STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495372	A. BUILDING ______ B. WING ______	C 03/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SENTARA WOODVIEW	103 ROSEHILL DRIVE SOUTH BOSTON, VA 24592

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid abbreviated standard survey was conducted on 3/20/18. One complaint was investigated during the survey. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The census in this 216 certified bed facility was 204 at the time of the survey. The survey sample consisted of two current resident reviews (Resident #1 and #2) and one closed record review (Resident #3).	F 000		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records,	F 842		5/1/18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed | TITLE | (X6) DATE 03/30/2018

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

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F 842	Continued From page 1 regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed	F 842		

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F 842	Continued From page 2 professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to ensure a complete and accurate clinical record for one of three residents in the survey sample. The assessment and events prompting Resident #3's discharge to the emergency room were not thoroughly documented in the clinical record. The findings include: Resident #3 was admitted to the facility on 9/12/17 and was discharged to the hospital on 12/14/17. Diagnoses for Resident #3 included chronic kidney disease, coronary artery disease, chronic anemia due to uterine bleeding, cerebrovascular accident (stroke), anxiety and history of myocardial infarction. The minimum data set (MDS) dated 10/10/17 assessed Resident #3 as cognitively intact. Resident #3's clinical record documented the resident was sent to the emergency room on 12/14/17 in response to a request from the family and chest pain. A physician's order dated 12/14/17 stated, "Send to ER [emergency room] for further evaluation. A nursing noted dated 12/14/17 at 5:20 p.m. documented the resident's color was pale, vital signs (temperature 98.4, pulse rate 60, respiration rate 18, blood pressure 112/53) and oxygen saturation at 100% on room air. A nursing note dated 12/14/17 at 6:20 p.m. documented, "Resident is to be sent to [emergency room] for treatment and evaluation. Report called to E.R. Patient transport called."	F 842	Corrective Action: On March 3/20/2018, the nurses involved in providing care to Resident #3 were re-educated concerning documentation in the medical record that includes a written progress note with supportive reasoning as to why a resident is transferred out of the facility to a higher level of care (i.e., Emergency Department) Identification: Facility residents who have been transferred to the Emergency Department within the past 30 days have had their medical records reviewed to ensure progress note documentation is present, to include rationale for the transfer out of the facility. Changes: When a facility resident is transferred to the Emergency Department, the reason for the transfer will be included within progress note documentation. Nursing staff will be re-educated by the Director of Nursing or designee concerning the requirements to include the reason for transfer to the Emergency Department within progress note documentation. Monitoring:	

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F 842	Continued From page 3 On 3/20/18 at 2:00 p.m., the nurse practitioner (NP) caring for Resident #3 on 12/14/17 was interviewed by telephone about the discharge. The NP stated the resident had been seen earlier in the day by the physician regarding low hemoglobin levels and was scheduled to go to the hospital the next day (12/15/17) for a blood transfusion. The NP stated the resident also was seen for a scheduled appointment with the cardiologist on the afternoon of 12/14/17. The NP stated after the resident returned from the cardiology appointment, the family reported the resident was not feeling well and wanted the resident sent to the hospital. The NP stated she went in to talk with the resident and when the resident reported chest pain, she immediately gave the order to send her to the hospital for evaluation and treatment. The NP stated she did not make a note about the situation but just gave the order to send the resident to the hospital On 3/20/18 at 2:55 p.m., LPN #2, caring for Resident #3 on the evening of 12/14/17, was interviewed. LPN #2 stated the family reported to her the resident was weak and "didn't look right." LPN #2 stated she checked the resident's vital signs. LPN #2 stated she told the NP who initially stated the resident was already scheduled to go to the hospital the next morning (12/15/17) for a blood transfusion due to low hemoglobin. LPN #2 stated when she went in and told the resident about the scheduled visit on 12/15/17, the resident complained of chest pain. LPN #2 stated the resident's daughter was on the phone with a family member at that time. LPN #2 stated the daughter wanted the resident sent to the emergency room. LPN #2 stated the NP then wrote the order to send the resident to the	F 842	Director of Nursing or designee will audit progress note documentation for residents transferred to the Emergency Department weekly to ensure an accurate and complete medical record. Audit findings will be reported to the Quality Assurance & Performance Improvement (QAPI) Committee for additional oversight and recommendation. The QAPI Committee will determine when to discontinue this practice.	

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F 842	Continued From page 4	F 842		

hospital. When asked if she documented any notes in the clinical record concerning the events that prompted the discharge, LPN #2 stated, "No, I didn't." LPN #2 stated she reported the vital signs and the events to the charge nurse (LPN #1) and she wrote a note.

The clinical record failed to thoroughly document events prior Resident #3's discharge to the emergency room. Nursing notes made no mention of the resident's report of chest pain or the family's request to send the resident to the emergency room.

These findings were reviewed with the administrator and director of nursing on 3/20/18 at 4:00 p.m.