

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

PRINTED: 02/05/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495270	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/23/2015
NAME OF PROVIDER OR SUPPLIER SENTARA NURSING CENTER VA BEAC			STREET ADDRESS, CITY, STATE, ZIP CODE 3750 SENTARA WAY VIRGINIA BEACH, VA 23452		
(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	F 000			
	<p>An unannounced Medicare/Medicaid standard survey was conducted 01/21/15 through 01/23/15. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. Three (3) complaints were investigated during the survey.</p> <p>The census in this 116 dual certified bed facility was 105 at the time of the survey. The survey sample consisted of 19 current Resident reviews (Residents #1 through #19) and six (6) closed record reviews (Residents #20 through #25).</p>		<p>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the fact alleged or conclusion set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of the Federal and State law.</p>		
F 280 SS=E	<p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</p> <p>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p>	F 280	<p>1. Residents #24,6,12,7,18,19,3,13,1,15,16,9,2, and 4 (and/or their responsible parties) were not invited to their care plan meetings.</p> <p>2. All residents have the potential to be affected by this deficient practice.</p> <p>3. The social worker (designee) will notify and invite residents and/or responsible parties to care plan meetings and document a note in the resident record when the invitation/notification is done.</p> <p>4. The MDS Coord. (designee) will contact 10% of those scheduled for care plan meeting each week for 4 weeks then contact four per month for two months to verify resident/responsible party was notified and report to QAPI.</p> <p>5. 03/06/2015</p>		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE 02-09-15

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 280	Continued From page 1	F 280	
<p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on a complaint investigation, resident interview, family interviews, staff interview, clinical record review, and review of the facility's policy the facility staff failed to ensure the resident, family members and/or representatives were involved in care plan meeting for 14 of 25 residents (Resident #24, 6, 12, 7, 18, 19, 3, 13, 1, 15, 16, 9, 2 and 4), in the survey sample. The facility's staff failed to invite and encourage resident and family participation in development of the care plan and to ongoing care plan meetings.</p> <p>The findings included:</p> <p>1. Resident #24 was originally admitted to the facility 5/1/14 and was discharged from the facility to home on 6/23/14. The diagnoses were CVA (cerebrovascular accident- stroke), intracranial hemorrhage with herniation, s/p (status post)craniotomy, left hemiparesis, hypertension, GERD (gastroesophageal reflux disease), and a history of drug abuse.</p> <p>The admission Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 5/8/14 coded the resident as having the ability to complete the Brief Interview for Mental Status (BIMS) and scoring 15 out of a possible 15. This indicates Resident #24's cognitive abilities for daily decision making were intact. An interview was conducted with the Social worker 1/22/15 at approximately 1:50 p.m. The Social worker was unable to provide documentation Resident #24 or his mother, or other representative were invited or participated his care plan meeting.</p> <p>An interview with the rehabilitation manager on 1/23/15 at approximately 11:20 a.m. revealed</p>			

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F 280	<p>Continued From page 2</p> <p>rehabilitation sessions were scheduled at times the mother could come to rehab with the resident. This time was 11:00 a.m. The rehabilitation manager stated she was not involved in a care plan meeting for Resident #24.</p> <p>An interview was conducted with the MDS coordinator on 1/23/15 at approximately 2:45 p.m. The MDS coordinator stated the list of residents to be reviewed by the team is generated by her to all team members and the Social Worker contacts the resident and families or other representative. The MDS coordinator was unable to produce the interdisciplinary care plan review form for Resident #24 and the Social Worker was unable to present anything indicating the resident, his mother, or other representative were invited or participated in his care plan meeting.</p> <p>Resident #24's mother stated on 1/23/15 at approximately 3:00 p.m. that she was at the facility daily and involved in the resident's care and rehabilitation program. She also stated there was never a care plan meeting held for her son and no one mentioned a meeting to her although the facility staff knew she was in the facility daily and Resident #24 wanted her involved in his care. Resident #24's mother stated the facility staff was aware when the resident was ready for discharge the resident would discharge to her home.</p> <p>Resident #24's mother also stated she learned there should have been a care plan meeting with her son and her from persons in the community familiar with long term care processes.</p> <p>2. Resident #6 was originally admitted to the facility 11/23/13 and has never been discharged from the facility. The current diagnoses are hypertension, sinoatrial node dysfunction, late effects CVA (cerebrovascular accident), hyperlipidemia, Dementia, thrombocytopenia,</p>	F 280		

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F 280	<p>Continued From page 3</p> <p>anemia and anorexia. The quarterly Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 1/6/15 coded the resident as having the ability to complete the Brief Interview for Mental Status (BIMS) and scoring 3 out of a possible 15. This indicates Resident #6's cognitive abilities for daily decision making are severely impaired. An interview was conducted with Resident #6's daughter in the facility on 1/22/14 at approximately 12:40 p.m. Resident #6's daughter had multiple concerns regarding her mother's care. She stated everyday she or her husband arrive at lunch time to feed Resident #6 and stay for the 2:00 p.m. activities to ensure she attends. The surveyor asked Resident #6's daughter if she attended the care plan meetings to voice concerns and aid in planning her mother's care. She stated she had never attended any meetings with or on behalf of her mother. The surveyor explained what a care plan meeting was and Resident #6's daughter stated again, "I have never attended a care plan meeting" and never invited to such a meeting in the 14 months her mother has been a resident of the facility. The care plan dated 1/15/15 read: the resident would remain long term care (LTC) related to Activities of daily living care (ADL) needs and supervision. The Goal read: the resident will maintain highest level of psychosocial well-being over the next 90 days 4/8/2015. Intervention #5 read: invite resident/family to care plans as scheduled. The MDS coordinator was unable to present an interdisciplinary care plan review form for Resident #6 and the Social Worker was unable to provide documentation the resident, family or representative were invited to any care plan meetings for Resident #6.</p>	F 280		

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F 280	Continued From page 4 3. Resident #12 was originally admitted to the facility 10/20/14 and has never been discharged from the facility. The current diagnoses are CVA (cerebrovascular accident -stroke) with hemiparesis, dysphagia, gastrostomy, hypertension, esophageal reflux, depressive d/o (disorder) and convulsion. The admission Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 10/27/14 coded the resident as not completing the Brief Interview for Mental Status (BIMS) because he was rarely to never understood. The staff interview was completed and indicated Resident #12 had long and short term memory problems and moderately impaired decision making abilities. An interview was conducted with Resident #12 on 1/22/15 at approximately 12:05 p.m. Resident #12 stated he had never attended a care plan meeting but would like to participate in such a meeting along with his daughter because she is his power of attorney. The MDS coordinator was unable to present an interdisciplinary care plan review form for Resident #12 and the Social Worker was unable to provide documentation the resident, family or representative were invited to the care plan meetings for Resident #12. 4. Resident #7 was originally admitted to the facility 8/23/13 and has never been discharged from the facility. The current diagnoses are diabetes insipidus, hypertension, hereditary edema of the legs, lymphedema, hypothyroidism, urinary retention, insomnia and anemia. The quarterly Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 12/31/14 coded the resident as	F 280	

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F 280	<p>Continued From page 5</p> <p>completing the Brief Interview for Mental Status (BIMS) and scoring 9 out of a possible 15. This indicates Resident #7's cognitive abilities for daily decision making are moderately impaired. Resident #7 had a care plan problem which read: Resident will remain LTC (long term care) related to ADL (activities of daily living) care needs and supervision. The goal read: Resident will maintain highest level of psychosocial wellbeing over the next 90 days 4/1/15. Intervention # 5 reads: Invite resident/family to care plans as scheduled. An interview was conducted with Resident #7 on 1/22/15 at 1:55 p.m. Resident #7 stated he thought he may have attended a meeting like that but he wasn't certain. Resident #7 interdisciplinary care plan review form did not have the resident's signature or the family member's signature for the meetings held 8/21/14 and 1/14/15. There was staff signatures only (nursing, activities, dietary and social services). The Social Worker did not provide documentation the resident, family or representative were invited to the care plan meetings for Resident #7.</p> <p>5. Resident #18 was originally admitted to the facility 10/21/14 and has never been discharged from the facility. The current diagnoses are cellulitis of the leg, atrial fibrillation, congestive heart failure, anemia, osteoarthritis, sleep apnea, hypertension, impaired renal function, vitamin B deficiency and morbid obesity. The quarterly Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 11/17/14 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 15 out of a possible 15. This indicates Resident #18's cognitive abilities for daily decision making are intact.</p>	F 280	

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F 280	<p>Continued From page 6</p> <p>An interview was conducted with Resident #18 on 1/22/14 at approximately 2:20 p.m. Resident #18 stated he couldn't say he had attended a care plan meeting but he would if he knew when and where they were being held. He also stated he would need assistance to get there because of his painful shoulders. His current method for making his needs known is through the nursing staff.</p> <p>The MDS coordinator presented an interdisciplinary care plan review form for Resident #18 on 1/23/15 at approximately 5:20 p.m. It contained signatures of the staff only (nursing, dietary and social services). There was no indication the resident or family member participated in the meeting. The Social Worker was unable to provide documentation the resident, family or representative were invited to any care plan meetings for Resident #18.</p> <p>6. Resident #19 was originally admitted to the facility 8/5/14 and has never been discharged from the facility. The current diagnoses are endstage renal disease, hypertension, PVD (peripheral vascular disease), anemia, depressive d/o (disorder), esophageal reflux, chronic pain, diabetes, macular degeneration and muscle spasms.</p> <p>The quarterly Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 11/24/14 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 15 out of a possible 15. This indicates Resident #19's cognitive abilities for daily decision making are intact.</p> <p>An Interview was conducted with Resident #19 on 1/23/15 at approximately 4:40 p.m. Resident #19 stated she had not attended a care plan meeting but she wasn't sure what it was. The surveyor</p>	F 280	

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explained the meeting to the resident and she stated she had never attended such a meeting. The MDS coordinator presented an interdisciplinary care plan review form for Resident #19 on 1/23/15 at approximately 5:20 p.m. It contained signatures of the staff only (nursing, dietary and social services). There was no indication the resident or family member participated in the meeting. The Social Worker was unable to provide documentation the resident, family or representative were invited to any care plan meetings for Resident #19. The Social worker a presented a sample letter on 1/22/15 at approximately 3:00 p.m. which is mailed to the resident's family member. The letter read: "we are having a care plan meeting on this date _____. The purpose of this care plan meeting is to discuss _____ care to date. You are encouraged to share any concerns or questions with the interdisciplinary care plan team. Please contact _____ Social Worker at _____ number if you plan to attend this meeting." On 1/23/15 at approximately 6:50 p.m. the surveyor was presented a list from the MDS coordinator of Residents who had care plan meetings scheduled for the week of 1/26/15 - 1/30/16. The MDS coordinator stated the meetings would take place on Monday 1/26/15 and Wednesday 1/28/15. The list was created and distributed on 1/21/15. The note at the bottom of the care plan list read: formal meeting day and time to be announced. On 1/23/15 at 7:00 p.m. the surveyor asked the Social Worker to provide a copy of a letter sent to a family for the care plan meeting scheduled for the week of 1/26/15 - 1/30/16. The Social Worker stated they had not been written yet but she would call all of the family members before she left on Friday night because the care plan

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meetings would not be held until Wednesday 1/28/15 or Thursday 1/29/15. On 1/23/15 at 7:00 p.m. the Administrator stated that each family would be notified and they would offer phone conferences to anyone who was unable to attend because of late notification. The facility's Care Plan policy with a revision date of 5/14/13 reads: It is the policy of Sentara Life Care Corporation to develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, nutritional and psychosocial needs. An interdisciplinary team is coordinated with the resident, family or representative (sponsor), and physician develops and maintains a comprehensive care plan for each resident. Residents' responsible parties and physicians are invited, in writing, to each appropriate care plan meeting. On 1/23/15 at approximately 7:05 p.m. The above findings were shared with the Administrator and Director of Nursing. No additional information was provided.

7. Resident #13 was 58 years old at the time of the survey and had been a resident of the facility since 11/28/11. Review of the resident's 12/26/15 comprehensive Minimum Data Set evidenced the resident scored an 11 of 15 on the brief interview for mental status indicating moderately cognitive impairment. Resident #13 was included in the survey sample for an individual resident interview. Resident #13's diagnoses included a stroke with residual right side paralysis, high blood pressure, seizure disorder and chronic pain syndrome.

During an interview with the resident on 1/23/15

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the resident was asked if he was invited to his care plan meeting. The resident responded, "what kind of meeting?" The surveyor explained the purpose of the meeting and the resident replied, "no, they never tell me nothing." The resident continued that he would like to be able to discuss his care with the facility staff.

8. Resident #3 was 49 years old and has been a resident of the facility for several years. Review of the 12/24/14 quarterly and 10/20/14 comprehensive MDS evidenced long and short term memory loss. The resident required the extensive assistance of one person with activities of daily living.

On 1/25/15 the facility Social Worker and MDS coordinator were requested to provide evidence that the resident's responsible party had been invited to Resident #3's care plan meetings. The staff was unable to produce a letter of invitation or a care plan sign in sheet evidencing the RP had attended.

9. Resident #1 was 69 years old and admitted to the facility in 2011 with a readmission date of 7/22/13. The resident had diagnoses that included a delusion disorder, high blood pressure, diabetes, depression and agitation. The 7/10/14 significant change MDS and the 1/20/15 quarterly MDS evidenced the resident scored a 9 of 15 on the Brief Interview for Mental Status indicating moderately cognitively impaired. The MDS noted the resident to have behaviors related to her mental illness and she was dependent on the staff for her activities of daily living.

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On 1/25/15 the facility Social Worker and MDS coordinator were requested to provide evidence that the resident's responsible party had been invited to Resident #3 care plan meetings. The staff was unable to produce a letter of invitation or a care plan sign in sheet evidencing the RP had attended.

10. Resident # 15 was originally admitted to the facility on 8/5/13. Diagnoses included but were not limited to hyperlipidemia (high cholesterol) and sleep apnea.

The most current MDS (Minimum Data Set - an assessment tool), with an ARD (Assessment Reference Date) of 11/18/14, assessed the Resident's BIMS (Brief Interview for Mental Status - to assess mental status) score as a 15 out of a possible 15 indicating cognitively intact.

On 1/23/15 at 8:25 p.m., the surveyor asked Resident #15 and his wife if they ever had been invited to the care plan meeting. Resident #15 and his wife indicated that they had never been invited to the care plan meeting. Resident # 15 stated, "I know what it is because I've been in long term care before."

11. Resident #16 was originally admitted to the facility in 5/17/13. Diagnoses Included but were not limited to Diabetes Mellitus type II (DM - uncontrolled blood sugars), and esophageal reflux..

Review of the resident's most recent MDS (minimum data set - an assessment protocol), with an ARD (assessment reference date) of 10/30/14. The resident's BIMS was coded as a

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F 280	Continued From page 11 15 out of a possible 15 indicating cognitively intact.	F 280		
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On 1/23/15 at 5:30 p.m., the surveyor asked Resident #15, "Have you ever been invited to your care plan meeting?" The surveyor indicated that the care plan meeting is meeting where the resident, different staff members, and possibly family members have a meeting about the type of care that is needed, various goals and objectives that need to be set, and review if any changes need to be made regarding care. Resident #15 stated, "I don't know about a care plan meeting. I haven't heard about one until now, it sounds like a good thing."

12. Resident #9 was originally admitted to the facility on 8/3/12, diagnoses included but were not limited to senile dementia and hypothyroidism.

Review of the resident's most recent MDS, a quarterly, with an ARD of 12/30/14, assessed the resident as a 6 out of a possible 15 indicating severely cognitively impaired.

On 1/22/15 at approximately 10:00 a.m., Resident #9's clinical record was reviewed. The nurse's notes dated for 1/14/15 read as follow:
"Careplan meeting held, out to PACE (Program of All-inclusive Care for the Elderly - a day program that provides health care) several times a week. Family visits once a week, uses wheelchair for mobility. Continent of bladder. Family not in attendance. PACE not represented at meeting. No significant changes with the resident. She may attend some activities but depends on her availability due to PACE.

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F 280	<p>Continued From page 12</p> <p>The Interdisciplinary Care Plan Review sheet was reviewed on 1/23/15 at approximately at 5:30 p.m. The care plan review sheet evidenced that a family member was not present at the quarterly care conference on 9/10/14, or the quarterly care conference on 1/14/15.</p> <p>13. Resident #2 was admitted to the facility on 09/22/14 after a stay at the hospital. Diagnoses included but were not limited to Diabetes Mellitus, Osteomyelitis of a lower extremity, Acute Kidney Failure, history of a CVA (stroke), failure to thrive, gastrostomy, pressure ulcers, dementia, Chronic DVT (deep vein thrombus)/Embolis in lower extremity and Hypertension.</p> <p>Review of the resident's clinical record revealed the most recent comprehensive MDS (minimum data set-an assessment protocol) was a Significant Change. The ARD (assessment reference date) was 09/29/14. The resident was not able to complete the BIMS (brief interview for mental status) and therefore, was coded as having short and long-term memory loss and severely impaired cognition regarding safe and consistent daily decision making. The resident was further noted to be coded as requiring extensive to dependent assistance with one to two staff members for the completion of ADLs (activities of daily living). The resident was also coded as requiring a Foley catheter for bladder control due to a sacral Stage III pressure ulcer and being incontinent of bowel.</p> <p>Review of Section V-CAA (care area assessment) Summary under V 02000 item C the</p>	F 280		

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F 280	<p>Continued From page 13</p> <p>Signature of the Person completing the Care Plan Decision was 10/02/14. A Care Plan Meeting for this assessment was 10/07/2014. No indication could be located to verify if Resident #2 or the resident's RP (responsible party-son) had been invited to attend the care plan meeting or had attended the care plan meeting.</p> <p>Further review of Resident #2's clinical record revealed a Quarterly MDS with an ARD of 11/21/14. The resident's BIMS score had been coded as a 4 which indicated severe cognitive impairment. The resident still required extensive to dependent assistance of one to two staff members to complete ADLs. The resident was coded as having one Stage II healed pressure ulcer. The resident still had a Foley catheter for urine control and continued to be incontinent of bowel.</p> <p>Review of the Care Plan noted that it had not been reviewed and had a goal date of 12/30/2014 for this Quarterly Assessment.</p> <p>An interview had been conducted on 01/23/15 at approximately 2:15 with the MDS Coordinator RN (registered nurse). When asked about the status regarding invitations and RP and resident being part of the care plan she stated: "The Social Worker used to handle the invitations and we have a different Social Worker now. When the RP and the resident did not attend I thought they had chosen not to attend. I was not aware the invitations had not been sent to either party and am not able to produce any documentation that noted that the parties had been invited."</p> <p>14. Resident #4 was originally admitted to the</p>	F 280	
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F 280	<p>Continued From page 14</p> <p>facility on 09/26/11 and had most recently been readmitted on 07/05/14 and had been given Hospice status. Diagnoses included but were not limited to Hypertension, Atrial Fibrillation, dementia with Behaviors, Coronary Artery Disease and a diagnosis of a CVA (stroke) which qualified the resident for Hospice.</p> <p>Review of the resident's clinical record revealed an Annual MDS (minimum data set-an assessment protocol) with an ARD (assessment reference date) of 08/16/2014. The resident was coded with both short and long-term memory loss and was severely impaired cognitively regarding safe and consistent daily decision making. The resident was coded as requiring extensive assistance of one to two staff members to meet ADLs (activities of daily living). Also, the resident was coded as being incontinent of both bladder and bowel.</p> <p>The care plan was reviewed and showed that Resident #4 or her RP (responsible party) daughter had not attended.</p> <p>Additional review of the resident's clinical record revealed a Quarterly MDS with an ARD of 11/07/14. The resident had not had any changes in her mental status or in the extensive assistance of one to two staff members to meet ADLs (activities of daily living). The resident continued to be incontinent of both bladder and bowel and also remained on Hospice services.</p> <p>Review of the Interdisciplinary Care Plan Review dated 11/26/14, did not indicate the resident or the RP had been in attendance.</p> <p>An interview had been conducted on 01/23/15 at</p>	F 280		

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F 280	Continued From page 15 approximately 2:15 with the MDS Coordinator RN (registered nurse). When asked about the status regarding invitations and RP and resident being part of the care plan she stated: "The Social Worker used to handle the invitations and we have a different Social Worker now. When the RP and the resident did not attend I thought they had chosen not to attend. I was not aware the invitations had not been sent to either party and am not able to produce any documentation that noted that the parties had been invited." The Administrator and the DON (director of nursing) was informed of the findings at a briefing on 01/23/14 at approximately 7:00 p.m. No additional information was submitted for review.	F 280		
F 309 SS=D	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 observation, staff review, clinical record review, and facility document review, facility staff failed to follow physician's orders for 1 of 25 residents in the survey sample, Resident #16. 1. Staff gave Novolog insulin and Prilosec after a meal was consumed by Resident #16.	F 309	1. Resident #16 did not receive medications and accucheck prior to meal as ordered. 2. Residents requiring medications and accuchecks prior to a meal are at risk for this deficient practice. 3. Nurses will be educated on providing medications and obtaining accuchecks prior to meals as ordered. 4. The SDC (designee) will observe 5 accuchecks and 5 ac medications weekly for four weeks then monthly for two months and report to QAPI. 5. 03/06/2015.	

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F 309	<p>Continued From page 16</p> <p>The findings included:</p> <p>Resident #16 was originally admitted to the facility in 5/17/13. Diagnoses included but were not limited to Diabetes Mellitus type II (DM - uncontrolled blood sugars), and esophageai reflux.</p> <p>Review of the resident's most recent MDS (minimum data set - an assessment protocol), with an ARD (assessment reference date) of 10/30/14 revealed the resident's BIMS (Brief Interview for Mental Status - an interview to assess mental status), was coded as a 15 out of a possible 15. This indicated the resident was cognitively intact. The resident was coded as having Gastroesophageal Reflux Disease (GERD) or ulcer and DM (Diabetes Mellitus).</p> <p>On 1/22/15 at 5:25 p.m., the surveyor and LPN (Licensed Practical Nurse) # 21 went into Resident #21's room. It was observed that Resident # 21 had her dinner tray on her bedside table and had already eaten dinner; the resident indicated that she ate spinach, soup, and some meat. LPN # 21 proceeded to take Resident # 21's blood sugar through finger stlck via an accucheck machine and the blood sugar result was 190. LPN # 21 proceeded to give Resident # 21 her medications which included one tablet of Prilosec (medication to treat GERD) 40 mg (milligrams).</p> <p>The surveyor asked LPN # 21, "Was (Resident # 21's name) supposed to get coverage (sliding scale insulin)?" LPN # 21 checked the MAR (Medication Administration Record) and stated, "Let me check...yes she is, she's supposed to get</p>	F 309	

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F 309	Continued From page 17 1 unit of Novolog (a fast acting insulin given before meals), and it's supposed to be given before dinner." The surveyor asked LPN #21, "When are accuchecks supposed to be done?" LPN #21 stated, "Accuchecks are supposed to be before dinner. I usually catch them before dinner." LPN # 21 went to the stat box to get the Novolog insulin at 6:00 p.m.. On 1/23/15 at approximately 9:45 a.m., the physician's orders were checked. The physician's orders for January 2015 read as follows: Scheduled for 4:30 p.m. "Fasting blood sugar, accucheck (blood sugar check using portable machine) before meals and at bedtime" Scheduled for 4:30 p.m. "Novolog inj (injection) 100/ml (100 per milliliter) Sliding scale (insulin dosage depends on the level of blood sugar), 150-199 (blood sugar number) 1UN (unit)." (For blood sugar of 190 1 unit of insulin was to be given) Scheduled for 4:30 p.m. "Omeprazole (Prilosec) capsule 40 mg (milligrams) take 1 capsule by mouth twice a day before meals." The MAR was checked and evidenced that LPN #21 signed the MAR to indicate that the Novolog insulin was given. On 1/23/15 at approximately 9:30 a.m., the surveyor asked Resident #16, "Did you get insulin around 6:00 p.m. last night?" Resident #16 stated, "Yes I did, I think it was one or two units." On 1/23/15 at approximately 10:00 a.m., Resident	F 309		

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F 309 Continued From page 18

F 309

#16's nurse's notes were reviewed. The nurse's notes evidenced that LPN # 21 did not call the physician to notify him that the Novolog insulin and Prilosec were given after Resident # 16 consumed dinner.

On 1/23/15 at approximately 5:00 p.m., the Administrator and Director of Nursing (DON) were made aware of the findings.

The Administration provided the facility policy titled, "Medication Administration", with a revision date of 3/12/13. The facility policy reads as follows:

"Policy Statement: Medications will be administered in accordance with prescribed orders, manufacturer's specifications regarding the preparation and administration of the drug or biological and accepted professional standards and principles. Medications must be given within one (1) hour prior to, or within (1) hour after scheduled time of administration unless specific orders are given (a.c., before meals)."

The Administration provided the facility policy titled, "Nursing Documentation", with a revision date of 10/4/13. The facility policy reads as follows:

"Policy statement: Define minimal documentation requirements.
NF (Nursing Facility) Residents: Narrative note is required at least every thirty days and more frequently when necessary. (Address decision making ability, memory/cognition, behaviors, ADL's (activities of Daily Living), pain, and any changes"

No additional information was given by the time of

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F 309	Continued From page 19 exit.	F 309		
F 332	483.25(m)(1) FREE OF MEDICATION ERROR SS=D The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on medication pour and pass observation, staff interview, facility document review and clinical record review the facility staff failed to ensure they were free of medication error rates less than 5%. There were 31 observed medication opportunities with 2 errors, resulting in a 6.45% medication error rate. The medication errors involved 1 of 24 residents in the survey sample, Resident #16. The findings included: Resident #16 was originally admitted to the facility on 5/17/13. Diagnoses included but were not limited to Diabetes Mellitus type II (DM - uncontrolled blood sugars), and esophageal reflux.. Review of the resident's most recent MDS (minimum data set - an assessment protocol), with an ARD (assessment reference date) of 10/30/14. The resident's BIMS (Brief Interview for Mental Status - an interview to assess mental status), was coded as a 15 out of a possible 15 indicating cognitively intact. The resident was coded as having Gastroesophageal Reflux Disease (GERD) or ulcer and DM.	F 332	1. Resident #16 did not receive medications and accucheck prior to meal as ordered. 2. Residents requiring medications and accuchecks prior to a meal are at risk for this deficient practice. 3. Nurses will be educated on providing medications and obtaining accuchecks prior to meals as ordered. 4. The SDC (designee) will observe 5 accuchecks and 5 ac medications weekly for four weeks then monthly for two months and report to QAPI. 5. 03/06/2015.	

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F 332	Continued From page 20	F 332	<p>On 1/22/15 at 5:25 p.m., the surveyor and LPN (Licensed Practical Nurse) # 21 went into Resident #21's room. It was observed that Resident # 21 had her dinner tray on her bedside table and had already eaten dinner. The resident indicated that she ate spinach, soup, and some meat. LPN # 21 proceeded to take Resident # 21's blood sugar through finger stick via an accucheck machine, the blood sugar result was 190. LPN # 21 proceeded to give Resident # 21 her medications which included one tablet of Prilosec (medication to treat GERD) 40 mg (milligrams).</p> <p>The surveyor asked LPN # 21, "Was (Resident # 21's name) supposed to get coverage (sliding scale insulin)?" LPN # 21 checked the MAR (Medication Administration Record) and stated, "Let me check...yes she is, she's supposed to get 1 unit of Novolog (a fast acting insulin given before meals), and it's supposed to be given before dinner."</p> <p>LPN # 21 went to the stat box to get the Novolog insulin at 6:00 p.m.</p> <p>On 1/23/15 at approximately 9:45 a.m., the physician's orders were checked.</p> <p>The physician's orders for January 2015 read as follows: Scheduled for 4:30 p.m. "Fasting blood sugar, accucheck (blood sugar check using portable machine) before meals and at bedtime" Scheduled for 4:30 p.m. "Novolog inj (inject) 100/ml (100 per milliliter) Sliding scale (insulin dosage depends on the level of blood sugar), 150-199 (blood sugar number) 1UN (unit)." (For</p>	

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F 332	<p>Continued From page 21</p> <p>blood sugar of 190 1 unit of insulin was to be given) Scheduled for 4:30 p.m. "Omeprazole (Prilosec) capsule 40 mg (milligrams) take 1 capsule by mouth twice a day before meals."</p> <p>The MAR was checked and evidenced that LPN #21 signed the MAR to indicate that the Novolog insulin was given.</p> <p>On 1/23/15 at approximately 9:30 a.m., the surveyor asked Resident #16, "Did you get insulin around 6:00 p.m. last night?" Resident #16 stated, "Yes I did, I think it was one or two units."</p> <p>On 1/23/15 at approximately 5:00 p.m., the Administrator and Director of Nursing (DON) were made aware of the findings.</p> <p>The Administration provided the facility policy titled, "Medication Administration", with a revision date of 3/12/13. The facility policy reads as follows: "Policy Statement: Medications will be administered in accordance with prescribed orders, manufacturer's specifications regarding the preparation and administration of the drug or biological and accepted professional standards and principles. Medications must be given within one (1) hour prior to, or within (1) hour after scheduled time of administration unless specific orders are given (a.c., before meals).</p> <p>No additional information was given by the time of exit.</p>	F 332	
F 441	483.65 INFECTION CONTROL, PREVENT SS=E SPREAD, LINENS	F 441	

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F 441	<p>Continued From page 22</p> <p>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.</p> <p>(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.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p>	F 441	<ol style="list-style-type: none"> 1. Nurse #21 and the lab technician did not wash hands as required. 2. All residents have the potential to be affected by this deficient practice. 3. All staff and the lab technicians will be educated on hand hygiene requirements. 4. The SDC (designee) will conduct six hand hygiene observations weekly for four weeks then monthly for two months and report to QAPI. 5. 03/06/015. 	

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NAME OF PROVIDER OR SUPPLIER SENTARA NURSING CENTER VA BEAC			STREET ADDRESS, CITY, STATE, ZIP CODE 3750 SENTARA WAY VIRGINIA BEACH, VA 23452		
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F 441	Continued From page 23 This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility document review facility staff failed to ensure proper handwashing to prevent the spread of infections for 3 out of 25 residents of the survey sample, Resident #16, Resident #14, and Resident #15. 1. LPN #21 did not wash her hands per policy after she took Resident #16's blood sugar via accucheck machine (blood sugar machine). 2. LPN #21 did not wash her hands per policy after she took Resident #14's blood sugar via accucheck machine and the lab technician did not wash her hands after she took Resident #14's blood. 3. The lab technician did not wash her hands after she took Resident #15's blood. The findings included: 1. Resident #16 was originally admitted to the facility in 5/17/13. Diagnoses included but were not limited to Diabetes Mellitus type II (DM - uncontrolled blood sugars). Review of the resident's most recent MDS (minimum data set - an assessment protocol), with an ARD (assessment reference date) of 10/30/14 revealed the resident's BIMS (Brief Interview for Mental Status - an interview to assess mental status), was coded as a 15 out of a possible 15. This indicated the resident was cognitively intact. On 1/22/15 at 5:25 p.m., LPN #21 put on gloves and took Resident #16's blood sugar with an accucheck machine (blood sugar machine). After LPN #21 took the resident's blood sugar she took	F 441			

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F 441	<p>Continued From page 24</p> <p>her gloves off. It was observed that LPN #21 washed her hands for five seconds.</p> <p>On 1/22/15 at approximately 5:45 p.m., the surveyor notified LPN #21 of the observation.</p> <p>The Administrator and Director of Nursing were made aware of the findings on 1/23/15 at approximately 5:00 p.m.</p> <p>The facility administration provided a facility policy titled, Procedure: Glucose Monitoring - Centers, with a revision date of 12/10/13. The policy reads as follows: Purpose: Blood for serum glucose levels will be obtained in aseptic manner. Discard disposable equipment. Wash hands.</p> <p>2. Resident #14 was originally admitted to the facility on 12/30/14 and readmitted on 1/19/15. Diagnoses included but were not limited to diabetes mellitus type 2, anemia, and hyperlipidemia (high cholesterol).</p> <p>The MDS (Minimum Data Set) was not yet completed since the resident was a new admission.</p> <p>On 1/22/15 at approximately 5:15 p.m., LPN #21 put on gloves, and took Resident #14's blood sugar with an accucheck machine (blood sugar machine). After LPN #21 took the resident's blood sugar she took her gloves off. It was observed that LPN #21 washed her hands for six seconds.</p> <p>On 1/23/15 at approximately 9:10 a.m., the surveyor observed the lab technician apply gloves</p>	F 441	

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	<p>F 441 Continued From page 25</p> <p>and draw blood from Resident #14's arm. After the blood was taken, the lab technician took the gloves off, did not wash her hands with soap and water, and did not use hand sanitizer that was readily available throughout the facility hallways. The lab technician proceeded to walk down the hall.</p> <p>3. Resident # 15 was originally admitted to the facility on 8/5/13. Diagnoses included but were not limited to hyperlipidemia (high cholesterol) and sleep apnea.</p> <p>The most current MDS (Mlinimum Data Set - an assessment tool), with an ARD (Assessment Reference Date) of 11/18/14, assessed the Resident's BIMS (Brief Interview for Mental Status - to assess mental status) score as a 15 out of a possible 15 indicating cognitively intact.</p> <p>On 1/23/15 at 9:05 a.m., the surveyor observed the lab technician draw blood from Resident #15's arm wearing gloves. After the lab technician drew the blood, she took the gloves off and walked down the hall. The lab technician did not wash her hands with soap or water, and did not use the hand sanitizer that was readily available in the hail. The lab technician stopped at the nurse's station to organize paper work, and proceeded to walk down the hall to the next resident's room.</p> <p>On 1/23/15 at approximately 10:00 a.m., the surveyor asked the administrative team, "Who draws the labs here?" The administrative team indicated the Sentara's lab services would send someone to do their labs.</p>	F 441	

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F 441	Continued From page 26 On 1/23/15 at approximately 10:15 a.m., the lab technician supervisor was interviewed. The lab technician supervisor indicated that employees should wash their hands properly before and after lab services are completed, and that if available hand sanitizer could also be used. The lab services supervisor indicated that he would educate the staff member that was observed earlier in the day. On 1/23/15 at approximately 5:00 p.m., the administrative team was made aware of the findings. The administrative team evidenced the policy titled, "Hand Hygiene, Section: Infection Control, with a revision date of 3/8/11. The policy read as follows: "Purpose: Guidelines are provided for proper and effective hand hygiene to prevent transmission of infections. Appropriate 15 second hand washing must be performed under the following conditions: Before performing invasive procedures (urinary catheterizations, insertion of IV) Before performing resident care Performed by: All Staff Procedure: Required Action Steps 1. Lather hands with soap and rub together vigorously using friction to all surfaces for 15 seconds under running water at comfortable temperature. 2. Rinse hands thoroughly under running water. Hold hands lower then wrists and do not allow fingertips to touch inside of sink. 3. Dry hands thoroughly with paper towels and then turn off faucets with those towels. 4. Discard towels into trash. 5. In areas/rooms where sinks are not readily	F 441			

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F 441	Continued From page 27 available, a waterless antiseptic hand preparation may be used between tasks that would normally require hand washing. If hands are visibly soiled, soap and water must be used at the first opportunity."	F 441			
F 514 SS=D	Complaint deficiency 483.75(I)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on observation, clinical record review, and staff interview the facility staff failed to ensure the clinical record was accurate for 1 of 25 residents in the survey sample, Resident #16. The findings included: Resident #16 was originally admitted to the facility in 5/17/13. Diagnoses included but were not limited to Diabetes Mellitus type II (DM -	F 514	1. The medication record for Resident #16 did not accurately reflect the time that a medication and an accucheck was administered. 2. All residents are at risk for this deficient practice. 3. Nurses will be educated on requirement to accurately record the time a medication or acucheck is administered. 4. The SDC (designee) will observe administration and documentation of ac medications and accucheck on five residents weekly for four weeks then five monthly for two months and report to QAPI. 5. 03/06/2015.		

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F 514	Continued From page 28 uncontrolled blood sugars). Review of the resident's most recent MDS (minimum data set - an assessment protocol), with an ARD (assessment reference date) of 10/30/14. The resident's BIMS (Brief Interview for Mental Status - an interview to assess mental status), was coded as a 15 out of a possible 15 indicating cognitively intact. The resident was coded as having DM. On 1/22/15 at 5:25 p.m., the surveyor and LPN (Licensed Practical Nurse) # 21 went into Resident #21's room. It was observed that Resident # 21 had her dinner tray on her bedside table and had already eaten dinner, the resident indicated that she ate spinach, soup, and some meat. LPN # 21 proceeded to take Resident # 21's blood sugar through finger stick via an accucheck machine; the blood sugar result was 190. The surveyor asked LPN # 21, "Was (Resident # 21's name) supposed to get coverage (sliding scale)?" LPN # 21 checked the MAR (Medication Administration Record) and stated, "Let me check...yes she is, she's supposed to get 1 unit of Novolog (a fast acting insulin given before meals), and it's supposed to be given before dinner." LPN # 21 went to the stat box to get the Novolog insulin at 6:00 p.m. On 1/23/15 at approximately 10:45 a.m., the surveyor asked Resident #16, "Did you get insulin around 6:00 p.m. last night?" Resident #16 stated, "Yes I did, I think it was one or two units."	F 514			

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F 514 Continued From page 29

F 514

The January MAR was checked and evidenced that LPN #21 signed the MAR to indicate that the Novolog insulin was given. LPN #21 initialed the Novolog insulin in the 4:30 p.m. time slot. The MAR evidenced that the Novolog insulin was to be given at 6:30 a.m., 11:30 a.m., 4:30 p.m., and 9:00 p.m. if sliding scale insulin was needed.

On 1/23/15 at approximately 5:00 p.m., the Administrator and DON (Director of Nursing) was notified of the findings. The surveyor showed the administrative team how LPN #21 initialed the Novolog insulin in the 4:30 pm time slot.

The DON indicated that medications can be given one hour before and one hour after the ordered time.

State of Virginia

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F 000 Initial Comments F 000

An unannounced biennial State Licensure Inspection was conducted 01/21//15 through 01/23/15. The facility was not in compliance with the Virginia Rules and Regulations for the Licensure of Nursing Facilities.

The census in this 116 dual certified bed facility was 105 at the time of the survey. The survey sample consisted of 19 current Resident reviews (Residents #1 through #19) and six (6) closed record reviews (Residents #20 through #25).

F 001 Non Compliance F 001

The facility was out of compliance with the following state licensure requirements:

This RULE: is not met as evidenced by: The facility was not in compliance with the following Virginia Rules and Regulations for the Licensure of Nursing Facilities:

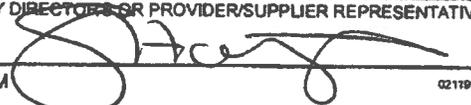
Resident Services
Director of Nursing
12VAC5-371-200 (E)

Based on observations, staff interviews and facility documentation review the facility failed to notify the State Agency in writing within five (5) days of a vacancy in the director of nursing position which should have included the name and Virginia license number of the individual appointed to serve as director nursing, and whether the appointment is permanent or temporary.

The findings included:

An Entrance Interview was conducted on 01/21/15 at approximately 7:30 a.m., with the Administrator.

1. Facility failed to notify state agency timely of director of nursing vacancy and the individual appointed temporarily or permanently.
2. All residents are risk.
3. The Administrator has reviewed the regulatory requirement 12VAC5-371-200 (E).
4. Notification regarding change in Director of Nursing will be reported at monthly QAPI meeting with state agency notification verified.
5. 03/06/2015

LABORATORY DIRECTOR OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Administrator	(X6) DATE 2/9/15
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State of Virginia

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F 001	<p>Continued From Page 1</p> <p>During the interview the Administrator stated: "We have an interim DON (director of nursing) as the previous DON left the facility on 11/2014." When asked if the appropriate notifications were made to the State Agency she stated, "I'm not sure as I am new here myself. I would think that Corporate would have taken care of it. I will find out."</p> <p>An interview was conducted on 01/21/15 at approximately 12:00 p.m., with the Administrator. The Administrator stated: "I contacted our Corporate office and discovered that the new Interim DON's start date of taking over the DON position on 11/16/14, and license number had not been sent to the State. I will take care of it today.</p> <p>Nursing Services 12 VAC 5-371-220 (B) Cross Reference F-309</p> <p>Infection Control 12 VAC 5-371-180 (C 3) Cross Reference F-441</p> <p>Clinical Records 12 VAC 5-371-360 (E. 8) Cross Reference F-514</p> <p>12 VAC 5-371-250 (I) Cross reference F280</p>	F 001	<p>Nursing Services 12 VAC 5-371-220 (B): please see POC for F - 309</p> <p>Infection Control: please see POC for F-441</p> <p>Clinical Records: please see POC for F-514 and F-280</p>	