

State of Virginia

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: VA0213	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/26/2017
--	---	---	---

NAME OF PROVIDER OR SUPPLIER SENTARA NURSING CENTER NORFOLK	STREET ADDRESS, CITY, STATE, ZIP CODE 249 SOUTH NEWTOWN RD NORFOLK, VA 23502
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
F 000	<p>Initial Comments</p> <p>An unannounced State licensure inspection was conducted 1/24/17 through 1/26/17. Six complaints were investigated during the survey. The facility was not in compliance with the following Virginia Rules and Regulations for the Licensure of Nursing Facilities.</p> <p>The Life Safety Code survey/report will follow.</p> <p>The census in this 197 certified bed facility was 167 at the time of the survey. The survey sample consisted of 29 resident reviews; 23 current residents (Residents #1 through 23) and 6 closed record reviews (Residents #24 through #29).</p>	F 000		
F 001	<p>Non Compliance</p> <p>The facility was out of compliance with the following state licensure requirements:</p> <p>This RULE: is not met as evidenced by: 12 VAC 5-371-180 A & B. Cross Reference F441 12 VAC 5-371-220 (C.1) Nursing Services Please Cross Reference F 314 12 VAC 5-371-220 (H). Nursing Services. Please Cross- Reference to F-157. 12 VAC 5-371-370 A, C & G. Cross Reference F253. 12 VAC 5-371-370 B. Cross Reference F323 COV 32.1-138.1 (6,10, &12). Please Cross-Reference to F-242</p>	F 001	<p>12 VAC 5-371-180 A&B F441 SS=D 483.80(a)(1)(2)(4)&(f) INFECTION CONTROL, PREVENT SPREAD, LINENS</p> <p>1a. Resident #2 continues to reside in the facility. Resident #2 is receiving dressing changes in accordance with physician's orders and established infection control practices. Employee #1 was re-educated by the Staff Development Coordinator on 1/26/17 with return demonstration for competency with performing a clean dressing change.</p> <p>1b. Residents with orders for</p>	3/6/17

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

TITLE

(X6) DATE

Electronically Signed

02/17/17

State of Virginia

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: VA0213	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/26/2017
--	---	---	---

NAME OF PROVIDER OR SUPPLIER SENTARA NURSING CENTER NORFOLK	STREET ADDRESS, CITY, STATE, ZIP CODE 249 SOUTH NEWTOWN RD NORFOLK, VA 23502
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
F 001	Continued From page 1	F 001	<p>dressings changes have the potential to be affected. The Clinical Managers have completed TX Observations with Licensed Nurses three times per week. No other residents were affected.</p> <p>1c. The Staff Development Coordinator will provide education to the staff regarding the established Infection Control Guidelines; to include maintaining infection control during dressing changes. The Licensed Nurse will perform treatments in accordance with the physicians orders and the established infection control practices.</p> <p>1d. The Staff Development Coordinator/ Designee will conduct Treatment Observations with three Licensed Nurses weekly for four weeks, then monthly to validate adherence to established Infection Control Practice standards. Findings will be submitted to QAPI Committee for review and further recommendations.</p> <p>F441 SS=D 483.80(a)(1)(2)(4)¿(f) INFECTIOUS CONTROL, PREVENT SPREAD, LINENS</p> <p>2a. The facility staff removed the identified shower mat from the shower bed and properly disposed of the mat. The shower mat has been</p>	

State of Virginia

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: VA0213	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/26/2017
--	---	---	---

NAME OF PROVIDER OR SUPPLIER SENTARA NURSING CENTER NORFOLK	STREET ADDRESS, CITY, STATE, ZIP CODE 249 SOUTH NEWTOWN RD NORFOLK, VA 23502
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
F 001	Continued From page 2	F 001	<p>replaced.</p> <p>2b. Residents who utilize the shower bed have the potential to be affected. No residents were affected.</p> <p>2c. The Staff Development Coordinator will provide education to the staff regarding the process for ensuring that the resident care environment remains free from accidental hazards; to include ensuring that equipment is maintained in proper operational order.</p> <p>2d. The Maintenance Director/Designee will conduct Environment of Safety Checklist Hazard Surveillance Rounds Weekly for four weeks, then monthly to validate that the environment is free of accidental hazards. Findings will be reported to the Safety Committee and QAPI Committee for review and further recommendations.</p> <p>12 VAC 5-371-220 (C.1) F314 SS=G 483.25(b)(1) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES</p> <p>1. Resident #9 continues to reside in the facility. The resident was readmitted to the facility on 12/06/2016. The Licensed Nurse Identified the presence of a Stage II pressure injury to the right ischium upon readmission; treatment orders</p>	

State of Virginia

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: VA0213	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/26/2017
--	---	---	---

NAME OF PROVIDER OR SUPPLIER SENTARA NURSING CENTER NORFOLK	STREET ADDRESS, CITY, STATE, ZIP CODE 249 SOUTH NEWTOWN RD NORFOLK, VA 23502
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
F 001	Continued From page 3	F 001	<p>were obtained and implemented along with an Interim Plan of Care to address the identified pressure injury; members of the Wound Care Team monitored the wound during Weekly Wound Rounds; treatment Orders and the plan of care were revised as indicated; resulting in resolution of the wound within 30 days. The wound was resolved prior to the time of the survey.</p> <p>2. Residents with actual or risk for alterations in skin integrity have the potential to be affected. No other residents were affected.</p> <p>3. The Staff Development Coordinator/ Designee has provided education to the nursing staff regarding the established practice standards that govern promoting and maintaining Skin Integrity, Wound Prevention and Wound Management. The Licensed Nurse will conduct a Skin Assessment/Evaluation upon admission, Quarterly and with a Significant Change in Condition. The Licensed Nurse will obtain and implement appropriate treatment orders for residents identified as having alterations in skin integrity. The IDT team will develop and implement an individualized, resident-centered plan of care to address the residents identified actual and/or risk factors for alterations in skin integrity. The Licensed Nurse will conduct weekly Head-to-To Skin Inspections in all</p>	

State of Virginia

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: VA0213	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/26/2017
--	---	---	---

NAME OF PROVIDER OR SUPPLIER SENTARA NURSING CENTER NORFOLK	STREET ADDRESS, CITY, STATE, ZIP CODE 249 SOUTH NEWTOWN RD NORFOLK, VA 23502
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
F 001	Continued From page 4	F 001	<p>residents. The Wound Care Team will evaluate progression of Wounds during Weekly Wound Rounds. The Licensed Nurse will complete the Weekly Wound Progress Report for residents with alterations in skin integrity.</p> <p>4. The Clinical Manager will review 100% of the Medical records for residents with alterations in Skin Integrity weekly for four weeks, then monthly to Validate adherence to the established practice standards for Skin Integrity. Findings will be submitted to the QAPI for review and further recommendations.</p> <p>12 VAC 5-371-220 (H) F157 SS=D 483.10(g)(14) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)</p> <p>1. Resident #18 continues to reside in the facility. The Emergency Contact has been informed of Resident #18's Change in Condition and transfer to the hospital.</p> <p>2. Residents experiencing a Change in Condition have the potential to be affected. The Clinical Managers reviewed 100% of the medical records</p>	

State of Virginia

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: VA0213	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/26/2017
--	---	---	---

NAME OF PROVIDER OR SUPPLIER SENTARA NURSING CENTER NORFOLK	STREET ADDRESS, CITY, STATE, ZIP CODE 249 SOUTH NEWTOWN RD NORFOLK, VA 23502
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
F 001	Continued From page 5	F 001	<p>of residents who experienced a Change in Condition over the last two weeks to validate notification of RP/Emergency Contact. No other residents were affected.</p> <p>3. The Staff Development Coordinator will provide education to the licensed nursing staff regarding the policy and procedure that governs the standards of practice related to Notification of Changes. The Licensed Nurses will notify the resident's RP and/or Emergency Contact when the resident experiences a change in condition. The IDT team will review the medical record of residents who experience a change in condition during the Morning Clinical Meeting to validate notification of RP/Emergency Contact.</p> <p>4. The Clinical Manager will audit 10% of the medical records of residents who experience a Change in Condition weekly for four weeks, then monthly to validate adherence to the established standards governing Notification of Changes. Findings will be reported to the QAPI Committee monthly for further</p>	

State of Virginia

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: VA0213	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/26/2017
--	---	---	---

NAME OF PROVIDER OR SUPPLIER SENTARA NURSING CENTER NORFOLK	STREET ADDRESS, CITY, STATE, ZIP CODE 249 SOUTH NEWTOWN RD NORFOLK, VA 23502
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
F 001	Continued From page 6	F 001	<p>review and recommendations.</p> <p>12 VAC 5-371-370 A,C&G F253 SS=D 483.10(i)(2) HOUSEKEEPING & MAINTENANCE SERVICES</p> <ol style="list-style-type: none"> 1. The shower chair was disinfected per the staff during the survey. 2. Residents who utilize equipment have the potential to be affected. No residents were affected. 3. The Staff Development Coordinator will provide education to the staff regarding the established Infection Control protocol for maintaining a sanitary, orderly and comfortable environment of care. The nursing staff will disinfect the shower equipment after each use. The Environmental Service Department will provide deep cleaning of the shower equipment weekly. 4. Members of the Safety Committee will conduct environmental rounds weekly to validate that the environment of care is maintained in an sanitary and orderly fashion; this includes adherence to Infection Control standards in maintaining shower equipment. Findings will be reported to the QAPI Committee monthly for further review and recommendations. <p>12 VAC 5-371-370B F323 SS=E 483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT</p>	

State of Virginia

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: VA0213	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/26/2017
--	---	---	---

NAME OF PROVIDER OR SUPPLIER SENTARA NURSING CENTER NORFOLK	STREET ADDRESS, CITY, STATE, ZIP CODE 249 SOUTH NEWTOWN RD NORFOLK, VA 23502
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
F 001	Continued From page 7	F 001	<p>HAZARDS/SUPERVISION DEVICES</p> <p>1a. Resident #20 continues to reside in the facility. Resident #20 has had no untoward affects from ambulating in the courtyard. The courtyard was immediately taken out of access for renovations. Residents were informed of the opportunity to utilize alternative outside areas as desired.</p> <p>1b. Residents who ambulate in the courtyard with or without assistive devices have the potential to be affected. No residents have been affected.</p> <p>1c. The courtyard is scheduled for repair to begin February 8, 2014. total renovations will include re-constructing of walking surfaces. Expected completion date is March 1, 2017.</p> <p>1d. The Maintenance Director/Designee will conduct Environment of Safety Checklist Hazard Surveillance Rounds Weekly for four weeks, then monthly to validate that the environment is free of accidental hazards. Findings will be reported to the Safety Committee and QAPI Committee for review and further Recommendations.</p> <p>F323 SS=E 483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION DEVICES</p> <p>2a. The facility staff removed the identified shower mat</p>	

State of Virginia

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: VA0213	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/26/2017
--	---	---	---

NAME OF PROVIDER OR SUPPLIER SENTARA NURSING CENTER NORFOLK	STREET ADDRESS, CITY, STATE, ZIP CODE 249 SOUTH NEWTOWN RD NORFOLK, VA 23502
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
F 001	Continued From page 8	F 001	<p>from the shower bed and properly disposed of the mat. The shower mat has been replaced.</p> <p>2b. Residents who utilize the shower bed have the potential to be affected. No residents were affected.</p> <p>2c. The Staff Development Coordinator will provide education to the staff regarding the process for ensuring that the resident care environment remains free from accidental hazards; to include ensuring that equipment is maintained in proper operational order.</p> <p>2d. The Maintenance Director/Designee will conduct Environment of Safety Checklist Hazard Surveillance Rounds Weekly for four weeks, then monthly to validate that the environment is free of accidental hazards. Findings will be reported to the Safety Committee and QAPI Committee for review and further recommendations.</p> <p>COV 32.1-138.1 (6,10,&12) F242 SS=D 483.10(f)(1)-(3) SELF-DETERMINATION RIGHT TO MAKE CHOICES</p> <p>1. Resident #19 continues to reside in the facility. Resident #19 was assured that it is a Resident Right to make choices regarding who is allowed in her room. The Business Office Manager (BOM) received education regarding Resident's Rights per the Staff Development Coordinator</p>	

State of Virginia

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: VA0213	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/26/2017
--	---	---	---

NAME OF PROVIDER OR SUPPLIER SENTARA NURSING CENTER NORFOLK	STREET ADDRESS, CITY, STATE, ZIP CODE 249 SOUTH NEWTOWN RD NORFOLK, VA 23502
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
F 001	Continued From page 9	F 001	<p>on 2/1/17 and a review of the Sentara Commitments per the Administrator on 2/1/17. The Business Office Manager verbalized understanding of Sentara's employees commitment to promoting and maintaining Resident's Rights.</p> <p>2. All residents have the potential to be affected. No other residents were affected.</p> <p>3. The Staff Development Coordinator Will provide education to the staff regarding Residents' Rights. The staff members will promote and maintain Residents' Rights in the provision of care and services.</p> <p>4. The Social Service Director/Designee will interview ten residents weekly for four weeks, then monthly for three months to validate adherence to practices for promoting and maintaining Residents' Rights.</p> <p>Findings will be submitted to the QAPI Committee for review and further recommendations.</p>	