what she				
			now if she was to transfer #40 stated, "Would not take				
		Resident #5, UNA	about how she could transfer				
١		and that she was fir	ne. It kinda backfired a week				
		later. I would have	used the sit to stand lift. They				
		(management) tried	d to fuss at me about why i				
l		was transferring he	r by myself, I was nervous so I				
		came in and I took	pictures the next day. Hooked				
			othing there, no signs about				
		transfers."					
		On 4/28/16 at 3:00	p.m. Resident #5's				
١		communication boa	ard above her bed was				
		observed, it was en	npty; no symbols indicating the				
١			transfer assistance, required				
l			d any required safety devices				
		were posted.					
		On 4/28/16 at appr	oximately 1:30 p.m. surveyor,				
		Resident #5. Rehal	bilitation Manager #55, Doctor				
		of Physical Therapy	y #56, and Certified				
l		Occupational Thera	apy Assistant #52 entered the				
l	5		he nurse's station where				
			d injured herself on 12/21/15.				
	:	Resident #5 was as	sked to verbally walk us				
1		through what happe	ened on the day of the fall.				

Facility IO: VA0216

Ì	DEFAIL	O COD MEDICAPE	& MEDICAID SERVICES				and the same of th	NO. 0930-039 1
	TATEMENT	S FOR MEDICARE  OF DEFICIENCIES  CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3)	DATE SURVEY COMPLETED
			495287	B. WING				05/02/2016
		ROVIDER OR SUPPLIER NURSING CENTER			2.	TREET ADDRESS, CITY, STATE, ZIP CODE 230 EXECUTIVE DRIVE IAMPTON, VA 23666		
_	(X4) ID PREFIX TAG	SUMMARY STA	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	(X5) COMPLETION E DATE
And the second s	F 323	the rehabilitation starveyor in her aborehabilitation staff in the incident as des Resident #5 stated happened."  The following note 4/28/16 by the Docard Certified Occurafter meeting with part, as follows:  "We have bee which Resident #5 21, 2015, while transhed the whole thair. Per Repositioned in front at a 45 degree and toilet) and was abligrab bar. Once should be compational the room for the transpivot in order to sit was unable to lift balance and fell.  Resident #5 we (occupational ther which time Resides sideboard transfer activities to increa mobility. Resident was minimal second (arthritic pain and legs), pain toles self-limiting behave could not participate activities and total participate activities and legs).	im explained the incident to aff as she had told the ove statement. The proceeded to physically act out cribed by Resident #5., "That's exactly what was presented to surveyor on tor of Physical Therapy #56, pational Therapy Assistant #52 Resident #5, documented in asked to assess a situation in sustained a fall on December nsferring to a toilet from her esident #5's memory, she was of the toilet with her wheelchair gle (facing the left aspect of the e was standing, she recalls the wheelchair to allow increased for. Resident #5 attempted to ton the toilet; however, she her right foot and lost her was discharged from OT apy) on October 6th, 2015 at ent #5 was performing rs and standing tolerance se independence in functional the #5's functional progress in OT indary to physical limitations limited range of motion in arms erance, and at times increased in therapy for various in #5 was performing		323			

### FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTER'S FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED DENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING 05/02/2016 495287 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2230 EXECUTIVE DRIVE SENTARA NURSING CENTER HAMPTON HAMPTON, VA 23666 PROVIDER'S PLAN OF CORRECTION (X5) COMPÉCTION DATE SUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) 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

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

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."

"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

PRINTED: 05/16/2016

Facility ID: VA0216

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

gaveroy	VENILL	D LOW MICHOWAY	A MEDICARD SERVICES	*			CIVID IV	<del>J. 0330-039</del> 1
		OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 '		CONSTRUCTION		TE SURVEY
			495287	B. WING		. White the same of the same o	0:	C 5/0 <b>2/2016</b>
	NAME OF P	ROVIDER OR SUPPLIER	1	L	STRI	EET ADDRESS, CITY, STATE, ZIP CODE		
			No.		2230	EXECUTIVE DRIVE		
	SENTARA	NURSING CENTER	HAMPTON		HAN	MPTON, VA 23666		
	(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
	F 323	Continued From particles bedside" -Stand up Lift -Two Person Assist Monitoring: Outcomes Monitoring admission and update and procument Manager with any significant of the Administrator procupation of Nursing was shared. The Director of Nursing was shared. The Director appropriate device of the following outline and the Administrator procupation of the Administr	ng:-Symbols are placed upon ated as changes occur. ment:-Reviewed quarterly and change."  eximately 5:30 p.m. a pre-exit with the Administrator and the and the above information irector of Nursing was asked a expected the CNA to 5 during the toilet transfer on ctor of Nursing stated, "Of m to transfer with the for the resident."  de document was provided by ior to exit documented in part:  ng of patient to floor during potential fracture.  n of this found the following: ing resident-Resident #5 or on 12/21/15 during  f alleged injury, resident was hysician at 3:08 p.m. as noted Per physician assessment, are noted to have edema x2 seline. No cyanosis or		323			
		12/22/15 At 8:09 p.	.m., resident complained of					

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STAT	PLAN OF	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		ONSTRUCTION	(X3) DATE SUF COMPLET	
			10 HOOM	D WING			C	104C
			495287	B. WING			05/02/2	010
VA	ME OF P	ROVIDER OR SUPPLIER				ET ADDRESS, CITY, STATE, ZIP CODE  EXECUTIVE DRIVE		
SE	NTARA	NURSING CENTER	HAMPTON			IPTON, VA 23666		
P	X4) ID REFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPERTIES OF THE A	DBE COM	(X5) MPLETION DATE
	F 32 <b>3</b>	Continued From pa	ago 69	Ė.	323			
	1 323	1						
		right great toe pain.	. LPN (Licensed Practical trevealed no bruising.					
		Nurse) assessmen	to LPN during this assessment					
		that she was dropp	ed yesterday while in the					
		shower.	au your au y					
		#40/00/45 At 8:05 i	o.m., LPN notified physician					
		and family of this re	eported incident. No new					
		orders from attendi	ng physician were given. No					
		further complaints	of pain were noted on this day.					
		: *12/23/15 Residen	t complained of pain to right			,		
		foot. Pain medicati	on given to address this pain.					
		Resident noted to h	nave an enjoyable visit with					
		family during eveni						
		*12/24/15 Residen	it went home with son as					
		planned for Christn	nas holiday and returned on					
		same day.						
		: *12/26/15 Residen	t complaining of pain, x-ray					
		ordered X-ray rev	ealed fracture of right 5th toe.					
		Also noted was that	t bones were subjectively					
		osteopenic.						
		•						
			g physician visited resident					
		following positive x	-ray.					
		: *40/20/45 Additions	al investigation was conducted					
		following positive x						
		IOHOMITA HOSITIAG V	iaji					
		: *Investigation revea	aled that resident was lowered					
		to floor during trans	sfer by CNA. This transfer did					
		not represent any o	leviation from standard					
		practice. Resident	was very familiar with this					
		CNA. Resident is a	alert and oriented as					
		evidenced by her B	BIMS score of 15. Resident					
		denied further pain	during this investigation.					

FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA COMPLETED IDENTIFICATION NUMBER: A. BUILDING\_ 05/02/2016 495287 B. WING

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

2230 EXECUTIVE DRIVE HAMPTON, VA 23666

### SENTAR A NURSING CENTER HAMPTON

SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX TAG DEFICIENCY)

(X5) COMPLETION DATE

PRINTED: 05/16/2016

F 323

(X4) ID

PREFIX

TAG

Continued From page 69

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 scierosis, 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.

F 323

ĮD.

	CENTER	S FOR MEDICARE	& MEDICAID SERVICES				(X3) DAT!	E SURVEY
J	TATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		NSTRUCTION		PLETED
d	ND PLAN O	CORRECTION	PERMIT RESERVED A CARDINAL ACTION OF THE PERMIT ACT	A. BUILD	MAG	ga, dissand de generalista en relación de plans dispulsa sindre del conscionado del relación de del conscionad	1	C
			495287	B. WING		1997 - June - Harris Machael Market (Machael Machael M	05/	02/2016
	11 6 6 2 2 2 1 1 1 1 1 2 N	ROVIDER OR SUPPLIER		1	ì	ET ADDRESS, CITY, STATE, ZIP CODE		•
١					ŀ	EXECUTIVE DRIVE		
	SENTARA	NURSING CENTER	HAMPTON		HAM	PTON, VA 23666		
	(X4) ID PREFIX TAG	JEACH DESIGNENCY	ITEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPERTICIENCY)	.D BE	(XS) COMPLETION DATE
	r 000	O U J Francisco	200 70	F	323			
	F 323	Continued From pa	onormal increase in the	•				
		neception of fat ce	lls, mainly in the viscera and					
		subcutaneous tissu	ues of the body.					
		The above definition	ons were derived from Mosby's					
		Dictionary of Medic	cine, Nursing, and Health					
		Professions 8th Ed	lition.					
		2. Resident #19 w	as admitted to the facility on					
		9/10/15 for skilled	nursing services following a agnoses on the Admission					
		MDS /Minimum Da	ata Set - an assessment					
		inrotocol) with an A	RD (assessment reference					
		date) of 9/17/15 in	cluded, but are not limited to dition where heart can't pump					
		the blood the body	needs), Arthritis, Osteoporosis	3				
		Uthinning of hone t	hat causes increase risk for					
		fracture), Cerebro Generalized Musc	vascular Accident (stroke), and					
		1						
1		The Resident Care	e Summary Assessment forms					
		I were requested to	r the following dates: 9/10/15,					
		9/18/15, and for the	e date of Resident #19's fall. are Summary Assessments					
		wore provided that	t were printed on 5/2/16 at					
		14.00 am. The fo	irms had no date other than the	<u>a</u>				
		printed date. The OT/PT" (Occupati	two forms document "Mobility: onal therapy and Physical					
		Therapy)	• •					
			tember 2015 orders					
Annual Control		Review of the Set	pecifics of who can ambulate	:				
		Resident #19.						
		Daview of the adr	nission Falls Risk Assessment					
		dated 9/10/15 do	cumented a score of 14. High					
		Risk if score of 10	or above is documented on the	ie i				

-	The Assessment of the State of	S FOR MEDICARE OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE CONSTRUCT	FION	(X3) DAT	TE SURVEY
1	NO PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING	and the second s		C
			495287	B. WING		AND A STATE OF THE	- 1	/02/2016
		ROVIDER OR SUPPLIER	and the same of th				)E	
	(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH	OVIDER'S PLAN OF CORRI N CORRECTIVE ACTION SI REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
Eggl	F 323	function. In addition the resident was cl Review of the Pain	nce as not able to perform n, the assessment documented nair bound.  Assessment Scale dated	FS	323			
		Review of the curre 3/15/16 to present problems: "1. At risk for falls	ed that no pain was present.  ent care plan effective dates documented the following related to communication and					
		risks of falls or inju Remind (Resident before moving from bed.	ded: f obstructions to reduce the ry. #19) to call for assistance n bed to chair and from chair to					
		Therapy referrals the falls as needed.  2. ADL (activity of required with translation), hydrone.	operly and have non-skid soles, to evaluate gait/balance/and dally living) deficit: assistance fers, bed mobility, tolleting, dressing, and grooming related					
		Interventions inclu Assist with ADL's ( feeding, ambulatir complete. Encour highest level capa 3. Locomotion on	(bathing, grooming, toileting, ig) if (Resident #19) unable to rage to participate in care at					
		#19) Interventions inclu Assist (Resident) ambulatory assist (Resident) Check location; re	to desired location. Make sure device remains close to					

CENTER	S FOR MEDICARE	& MEDICAID SERVICES	г			(X3) DATE SURV	/EY
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		ONSTRUCTION	COMPLETE	
AND PLAN O	CORRECTION	DEMTPOXIEM NOMBELS	A. BUILDI	NG		C	
		495287	B. WING			05/02/20	16
NAME OF P	ROVIDER OR SUPPLIER		LT	STRE	ET ADDRESS, CITY, STATE, ZIP CODE		
					EXECUTIVE DRIVE		
SENTARA	NURSING CENTER	HANIPION		HAN	MPTON, VA 23666		
(X4) ID PREFIX TAG	(FACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	<b>‹</b>	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROVIDERICENCY)	D BE COMP	(X5) PLETION NATE
F 323	Continued From pa	age 72	F 3	23			
F 323		essment dated 9/25/15					
	documented a sco	re of 16. High risk if a score of					
	10 or above is doc	umented on the form. In					
	addition, the form	documented Ambulation status d Mobility: Gait/balance as not					
	able to perform fur	nction.					
	4						
	A Facility Clinical P.	Note dated 9/25/15 at 11:22					
	Patient was seen to	ov CNA working with the					
	walker, CNA assis	ted patient to the bathroom and					
	reported she had t	o assist patient to the floor ave up. Patient vital signs					
	stable. Patient de	enies pain, able to move upper					
	and lower extremit	lies without difficulty, patient					
	reported her husb	and told her she had to walk, continue using the call light to					
	help her when she	needs to walk, Husband called					
	and made him aw						
	A Essility Life Care	e Corporation Fall Investigation					
	Assessment dated	9/26/15 was reviewed. It					
	documented:						
		essed as being at high risk for					
	falls Yes Unsteady gait						
	Vec Resident dem	constrated unsafe mobility habits	3				
	(explanation docu	mented: "husband encourages ession. Pt (patient) compliant				•	
	even when PT (pl	nysical therapy states unsafe)		į			
	Yes Resident uses	s assistive device and					
	wheelchair is circl circled.	ed. NOTE: Walker is not		1			
	A Frailib. Clinical	Addendum Note dated 9/26/15					
	i at 1:01 a.m. doc⊔	mented the following:					
	Husband at the be	edside, patient started c/o					
	(complain of) hip	pain bilaterally, MD (Medical					
	<ul> <li>Doctor) made awa</li> </ul>	are and new order received to					

PRINTED: 05/16/2016 FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTER\$ FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA ATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: A. BUILDING \_ AND PLAN OF CORRECTION 05/02/2016 B. WING 495287 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2230 EXECUTIVE DRIVE SENTARA NURSING CENTER HAMPTON HAMPTON, VA 23666 (X5) COMPLETION DATE PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECTIVE ACTION SHOULD BE (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL CROSS-REFERENCED TO THE APPROPRIATE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 323 Continued From page 73 F 323 send patient to ER (emergency room) to be evaluated. The SBAR (situation, background, assessment, ecommendation) 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, eft > (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:

muscular tenderness.

Musculoskeletal: positive for arthralgias and falls.

Musculoskeletal: Total Trochar Prosthetic left hip and right hip (artificial hip replacements) on palpation (feel). No peripheral edema or other

Chest xray: Preliminary result: Mild haziness c/w (consistent with) CHF (congestive heart failure)

Physical Exam: Back: Non tender.

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

j	CENIER	S FOR MEDICARE	& WEDICAID SERVICES	T		graphy and the control of the contro	12/01 DATE	- cunvey
3	TATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			ONSTRUCTION		E SURVEY PLETED
7	MATERIAL CAN	WALLES AND A SOUTH		7. 3016	23 The		(	c
	ļ		495287	B. WING			05/9	02/2016
-	NAME OF P	ROVIDER OR SUPPLIER	The second secon			ET ADDRESS, CITY, STATE, ZIP CODE		
	SENTARA	NURSING CENTER	HAMPTON			EXECUTIVE DRIVE IPTON, VA 23666		
	SEMINO		The state of the s		HAIW	PROVIDER'S PLAN OF CORRECTIO	NI	(X5)
	(X4) ID PREFIX TAG	/EACH DEFICIENCY	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	COMPLETION DATE
	F 323	Continued From pa	age 74	F	323			
			eral (both sides): No fracture,	•	•••			
		prosthetic in place						
		Physician's notes:	Patient with fall. No evidence					
		of fracture or disloc	cation on evaluation. No sign in the skull), chest, or					
		ot intracraniai (with abdominal injury. \	Will treat for contusions with					
		pain management.	ice, elevation and close					
		followup with prima	ary medical doctor. Worrisome					
		symptoms discussi	ed with patient and she agrees ency Department for					
		worsening.						
		Final Diagnosis: F	all, initial encounter; pain of					
		both hip joints; and normalized ration (	subtherapeutic international					
		Discharge Prescrip	otions: Lidocaine (Lidoderm)					
	-	5% (700 milligram	patch) apply 1 patch as					
		directed for 12 hou on, 12 hours off	irs every 24 hours (12 hours					
		Medline Plus docu	ments: "Lidocaine is in a class					
		of medications call	ed local anesthetics. It works					
		by stopping nerves	s from sending pain signals."					
		1						
		Facility clinical note	e dated 9/26/15 05:18 a.m.					
		documented: 043	5 Patient returned from	1				
		enh (shortness of )	via stretcher alert and verbal, no breath), no resp (respiratory)					
		distress husband	reported no injury was found at					
		the hospital, per hi	usband patient received 5 mg hospital for low iNR. New					
		order received for	Lidoderm patch. Patient					
		assisted to bed, cl-	eaned and dried, appeared					
		comfortable. Vital	signs stable BP 126/62; Pulse					
		63; Temperature 9 room air. Call ligh	17.2; Pulse oximetry 97% on tin reach.					
١		Medline plus docu	ments: 'Coumadin is used to					
		prevent blood clots	s from forming or growing					
		larger in your bloo-	d and blood vessels"					

### FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING 05/02/2016 B. WING 495287 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2230 EXECUTIVE DRIVE SENTARA NURSING CENTER HAMPTON HAMPTON, VA 23666 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION DATE SUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECTIVE ACTION SHOULD BE (X4) ID PREFIX PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 323 F 323 Continued From page 75 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

compress the conus.

which the body is bent backward) of chronic compression fracture. This abuts but does not

PRINTED: 05/16/2016

PRINTED: 05/16/2016 FORM APPROVED OMB NO. 0938-0391

DEPAK I	VICINI OF TILALIT	O MEDICAID SERVICES				<u> </u>	<u>MB NO</u>	<u>. 0938-0391</u>
		& MEDICAID SERVICES	COLLA	TIDI E CO	NSTRUCTION		(X3) DAT	E SURVEY
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					COM	APLETED .
NO PLAN C	F CORRECTION	IDENTIFICATION NOMBER.	A, BUILD	ING	CONTRACTOR OF THE PROPERTY OF			С
							1	
		495287	B. WING			-	05/	/02/2016
	TOWNS OF STREET		I	STREE	T ADDRESS, CITY, STATE, ZIP CO	BOC		
NAME OF 1	PROVIDER OR SUPPLIER			2230 1	EXECUTIVE DRIVE			
CENTAR	A NURSING CENTER	R HAMPTON			PTON, VA 23686			
OKNIMI	A HOROMO TENE			177		TOPOTIO		/VEX
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	1D		PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION	SHOULE	) BE	(X5) COMPLETION
PREFIX	/CACH DESIGNATION	Y MUST BE PRECEDED BY FULL	PREF TAG		CROSS-REFERENCED TO THE	APPROP	RIATE	DATE
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	1740	,	DEFICIENCY)			
			<del></del>			<del>,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,</del>		
	• ]							
F 323	Continued From pa	age 76	F	323				
		pression fractures of T12 (12th						
	Z. Norlacute comp	inferior endplate and L1 (1st						
	thoracic vertebra)	superior endplate appear to						
	Lumbar vertebra/s	had a components with						
	nave incompletely	healed components with e clefts. Please correlate with						
	edematous tractur	e Della. Flease confede mon						
	localizing sympton	ns/any mechanical pain.						
	3. Fairly large ner	nangioma in the L1 (1st						
		body, but without aggressive						
	features.	v						
	4. Multilevel dege	nerative disc disease,						
	particularly at L 4-	5 (4th and 5th Lumbar						
	vertebra), with bro	ad disc bulge and right						
	eccentric disc prof	trusion crowding right lateral						
	recess in particula	ar. Multilevel facet (joints						
	between the spine	e) degenerative changes are						
	also present, parti	icularly at L4-5 and L3-4, and		1				
	there is mild to mo	oderate central stenosis at						
	these levels secor	ndary to degenerative changes.						
	5 Lower lumbar (	dorsal paraspinal muscle						
	atrophy and asym	metric left psoas (large muscles	5					
	that run from the	umbar spine through the groin)						
	muscle atrophy.							
	Rone Density Stu	dy dated 10/22/15 at 12:43 p.m.						
	impression:	,						
	1 Based on the a	above findings, the patient has						
	low hone mass/os	steopenial based on a T-score						
1	of 1.9* at the lumb	par spine based on WHO						
	/World Health Org	nanization) criteria.						
1	No FRAX (WHO	- World Health Organization						
	Fracture Rick Acc	sessment Tool) has been given						
	se the nationt has	been treated for osteoporosis						
	and has everess	ed a prior osteoporotic fracture.						
	*Addendum:	a a bitot agraphatana						
	The impression s	hould state: a T score of -1.9						
1	Monative 1 (1) with	thin the lumbar spine indicating						
	(Ivegative 1.5) Wil	steopenia (reduced bone mass						
. 1	of looses sought	than osteoporosis)						
	or resser seventy	f osteoporosis and osteopenia						
	MAMO delibition o	i naicohornaia gira narenheria						

on DXA (al-energy X-ray absorptiometry)

1	JEPAKII	MENT OF MEDICADE	& MEDICAID SERVICES					), 0938-0391
1	ATEMENT C	S FOR MEDICARE  F DEFICIENCIES  CORRECTION	& MEDICAID SERVICES  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			INSTRUCTION	(X3) DA CO	TE SURVEY MPLETED
			495287	8, WING			05	C 5/02/2016
1		ROVIDER OR SUPPLIER	l de la constant de l		2230	ET ADDRESS, CITY, STATE, ZIP CODE EXECUTIVE DRIVE		
	SENTARA	NURSING CENTER	HAMPTON		HAM	PTON, VA 23666	and the same of th	
_	(X4) ID PREFIX TAG	CACH DESICENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPE DEFICIENCY)	ULD BE	(X6) COMPLETION DATE
м	E 323	Continued From pa	age 77	F	323			
	1 323	Condition for post	nenopausal Caucasian					
		females).						
		(T-score is the rele	evant measure when screening					
		for osteoporosis)	at an about 1 CD					
		Normal T Osteopenia	score at or above -1 SD T score between -1 and -2.5					
		SD						
		Osteoporosis:	T score at or below -2.5					
		SD	porosis Tiscore at or below					
		Established osteop 2.5 SD plus fragili						
		#127/16 at approxing the was in bed, I bathroom using water getting ready to siturned, knees but position." When a CNA #66, stated: When asked what stated: "happened CNA #66 stated the Resident's husbar with the Nurse. Wassigned to walk I No." When asked #10, CNA #66 stated #10, CNA #10, CN	conducted with CNA #66 on mately 6:20 p.m. CNA stated: got her up. We walked to alker. When got in there, as ton toilet as she (Resident #19) kled. I lowered her to a sitting asked what happened next, "Went out and got help." time the fall occurred, CNA d after dinner after 7;30 about." hat she left the room once the and arrived and began talking when CNA was asked if she was Resident #19, CNA #66 stated: d why she ambulated Resident ted: "She said and insisted I was determined to walk. The room."					
		approximately 6:3 Nursing (DON). Admission MDS (	conducted on 4/27/16 at 30 p.m. with the Director of The DON was shown the Minimum Data Set - an ocol) with an ARD (assessment					
		reference date of	9/17/15 and then the DUN was					
		acked. How shou	ald she be transferred? The					
١	1	MDS documented	d 2 staff person should transfer.					

	CENTER	S FOR MEDICARE	& MEDICAID SERVICES		A-1	The second secon	(V2) DA	TE SURVEY
	TATEMENT O	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUC		CON	MPLETED
١	AD LEVIA CAL	CONTECTION		A. BUILL		Committee of the Commit		C
-			495287	B. WING				/02/2016
	MANE OF CH	OVIDER OR SUPPLIER		L	STREET ADDRE	ESS, CITY, STATE, ZIP CODE		
					2230 EXECUT			
	SENTARA	NURSING CENTER	HAMPTON		HAMPTON, \		the second secon	
	(X4) ID PREFIX TAG	/EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC (DENTIFYING INFORMATION)	ID PREF TAG	X (EAC	OVIDER'S PLAN OF CORREC H CORRECTIVE ACTION SHO -REFERENCED TO THE APPE DEFICIENCY)	NULD RE	(X5) COMPLETION DATE
	2	, ,						
	F 323	Continued From pa		F	323			
		The DON stated: "	'No, that did not happen." The					
		DON was asked if	there is an order that the					
		Resident can ambu	late with CNA. The DON					
		stated: "Urgers size	ate High Risk for Falls. I'd also at the chart." The DON was					
		asked how does th	erapy relay updates so that the					
		Unit nurses and sta	aff know when a resident can					
		begin walking on th	ne unit. She stated: "In					
		management meet	ting if a change, it would get					
		reported for our the	erapy patients. The Unit ack to their Unit staff."					
		An interview was o	onducted on 4/27/16 at					
		approximately 7:05	p.m., with the Rehab e rehab manager was asked if			-		
		Resident #19 shou	ild have been walking on the					
		Unit on 9/25/15. S	he stated: "Typically if a					
		walker in room the	re'd be a verbal					
		communication. I'	d have to look at other notes.					
		The Nurses on the	n their clinical background and					
		knowledge of the r	patient would determine if a					
		Resident should be	e walked based on the					
Į		activities with her t	herapist."					
			was panduoted with Dactor					
		A phone interview	was conducted with Doctor 3 at approximately 11:05 a.m.		-			
		The Dr. stated tha	t the Resident fell on 9/25/15					
		and was sent to th	e Emergency Room for					
		evaluation. When	asked if the Dr. felt that the	,				
		Resident's progres	ss declined in Physical Therapy ated: "no decline in PT					
		Inhysical therapy	Let me say this, (the Resident	)				
		is now in the hosp	ital for evaluation of chest pain.					
		Cardiology, Pulmo	nary, and Nephrology					
		colleagues are as	king why are they being					
		consulted. She (F	Resident #19) is medically mily have unrealistic					
		pynertations Sha	e is from the medical end, she's	;				
		expectations. one	15 HOIL HE MOUNT CHE					

ABOPLAN OF CORRECTION  A95287  A95287  A BUILDING  STREET ADDRESS, CITY, STATE, 2P CODE  2230 EXECUTIVE DRIVE  HAMPTON, VA. 23666  CO 5/02/2/C  ANALON DESCRIPTION PROVIDER OF PROVIDERS SUMMARY STATEMENT OF DEFICIENCES (SACH DEFICIENCES) (SACH DEFICIENCY MUST BE PRECIDED BY PULL REGULATORY OR LISC IDENTIFYING INFORMATION)  F 323  Continued From page 79  mproved 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 saked 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 the Resident Manager RN #22 on 4/29/16 at approximately 12:30 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. If 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 as processment.	water	ANTO-SECURIOR SECURIOR SECURIO	FOR MEDICARE OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
MANE OF PROVIDER OR SUPPLIES  SENTARA NURSING CENTER HAMPTON  DESCRIPTION OF CORRECTION CONTINUED SENTARY STATEMENT OF DEFICIENCIES (CAY) TO SENTARY STATEMENT OF DEFICIENCY STATEMENT OF DEFOCENCIES (CAY) TO SENTARY STATEMENT OF DEFOCUTOR OF THE AMPROPRIATE (CAY) TO SENTARY STATEMENT OF DE	A	D PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	DING	
SENTARA NURSING CENTER HAMPTON    CAN ID   SUMMARY STATEMENT OF DEFICIENCES   FREE PROPERTIES   FREE P				495287	B. WING		05/02/2016
F 323  Continued From page 79  mproved 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 A/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 A/29/16 at approximately 12:30 p.m. When asked 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 pointy statement: "A resident will yeceive 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.				HAMPTON		2230 EXECUTIVE DRIVE	
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F 332 483.25(m)(1) FREE OF MEDICATION ERROR F 332 SS=D RATES OF 5% OR MORE		F 332	mproved as much anticipate further d professional opinion noted on the MRI v 9/25/15, he stated: that 8 weeks old. Of fracture. She had after the fall." The should have been therapy staff. He should have been the she is wheel chair. An interview was of Manager RN #22 decreased from therapy staff. There is wheel chair and the CNAs."  A policy and proceed following policy staff of 10/4/13 was restfollowing policy staff of 10/4/13 was restfollowed the 10/4/13 was restfollowed	as expected. I would ecline." When asked the Dr's in if the non acute Fracture was related to the fall of "No. Non acute means more obteoporosis played into the increased pain the first week Dr. was asked if the Resident walking on the Units with non stated: "No."  conducted with LPN #35 on mately 12:30 p.m. When #19 was to be walking on the ed: "She is non ambulatory." bound."  conducted with the Unit conducted with the Unit on 4/29/16 at approximately asked how information is apy, to the Units, apy lets us know and we pass edure entitled "Fall Prevention all Program with a revision date viewed. It documented the atement: "A resident will priate assessment, care and fall."  In consisting of the Administrator is briefed of the findings on imately 6:00 p.m. No further presented.	r		

5	<u> PENTERS</u>	S FUR MEDICARE	& MEDICHID SEKAICES			OND 110: 0000 0001
		F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	LTIPLE CONSTRUCTION DING	(X3) DATE SURVEY COMPLETED
			495287	B WING		C 05/02/2016
_			433201		STREET ADDRESS, CITY, STATE, ZIP CODE	03/02/2010
ì	IAME OF PE	OVIDER OR SUPPLIER				
	SENTARA	NURSING CENTER	HAMPTON		2230 EXECUTIVE DRIVE	
7	, , , , , , , , , , , , , , , , , , ,				HAMPTON, VA 23666	· No en announcement and an announcement and a
	(X4) ID FREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG		JLD BE COMPLETION
	E 222	Continued From pa	.go 90	E 3	332	
	1		**	1 .	1. Resident #22 did not receive	llc h
			isure that it is free of			u ali
		medication error ra	tes of five percent or greater.		medications per medication administration record. Nurse w	rae.
			*		educated on medication admini	
						3(10(10))
		This REQUIREMEN	VT is not met as evidenced		procedures.	
	1	by:			2. All residents receiving medic	ation
		Based on medicati	on pass observation, staff		have the potential to be affecte	
			locument review and clinical		have the potential to be anected	u.
		record review the fa	acility staff failed to ensure		3. All licensed nursing staff will	he
		they were tree from	a medication error rate of ere were 36 observed		educated regarding medication	
		g% of greater. The	inities with 2 errors, resulting in		administration.	
		a 5,55% medicatio	n error rate. The resident		Barranseacon	
		involved in the med	lication errors was Resident #		4. Director of Nursing and/or o	lesignee
		<b>2</b> 2.			will conduct medication observa	
		: 			audits 3x (times) week for 8 we	
		The findings include	ed:		Audit results will be reported at	
		Desident #00 mag	admitted to the facility on		Meeting.	
		AMESIGENT #22 Was a	ses included but were not			
		limited to Hunerten	sion, muscle weakness,		5. Completion Date: 06/10/16	
		aftercare following	joint replacement, anemia and			
		seizures.	• - · · · · · · · · · · · · · · · · · ·			
		Review of Residen	t #22's clinical record revealed			
		an Admission Com	prehensive MDS (minimum ment protocol) with an ARD			
		(becessment refere	ence date) of 4/25/16. The			
		resident's RIMS (b)	rief interview for mental status)			
		score was coded a	s a 15 which indicated no			
		dognitive impairme	nt. The resident was further			
		coded as requiring	limited assistance by one to			
		two staff members	to complete her ADLs and was	· *	:	
		continent of both b	ladder and bowel.			
		o nome to	the marries medication pass			
		On 4/2//16, during	the morning medication pass 0:00 a.m., RN (registered			
		nurse) #23 adminis	stered the following		·	
	1	Harsel Area adminis	NOTO A 11 IA 14 14 14 14 14 14 14 14 14 14 14 14 14			

### PRINTED: 05/16/2016 FORM APPROVED DEPARTIMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 DENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING\_ 05/02/2016 B. WING 495287 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2230 EXECUTIVE DRIVE SENTARA NURSING CENTER HAMPTON HAMPTON, VA 23666 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION DATE SUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECTIVE ACTION SHOULD BE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX CROSS-REFERENCED TO THE APPROPRIATE PRÉFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) TAG F 332 Continued From page 81 F 332 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 Celecoxib 100 MG- anti-inflammatory, treats arthritis Carvedilol 12.5 MG-used to treat HTN and heart

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

Dxycodone 5 MG (2 Tablets)-pain reliever often

T.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

fallure

used with aspirin

### PRINTED: 05/16/2016 FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA COMPLETED IDENTIFICATION NUMBER: A. BUILDING 05/02/2016 B. WING 495287 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2230 EXECUTIVE DRIVE SENTARA NURSING CENTER HAMPTON HAMPTON, VA 23666 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION DATE SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) F 332 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 part 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 hursing) 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. 483.25(m)(2) RESIDENTS FREE OF F 333

by:

SS=E

SIGNIFICANT MED ERRORS

any significant medication errors.

The facility must ensure that residents are free of

This REQUIREMENT is not met as evidenced

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

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

PRINTED: 05/16/2016 FORM APPROVED OMB NO. 0938-0391

			& MEDICAID SERVICES	(5/05) \$41.0	Tribi IT	ACMETOHOTICAL	/Y3) DAT	E SURVEY
		OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION		APLETED
10,0	. 10 4 4	The rest and an expect a		A. BUILL	WAO <sup></sup>	We will see the second of the second control	į.	С
			495287	B. WING		and the second s	ł	/02/2016
NAME	OF P	ROVIDER OR SUPPLIER		L	ST	REET ADDRESS, CITY, STATE, ZIP CODE		
					223	O EXECUTIVE DRIVE		
SEN	TARA	NURSING CENTER	HAMPTON		НА	MPTON, VA 23666		
(X4) PREI TAC	FIX	(FACH DEFICIENCY	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIV (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	DBE	(X5) COMPLETION DATE
F3	333	Continued From pa		F	333	1. Resident #17 is no longer at t	hic	
		significant medicat	ion error, Resident #17.				1113	
		- 100 A . 47 . 15	t and a decident and a shoot of and a			facility.		
		The facility staff did	d not administer the physician's (an anticonvulsant) 250 MG			2. All residents receiving medica	tion	
		(milligrams) used to	o treat seizures to Resident #			have the potential to be affected		
		17 from 9/7/15 thro				that the parameter a to an every	•	
						3. All licensed nursing staff will b	oe e	
		The findings includ	led:			educated regarding medication		
		1. 11	and aint investigation			administration.		
		In the course of a C	complaint investigation placed in the survey sample as					
		a closed record as	this resident was no longer at			<ol><li>Director of Nursing and/or de</li></ol>		
		the facility. Reside	ent #17 was admitted to the			will conduct medication observa		
		facility on 9/1/15 ar	nd discharged home on	:		audits 3x's (times) weekly for 6 v		
		9/21/15. Diagnose:	s for Resident #17 included but			Audit results will be reported at	QAP!	
		not limited to seizu	re disorder, enlarged prostate ymptoms, constipation, muscle			Meeting.		
		weakness, stroke, type of blood cano	and non-Hodgkin lymphoma (a			5. Completion Date: 06/10/16		
		Resident #17's Mi	nimum Data Set (an					
		assessment protoc	col) with an Assessment					
		Reference Date of	9/8/2015 coded Resident #17					
		with a BIMS (Brief	Interview Mental Status) score cognitive impairment. In					
		addition the Minim	num Data Set coded Resident					
		#17 requiring exte	nsive assistance with a two					
		iperson physical as	sistance for Activities of Daily					
		Living, Also Reside	ent # 17 was coded as					
		frequently incontit occasionally incor	nent of bladder and		٠			
		occasionany incor	million of bown.	,				
		Per physicians ord	lers Primidone 250 MG (2					
		Tablets) was order	red on 9/1/15 two times daily					
		for Resident #17 a	and discontinued on 9/4/15.					
		Another order was	started on 9/7/15 for					
		discontinued on 9/	G two times a day and					
1 1		niscouringen on a	Z II I U					

Facility ID: VA0216

### PRINTED: 05/16/2016 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 CENTER'S FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A BUILDING 05/02/2016 B. WING 495287 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PIROVIDER OR SUPPLIER 2230 EXECUTIVE DRIVE BENTARA NURSING CENTER HAMPTON HAMPTON, VA 23666 (X5) COMPLETION DATE PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECTIVE ACTION SHOULD BE (X4) IO PREFIX PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) TAG 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 prder was rewritten in computer, and said that it

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.

was acknowledged, re-entered the order awaiting

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 483.30(e) POSTED NURSE STAFFING

F 356

delivery."

-	CENTER	S FOR MEDICARE	& MEDICAID SERVICES			<u>OMB N</u>	O. 0938-0391
S	TATEMENT	.,	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	PLE CONSTRUCTION  G		ATE SURVEY OMPLETED
			495287	B. WING		0	C 5/02/2016
	NAME OF P	ROVIDER OR SUPPLIER	and the second control of the second control	L	STREET ADDRESS, CITY, STATE, ZIP CODE		
	SENTARA	NURSING CENTER	HAMPTON		2230 EXECUTIVE DRIVE HAMPTON, VA 23666		
	(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
		Continued From pa INFORMATION	ge 85	F 35	<ul> <li>1. The staffing data was immed posted at each unit.</li> </ul>	iately	
		The facility must po a daily basis: o Facility name, o The current date.	st the following information on		<ol><li>Any person desiring to review data has the potential to be affern</li></ol>		
		o The total number by the following cate	and the actual hours worked egories of licensed and staff directly responsible for		Licensed RN's were in-servic regarding regulation requireme	nt.	
		- Registered nui - Licensed pract	rses. tical nurses or licensed as defined under State law).		<ol> <li>Administrator and/or design verify posted staffing pattern 5: weekly for 5 weeks. Findings w reported at the monthly QAPI A</li> </ol>	t's (times) ill be	
		b Resident census.	·		5. Completion Date: 06/10/16		
		specified above on of each shift. Data o Clear and readabl	ice readily accessible to		3. Completion Date: 30/10/20		
		make nurse staffing	oon oral or written request, data available to the public not to exceed the community				
		staffing data for a m	aintain the posted daily nurse ainlmum of 18 months, or as w, whichever is greater.				
		by: The facility staff fail	IT is not met as evidenced led to ensure nurse staffing lily basis, and specified data				

	TATEMENT C	F DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA		LTIPLE CONSTRUCTION	(X3)	DATE SURVEY COMPLETED
Ą	ND PLAN OF	N OF CORRECTION LIDENTIFICATION NUMBER:			DING		С
			495287	B. WING			05/02/2016
-		ROVIDER OR SUPPLIER NURSING CENTER	HAMPTON		STREET ADDRESS, CITY, STATE, ZIP C 2230 EXECUTIVE DRIVE HAMPTON, VA 23666	CODE	
***	(X4) ID PREFIX TAG	(EACH DEFICIENC)	(TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAC	FIX (EACH CORRECTIVE ACTION	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
-	1	Continued From pa	<del>-</del>	F	356		
		information was obunits. Both of these The posts included category, it did not worked by each canurses, licensed progress aides.  On 5/2/16 at 10:30 was interviewed. The session of the proposting information was responsible for Monday through Flaiways posted on thave a full-time were assumed to the facility mustanton of the facility mustanton of the session of the session of the facility mustanton of the	a.m., the nurse staffing served posted on both nursing e posts were dated 4/29/16. I only the total numbers of each include the actual hours stegory to include the registered ractical nurses and certified a.m., the Director of Nursing the above findings was shared. Sees of completing the nurse of for that day. She stated she or the posting of the staffing riday. She stated it is not the weekends as she does not sekend supervisor.  ROCURE, E/SERVE - SANITARY  From sources approved or actory by Federal, State or local distribute and serve food additions.		= 371		

# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTER S FOR MEDICARE & MEDICAID SERVICES

STA	TEMENT C	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION DING	(X3) DATE COME	SURVEY PLETED
				A. DUILL	1270		)
			495287	B. WING		the state of the s	)2/2016
S		(EACH DEFICIENC		ID PREF TAG		DRRECTION IN SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
		refrigerated foods kitchen walk-in an The findings included on 4/26/16 at 12:6 kitchen was done, accompanied the observed:  1. Two pre-package to matoes were storefrigerator. Both I date of 4/12/16.  2. A clear plastic of that had been use container, was four efrigerator. The opened on 4/21/16.  3. Caramel sauce	n staff failed to ensure outdated were not stored inside the direach-in refrigerators.  ded:  50 a.m., an inspection of the The Food Service Director inspector. The following was ged trays of 2-3 pound diced ored inside the walk-in trays were dated with a use by container of cranberry sauce, and and out of the original und stored inside the walk-in cranberry sauce was dated as 6.  In not in its original container was de a reach-in refrigerator. The		<ol> <li>Outdated refrigerated immediately removed an</li> <li>All residents have the affected.</li> <li>Dining Services staff e appropriate date labeling of food.</li> <li>The Dining Services D designee will inspect the refrigerator 3 times per vidays. Findings will be rep QAPI Meeting.</li> <li>Completion Date: 06</li> </ol>	potential to be ducated on g and discarding director and/or e walk in week for 60 ported at the	
		above food items inspector during the On 4/29/16 at 12: Dietician (RD) wa	Director discarded each of the when discovered by the he tour.  03 p.m., the Registered s interviewed. The above red. The RD stated refrigerated				
The second secon		foods that are not containers should The facility policy and Procedures of product is remove label with a use b	stored in their original labe discarded within 72 hours. It be discarded within 72 hours. It titled Food Production Policies dated 11/18/15 read, in part:If a label from the original container, by date not to exceed 72 hours. ARMACEUTICAL SVC -		425		

### PRINTED: 05/16/2016 FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 **GENTER'S FOR MEDICARE & MEDICAID SERVICES** (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING B. WING 05/02/2016 495287 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2230 EXECUTIVE DRIVE SENTARA NURSING CENTER HAMPTON HAMPTON, VA 23666 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (X5) COMPLETION DATE SUMMARY STATEMENT OF DEFICIENCIES X4) (D PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 425 Continued From page 88 F 425 1. The facility failed to properly ensure SS=E ACCURATE PROCEDURES, RPH medications were available for patient #17 who no longer resides at the facility The facility must provide routine and emergency drugs and biologicals to its residents, or obtain and resident #22 medication was them under an agreement described in ordered immediately and delivered. §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State 2. All residents have the potential to be law permits, but only under the general affected. supervision of a licensed nurse. 3. All licensed LPN's and RN's were Afacility must provide pharmaceutical services educated on the policy for reordering (including procedures that assure the accurate medication. acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. 4. The Clinical Manager and/or designee will verify that medications are The facility must employ or obtain the services of ordered and available 3x (times) weekly a licensed pharmacist who provides consultation for 6 weeks. Audit findings will be on all aspects of the provision of pharmacy reported to the QAPI Meeting. services in the facility. 5. Completion Date: 06/10/16 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.

for Resident #17.

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

2. During Medication Administration Observation

-	CENTER	S FOR MEDICARE	& MEDICAID SERVICES	-	and the second control of the second second control of the second		DATE SURVEY
S	ATEMENT C	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 '	TIPLE CONSTRUCTION DING	(X3)	COMPLETED
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			495287	B. WING			05/02/2016
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			+1 A B#PT (- B)		2230 EXECUTIVE DRIVE		
	BENTARA	NURSING CENTER	HAMPION		HAMPTON, VA 23666		
	(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		A SHOULD RE	(X5) COMPLETION E DATE
	F 425	Continued From pa	ace 89	F	425		
			n (Miralax-used to relieve				:
		constipation) was r	ot available and not				
		administered twice physician's orders	a day on 4/27/16 per				
		The findings includ	ed:				
		a closed record as facility. Resident # on 9/1/15 and discluding plagnoses for Res fimited to seizure duringry tract symptoms.	placed in the survey sample as this resident is no longer at the 17 was admitted to the facility harged home on 9/21/15. ident #17 included but not isorder, enlarged prostate with oms, constipation, muscle and non-Hodgkin lymphoma (aer).	. ,			
		assessment protoc Reference Date of with a BIMS (Brief of 15 indicating no addition, the Minim #17 requiring exter berson physical as Living. Also Reside frequently incontir occasionally incon					
		Tablets) was order Resident #17 and Another order was	ders Primidone 250 MG (2 ed two times daily on 9/1/15 for discontinued on 9/4/15. started on 9/7/15 for 3 two times a day and 21/15.	•			
-		Review of the clinion 9/4/16 read reside	cal record nursing notes dated nt inquires about why				

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5	ATEMENT O	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED
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			495287	B. WING	all construction (the first construction of the construction of th		05/02/2016
-	IAME OF PE	OVIDER OR SUPPLIER		T	STREET ADDRES	S, CITY, STATE, ZIP CODE	
			standywas:		2230 EXECUTIV	E DRIVE	
1	SENTARA	NURSING CENTER	HAMPION		HAMPTON, VA		
******	(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	(EACH (	VIDER'S PLAN OF CORRECTIO CORRECTIVE ACTION SHOULD EFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETION
	F 425	Continued From pa	an 00	F 4	25:		
	F 423	· ·	e medication) had been	• •			
		discontinued last ev	vening per doctorresident				
	,	was taking it for trea	atment of seizures. In a clinical				
	ı	nursing note dated	9/21/15 Resident				
	1	#1/"complained of medication, advised	of not getting Primidone d patient that the medication				
	,	was not available e	xplained that it was not in stat				
		box either, called pl	harmacy to refillsaid that they				
			er and that the order was ed the pharmacy that the				
		order was rewritten	in computer, and said that it				
	1	was acknowledged	, re-entered the order awaiting				
	ı	delivery."					
		According to the Ph	armacy History for Order		-		
		dentification sheet	the pharmacy received a new				
	1	prder for Primidone 9/7/15 of 12:10 nm	250 MG for Resident #17 on and again on 9/21/15 at 1:22				
		bm to discontinue.	showing that the order was				
		active from 9/7/15 u					
		n an interview with	the Pharmacy Technician				
		Others #56) on 4/2	29/16 at approximately 6:00 at Resident #17 did not receive				
		pm it was noted that Primidone from 9/7.	/15 until 9/21/15. It was				
		confirmed by Other	s #56 that the order was				
	١.	submitted to the ph	armacy but not delivered it				
	1	was for Primidone 2	250 MG two times a day and eliver this daily but not in this	•			
	! :	situation it was not	delivered. Others #56 stated,				
	'	I don't know why th	ne new order on 9/7/15 was				
		efusedand we ha	ave no notes that facility called				
		until the next order	came in on 9/21/15."				
		: ;					
	] :	2. Resident #22 wa	s admitted to the facility on				
		4/18/2016. Diagnos	ses included but were not ion, muscle weakness,				
		aftercare following i	oint replacement, anemia,				

### PRINTED: 05/16/2016 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 CENTER'S FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY COMPLETED STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: A, BUILDING \_\_ 05/02/2016 B, WING 495287 STREET ADDRESS, CITY, STATE, ZIP CODE VAME OF PROVIDER OR SUPPLIER 2230 EXECUTIVE DRIVE SENTARA NURSING CENTER HAMPTON HAMPTON, VA 23666 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION DATE SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH CORRECTIVE ACTION SHOULD BE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 425 F 425 Continued From page 91 and seizures. Review of Resident # 22's clinical ecord 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

used with aspirin

Oxycodone 5 MG (2 Tablets)-pain reliever often

During the reconciliation process of the medications given and the physician orders the

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

following error was revealed:

PRINTED: 05/16/2016 FORM APPROVED OMB NO. 0938-0391

	CENTER	S FOR MEDICARE	& MEDICAID SERVICES	r			them to a tree to the total
		OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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kengeri	NAME OF PI	ROVIDER OR SUPPLIER	And the state of t	<u></u>		EET ADDRESS, CITY, STATE, ZIP CODE	
		NURSING CENTER	намртом		l	0 EXECUTIVE DRIVE	
	DENTAIN		\$ \$ \$ \$ \$		HA	MPTON, VA 23666  PROVIDER'S PLAN OF CORRECTIO	M (X5)
	(X4) ID PREFIX TAG	/FACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	DBE COMPLETION
0000	F 425	Continued From pa	ige 92	F	425		
		(17 grams) powder am and 9:00 pm) si	(gram) two times daily (9:00 tarting 4/18/2016 ".				
		administration reco was to be for 14 da powder (gram) two pm). RN #23 negle	2016 MAR (medication rd) noted the medication dose by 17 gram/dose (17 grams) times daily (9:00 am and 9:00 cted to give Resident #22 9:00 am medication				
		approximately 5:00 that Resident #22 has this am. Whe	onducted on 4/27/16 at pm with RN #23 who revealed had not received her Miralax n this error was pointed out did not have Miralax in the not give Miralax."				
		at 11:00 am it was with availability of hedications such a weeks nursing staff concernsthere is supplies are availa medication is not a werbally alerts me to a locked area on the storing medication.	Administration #2 on 4/27/16 noted that a problem exists house stock (over the counter) as Miralaxin the last 3-4 if alerted me about stock no formal process to ensure ble on each carl/unitwhen a vailable the nursing staff to order moreI will designate he unit to change this process onsand RN #21 will continue tion audits weekly and I will ay.				
		revised on 3/12/20 within one (1) hour after scheduled tim specific orders are DON (director of n	ledication Administration Policy 13 Medications must be given prior to or within one (1) hour ne of administration unless given. The Administrator and ursing) were informed of the ng on 4/28/16 at approximately				

Facility ID: VA0216

#### FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING B. WING 495287

STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2230 EXECUTIVE DRIVE

SENTARA NURSING CENTER HAMPTON HAMPTON, VA 23666 (X5) COMPLETION DATE PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES 10 (X4) 10 (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFIGIENCY)

F 425 Continued From page 93

5:38 pm. No other information was submitted by the facility.

Complaint deficiency

483.65 INFECTION CONTROL, PREVENT F 441 SPREAD, LINENS SS=D

> 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 solate 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 425

F 441

- 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

PRINTED: 05/16/2016

COMPLETED

C05/02/2016

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

ST	ATEMENT C	F DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 '		ONSTRUCTION		re survey MPLETED
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		OVIDER OR SUPPLIER			2230	ET ADDRESS, CITY. STATE. ZIP COBE EXECUTIVE DRIVE IPTON, VA 23666		
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nge over		Continued From pa Personnel must ha transport linens so infection.	age 94 andle, store, process and as to prevent the spread of	F	441			
		by: Based on observation documentation review the course of a facility staff failed the survey sample infection control properties.  A. Facility satff fahandwashing practices.	illed to follow proper tices during wound care					
		dorrect anchoring the spread of infec- The findings include						
		with readmissions Diagnoses for Res Ilmited to Multiple Urinary Tract Infec	on 2/21/14 and 2/24/15. sident #4 included but are not Sclerosis, Diabetes Mellitus, ction, Peripheral Vascular sure Ulcers (bed sores) to					
		(MDS) (an assess Assessment Refe goded Resident # Interview for Ment indicating a sever	arterly Minimum Data Set sment protocol) with an rence Date (ARD) of 1/8/16 4 as having a BIMS (Brief ial Status) of 4 out of 15 e impairment in cognition. In t #4 was coded as being totally				, , , , , , , , , , , , , , , , , , ,	

## DEPARTMENT OF HEALTH AND HUMAN SERVICES DENTERS FOR MEDICARE & MEDICAID SERVICES

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ST AN	ATEMENT O D PLAN OF	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		ONSTRUCTION	(X3) DATE SURVEY COMPLETED
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			495287	B. WING			05/02/2016
N	AME OF PR	OVIDER OR SUPPLIER			STRE	ET ADDRESS, CITY, STATE, ZIP CODE	
					2230	EXECUTIVE DRIVE	
3	ENTARA	NURSING CENTER	HAMPION		HAN	1PTON, VA 23666	
		CUMMADV STA	TEMENT OF DEFICIENCIES			PROVIDER'S PLAN OF CORRECTIO	N (X5)
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	F 441 (	Continued From pa	ge 95	F	141		
			assistance of two staff				
	ŗ	ersons for bed mo	bility. Resident #4 was coded				
			lling foley catheter and coded				
	a	s being always inc	ontinent of bowel function.				
	,	An abassation	of Decident #46 wound goes				
	_		of Resident #4's wound care and Wound Care Nurse LPN				
			Nurse) #34 was observed on				
			nately 9:30 a.m Both staff				
	r	nembers washed h	ands prior to care initation.				
		, •	ansed the bedside table and				
			wound care supplies onto the				
			as used underneath the				
			#4 was turned from her back int side. Dr. #8 took the foley				
			it's cover and tossed it on the				
			ped. After washing hands,				j. Je
			he dressing from the sacral				
			to decribe the wound LPN				y de la constant de l
			ation with some slough".				
			asurements of sacral cluster				- value
			s (cm) by 8 cm by 0.9 cm.				İ
			observed by both Dr.#8 and				
			cleansed one sacral wound it to cleanse the other sacral				
			ning hands in between each				
			nent was applied to both				
	s	acral wounds. Algi	inate dressing was applied to				
	_		and then covered with				
			nen washed her hands and				
		tated: "The sacral yound."	cluster used to be one				
	V	vouna.					
l	i	Dr. #8 was asked b	y the LPN #34 to get the				
İ			ound treatment cart. Dr. #8				
			the LPN #34. LPN #3,				
			cissors off, began to cut the				1
			ressing wrap) boot off of the				
	re	esident's leg. The	scissors were then placed on :				

PRINTED: 05/16/2016

¢	EPARTA	IENT OF HEALTH	AND HUMAN SERVICES			0	FORM APPROVEL 1938-039 MB NO. 0938	
	ENTERS	FOR MEDICARE	& MEDICAID SERVICES	T	*		(X3) DATE SURVEY	7
		F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		CONSTRUCTION	COMPLETED	Annahugung parameter san
			495287	B. WING			05/02/2016	
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					223	0 EXECUTIVE DRIVE		
9	ENTARA	NURSING CENTER	HAMPTON	and the second second second second second second second second second second second second second second seco	HAI	MPTON, VA 23666		_
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	F 441 (	Continued From pa	ge 96	F	441			
			4 cleansed vascular wounds of					Ī
			oceeded to cleanse the ankle					
	,	wound with normal	saline. Alginate dressing was					
	í	pplied, and then L	_PN #34 opened the UNNA					
	ŀ	oot without washir	ng hands. At this time LPN					
	#	34 washed hands	and proceeded to wrap the					
	1	eft foot and leg. A	After completing this LPN #34					
	ļ	laced the scissors	in a box of unopened ime the two staff members					
		ressings. At this t	were done. They responded:					
	,	Yes " At that time	, the surveyor asked about					
	1	inear open wounds	s noted at the upper end of the					
	I	oot. Dr. #8 stated	d: "I have not seen those."					
	l i	r. #8 washed her	hands and began to assess					
	1	he linear wounds.	Dr. #8 measured them at 0.3					
	(	m by 5 cm by 0.1	cm. She stated it was					
	1	drobably due the U	JNNA boot. Dr. #8 asked for					
	1	alginate dressing, v	which she applied after					
		cleaning the wound	I with normal saline and then					
	1	the UNIVA DOOL Was	s applied over the area. A as then applied over the UNNA					
	'	copan dressing wa	d care observation, Dr.#8					
		otated that the beel	and sacral wounds were					
		riressure ulcers and	d the leg were vascular ulcers.					
		1						
	,	At this time, after w	ashing hands, Dr. #8 left the					
			4 cleansed up supplies from					
		4	ed the table with sanitizer.					
	,	An Interview was co	onducted with the Wound Care					
	1	Nurse, LPN #34 on	4/28/16 at approximately 2:45					
		g.m. The LPN state	ed: "We are not allowed to					
	1	oring into the room	the disinfectant. That is why I					
		didn't wipe the siss	ors off after I finished with					
1	1	them in the room.	I didn't realize I didn't wash					
1		nny nanos aπer ope	ening the UNNA boot. I ny hands when doing each of					
1		thought i wasiled it	Yes, I would agree now that					
1	1	me sariar wounds.	(DO) I NOMIA AND STORY WHAT					

the sacral cluster has two separate wounds."

PRINTED: 05/16/2016 FORM APPROVED OMB NO. 0938-0391

		S COD MEDICARE	& MEDICAID SERVICES			O	<u>MB NO. (</u>	0938-0391
S	ATEMENT (	F DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA			CONSTRUCTION	(X3) DATE	SURVEY LETED
A	ID PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	NG		С	
			495287	B. WING				2/2016
~	VAME OF PE	OVIDER OR SUPPLIER				EET ADDRESS, CITY, STATE, ZIP CODE		
	SENTARA	NURSING CENTER	HAMPTON			0 EXECUTIVE DRIVE MPTON, VA 23666		
			TEMENT OF DEFICIENCIES	<u> </u>  D	1174	PROVIDER'S PLAN OF CORRECTION	ч	(X5)
	(X4) ID PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	COMPLETION DATE
	F 441	Continued From pa	ge 97	F4	41			
		approximately 2:55 ying in bed on her lassistant) #62 was so that I could obse An anchor was obshowever, the foley the secured in the tubins of the foley tubin she did. The CNA coutine urinary cath CNA (Certified Nurse CNA #61 came into explaining to Resid doing. The CNA the hands and look in the foley care." The Cdrainage bag on the bed and the window shouldn't be on the bag, measured the the bag in it's cover thands. The CNA of allowed the resident water, which the resident water, which the resident could be considered to following the facility entitled Perineal Carthe CNA was asked.	was made on 4/26/16 at p.m. Resident was observed back. CNA (Certified Nursing asked to pull down the covererved foley catheter tubing. erved to be placed on thigh; tubing was not correctlying. CNA #62 was asked to g a little bit either way which did not comment that the ured properly in the anchor. It is made of Resident #4's eter care being performed by sing Assistant) #61. When the room she was observed ent #4 what she would be en proceeded to wash her he Foley bag cover for the ag. She stated at that time:  I want to empty it before I do CNA located the urinary e floor between the Resident's v. The CNA stated: "This floor." The CNA emptied the amount of urine and placed: The CNA then washed her btained a basin of water, and at to test the temperature of the sident stated: "it's fine." The perform foley catheter care by are of Resident with a Foley". It is the unreses change them when					
		they need it:"	THE Harses change them when					

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

CENTER:	D FUR MEDICARE	& MEDICAID SERVICES				CIVID IA	J. 0330°039 I
	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 '	TIPLE CONSTRU			ATE SURVEY DMPLETED C
		495287	B, WING			0	5/02/2016
	OVIDER OR SUPPLIER NURSING CENTER	HAMPTON		STREET ADDR 2230 EXECU HAMPTON,		E	
 (X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX (EAC	PROVIDER'S PLAN OF CORRECTIVE ACTION SH SS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
	could observe the ubing was observe he anchor. When surveyor, LPN #39 catheter care." LPN ecure the catheter tow.  Resident #4's curredate of 4/19/16 to pof:  At risk for infectivatheter. Interventimited to: Clean arwater, Keep tubing ree of kinks or twisinfection.  Impaired skin into left leg. The goal are complications tegrity for next 90 beserve any specification control relations.	ge 98 covers of Resident #4 so that foley catheter. The catheter d to not be properly secured in this was mentioned by the stated: "The aide do foley with #39, when asked to properly in the anchor, did not know the careplan with an effective resent, documented Problem on R/T (related to) indwelling ons included but were not ound catheter with soap and below level of bladder and ts, Report any sign of the grity related to venous ulcer a lincluded: "Resident will not from impairment of skin days." The surveyor did not conterventions related to wound other than the ep it clean and dry."	F	441			
i c	Infection Preventic evision date of 5/20 locumented the foll Wash hands with I andwashing when ontaminated with p efore doing invasiv	d Hyglene/Fingernail Hyglene on and Control #204 with a 014 was reviewed. It lowing: liquid soap for routine					

### PRINTED: 05/16/2016 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY COMPLETED STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION **IDENTIFICATION NUMBER:** A. BUILDING 495287 B. WING 05/02/2016 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2230 EXECUTIVE DRIVE SENTARA NURSING CENTER HAMPTON HAMPTON, VA 23666 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION DATE SUMMARY STATEMENT OF DEFICIENCIES IO (EACH CORRECTIVE ACTION SHOULD BE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREEIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 441 F 441 Continued From page 99 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" 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.

www.cdc.gov

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.

Facility ID: VA0216

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

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	(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLÉTION
	F 441	Continued From pa	no 100	F 4	44:		
		•	•	ГЧ	41		
			thth edition of Fundamentals				
	(	of Nursing written by	y Potter and Perry; to inner tigh reduces				
	,		, thus reducing possibility of				
			so minimizes risk for bleeding,				
			rosis, and bladder spasms				
	Í	rom pressure and t	raction."				
	-	The Center of Disea	ase Control (CDC) Guideline				
			itheter associated Urinary				
			09 documents that a foley				
			g is to be secured below the				
		bladder to allow pro- o reduce infection.	per drainage, but off the floor				1
	Ų	o reduce imedion.					
			ided to the Director of				
			/27/16 at approximately 11:30 N was informed that the				
		,	id not wash her hands				lannon de la decembra de la decembra de la decembra de la decembra de la decembra de la decembra de la decembra de la decembra de la decembra de la decembra de la decembra de la decembra de la decembra de la decembra de la decembra de la decembra de la decembra de la decembra de la decembra de la decembra de la decembra de la decembra de la decembra de la decembra de la decembra de la decembra de la decembra de la decembra de la decembra de la decembra de la decembra de la decembra de la decembra de la decembra de la decembra de la decembra de la decembra de la decembra de la decembra de la decembra de la decembra de la decembra de la decembra de la decembra de la decembra de la decembra de la decembra de la decembra de la decembra de la decembra de la decembra de la decembra de la decembra de la decembra de la decembra de la decembra de la decembra de la decembra de la decembra de la decembra de la decembra de la decembra de la decembra de la decembra de la decembra de la decembra de la decembra de la decembra de la decembra de la decembra de la decembra de la decembra de la decembra de la decembra de la decembra de la decembra de la decembra de la decembra de la decembra de la decembra de la decembra de la decembra de la decembra de la decembra de la decembra de la decembra de la decembra de la decembra de la decembra de la decembra de la decembra de la decembra de la decembra de la decembra de la decembra de la decembra de la decembra de la decembra de la decembra de la decembra de la decembra de la decembra de la decembra de la decembra de la decembra de la decembra de la decembra de la decembra de la decembra de la decembra de la decembra de la decembra de la decembra de la decembra de la decembra de la decembra de la decembra de la decembra de la decembra de la decembra de la decembra de la decembra de la decembra de la decembra de la decembra de la decembra de la decembra de la decembra de la decembra de la decembra de la decembra de la decembra de la decembra de la decembra de la decembra de la decembra
	ģ	etween certain asp	ects of wound care, no verbal				
			. At this time a copy of				
		ntection Control pol vas requested.	licy related to handwashing				
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			consisting of the Administrator				
ı			oriefed of the findings on ately 6:00 p.m. No further				
-		nformation was pres					
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