| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495201 | A. BUILDING _____ B. WING _____ | 08/11/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SENTARA NURSING CENTER PORTSMOUTH | 4201 GREENWOOD DRIVE PORTSMOUTH, VA 23701 |

| (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 |
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| F 000 | Initial Comments<br><br>An unannounced Medicare/Medicaid standard survey and biennial State Licensure Inspection was conducted was conducted 8/9/16 through 8/11/16. Significant corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. Four complaints were investigated during the survey.<br><br>The census in this 132 certified bed facility was 105 at the time of the survey. The survey sample consisted of 25 current Resident reviews (Residents #1 through 19, 25) and 5 closed record reviews (Residents #20 through 24). | F 000 | F000<br><br>Preparation and/or execution of this plan of correction do not constitute admission or agreement by the provider of the truth of the fact alleged or of any conclusion set forth in the statement of deficiencies. This plan of correction is prepared and/or executed solely because it is required by the provisions of Federal and State laws. | |
| F 001 | Non Compliance<br><br>The facility was out of compliance with the following state licensure requirements:<br><br>This RULE: is not met as evidenced by:<br>12 VAC 5-371-190 (A) Safety and Emergency Procedures<br>Please Cross Reference F 518<br><br>12 VAC 5-371-220( A, C.1) Nursing Services<br>Please Cross Reference F 314 and F 323<br><br>12 VAC 5-371-290 (A) Specialized Rehabilitative Services<br>Please Cross Reference F 406<br><br>12 VAC 5-371-300 (B) Pharmaceutical Services<br>Please Cross Reference F 425<br><br>12 VAC 5-371-360 (E) Clinical Records<br>Please Cross Reference F 514<br><br>12 VAC 5-371-220 (D) Nursing Services: | F 001 | 12VAC 5-371-190 (A) Safety and Emergency Procedures, please cross reference F 518<br><br>12VAC 5-371-220 (A, C.1) Nursing Services, please cross reference F 314 and 323.<br><br>12VAC 5-371-290 (A) Specialized Rehabilitation, please cross reference F 406<br><br>12VAC 5-371-300 (B) Pharmaceutical Services, please cross reference F 425<br><br>12VAC 5-371-360 (E) Clinical Records, please cross reference F 514 | |

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|---|---|---|---|
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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| SENTARA NURSING CENTER PORTSMOUTH | 4201 GREENWOOD DRIVE PORTSMOUTH, VA 23701 |

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|---|---|---|---|---|
| F 001 | Continued From Page 1 | F 001 | 12VAC 5-371-220 (D) Nursing Services | |

Based on resident interviews, staff interviews, clinical record review and facility document review the facility staff failed to offer and or provide a tub or shower bath as often as needed, but not less than twice weekly to 2 of 25 residents in the survey sample, Residents #3 and #18.

The findings included:

1. Resident #3 was admitted to the facility on 2/19/16 with diagnoses to include lupus and seizure disorder.

Lupus is a chronic, autoimmune disease that can damage any part of the body (skin, joints, and/or organs inside the body). Chronic means that the signs and symptoms tend to last longer than six weeks and often for many years. www.lupus.org

The current MDS (Minimum Data Set) with an assessment reference date of 5/18/16 coded the resident as scoring a 15 out of 15 on the Brief Interview for Mental Status (BIMS), indicating the resident's cognition was intact. Section E. Behaviors E 0800. Rejection of care was not coded for the resident exhibiting this behavior. The resident was dependent on staff for full-body bath/showers. The resident resided on unit 2.

On 8/9/16 at 4:25 p.m., an interview was conducted with Resident #3. The resident was lying in bed using a personal lap top computer. The resident was asked if the staff offer or provide twice weekly showers. The resident stated, "No, I haven't received a shower since January or February, whenever I was admitted."

The comprehensive plan of care with a goal date of 8/19/16 identified a grooming, hygiene and bathing deficit. The deficit was related to the

12VAC 5-371-220 (D) Nursing Services

The facility staff must ensure a tub or shower bath is offered and/or provided as often as needed, but not less than twice weekly.

1. Resident #3 was offered and/or provided a shower on 8/11/16. Resident #18 was provided a shower on 8/13/16.

2. All residents requiring assistance with tub or shower baths are at risk.

3. Direct care staffs were inserviced on the ADL policy on 8/29-9/3/16. All tub and shower bath schedules for those residents able to communicate their preferences have been reviewed to accommodate individual wishes. Each tub and shower bath has been assigned on the CNA schedule to delineate responsibility.

4. The Clinical Manager or designee will audit four residents twice weekly to assure tub or shower baths are offered and/or provided. Audits will be forwarded to the DON who will summarize and report to the QAPI committee for additional oversight.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495201 | A. BUILDING _____ B. WING _____ | 08/11/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SENTARA NURSING CENTER PORTSMOUTH | 4201 GREENWOOD DRIVE PORTSMOUTH, VA 23701 |

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|---|---|---|---|---|
| F 001 | Continued From Page 2 | F 001 | | |

resident being "totally dependent on the staff." The goal was that the resident would be clean and free from odor through daily care. The interventions included to offer twice weekly showers.

The unit 2 shower schedule evidenced the resident was scheduled to be offered/provided a shower on Mondays and Thursdays on the 7 am - 3 pm shift.

A certified nurse aide (CNA #1) was interviewed on 8/9/16 at 10:30 a.m. The CNA was asked how do they know which resident gets a shower that day, and where do they document whether a shower was given or refused. The CNA stated the assignment sheet used to have a section that lists the showers for that day. This assignment sheet is no longer used. The CNAs now have to look on the daily shower log. The CNA stated if a shower is refused they are to report it to the nurse.

The above findings was shared with the interim Administrator and the interim Director of Nursing (DON) during an end of day meeting conducted on 8/10/16 at 6:10 p.m.

During a follow up with the DON on 8/11/16 at 10:20 a.m., she stated the resident was offered a shower this morning and declined twice. The DON also stated, "There is no way to document in (name of computer program) whether showers were provided or refused."

Review of the clinical record nursing progress notes from 7/3/16 through 8/10/16 failed to evidence any documentation of the resident refusing a shower.

The facility policy titled "Personal Hygiene and Grooming" with a revision date of 12/10/2013

5. Date certain: 9/19/16

Please cross reference F 312 ADL CARE PROVIDED FOR DEPENDENT RESIDENTS

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495201 | A. BUILDING _____ B. WING _____ | 08/11/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SENTARA NURSING CENTER PORTSMOUTH | 4201 GREENWOOD DRIVE PORTSMOUTH, VA 23701 |

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|---|---|---|---|---|
| F 001 | Continued From Page 3 | F 001 | | |

read, in part: Purpose-Residents receive personal care to maintain adequate hygiene.
4. Each resident will receive tub or shower baths as often as needed, but not less than twice weekly.

The facility was allowed an opportunity to provide any additional information to indicate that a twice weekly shower was offered/provided to Resident #3.

No further information was provided prior to exit.

2. Resident #18 was admitted to the facility on 3/25/15. Diagnoses for Resident #18 included but are not limited to autonomic neuropathy (damaged nerves) peripheral vascular disease (numbness in extremities), osteoporosis with fracture, right forearm with delayed healing and end stage renal disease (kidneys cease functioning). Resident #18's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 8/8/16 coded Resident #18 with limited assist with ADLs (dressing, transfers) and extensive assist with toileting and total dependence for bathing. Resident #18 was coded with the highest BIMS (Brief Interview Mental Status-an assessment tool) score of 15 with no cognitive impairment.

During the survey from 8/9/16 through 8/11/16 observations were made of Resident #18 in her wheelchair self propelling and no observations were made of her walking.

On 8/10/16 and 8/11/16, Resident #18's clinical record was reviewed. The review documented a physicians order for dialysis (externally cleansing blood) 3 x (3 times) weekly starting 6/28/16 with a note: "Every Monday, Wednesday, and Friday".

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495201 | A. BUILDING _____ B. WING _____ | 08/11/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SENTARA NURSING CENTER PORTSMOUTH | 4201 GREENWOOD DRIVE PORTSMOUTH, VA 23701 |

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|---|---|---|---|---|
| F 001 | Continued From Page 4 | F 001 | | |

According to the TAR (Treatment Record Administration) for August 2016 Resident #18 was documented to go out of the facility for dialysis treatment each Monday, Wednesday, and Friday.

Review of the care plan documented Resident #18 as totally dependent on staff for bathing and the goal to bath/shower her by staff over the next 90 days starting 7/14/16.

The Station 2 Shower Check List documented that Resident #18 was scheduled to be showered on Mondays and Thursdays on the 7:00 a.m. through 3:00 p.m. shift.

On 8/9/16 at approximately 3:00 p.m. during the group interview with 8 facility residents, Resident #18 stated, "I only have showers on Thursdays and none on Mondays, I go out on Mondays for dialysis so I don't shower on Mondays." Resident #1 also stated I only get one shower a week and I try and wash myself the other days. On 8/11/16 at 2:15 p.m. Resident #18 stated, "I like showers in the morning and Tuesday mornings would be fine for showers."

On 8/11/16 at 2:25 p.m. RN #1 the clinical manager on the unit where Resident #18 lives stated, "I do not know anything about this [Resident #18] having one shower a week] check with the CNA [#6] because she gives her [Resident #18] showers.

On 8/11/16 at 2:30 p.m. CNA #6 stated, "I give her [Resident #18] a shower every Thursday if I am assigned to her, once a week and the resident hasn't mentioned this [having only one shower a week]. On 8/11/16 at approximately 3:00 p.m. CNA #1 stated, "I make the schedule for CNAs for showers and we can offer Saturday or Tuesday to [Resident #18], it's up to the resident."

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495201 | A. BUILDING _____ B. WING _____ | 08/11/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SENTARA NURSING CENTER PORTSMOUTH | 4201 GREENWOOD DRIVE PORTSMOUTH, VA 23701 |

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|---|---|---|---|---|
| F 001 | Continued From Page 5 | F 001 | | |

Director of Nurses (DON) was debriefed on 8/11/16 at 7:40 p.m. with no information presented. The DON stated we need to give baths and showers at least 2 days a week and we can change her (Resident #18's) day to Tuesday. Resident #18 had only one shower on Thursdays from 7/14/16 through 8/11/16.

The Personal Hygiene and Grooming Policy revised on 12/10/2013 requires residents to have tub or shower baths as often as needed but not less than twice weekly...residents whose medical condition prohibit tub or shower baths will have a sponge bath daily. The facility policy does not document consideration for residents' preference for time and type of bathing. According to the DON and Administration if the resident has a preference for showers the staff would try to accommodate.

The facility administration was informed of the findings during a briefing on 8/11/16 at approximately 7:50 p.m. The facility did not present any further information about the findings.

12 VAC 5-371-220 (H). Nursing Services. Cross-Reference to F157
12VAC 5-371-220 (A/B/C) Nursing Services. Cross Reference to F309 and F311
12 VAC 5-371-300 A/B. Pharmaceutical Services. Cross reference to F431
COV 32.1-138-A9. Residents Rights under Code of Virginia. Cross Reference F164

12VAC 5-371-220 (H) Nursing Services, please cross reference F 157

12VAC 5-371-220 (A/B/C) Nursing Services, please cross reference F 309 and 311

12VAC 5-371-300 (A/B) Pharmaceutical Services, please cross reference F 431

COV 32.1-138-A9 Resident Rights, please cross reference F 164

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495201 | A. BUILDING _____ B. WING _____ | 08/11/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SENTARA NURSING CENTER PORTSMOUTH | 4201 GREENWOOD DRIVE PORTSMOUTH, VA 23701 |

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| F 000 | INITIAL COMMENTS | F 000 | | |

An unannounced Medicare/Medicaid standard survey was conducted 8/9/16 through 8/11/16. Significant corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. Four complaints were investigated during the survey.

The census in this 132 certified bed facility was 105 at the time of the survey. The survey sample consisted of 25 current Resident reviews (Residents #1 through 19, 25) and 5 closed record reviews (Residents #20 through 24).

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| F 157 SS=D | 483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) | F 157 | F157 |

A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).

The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a

The facility staff must ensure records are periodically updated to include the address and phone number of the resident's legal representative or interested family member.

1. Resident #22 expired on 8/12/15. No immediate correction is possible.

2. All residents with inaccurate face sheet information are at risk.

3. Facility staffs were inserviced on the ADL System Update Patient Data policy on 8/29-9/3/16. A 100% chart review was completed on 8/19/16. Face sheets are assigned to the Social Services department for twice yearly reviews and updates.

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| Karen Wilhelm, LNHA | | 9/8/16 |

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.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495201 | A. BUILDING _____ B. WING _____ | 08/11/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| SENTARA NURSING CENTER PORTSMOUTH | 4201 GREENWOOD DRIVE PORTSMOUTH, VA 23701 |

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|---|---|---|---|---|
| F 157 | Continued From page 1 | F 157 | | |

change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.

The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.

This REQUIREMENT is not met as evidenced by:
Based on information gathered during a complaint investigation, staff interviews, clinical record review, and review of the facility's policy the facility staff failed to keep the responsible party's/emergency contact's addresses and phone numbers updated for of 1 of 25 residents (Resident # 22), in the survey sample.

The findings included:

Resident #22 was originally admitted to the facility 11/28/12 and had never been discharged from the facility prior to her death 8/12/15. The diagnoses included anemia, hyperlipidemia, heart failure, hypothyroidism, hypertension (high blood pressure), osteoarthritis, vitamin D deficiency.

The significant change Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 7/28/15 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 13 out of a possible 15. This indicated Resident #22 cognitive abilities for daily decision making were intact. The MDS assessment also revealed Resident #22 had no mood or behavior problems, required extensive

F 157

4. The Social Service department will audit 10 charts each month X 3 months to assure accurate information is available for legal representative or interested family member contact. Results of audits will be reported to the QAPI committee for additional oversight.

5. Date certain: 9/19/16

Please cross reference 12VAC 5-371-220 (H) Nursing Services

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495201 | A. BUILDING _____ B. WING _____ | 08/11/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SENTARA NURSING CENTER PORTSMOUTH | 4201 GREENWOOD DRIVE PORTSMOUTH, VA 23701 |

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|---|---|---|---|---|
| F 157 | Continued From page 2 | F 157 | | |

assistance of 2 persons with bed mobility, transfers, dressing, toileting, and personal hygiene. The resident did not walk, required limited assistance with locomotion, total care with bathing and incontinent of bowels and bladder.

An interview was conducted on 8/11/12 at 12:35 p.m., with Resident #22's niece. The niece stated she learned of Resident #22's death from the local funeral home staff. The funeral home staff stated a past neighbor of Resident #22's called the funeral home after going to the nursing facility to visit and not finding the resident. The past neighbor stated when she asked the nursing facility staff of the resident's whereabouts, she was instructed to contact (name of the funeral home). The past neighbor contacted the local funeral home and the funeral home staff said the facility told them there was no next to kin. The neighbor gave the funeral home staff the phone number of a niece who resided in a distant city. The niece of Resident #22 stated when she contacted the nursing facility, the staff stated they had made attempts to contact the responsible parties listed on the "Face Sheet" (a form containing demographic information) but they were unable to reach anyone. The niece stated she informed the facility staff that there were letters with addresses because she was one of the individuals who frequently corresponded with the resident by mailing letter through the United States Postal Services. The niece stated the facility staff informed her Resident #22's personal belongings had been discarded because there was no one to pick them up and the facility had no place to store them. The niece further stated the first responsible party listed on the Face Sheet had died 2/14/2011 and the second responsible party/emergency contact listed on the

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495201 | A. BUILDING _____ B. WING _____ | 08/11/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| SENTARA NURSING CENTER PORTSMOUTH | 4201 GREENWOOD DRIVE PORTSMOUTH, VA 23701 |

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|---|---|---|---|---|
| F 157 | Continued From page 3 | F 157 | | |

Face Sheet had died 5/9/2012.

Review of the clinical record revealed a nurse's note dated 8/12/15 at 8:14 a.m. It read; "0530 (5:30 am) Resident complained of a cough. Administered cough medicine and head of bed up. Certified Nursing Assistant (CNA) followed me in and went to get supplies to clean her up from a bowel movement. This nurse headed down the hall and was called back in immediately to patient's room. Resident had very shallow respirations and was non responsive. Unable to get vital signs. Breathing stopped Cardiopulmonary Resuscitation (CPR) started, 911 called. Emergency Medical Technicians arrived 0545 (5:45 am) and took over. 0622 (6:22 am) was called for time of death. Resident moved to room (room number) for privacy. (name of doctor) notified. Director of Nursing (DON) notified. Several attempts were made to contact emergency contacts. One phone number given is the wrong number and no answer on the other number. The police officer answering the call attempted to find information pertaining to resident and found she did not have a state identification card or drivers license. Called (name of funeral home) to pick up the body."

An interview was conducted with the current Director of Social Worker (SW) on 8/11/16 at approximately 1:00 p.m. The SW stated she was not employed at the nursing facility when Resident #22 was a resident. When the SW was asked who is responsible for updating the demographic Face Sheets she stated she could update them as well as other facility staff but she thought it was the responsibility of Medical Records to update the Face Sheet.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495201 | A. BUILDING _____ B. WING _____ | 08/11/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SENTARA NURSING CENTER PORTSMOUTH | 4201 GREENWOOD DRIVE PORTSMOUTH, VA 23701 |

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|---|---|---|---|---|
| F 157 | Continued From page 4 | F 157 | | |

An interview was conducted with the Medical Records Clerk (MRC) on 8/11/16 at approximately 1:30 p.m. The MRC stated she was not responsible for updating the Face Sheets and she believed the Business Office Manager (BOM) was responsible.

An interview was conducted with the BOM on 8/11/16 at approximately 1:50 p.m. The BOM stated she as well was not employed at the facility when Resident #22 resided at the nursing facility. The BOM stated she wasn't aware she was responsible for updating the Face Sheets but she would start updating it if it was her responsibility.

The facility's policy titled "ADL System - Update Patient Data" with a revision date of 3/11/14 read: Patient data changes will be entered accurately and in a timely fashion into the ADL System. #2 Demographic information (address, phone numbers, responsible party changes, etc.) Level of Care (LOC) changes will be entered into the Activities of Daily Living (ADL) System by the facility Administrator or Social Worker within 24 hours of notification. Under Control and Reporting Mechanisms it read; The ADL Administrator shall monitor compliance with this policy by directing the following auditing and tracking activities: #5 Face sheet information will be audited quarterly by the facility Administrator, or the Interdisciplinary Team.

The above findings were shared with the Administrator and Director of Nursing on 8/11/16 at approximately 7:00 p.m. The Director of Nursing stated the Face Sheet should be updated whenever a change in information is obtained and the Face Sheet should be reviewed periodically to ensure the contact information remains accurate.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495201 | A. BUILDING _____ B. WING _____ | 08/11/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SENTARA NURSING CENTER PORTSMOUTH | 4201 GREENWOOD DRIVE PORTSMOUTH, VA 23701 |

| (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 157 | Continued From page 5<br>No additional information was provided prior to the survey teams exit. | F 157 | | |
| F 164 SS=E | COMPLAINT DEFICIENCY<br>483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS<br><br>The resident has the right to personal privacy and confidentiality of his or her personal and clinical records.<br><br>Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.<br><br>Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility.<br><br>The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law.<br><br>The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident.<br><br>This REQUIREMENT is not met as evidenced | F 164 | F164<br><br>The facility staff must ensure the confidentiality of all information contained in the resident's records, regardless of the form of storage methods.<br><br>1. The scanned note regarding restorative services for another resident was removed from resident #25's chart.<br><br>2. All residents with scanned documents in their healthcare records are at risk.<br><br>3. A 100% audit was completed to identify any records that may have been inadvertently scanned and uploaded to the wrong charts. Any identified issues were corrected immediately. Facility staffs were inserviced on the policy for Charting Errors and Omissions on 8/29-9/3/16.The Medical Records clerk and licensed nursing staffs were inserviced on 8/24/16 to address confidentiality and caution when | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495201 | A. BUILDING _____ B. WING _____ | 08/11/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SENTARA NURSING CENTER PORTSMOUTH | 4201 GREENWOOD DRIVE PORTSMOUTH, VA 23701 |

| (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 164 Continued From page 6

by:
Based on electronic record review and staff interview it was determined for Resident #25, one resident of 25 in the survey sample, that facility staff failed to assure confidentiality of her clinical information. Resident #25 had documentation regarding her restorative services scanned into Resident #15's electronic record.

The findings included:

Resident #25 was 89 years old and was admitted to the facility on 4/23/16. The 14 day admission Minimum Data Set (MDS) was completed following a hospital admission with a readmission date of 7/13/16.

The resident's brief interview for mental status evidenced she was a 13 out of 15 indicating no cognitive impairment. Resident #15's diagnoses evidenced depression, anxiety disorder, respiratory failure and cardiomyathy. The resident required limited assistance of one person with locomotion on and off the unit in a wheelchair.

During the review of Resident #15's electronic record Resident #'s 25 "RESTORATIVE NURSING REFERRAL" was observed.

This was discussed with the acting Administrator and DON on 8/11/16 at approximately 8:30 p.m., no additional information was received.

F 174 SS=D 483.10(k),(l) RIGHT TO TELEPHONE ACCESS WITH PRIVACY

§483.10(k) Telephone
The resident has the right to have reasonable access to the use of a telephone where calls can

F 164

scanning information into a resident's medical record.

4. The Medical Records clerk will randomly audit 5 records each week for 6 weeks to assure accuracy of scanning activities. All audits will be submitted to the DON and will be summarized for presentation to the QAPI committee for additional oversight.

5. Date certain: 9/19/16

Please cross reference COV 32.1-138-A9 Resident Rights

F 174

F174

The facility must ensure residents are allowed to retain and use personal possessions.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495201 | A. BUILDING _____ B. WING _____ | 08/11/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SENTARA NURSING CENTER PORTSMOUTH | 4201 GREENWOOD DRIVE PORTSMOUTH, VA 23701 |

| (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 174 | Continued From page 7 | F 174 | | |

be made without being overheard.

§483.10(l) Personal Property
The resident has the right to retain and use personal possessions, including some furnishings, and appropriate clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other residents.

This REQUIREMENT is not met as evidenced by:
Based on resident interview, staff interviews, and clinical record review the facility staff failed to treat with respect and allow the right to retain personal possessions for 1 of 25 residents in the survey sample, Resident #3.

Resident #3 was transferred into another room due to a suspected bed bug infestation. The facility staff responsible for bagging and removing items from the room failed to thoroughly search through a large white paper bag containing the residents personal possessions. The paper bag was discarded into a large commercial trash receptacle. The white paper bag had contained sentimental irreplaceable personal photos.

The findings included:

Resident #3 was admitted to the facility on 2/19/16 with diagnoses to include lupus and seizure disorder.

Lupus is a chronic, autoimmune disease that can damage any part of the body (skin, joints, and/or organs inside the body). Chronic means that the signs and symptoms tend to last longer than six weeks and often for many years. www.lupus.org

F 174

1. Resident #3's personal photographs had been discarded on 7/7/16. No immediate correction is available.

2. All residents with personal belongings are at risk.

3. Facility staff has been updated on the policy regarding discarding potentially infected items on 8/29-9/3/16. No belongings will be discarded without administrative approval and without attempts to contact the resident's family member. The Director of ESD will maintain an inventory of items that may need to be discarded with notation of approval and family contact.

4. The Administrator will review the inventory log weekly to assure all processes are followed. The Director of ESD will summarize the inventory log and report any items discarded to the QAPI committee for additional oversight.

5. Date certain: 9/19/16

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495201 | A. BUILDING _____ B. WING _____ | 08/11/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SENTARA NURSING CENTER PORTSMOUTH | 4201 GREENWOOD DRIVE PORTSMOUTH, VA 23701 |

| (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 174 | Continued From page 8 | F 174 | | |

The current MDS (Minimum Data Set) with an assessment reference date of 5/18/16 coded the resident as scoring a 15 out of 15 on the Brief Interview for Mental Status (BIMS), indicating the resident's cognition was intact.

On 8/9/16 at 4:25 p.m., an interview was conducted with Resident #3. The resident stated the staff had thrown away her personal photos to include sonogram pictures of her children. Resident #3 stated this occurred during a room change due to bed bugs. The resident stated the photos were stored in a box, inside a white bag that had been in the wardrobe closet. The resident was tearful and clearly upset during the conversation over the loss of her personal possessions.

The clinical record nurses notes dated 7/6/16 at 12:17 a.m.,read in part: Resident noted to have bed bugs in her brief that she was wearing. Called administrator, MD (medical doctor). Cleaned up resident and moved to empty room... Room is closed and blocked off by sheet until cleaned by housekeeping.

On 8/10/16 at 6:10 p.m., an end of day meeting occurred with the interim Administrator and interim Director of Nursing (DON). The DON was asked about the box of photos and stated, "I got a call one night that the resident had bed bugs, I instructed the staff to bag things up, bathe the resident and move her to another room. The next morning the pest control came in and treated the room. The staff were directed to bag and discard items." The DON stated she later learned that a white bag inside the closet contained photos. She stated she went to the trash receptacle and could not find the bag. She also stated Resident

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495201 | A. BUILDING _____ B. WING _____ | 08/11/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SENTARA NURSING CENTER PORTSMOUTH | 4201 GREENWOOD DRIVE PORTSMOUTH, VA 23701 |

| (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 174 | Continued From page 9 | F 174 | | |

#3's husband also looked into to the trash receptacle and could not find the discarded bag. The DON stated she had apologized to the resident. The DON stated the pest control vendor did not find any other bed bugs, and there was no infestation. The DON stated the bed bug likely came from personal belongings such as clothes that were bought into the building by the husband.

On 8/11/16 at 2:50 p.m., the Environmental Service Director (ESD) was interviewed. She stated she was called at home one night and was told that "We had a problem with a resident room...bed bugs". She was directed by the DON to disinfect the room, and to bag and discard items from inside the resident room the following morning. The ESD stated she stayed at the resident room doorway as the pest control vendor treated the room the following morning. She stated adjacent rooms were also inspected, and that the pest control vendor stated there was no signs of bed bugs. The pest control person advised the ESD to discard all food items from the resident room. The ESD stated, " I bagged up everything, placed into water soluble bags...soiled items were sent to the laundry, inside the wardrobe closet she had bags of snacks stored inside a large white paper bag". The ESD stated she did not thoroughly check the contents of the white bag. The white bag was bagged and discarded it into the trash. The ESD stated, "I did not know there were personal belongings inside of it".

The ESD was asked if she had read the facility policy titled Bed Bugs, with a revision date of 3/2013. She stated, "I read it, but I didn't do all the steps". I have learned from this...I should pull up the policy first...I did apologize to the resident."

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495201 | A. BUILDING _____ B. WING _____ | 08/11/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SENTARA NURSING CENTER PORTSMOUTH | 4201 GREENWOOD DRIVE PORTSMOUTH, VA 23701 |

| (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 174 | Continued From page 10<br>She stated the resident was "frustrated...she was yelling at me, asking me why would I do that (discarding personal possessions).<br><br>The facility policy titled "Bed Bugs" with a revision date of 3/2013 read in part: Purpose-To effectively manage and treat an incidence of bed bugs within a facility.<br>Procedure:<br>1. Upon discovery or suspected activity of bed bugs, immediately bathe the patient and remove the patient from the room.<br>2. Remove all linens by utilizing proper bagging and tying bag closed protocols. Immediately bag all patients personal items...As belongings are bagged there should be consideration for valuables (purses, wallets, jewelry, etc) which should be placed in a separate bag from the clothing bag. All personal belongings are to be given to a family member...If no family members are found or if they refuse responsibility of the belongings contact your facility Risk Management for discussion of disposal of belongings. Patient belongings will be held for a maximum of 30 days.<br><br>The family was not provided the opportunity to pick up the bagged items prior to discarding them.<br><br>The above findings was shared with the Administrator and the Director of Nursing during an end of day meeting conducted on 8/10/16 at 6:10 p.m. | F 174 | | |
| F 242 SS=D | 483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES<br><br>The resident has the right to choose activities, | F 242 | F242<br><br>The facility staff must ensure the resident has the right to choose activities and schedules, and, health care consistent with their interests. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495201 | A. BUILDING _____ B. WING _____ | 08/11/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SENTARA NURSING CENTER PORTSMOUTH | 4201 GREENWOOD DRIVE PORTSMOUTH, VA 23701 |

| (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 242 | Continued From page 11 | F 242 | | |

schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident.

This REQUIREMENT is not met as evidenced by:
Based on resident interviews, staff interviews and clinical record reviews the facility staff failed to recognize the residents right and self determination to choose a schedule for health care consistent with their preference for 2 residents (#5 and #4), and failed to allow 1 resident (Resident #19) assess to the group meeting with surveyors in a resident sample of 25.

1. Resident #5's pressure ulcer dressing changes were scheduled to be changed on the night shift, waking the resident up between 3 am and 4 am. Resident #5 questioned the staff about the scheduled time. The resident was not offered an opportunity to choose a schedule time according to his preference.

2. . For Resident #4, the facility staff failed to provide preferred shower times other than 2:00 a.m..

3. For Resident #19, the facility staff failed to assure he was able to attend the group meeting with the survey team.

The findings included:

1. Resident #5's schedule for wound care was revised on 8/11/16 to be completed on the 3-11 shifts instead of the 11-7 shift. Resident #4's shower schedule was changed to the 3-11 shifts per her request. Resident #19 did not attend the group meeting with the surveyors. No immediate correction is available.

2. All residents capable of choosing their activities and schedules are at risk.

3. All staff was inserviced on Resident Rights on 8/29-9/3/16. The Administrator attended a resident meeting on 8/22/16 to allow residents to discuss any concerns they had regarding their preferences. They were informed how to contact the Social worker, Clinical manager or Administration if any issues arise

4. The Social worker will conduct interviews with 4 residents each week X 3 months to assess if their preferences are being met. Any identified issues will be resolved immediately. Results of these interviews will be

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495201 | A. BUILDING _____ B. WING _____ | 08/11/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SENTARA NURSING CENTER PORTSMOUTH | 4201 GREENWOOD DRIVE PORTSMOUTH, VA 23701 |

| (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 242 | Continued From page 12 | F 242 | | |

1. Resident #5 was readmitted to the facility on 4/11/16 with diagnoses to include chronic pressure ulcers/sores and paraplegia (paralysis of the legs and lower body) caused by a traumatic fall and spinal injury.

The current MDS (Minimum Data Set) with an assessment reference date of 8/4/16 coded the resident as scoring a 15 out of a possible 15 on the Brief Interview for Mental Status (BIMS), indicating the resident's cognition was intact. Section M. Skin condition coded the resident as having 3 stage III pressure sores and 4 stage IV pressure sores.

The MDS describes pressure ulcers/sores as:
1. Stage III-Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle is not exposed. Slough may be present but does not obscure (hide) the depth of tissue loss. May include undermining and tunneling.
2. Stage IV-Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar (dead tissue) may be present on some parts of the wound bed. Often includes undermining and tunneling.

On 8/8/16 at 2:50 p.m., an interview was conducted with the resident. Resident #5 was in a speciality bed with a low air loss mattress. The resident stated that he is awakened between 3 and 4 a.m., every night for the pressure ulcer dressing changes. The resident stated he had asked the nurse why do they have to do the dressing change at that time, the staff's response did not offer the resident a preference instead, the reply was that it was scheduled to be done on

summarized and presented to the QAPI committee for additional oversight.

5. Date certain: 9/19/16

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495201 | A. BUILDING _____ B. WING _____ | 08/11/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SENTARA NURSING CENTER PORTSMOUTH | 4201 GREENWOOD DRIVE PORTSMOUTH, VA 23701 |

| (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 242 | Continued From page 13 | F 242 | | |

the night shift. He stated he would prefer to have the dressing change done right before bedtime, instead of being woken up in the middle of the night. At this time, the resident's roommate entered the resident room, and confirmed that the nursing staff did the dressing changes between 3-4 am, stating "they come and turn on the lights, and talk to each other during the dressing change...this wakes me up."

The treatment administration record (TAR) for August 2016 was reviewed.
The TAR evidenced the following treatments and dressings were scheduled on the night shift (11 pm-7 am):
1. Skin prep and xerofoam to both heels, wrap with kerlix every night.
2. Right lateral (side) calf cleanse and apply xerofoam and kerlix every night.
3. Aquacel AG to sacral wounds every night.
4. Left plantar foot iodosorb 0.9% and kerlix every night.

The above findings was shared with the Administrator and the Director of Nursing during an end of day meeting conducted on 8/10/16 at 6:10 p.m.
The DON stated, "I would not want to be woken up at 3 or 4 in the morning".

2 . Resident #4 was re-admitted to the facility on 1/8/16. Diagnoses for Resident #4 included but are not limited to acute respiratory distress, blindness in one eye, cerebral infarction (stroke) causing right side weakness, type II diabetes, and chronic kidney disease.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495201 | A. BUILDING _____ B. WING _____ | 08/11/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SENTARA NURSING CENTER PORTSMOUTH | 4201 GREENWOOD DRIVE PORTSMOUTH, VA 23701 |

| (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 242 | Continued From page 14 | F 242 | | |

Resident #4 's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 3/3/16 coded Resident #4 with extensive assistance for ADLs (Activities of Daily Living- dressing, transfers, bathing) and needing one person physical assist for bathing. Resident #4's BIMS (Brief Interview Mental Status- assessment tool) coded the highest level of cognitive functioning with a score of 15.

On 8/9/16 at 5:05 p.m. Resident #4 was observed in bed watching TV and eating a cookie. Resident #4 presented alert and able to communicate and welcomed an interview for the next day.

On 8/10/16 and 8/11/16, Resident #4's clinical record was reviewed. The reviewed showed the most current care plan report identified and documented a problem, "[Resident #4] has bathing and hygiene and grooming deficits r/t [related to] decreased mobility secondary to hx [history] of respiratory failure CHF [congestive heart failure], CVA [stroke], with rt [right sided] weakness and PVD [peripheral vascular disease]". The care plan report documented interventions included but not limited to, "twice weekly showers...maintain consistent time for bathing..."

For Resident #4 an August 2016 Physician Order Sheet documented, "S=Shower, by shift starting 8/11/16." According to the TAR (Treatment Administration Record) for August 2016 documented that Resident #4 is scheduled for showers on the evening shift ordered on 8/11/16. On the ADL Verification Worksheet for the month of August 2016, Resident #4 is coded as an extensive assist with a one person physical assist for bathing. On this worksheet dates and times

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495201 | A. BUILDING _____ B. WING _____ | 08/11/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SENTARA NURSING CENTER PORTSMOUTH | 4201 GREENWOOD DRIVE PORTSMOUTH, VA 23701 |

| (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 242 | Continued From page 15 | F 242 | | |

are listed but no distinction is made as to what type of ADL was completed.

On 8/9/16 at approximately 3:00 p.m. during the group interview with 8 facility residents, Resident #4 stated, "My shower time is 4:00 a.m. on Monday and Thursday." Resident #4 also stated, "I said this is not ok." Resident #4 also reported that other residents have to get showers at 4:00 a.m. She added, "I can't pick and choose [when to have showers]". According to Unit (Number of the unit Resident #4 lives on ) shower schedule it was reported that 14 rooms were assigned to the night shift.

On 8/10/16 at 1:40 p.m. Resident #4 stated, "I get showers from 2:00 am to 4:00 a.m. since I've been a resident." When asked how she feels about this Resident #4 said, "I don't want to be woken up in the middle of the night because I can't go back to sleep." She further explained when they (nursing aides) started doing this (showering) in the early morning, "I told the aide who was going to bathe me, "I didn't want to be woken up for showers [at 2-4 am] but she said, 'that's the schedule." Resident #4 could not recall which aide she talked to. Resident #4 also said she had accepted this [shower schedule to bathe from 2-4 a.m.] because, "I have to take what I can get."

On 8/11/16 at approximately 2:00 p.m. CNA (Certified Nursing Assistant) #4 explained that the shower schedule for rte 3rd shift (11:00 p.m. to 7:00 a.m.) referred to as the night shift would do rounds at about 2:00 a.m. and thought that showers occurred between 5:00 a.m. and 5:30 a.m. for Resident #4. On 8/11/16 at approximately 2:05 p.m. LPN (Licensed Practical

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495201 | A. BUILDING _____ B. WING _____ | 08/11/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SENTARA NURSING CENTER PORTSMOUTH | 4201 GREENWOOD DRIVE PORTSMOUTH, VA 23701 |

| (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 242 | Continued From page 16 | F 242 | | |

Nurse) #3 added that on the 11:00 p.m. to 7:00 a.m. shift there were residents who stayed up late and asked for showers. Neither CNA #4 nor LPN #3 could recall any concerns given in report regarding Resident #4 having showers early in the morning. The report would simply state if she had a shower on the night shift. CNA #5 was in charge of giving Resident #4 showers on the evening shift but was unavailable for interview during the survey. Both had agreed that CNA #5 had reported giving Resident #4 showers on the night shift.

On 8/11/16 at approximately 10:00 a.m., the DON (Director of Nursing) explained, "There is no way for the CNAs to document [in the computer program] any notes regarding showers." The DON added, "the ADL sheets only document what is needed to assist [resident] with bathing." There is no documentation system to track if residents are receiving baths, showers, bed baths but it might say in a nursing note if resident refused a bath or in report information is passed on from evening shift to morning shift. According to the DON on 8/11/16 at 7:40 p.m. the ADL Worksheet gives dates and times but no description of what ADL took place.

The "Personal Hygiene and Grooming Policy" revised on 12/10/2013 requires residents to have tub or shower baths as often as needed but not less than twice weekly...residents whose medical condition prohibit tub or shower baths will have a sponge bath daily. The facility policy does not document consideration for residents' preference for time and type of bathing. According to the DON and Administration if the resident has a preference for showers the staff would try to accommodate.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495201 | A. BUILDING _____ B. WING _____ | 08/11/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SENTARA NURSING CENTER PORTSMOUTH | 4201 GREENWOOD DRIVE PORTSMOUTH, VA 23701 |

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|---|---|---|---|---|
| F 242 | Continued From page 17 | F 242 | | |

The facility administration was informed of the findings during a briefing on 8/11/16 at approximately 7:50 p.m. The facility did not present any further information about the findings.

3. Resident #19 was 60 years old with an admission date of 3/31/15. Review of his 3/22/16 annual and 6/15/16 quarterly MDS (Minimum Data Set) evidenced the resident was cognitively intact with a BIMS (brief interview for mental status) score of 14 out 15. His functional status was limited assistance of one for bed mobility, extensive assist of one for transfers and he was independent in eating. The resident was independent in a motorized scooter for locomotion on and off the unit.

The resident's diagnoses included high blood pressure, viral hepatitis (liver infection) and depression.

On 8/10/16 at 3 p.m. Resident #19 was interviewed. He explained that he had wished to attend the group meeting with the state surveyor but when he tried to enter the room he was informed he was unable to participate.

Following this resident interview the Director of Activities was interviewed. This staff member was identified by the resident as the person who denied him entrance to the group meeting. The Activity Director stated she was in the corridor outside the meeting room where the group interview was taking place. Resident #19 approached her and she did tell him he was not on the list (provided prior to meeting by Activities) and the meeting was already in progress and it would be disruptive for him to enter the meeting.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495201 | A. BUILDING _____ B. WING _____ | 08/11/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SENTARA NURSING CENTER PORTSMOUTH | 4201 GREENWOOD DRIVE PORTSMOUTH, VA 23701 |

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|---|---|---|---|---|
| F 242 | Continued From page 18<br><br>The surveyor conducting the group meeting later informed the team that three additional residents entered the room from the courtyard and were welcomed into the meeting. | F 242 | | |
| F 309 SS=D | 483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING<br><br>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.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, clinical record review, staff interviews and facility documentation, the facility staff failed to ensure ordered treatment and care was provided to promote healing and prevent deterioration of a diabetic ulcer for 1 of 25 residents (Resident #9) in the survey sample.<br><br>The findings included:<br><br>Resident #9 was originally admitted to the facility 3/10/16 and has not been discharged from the facility since this admission. The current diagnoses are include diabetes, lymphedema (swelling in arms or legs) and venous insufficiency.<br><br>The quarterly Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 6/21/16 coded the resident as | F 309 | F309<br><br>The facility staff must ensure ordered treatment and care is provided to promote healing and prevent deterioration of diabetic foot ulcers.<br><br>1. A dressing change had not been completed for resident #9. No immediate correction is possible.<br><br>2. All residents requiring wound care are at risk.<br><br>3. A 100% audit was conducted on 8/15/16 to assure dressing changes had been done as ordered. Licensed nursing staff were inserviced on the wound care policy on 8/24/16, and, again on 8/29-9/3/16.<br><br>4. The Clinical manager will conduct weekly audits on 10% of all residents with wound care orders to assure dressing changes are being conducted. Dressings will be monitored for current dates. All audits will be | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495201 | A. BUILDING _____ B. WING _____ | 08/11/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SENTARA NURSING CENTER PORTSMOUTH | 4201 GREENWOOD DRIVE PORTSMOUTH, VA 23701 |

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|---|---|---|---|---|
| F 309 | Continued From page 19 | F 309 | | |

completing the Brief Interview for Mental Status (BIMS) and scoring 14 out of a possible 15. This indicated Resident #9 cognitive abilities for daily decision making were intact. This MDS assessment revealed Resident #22 was without mood or behavior problems, was continent of bowels and bladder, required extensive assistance of 2 with transfers, extensive assistance of 1 with bed mobility, locomotion, dressing, toileting, personal hygiene and bathing.

Resident #9 was observed lying on a low air loss mattress/bed on 8/9/16 at approximately 3:45 p.m. dressed in a hospital gown. His legs were edematous (swollen) and dark purple to black from the knees to the top of the feet. A tan dressing dated 8/5/16 with dark drainage on it was observed to the left lateral foot and continuing halfway beneath the left foot. The resident stated this was the second admission to the nursing facility and the plan was to receive rehabilitation services and return to the community. Resident #9 continued to say, there was an open wound to the left foot and the wound care physician and podiatrist had instructed him not to wear the shoes (a Croc type slip-on) in his room because they were too hard for an individual with circulation problems, decreased feelings in the legs and feet and prone to develop wounds to the feet. The resident stated one of the physicians told him he needed diabetic shoes but he still did not have them.

Review of Resident's #9 care plan revealed a problem dated 7/26/16 which read; "(resident name) has a history of venous ulcers, diabetic ulcers, varicose veins, edema and is at risk for further compromised skin integrity. Left plantar diabetic foot ulcer (6/14/16) treatment initiated

F 309

forwarded to the DON. Audits will be summarized and presented to the QAPI committee for additional oversight.

5. Date certain: 9/19/16

Please cross reference 12VAC 5-371-220 (A/B/C) Nursing Services

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495201 | A. BUILDING _____ B. WING _____ | 08/11/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SENTARA NURSING CENTER PORTSMOUTH | 4201 GREENWOOD DRIVE PORTSMOUTH, VA 23701 |

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|---|---|---|---|---|
| F 309 | Continued From page 20 | F 309 | | |

7/13/16..."The goal read; (resident name) will remain free of skin breakdown over the next 90 days 9/25/16. The interventions read; 7/22/16 Apply Bactroban (topical antibiotic) as directed. 7/15/16 Zeasorb (antifungal powder) athletes foot powder apply as directed. 8/4/16 Skin prep to bilateral heels as ordered. Mepilex (foam dressing) to left plantar foot as ordered. Weekly body checks per licensed nurse. Report changes in skin condition to charge nurse. Encourage the resident to turn and reposition every 2 hours and as needed. Apply Calmoseptine (moisture barrier cream) as directed per physician's order. Float heels intermittently. (brand name of speciality mattress) mattress. Daily skin inspection for redness, blistering, irritation."

An interview was conducted with the wound care physician on 8/10/16 at approximately 2:40 p.m., prior to observation of the resident's wound care, assessment and measurements by the physician. The wound care physician stated the resident had a diabetic ulcer not a pressure ulcer and the expectation was for the wound to be healed or very close to healed when assessed today (8/10/16). The wound care physician stated off-loading the wound, eliminating the edema and good blood sugar control were important factors in healing Resident #9 diabetic ulcer and the facility staff had been effective in healing other open areas to his feet by maintaining those interventions.

The wound care nurse assisting the wound care physician removed Resident #9 soiled dressing on 8/10/16 at approximately 2:45 p.m. The wound care physician cleaned the wound and proceeded to measure it. The 8/10/16 measurements were 1 x 1 x 0.1 centimeters, surface area 1 centimeters

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495201 | A. BUILDING _____ B. WING _____ | 08/11/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SENTARA NURSING CENTER PORTSMOUTH | 4201 GREENWOOD DRIVE PORTSMOUTH, VA 23701 |

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|---|---|---|---|---|
| F 309 | Continued From page 21 | F 309 | | |

squared, with light serous exudate and 100 percent granulation tissue. The diabetic wound of the left lateral foot had deteriorated. The 8/3/16 measurements were 0.2 x 0.2 x 0.1 centimeters, surface area 0.04 centimeters squared, without exudate and 100 percent granulation tissue. The wound care physician stated because of the deterioration a new treatment was warranted. The wound care physician stated an agent with silver (Silver Hydrogel) was indicated because it would create a moist environment and is effective against a wide variety of bacterias. A daily dressing change was also ordered instead of every 3 day dressing changes. A recommendation for diabetic shoes was made by the wound care physician.

Review of the treatment record revealed for August 2016, a physician's order dated 8/4/16 for Mepilex to the left plantar foot every 3 days starting 8/4/16. The treatment record was signed as the wound care was completed on 8/4/16. No dressing change was scheduled for 8/5/16 or 8/6/16 yet Resident #9's dressing removed prior to wound care on 8/10/16 was dated 8/5/16 not 8/4/16. No documentation was observed indicating why a dressing was applied on 8/5/16. The treatment record also revealed the next dressing change was due 8/7/16 and the treatment record had been signed off as completed on 8/7/16 yet when Resident #9's dressing was removed prior to wound care on 8/10/16 the dressing was dated 8/5/16 not 8/7/16. The treatment record revealed no treatment was scheduled for 8/8/16 or 8/9/16.

On 8/12/16 at approximately 4:00 p.m. the Nurse Consultant was asked if there was a facility policy on caring for diabetic ulcers, the Nurse

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495201 | A. BUILDING _____ B. WING _____ | 08/11/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SENTARA NURSING CENTER PORTSMOUTH | 4201 GREENWOOD DRIVE PORTSMOUTH, VA 23701 |

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|---|---|---|---|---|
| F 309 | Continued From page 22 | F 309 | | |

Consultant stated he would look for a policy but he did not believe there was one. A policy for caring for diabetic ulcers was not provided by the facility staff.

Diabetic foot ulcer care: To care for your wound; keep your blood sugar level under tight control. This helps you heal faster, keep the ulcer clean and bandaged, cleanse the wound daily, using a wound dressing or bandage, try to take fewer steps, do not walk barefoot unless your doctor tells you it is OK. Wear shoes made of canvas, leather, or suede. Do not wear shoes made of plastic or other materials that do not allow air to pass in and out of the shoe. Wear shoes you can adjust easily. They should have laces, Velcro, or buckles. Wear shoes that fit properly and are not too tight. You may need a special shoe made to fit your foot. (https://medlineplus.gov/ency/patientinstructions/000077.htm)

The above findings were shared with the Administrator and Director of Nursing on 8/11/16 at approximately 7:00 p.m. The Director of Nursing stated the expectation was for the assigned nurse to provide Resident # 9 wound care as ordered. The Director of Nursing stated the the nurse who did not provide the wound care to Resident #9's foot was no longer eligible to work in the facility for failure to provide the ordered care. The Director of Nursing then presented a letter she had written to the staffing agency with the identified nurse's name stating the staff member is considered "DO NOT RETURN" to the nursing facility. The facility staff also provided an order for Resident #9 to receive diabetic shoes.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495201 | A. BUILDING _____ B. WING _____ | 08/11/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SENTARA NURSING CENTER PORTSMOUTH | 4201 GREENWOOD DRIVE PORTSMOUTH, VA 23701 |

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|---|---|---|---|---|
| F 311 SS=E | Continued From page 23<br>483.25(a)(2) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS<br><br>A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on clinical record review, staff and resident interview it was determined facility staff failed to assure four of 25 residents (#s 9, 19, 18 and 25) received appropriate treatment and services to maintain or improve transfers and ambulation.<br><br>1. For Resident #9, the facility staff failed to implement a validated Restorative Nursing Program (RNP) designed to maintain and/or improve the resident's balance, transfers and ambulation abilities.<br><br>2. For Resident #19, the facility failed to provide restorative services for ambulation three to five times a week per the facility program policy.<br><br>3. For Resident #25, a 5/25/16, "RESTORATIVE NURSING REFERRAL" was scanned into the wrong electronic record and the resident never received the recommended services.<br><br>4. For Resident #18, the facility staff failed to provide restorative therapy, specifically ambulation, 3x (times) per week and stair training 1x (time) per week from 7/18/16 until the day of survey 8/9/16. | F 311<br>F 311 | F311<br><br>The facility staff must ensure the resident is given the appropriate treatment and services to maintain or improve his or her abilities.<br><br>1. Residents #9 and 18 have been re-screened for Restorative Nursing. Resident #19 has been evaluated by Rehabilitation and started on Physical Therapy. Resident #25 is currently enrolled in Hospice and is not a candidate for Restorative Nursing.<br><br>2. All residents requiring restorative services are at risk.<br><br>3. All residents in need of assistance with ambulation, ROM, or bracing/splinting have been reviewed by the Interdisciplinary team to determine appropriateness for a Restorative Nursing program. Nursing staff were inserviced on the RNP policy on documentation | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495201 | A. BUILDING _____ B. WING _____ | 08/11/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SENTARA NURSING CENTER PORTSMOUTH | 4201 GREENWOOD DRIVE PORTSMOUTH, VA 23701 |

| (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 311 | Continued From page 24 | F 311 | | |

The findings included:
1. For Resident #9, the facility staff failed to implement a validated Restorative Nursing Program (RNP) designed to maintain and/or improve the resident's balance, transfers and ambulation abilities. The failure to implement the Restorative Nursing Program resulted in a loss of Resident #9's walking abilities and other goals achieved while receiving skilled physical therapy.

Resident #9 was originally admitted to the facility 3/10/16 and has not been discharged from the facility since this admission. The current diagnoses are include diabetes, lymphedema and venous insufficiency.

The quarterly Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 6/21/16 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 14 out of a possible 15. This indicated Resident #9 cognitive abilities for daily decision making were intact. The 6/21/16 MDS assessment also revealed Resident #9 was without mood or behavior problems, was continent of bowels and bladder, did not walk, required extensive assistance of 2 with transfers, extensive assistance of 1 with bed mobility, locomotion, dressing, toileting, personal hygiene and bathing.

Resident #9 was observed in bed on 8/9/16 at approximately 3:45 p.m. dressed in a hospital gown. His legs were edematous (swollen) and dark purple to black from the knees to the top of the feet. A tan dressing dated 8/5/16 with dark drainage on it was observed to the left lateral foot and continued halfway beneath the left foot.

F 311

requirements and provision of services on 8/29-9/3/16.

4. The Director of Rehabilitation will audit 10% of all records for those residents receiving restorative services weekly X 6 weeks. Audits will be summarized and presented to the QAPI committee for additional oversight.

5. Date certain: 9/19/16

Please cross reference 12VAC 5-371-220 (A/B/C) Nursing Services

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495201 | A. BUILDING _____ B. WING _____ | 08/11/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SENTARA NURSING CENTER PORTSMOUTH | 4201 GREENWOOD DRIVE PORTSMOUTH, VA 23701 |

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|---|---|---|---|---|
| F 311 | Continued From page 25 | F 311 | | |

Resident #9 stated this was his second admission to the nursing facility and his plan was to receive rehabilitation services and return to the community. Resident #9 stated his greatest concern was the therapists were not working with him any longer and because the therapists were no longer working with him he had loss the ability to walk.
The resident stated, all he could currently do was stand and turn with the staff's help. Resident #9 continued to say, there was an open wound to the left foot and the wound care physician and podiatrist had instructed him not to wear the shoes (a Croc type slip-on) in his room because they were too hard for an individual with circulation problems, decreased feelings in the legs and feet and prone to develop wounds to the feet. The resident stated one of the physicians told him he needed diabetic shoes but he still did not have them.

An interview was conducted with the Rehabilitation Coordinator on 8/11/16 at approximately 12:20 p.m. The Rehabilitation Coordinator stated Resident #9 had received physical therapy and was discharged 7/6/16. The Rehabilitation Coordinator stated the resident was not always compliant with therapy and often complained of pain to his feet. The Physical Therapist discharge summary dated 7/8/16 at 2;25 p.m., was presented by the Rehabilitation Coordinator. The discharge summary read; discharge reason highest practical level achieved. The Rehabilitation Coordinator stated prior to Resident #9's discharge from skilled physical therapy, the physical therapist developed a validate Restorative Nursing Program and made recommendations for nursing to follow. The Rehabilitation Coordinator also stated it is up to

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495201 | A. BUILDING _____ B. WING _____ | 08/11/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SENTARA NURSING CENTER PORTSMOUTH | 4201 GREENWOOD DRIVE PORTSMOUTH, VA 23701 |

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|---|---|---|---|---|
| F 311 | Continued From page 26 | F 311 | | |

nursing to follow through with the recommendations.

The Interdisciplinary care plan had no interventions for the Restorative Nursing Program. The Corporate MDS Consultant stated on 8/10/16 at approximately 12:20 p.m. a physician's order for restorative nursing is not necessary, the recommendations from the skilled therapist is followed by nursing.

The Physical Therapist discharge summary dated 7/8/16 at 2;25 p.m., stated Resident #9 was discharged to reside in this long term care facility and the prognosis to maintain the current level of functioning was good with consistent staff follow - through. Functional Outcomes; bed mobility (supervised assistance), transfers (supervised assistance), level Surfaces (supervised assistance). The discharge recommendations: Home exercise program, assistive device for safe functional mobility, Elevated toilet seat (3 in 1 commode), Assistance with Independent Activities of Daily Living and In-home aide. Restorative Nursing Program: To facilitate patient maintaining current level of performance and in order to prevent decline, development of instruction in the following Restorative Nursing Programs has been completed with the Interdisciplinary Team: ambulation. However, patient does not exhibit motivation to participate.

Review of the Physical Therapist discharge summary dated 7/8/16 revealed Resident #9 met many goals in skilled physical therapy including; the ability to perform bed mobility task with supervision assistance on (goal met 7/4/16). The resident gained the ability to stand supported greater than 3-5 minutes to increase safety with

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495201 | A. BUILDING _____ B. WING _____ | 08/11/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SENTARA NURSING CENTER PORTSMOUTH | 4201 GREENWOOD DRIVE PORTSMOUTH, VA 23701 |

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|---|---|---|---|---|
| F 311 | Continued From page 27 | F 311 | | |

mobility task (goal met 7/6/16). The resident met the goal on 6/27/16 to complete sit to stand transfers with contact guard assistance, to safely ambulate on level surfaces 50 feet using a front wheeled walker with contact guard assistance with adequate weight acceptance. On 6/27/16 the goal was met with the resident walking 75 feet and requiring only stand by assistance. The Physical Therapist discharge summary also revealed 2 long term goals which were met 7/6/16. They were the resident would perform functional transfers with supervised assistance to facilitate increased participation with functional daily activities and the resident will safely ambulate on level surfaces 150 feet using a front wheeled walker with supervised assistance with safety during turning.

Review of the Physical Therapist discharge summary dated 7/8/16 also revealed documentation of Patient and Caregiver Training. It read; Instructed patient and primary caregivers in positioning maneuvers, proper body mechanics, safety sequencing techniques, safe transfer techniques and use of assistive devices in order to facilitate improved functional abilities, increased safety and decrease need for assistance and increase functional mobility skills with carryover demonstrated 75 percent of therapeutic opportunities.

An interview was conducted with the Restorative Nurses Assistant (RNA) #2 on 8/11/16 at 11:45 a.m. RNA #2 stated he was not working with Resident #9 on a restorative nursing program but that did not mean the resident wasn't in a program; RNA #2 referred the surveyor to a lead RNA for further clarification. RNA #2 stated on most days there is a great need for direct care

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495201 | A. BUILDING _____ B. WING _____ | 08/11/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SENTARA NURSING CENTER PORTSMOUTH | 4201 GREENWOOD DRIVE PORTSMOUTH, VA 23701 |

| (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 311 | Continued From page 28 | F 311 | | |

staff, Certified Nursing Assistant (CNA), and usually his assignment is to work as a CNA instead of a RNA.

An interview was conducted with Restorative Nurse's Assistant (RNA) #1 on 8/11/16 at approximately 1:40 p.m. RNA #1 stated all referrals for the Restorative Nursing Program (RNP) come to her and the therapist instructs her and/or others if available on the specific program for the referred individual. RNA #1 stated sometimes the Care Plan team makes referrals but most are recommended by the therapist. RNA #1 states if the treating RNA is not available for instructions directly from the therapist she educates them prior to RNA services beginning. RNA #1 stated most RNP are recommended a frequency of 3-5 times per week for 15 minute sessions. RNA #1 also stated when the referral is received, she gives it to a charge nurse and the charge nurse enters it in the software program to enable the treating RNA to document. RNA #1 stated if the treating RNA observes concerns with follow through the charge nurse is notified and a hold may be put on the RNP services. RNA #1 stated on Unit 2, eight residents were receiving RNA services and neither was Resident #9. RNA #1 stated a referral for restorative services for Resident #9 was not received and neither did she or any other RNA receive education on implementing a RNP for Resident #9.

The facility's policy titled "Functional Restorative Program" with a revision date of 4/10/12 stated the purpose of the Functional Restorative Program is to assist residents in achieving and maintaining optimal physical, mental and psychological functioning... The Clinical Manager/Director of Nursing shall be responsible

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495201 | A. BUILDING _____ B. WING _____ | 08/11/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SENTARA NURSING CENTER PORTSMOUTH | 4201 GREENWOOD DRIVE PORTSMOUTH, VA 23701 |

| (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 311 | Continued From page 29 | F 311 | | |

for implementation and maintenance of the program in their facility/unit. Under Actions the policy stated: the licensed nurse (Registered Nurse or Licensed Practical Nurse) would obtain an order if required, develop an individualized program for the resident, which includes goals/outcomes, interventions/approaches, precautions and special instructions. Consult with rehabilitation specialist (physical, occupational, speech) and other health professionals as needed. Re-evaluate the program monthly. Document functional Restorative programs in the medical record as defined by facility policy.

The above findings were shared with the Administrator and Director of Nursing on 8/11/16 at approximately 7:00 p.m. No additional information related to Resident #9's Restorative Nursing Programs was provided prior to the survey teams exit but an order to obtain diabetic shoes was presented.

2. Resident #19 was 60 years old with an admission date of 3/31/15. Review of his 3/22/16 annual and 6/15/16 quarterly MDS (Minimum Data Set-an assessment protocol) evidenced the resident was cognitively intact with a BIMS (brief interview for mental status) score of 14 out 15. His functional status was limited assistance of one for bed mobility, extensive assist of one for transfers and he was independent in eating. The resident was independent in a motorized scooter for locomotion on and off the unit.

The resident's diagnoses included high blood pressure, viral hepatitis (liver infection) and

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495201 | A. BUILDING _____ B. WING _____ | 08/11/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SENTARA NURSING CENTER PORTSMOUTH | 4201 GREENWOOD DRIVE PORTSMOUTH, VA 23701 |

| (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 311 | Continued From page 30 | F 311 | | |

depression.

Review of the resident's clinical record evidenced a 6/2/15, "RESTORATIVE NURSING REFERRAL". The goal was, Pt (patient) will be able to ambulate up to 50' x 1 (fifty feet one time) with FWW/CGA (front wheeled walker with contact guard assistance). Pt will be able to complete NUSTEP (exercise equipment) on L (level) 5 for minutes."

Review of the, "ADL (activities of daily living) Verification Worksheet" evidenced the resident received restorative ambulation eight times or an average of twice a week. In July the services were provided nine times. In August, once on 8/8/16.

On 8/11/16 at 7:10 pm Resident #19 was interviewed regarding his restorative services. The resident stated, "I don't know why they have the program...they don't do it, to get walked I have to raise hell. I'm not but 60 years old I don't want to spend the rest of my life here."

Following the interview with the resident the restorative program was discussed with the Acting Director of Nurses. The acting DON knew the resident and stated that she has personally walked the resident herself. The acting DON acknowledged she did not document the activity or time spent with the resident.

3. Resident #25's 5/25/16, "RESTORATIVE NURSING REFERRAL" was scanned into the wrong electronic record and she never received the recommended services.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495201 | A. BUILDING _____ B. WING _____ | 08/11/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SENTARA NURSING CENTER PORTSMOUTH | 4201 GREENWOOD DRIVE PORTSMOUTH, VA 23701 |

| (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 311 | Continued From page 31 | F 311 | | |

Resident #25 was 89 years old and was admitted to the facility on 4/23/16. The 14 day admission MDS was completed following a hospital admission with a readmission date of 7/13/16.

The resident's brief interview for mental status evidenced she was a 13 out of 15 indicating cognition was intact. Resident #15's diagnoses evidenced depression, anxiety disorder, respiratory failure and cardiomyathy. The resident required limited assistance of one person with locomotion on and off the unit in a wheelchair.

The restorative referral's goal was, "maintain ambulatory status". Ambulates short distances with a front wheeled walker with moderated to minimum assistance.

The restorative aides were unable to provide documentation that the services had been started.

This was discussed with the acting Administrator and DON on 8/11/16 at approximately 8:30 p.m., no additional information was received.

4. Resident #18 was admitted to the facility on 3/25/15. Diagnoses for Resident #18 included but are not limited to autonomic neuropathy (damaged nerves) peripheral vascular disease (numbness in extremities), and osteoporosis with right forearm fracture with delayed healing.

Resident #18's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 5/18/16 coded Resident #18 with extensive assist for transfers (how resident moves between surfaces

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495201 | A. BUILDING _____ B. WING _____ | 08/11/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SENTARA NURSING CENTER PORTSMOUTH | 4201 GREENWOOD DRIVE PORTSMOUTH, VA 23701 |

| (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 311 | Continued From page 32 | F 311 | | |

including to and from bed, chair wheelchair, standing position). Resident #18 was coded independent and no set up or physical assist for locomotion (on and off unit-moving between locations in room and areas set aside for activities and dining.) if in a wheelchair, self sufficiency once in chair. Resident #18 had a mobility device (wheelchair) and was coded as activity did not occur for walking. Resident #18 was coded with the highest BIMS (Brief Interview Mental Status-an assessment tool) score of 15 with no cognitive impairment.

Resident #18 's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 8/8/16 coded Resident #18 with limited assist with ADLs (dressing, transfers) and extensive assist with toileting and independent with set up locomotion on and off unit (moving to and from locations on the unit and off the unit with wheelchair). Resident #18 had an a mobility device (wheelchair) and was coded as activity did not occur for walking.

During the survey from 8/9/16 through 8/11/16 observations were made of Resident #18 in her wheelchair self propelling and no observations were made of her walking.

On 8/10/16 and 8/11/16 Resident #1's clinical record was reviewed. The review showed a physician order dated 7/15/2016. The order read Resident #18 was to get "restorative nursing program for ambulation and stair training" with notes: "Resident [#18] to ambulate and stair training (3x/week and 1x week) respectively."

The Restorative Nursing Referral for Resident #18 dated 7/15/16 documented the goal: "preserve current function in ambulation and stair

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495201 | A. BUILDING _____ B. WING _____ | 08/11/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SENTARA NURSING CENTER PORTSMOUTH | 4201 GREENWOOD DRIVE PORTSMOUTH, VA 23701 |

| (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 311 | Continued From page 33<br>climbing for expected future d/c [discharge] to home." The recommendations documented: "amb [ambulate] and stair training (3x/wk and 1x/wk) respectively."<br><br>The ADL Verification Worksheet showed all observations from 5/11/16 (Resident #18's re-admission date to the facility) until 8/11/16 (last day of the survey). Only one observation was documented on 7/19/16 and read, "walking distance 200 and walking minutes 15, tolerance: good."<br><br>On 8/11/16 at approximately 3:00 p.m. the restorative CNA #1 stated, "I have no more documentation [for Resident #18 regarding restorative therapy]. The only documentation submitted documented 15 minutes of restorative walking from 7/18/16 to 8/11/16.<br><br>The Director of Nurses (DON) was made aware of the findings on 8/11/16 at 7:40 p.m. with no further information presented. The DON added to go with what the restorative CNA gave you.<br><br>The facility administration was informed of the findings during a briefing on 8/11/16 at approximately 7:50 p.m. The facility did not present any further information about the findings. | F 311 | | |
| F 312 SS=E | 483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS<br><br>A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. | F 312 | F312<br><br>The facility staff must ensure a tub or shower bath is offered and/or provided as often as needed, but not less than twice weekly. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495201 | A. BUILDING _____ B. WING _____ | 08/11/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SENTARA NURSING CENTER PORTSMOUTH | 4201 GREENWOOD DRIVE PORTSMOUTH, VA 23701 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 312 | Continued From page 34 | F 312 | | |

This REQUIREMENT is not met as evidenced by:
Based on resident interviews, staff interviews, clinical record review and facility document review the facility staff failed to offer and or provide a tub or shower bath as often as needed, but not less than twice weekly to 2 of 25 residents in the survey sample, Residents #3 and #18.

The findings included:

1. Resident #3 was admitted to the facility on 2/19/16 with diagnoses to include lupus and seizure disorder.

Lupus is a chronic, autoimmune disease that can damage any part of the body (skin, joints, and/or organs inside the body). Chronic means that the signs and symptoms tend to last longer than six weeks and often for many years. www.lupus.org

The current MDS (Minimum Data Set) with an assessment reference date of 5/18/16 coded the resident as scoring a 15 out of 15 on the Brief Interview for Mental Status (BIMS), indicating the resident's cognition was intact. Section E. Behaviors E 0800. Rejection of care was not coded for the resident exhibiting this behavior. The resident was dependent on staff for full-body bath/showers. The resident resided on unit 2.

On 8/9/16 at 4:25 p.m., an interview was conducted with Resident #3. The resident was lying in bed using a personal lap top computer. The resident was asked if the staff offer or provide twice weekly showers. The resident stated, "No, I haven't received a shower since January or February, whenever I was admitted."

1. Resident #3 was offered and/or provided a shower on 8/11/16. Resident #18 was provided a shower on 8/13/16.

2. All residents requiring assistance with tub or shower baths are at risk.

3. Direct care staffs were inserviced on the ADL policy on 8/29-9/3/16. All tub and shower bath schedules for those residents able to communicate their preferences have been reviewed to accommodate individual wishes. Each tub and shower bath has been assigned on the CNA schedule to delineate responsibility.

4. The Clinical Manager or designee will audit four residents twice weekly to assure tub or shower baths are offered and/or provided. Audits will be forwarded to the DON who will summarize and report to the QAPI committee for additional oversight.

5. Date certain: 9/19/16

Please cross reference 12 VAC 5-371-220 (D) Nursing Services

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495201 | A. BUILDING _____ B. WING _____ | 08/11/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SENTARA NURSING CENTER PORTSMOUTH | 4201 GREENWOOD DRIVE PORTSMOUTH, VA 23701 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 312 | Continued From page 35 | F 312 | | |

The comprehensive plan of care with a goal date of 8/19/16 identified a grooming, hygiene and bathing deficit. The deficit was related to the resident being "totally dependent on the staff." The goal was that the resident would be clean and free from odor through daily care. The interventions included to offer twice weekly showers.

The unit 2 shower schedule evidenced the resident was scheduled to be offered/provided a shower on Mondays and Thursdays on the 7 am-3 pm shift.

A certified nurse aide (CNA #1) was interviewed on 8/9/16 at 10:30 a.m. The CNA was asked how do they know which resident gets a shower that day, and where do they document whether a shower was given or refused. The CNA stated the assignment sheet used to have a section that lists the showers for that day. This assignment sheet is no longer used. The CNAs now have to look on the daily shower log. The CNA stated if a shower is refused they are to report it to the nurse.

The above findings was shared with the interim Administrator and the interim Director of Nursing (DON) during an end of day meeting conducted on 8/10/16 at 6:10 p.m.

During a follow up with the DON on 8/11/16 at 10:20 a.m., she stated the resident was offered a shower this morning and declined twice. The DON also stated, "There is no way to document in (name of computer program) whether showers were provided or refused.

Review of the clinical record nursing progress

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495201 | A. BUILDING _____ B. WING _____ | 08/11/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SENTARA NURSING CENTER PORTSMOUTH | 4201 GREENWOOD DRIVE PORTSMOUTH, VA 23701 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 312 | Continued From page 36 | F 312 | | |

notes from 7/3/16 through 8/10/16 failed to evidence any documentation of the resident refusing a shower.

The facility policy titled "Personal Hygiene and Grooming" with a revision date of 12/10/2013 read, in part: Purpose-Residents receive personal care to maintain adequate hygiene.
4. Each resident will receive tub or shower baths as often as needed, but not less than twice weekly.

The facility was allowed an opportunity to provide any additional information to indicate that a twice weekly shower was offered/provided to Resident #3.

No further information was provided prior to exit.

2 . Resident #18 was admitted to the facility on 3/25/15. Diagnoses for Resident #18 included but are not limited to autonomic neuropathy (damaged nerves) peripheral vascular disease (numbness in extremities), osteoporosis with fracture, right forearm with delayed healing and end stage renal disease (kidneys cease functioning). Resident #18's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 8/8/16 coded Resident #18 with limited assist with ADLs (dressing, transfers) and extensive assist with toileting and total dependence for bathing. Resident #18 was coded with the highest BIMS (Brief Interview Mental Status-an assessment tool) score of 15 with no cognitive impairment.

During the survey from 8/9/16 through 8/11/16 observations were made of Resident #18 in her wheelchair self propelling and no observations

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495201 | A. BUILDING _____ B. WING _____ | 08/11/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SENTARA NURSING CENTER PORTSMOUTH | 4201 GREENWOOD DRIVE PORTSMOUTH, VA 23701 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 312 | Continued From page 37 | F 312 | | |

were made of her walking.

On 8/10/16 and 8/11/16, Resident #18's clinical record was reviewed. The reviewed documented a physicians order for dialysis (externally cleansing blood) 3 x (3 times) weekly starting 6/28/16 with a note: "Every Monday, Wednesday, and Friday".

According to the TAR (Treatment Record Administration) for August 2016 Resident #18 was documented to go out of the facility for dialysis treatment each Monday, Wednesday, and Friday.

Review of the care plan documented Resident #18 as totally dependent on staff for bathing and the goal to bath/shower her by staff over the next 90 days starting 7/14/16.

The Station 2 Shower Check List documented that Resident #18 was scheduled to be showered on Mondays and Thursdays on the 7:00 a.m. through 3:00 p.m. shift

On 8/9/16 at approximately 3:00 p.m. during the group interview with 8 facility residents, Resident #18 stated, "I only have showers on Thursdays and none on Mondays, I go out on Mondays for dialysis so I don't shower on Mondays." Resident #1 also stated I only get one shower a week and I try and wash myself the other days. On 8/11/16 at 2:15 p.m. Resident #18 stated, "I like showers in the morning and Tuesday mornings would be fine for showers."

On 8/11/16 at 2:25 p.m. RN #1 the clinical manager on the unit where Resident #18 resides stated, "I do not know anything about this

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495201 | A. BUILDING _____ B. WING _____ | 08/11/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SENTARA NURSING CENTER PORTSMOUTH | 4201 GREENWOOD DRIVE PORTSMOUTH, VA 23701 |

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

F 312 Continued From page 38

[Resident #18] having one shower a week] check with the CNA [#6] because she gives her [Resident #18] showers.

On 8/11/16 at 2:30 p.m. CNA #6 stated, "I give her [Resident #18] a shower every Thursday if I am assigned to her, once a week and the resident hasn't mentioned this [having only one shower a week]. On 8/11/16 at approximately 3:00 p.m. CNA #1 stated, "I make the schedule for CNAs for showers and we can offer Saturday or Tuesday to [Resident #18], it's up to the resident."

DON was debriefed on 8/11/16 at 7:40 p.m. with no information presented. The DON stated staff need to give baths and showers at least 2 days a week and we can change her (Resident #18's) day to Tuesday. Resident #18 had only on shower on Thursdays from 7/14/16 through 8/11/16.

The Personal Hygiene and Grooming Policy revised on 12/10/2013 requires residents to have tub or shower baths as often as needed but not less than twice weekly...residents whose medical condition prohibit tub or shower baths will have a sponge bath daily. The facility policy does not document consideration for residents' preference for time and type of bathing. According to the DON and Administration if the resident has a preference for showers the staff would try to accommodate.

The facility administration was informed of the findings during a briefing on 8/11/16 at approximately 7:50 p.m. The facility did not present any further information about the findings.

F 312

F 314 483.25(c) TREATMENT/SVCS TO

F 314

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495201 | A. BUILDING _____ B. WING _____ | 08/11/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SENTARA NURSING CENTER PORTSMOUTH | 4201 GREENWOOD DRIVE PORTSMOUTH, VA 23701 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 314 SS=G | Continued From page 39 PREVENT/HEAL PRESSURE SORES | F 314 | F314 | |

Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.

This REQUIREMENT is not met as evidenced by:
Based on observation, staff interviews, facility document review and during the course of a complaint investigation the facility staff failed to provide the necessary care and services to prevent pressure sore development and promote healing of a pressure sore for 2 of 25 residents in the survey sample, Resident #21 and #3.

1. Resident #21 developed a facility acquired advanced stage III pressure sore to the sacrum. The pressure sore was first identified by the wound care specialist during a routine assessment. The facility staff failed to implement treatments in a timely manner. The wound further deteriorated to a stage IV pressure sore resulting in harm.

2. The facility staff failed to follow the physician orders for a once a day dressing change for Resident #3's stage IV sacral pressure sore.

A pressure ulcer is localized injury to the skin and/or underlying tissue usually over a bony prominence (area), as a result of pressure,or

The facility staff 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, facility staff must ensure that a resident having pressure sores receives necessary care and services to promote healing.

1. Resident #21 was discharged from the facility on 12/26/15. No immediate correction is possible. Resident #3's dressing change was completed on 8/10/16.

2. All residents with or without pressure sores are at risk.

3. A 100% audit of all residents was completed on 7/22/16 to assess for any unidentified pressure ulcers. All licensed nursing staff were educated on the policy and procedures for identification, prevention, care, and, documentation of pressure ulcers on 7/27/16, 8/3/16, 8/5/16, and, 8/29-9/3/16. C.NA staff were educated on the policy and procedure for repositioning, skin, and, incontinence care on 7/27/16, and, 8/29-9/3/16.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495201 | A. BUILDING _____ B. WING _____ | 08/11/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SENTARA NURSING CENTER PORTSMOUTH | 4201 GREENWOOD DRIVE PORTSMOUTH, VA 23701 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 314 | Continued From page 40 | F 314 | | |

pressure in combination with shear. National Pressure Ulcer Advisory Panel.

The findings included:

1. Resident #21 entered the facility without a pressure sore and was discharged home on 12/26/15 with a stage IV pressure sore.

Resident #21 was admitted to the facility on 9/15/15 for specialized rehabilitative services with a discharge plan to go home. The resident diagnoses included advanced Parkinson disease, advanced dementia and diabetes.

Parkinson's disease is a progressive disorder of the nervous system that affects movement.

The admission MDS (Minimum Data Set) with an assessment reference date (ARD) of 9/22/15 coded the resident as having long and short-term memory deficits; and severely impaired daily decision making skills. The resident required extensive assistance of two staff for bed mobility (turning and repositioning) and transfers. The resident was wheelchair bound. Under Skin Conditions the resident was coded as having a stage II pressure ulcer identified on admission 9/15/15 (this was an inaccurate coding). Under Section K. Nutritional Status the resident's weight was recorded as 178 pounds. The quarterly MDS with an ARD date of 12/13/15 recorded the resident's weight as 180 pounds.

The MDS describes a stage II pressure ulcer as partial thickness loss of dermis, presenting as a shallow open area with a red or pink wound bed, without slough (dead tissue). May also present as an intact or open/ruptured serum-filled blister.

Wound care orders were audited on 7/29/16 to assure accurate orders were in place for wound treatments.

4. The Clinical manager will audit 5 skin assessments weekly X 3 months for accuracy. The Clinical manager will audit 10% of dressing changes biweekly X 6 weeks to ensure dressings are changed as ordered. Audits will be forwarded to the DON who will summarize and report to the QAPI committee for additional oversight.

5. Date certain: 9/19/16.

Please cross reference 12VAC 5-371-220 (A, C.1) Nursing Services

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495201 | A. BUILDING _____ B. WING _____ | 08/11/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SENTARA NURSING CENTER PORTSMOUTH | 4201 GREENWOOD DRIVE PORTSMOUTH, VA 23701 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 314 | Continued From page 41 | F 314 | | |

The Nursing Admission Assessment Comprehensive dated 9/15/15 was reviewed. Under Skin, the resident was identified with "red abrasions" to both gluteal folds. The resident's skin was checked as having "abrasions". M0445 Does the patient have a pressure ulcer? was marked "No".

The wound care specialist's (#1) initial assessment of the resident was on 9/16/15. The chief complaint was that the resident had a wound on their buttock. The focused wound exam indicated the etiology (source) of the wound was an infection. The right buttock wound measured 0.4 x 0.2 x 0.2 centimeters with 100% granulation tissue (healthy). The physician documented: Patient appears to have had a follicullitis leading to abscess and open area. Will start Hydrogel (a treatment), apply a dry protective dressing daily and Keflex (an antibiotic) 500 mg (milligrams) twice a day for 7 days.

Folliculitis is a skin condition caused by an inflammation of one or more hair follicles in a limited area.

A Hydrogel dressing is designed to hold moisture in the surface of the wound, providing the ideal environment for both cleaning the wound, and allowing the body to rid itself of necrotic tissue.

The wound care specialist's (#2) follow up assessment was conducted on 9/25/15. The right buttock wound (follicullitis) was resolved. The resident presented with a new skin condition; a skin shear wound to the left buttock. The wound measured 1.5 x 0.5 x 0.1 centimeters. The treatment was to continue the Hydrogel with a

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495201 | A. BUILDING _____ B. WING _____ | 08/11/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SENTARA NURSING CENTER PORTSMOUTH | 4201 GREENWOOD DRIVE PORTSMOUTH, VA 23701 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 314 | Continued From page 42 | F 314 | | |

foam dressing every day; and a follow up within 7 days.

Skin Shear: an injury caused by applied force that tends to cause an opposite but parallel sliding motion of the planes of an object. Such motions cause tissues and blood vessels to move in such a way that blood flow may be interrupted, placing the patient at risk for pressure ulcers. An example of a shearing force is seen when a patient slumps in a chair; the skin around the buttocks is stretched by the movement and interferes with circulation. www.medical-dictionary.com

On 10/1/15 the wound care specialist (#2) conducted the follow up assessment. During this evaluation the resident presented with a stage III pressure ulcer/sore to the sacrum. Etiology-pressure. The wound measured 3 x 2.5 x 0.1 centimeters, with 75% yellow necrotic tissue (dead) and 25% granulation (healthy tissue). The wound required surgical excisional debridement of subcutaneous tissue (to remove the dead tissue). The treatment was changed to include Santyl (an enzymatic debriding ointment), and a dry dressing every day. The wound care specialist documented under consent that she spoke with the responsible party who agreed to proceed with the procedure (debridement). The assessment and plan read, in part: Deteriorated due to generalized decline of patient: change dressing, optimize nutrition.

According to the Treatment Administration Record for October 2016, the Santyl was not started until five days later, on 10/6/15.

The MDS describes a stage III pressure ulcer as: Full thickness tissue loss. Subcutaneous fat may

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495201 | A. BUILDING _____ B. WING _____ | 08/11/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SENTARA NURSING CENTER PORTSMOUTH | 4201 GREENWOOD DRIVE PORTSMOUTH, VA 23701 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 314 | Continued From page 43 | F 314 | | |

be visible but bone, tendon or muscle is not exposed. Slough may be present but does not obscure (hide) the depth of tissue loss. May include undermining and tunneling.

On 8/10/16 at 4:25 p.m., wound care specialist #2 was interviewed. She stated, "I would not have expected the wound (shear) to have gotten worse". She stated there was no nutritional reason for the decline of the wound, stating,"It became larger.. definitely got worse over that period of time...quite a bit larger...". The wound care specialist was asked in her professional opinion based on the presentation of the wound how long do you believe the wound was like this, prior to her assessment on 10/1/15? She stated, "At least three days...". When asked if she would have expected the staff to have notified her of a change in condition of the wound, she stated, "If there is a significant deterioration, yes, I would expect them to notify me". When asked did the wound have a significant deterioration she stated, "Yes". She further stated, "They know how to get a hold of me, I could have come in to see the wound sooner or change treatment". The wound care specialist stated the left buttock shear had enlarged, deteriorated and now was on the sacrum as a stage III pressure sore. The 10/1/15 assessment and plan that indicated the wound deteriorated due to a generalized decline of the patient was clarified. She stated the electronic program used for documentation includes this as a general response as to why a wound would deteriorate. She could not state what the generalized decline was.

On 9/28/15 the Registered Dietician (RD) documented, "weight down 10 lbs (pounds) since admission. Resident with good po (by mouth)

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495201 | A. BUILDING _____ B. WING _____ | 08/11/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SENTARA NURSING CENTER PORTSMOUTH | 4201 GREENWOOD DRIVE PORTSMOUTH, VA 23701 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 314 | Continued From page 44 | F 314 | | |

intake; weight loss may be related to fluid shift as meds include Lasix (a diuretic)..." On 9/30/15 the RD documented the resident's recorded weight was 177 pounds.

A second interview with the wound care specialist was conducted on 8/11/16 at 2:20 p.m. She was asked what would have caused the sacral wound to have deteriorated that rapidly? She stated, "Usually from someone laying in one position too long..it could have deteriorated if he laid on it for 24 hours or longer...unless he wasn't being turned, I rarely ever see it in someone being turned and repositioned."

Review of the Nursing Daily Notes and TAR's from 9/25/15 through 10/1/15 failed to evidence the resident was turned and repositioned every two hours.

The facility policy titled "Pressure Ulcer Prevention" revised 11/12/13 read, in part: "Policy Statement: To prevent development of pressure ulcers. Turning and repositioning frequency is dependent on resident assessment and chart on TAR (treatment administration record)."

On 10/8/15 the wound care specialist assessed the wound. The wound had further deteriorated, and was now unstageable, the wound bed measured 4 x 5 x 0.1 centimeters and covered with 80% thick black necrotic tissue, 10% yellow necrotic tissue and 10% granulation tissue (healthy). A recommendation included to change the support surface (bed mattress) to a Group 2 mattress (an alternating pressure and low air loss mattresses and overlays).

The Group 2 support surface was not ordered

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495201 | A. BUILDING _____ B. WING _____ | 08/11/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SENTARA NURSING CENTER PORTSMOUTH | 4201 GREENWOOD DRIVE PORTSMOUTH, VA 23701 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 314 | Continued From page 45 | F 314 | | |

until 10/9/16; eight days after the stage III pressure sore was discovered and continued deterioration.

According to the "Quick Reference Guide for Clinicians Number 15 Pressure Ulcer Treatment" from the U.S. Department of Health and Human Services read, in part: Managing Tissue Load-the goal of tissue load management is to create an environment that enhances soft tissue viability and promotes healing of the pressure ulcer(s). Positioning techniques and support surfaces for patients in bed are important factors in the management of tissue loads.

On 10/15/15 the wound care specialist assessed the wound. The wound was now a stage IV.

The MDS describes a stage IV pressure sore as: Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar (dead tissue) may be present on some parts of the wound bed. Often include undermining and tunneling.

A protein supplement (Prostat AWC-advance wound care daily) to aid in wound healing was not initiated until 10/15/15; fifteen days after the stage III pressure ulcer was identified on 10/1/15. In those 15 days the wound continued to deteriorate to an unstageable on 10/8/15, and a stage IV on 10/15/15.

According to the "Quick Reference Guide for Clinicians Number 15 Pressure Ulcer Treatment" from the U.S. Department of Health and Human Services read, in part: Nutritional Assessment and Management...the goal of nutritional assessment and management is to ensure that the diet of the individual with a pressure ulcer

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495201 | A. BUILDING _____ B. WING _____ | 08/11/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SENTARA NURSING CENTER PORTSMOUTH | 4201 GREENWOOD DRIVE PORTSMOUTH, VA 23701 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 314 | Continued From page 46 | F 314 | | |

contains nutrients adequate to support healing.

The resident was followed weekly by the wound care specialist. The wound deteriorated, became infected and required additional excisional debridement on 10/8, 10/15, 10/22, 10/29, 11/5, 11/12, 11/18, 11/24, and 12/2/15. Treatment changes were ordered.

The TAR's and MAR's (Treatment Administration Records and Medication Administration Records) were reviewed for compliancy with the recommendations/orders.

Delay in treatment changes and medications were found as follows:
1. 10/1/15 Santyl order once a day; not started until 10/6/15.
2. 10/8/16 added Mepilex dressing (a foam absorbent dressing); not started until 10/15/15.
3. 10/15/15 added Dakins 1/4 strength once a day; not started until 10/19/15. Dakins' SolutionÂ® Quarter Strength is a broad-spectrum topical antimicrobial solution, effective against MRSA, VRE, other bacteria, viruses, molds, fungi and yeast. Also used for odor control.
4. 10/22/15 increased Dakins to twice a day, and added the antifungal Flagyl 500 mg twice a day for 7 days to be placed into the wound bed due to wound odor and suspected infection. The Flagyl was applied only once, on 10/22/15, due to a transcription error.
5. 10/29/15 discontinued the Dakins solution added Gentamycin 0.1% once a day (an antibiotic). The Dakins solution was not discontinued until 11/13/15.
6. 11/18/15 the Gentamycin 0.1% was discontinued. The staff continued to administer the Gentamycin until 11/25/15.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495201 | A. BUILDING _____ B. WING _____ | 08/11/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SENTARA NURSING CENTER PORTSMOUTH | 4201 GREENWOOD DRIVE PORTSMOUTH, VA 23701 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 314 | Continued From page 47 | F 314 | | |

7. 11/18/15 the Cipro 500 mg, added on 10/22/15, last dose was scheduled for 11/18/15. The Cipro was ordered for an additional 14 days, and not restarted until 11/25/15.
8. 12/9/15 added Calcium alginate dressing once a day; was not started until 12/11/15. Calcium alginate is used for moderate to heavy exudate (drainage), including infected wounds.

The above findings of the staff failing to implement orders in a timely manner as recommended was shared during a second interview with the wound care specialist conducted on 8/11/16 at 2:20 p.m. Her response was, "That is a problem...the break is from the person who takes the order off..." She stated the nurse prints out her notes and they are placed into orders. She stated, "ultimately the primary care physician writes the order, but also has access to my notes". She stated she was not made aware of the aforementioned delay and/failure to follow treatment change orders for Resident #21. She also was asked why Prostat AWC was not started when the stage III pressure ulcer was first identified, she stated, "Prostat recommendations are the responsibility of the dietician."

On 8/11/16 at 5:30 p.m., the director of nursing (DON) was interviewed. The above findings was shared. The DON stated she would have expected the staff to have notified the physician of the deterioration of the wound, instead of the wound doctor discovering it first. She also stated she would have put a low air loss mattress in place as soon as the wound presented as a stage III. She stated the nurse does not need an order to initiate the change in mattress. She stated pressure sores are reviewed weekly at the

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495201 | A. BUILDING _____ B. WING _____ | 08/11/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SENTARA NURSING CENTER PORTSMOUTH | 4201 GREENWOOD DRIVE PORTSMOUTH, VA 23701 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 314 | Continued From page 48 | F 314 | | |

standards of care meetings. She also stated that she was fairly new to the facility and identified there were concerns with pressure sores. She stated, "There didn't seem to be a good system in place to identify and reporting of (pressure sores). I have since developed an action plan." The action plan included pressure ulcer prevention, identification, care and documentation.

2. Resident #3 was admitted to the facility on 2/19/16 with diagnoses to include lupus, seizure disorder and a chronic stage IV pressure sore.

Lupus is a chronic, autoimmune disease that can damage any part of the body (skin, joints, and/or organs inside the body). Chronic means that the signs and symptoms tend to last longer than six weeks and often for many years. www.lupus.org

The current MDS (Minimum Data Set) with an assessment reference date of 5/18/16 coded the resident scoring a 15 out of 15 on the Brief Interview for Mental Status (BIMS), indicating the resident's cognition was intact. Section M. Skin Condition coded the resident as having one stage IV pressure sore.

The MDS describes a stage IV pressure sore as: Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar (dead tissue) may be present on some parts of the wound bed. Often include undermining and tunneling.

The resident's pressure sore was being evaluated on a weekly basis by the wound care specialist. The current notes dated 8/10/16 describes the stage IV pressure sore as measuring 3.1 x 2 x 0.3 centimeters. The wound had 100% granulation tissue (healthy).

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495201 | A. BUILDING _____ B. WING _____ | 08/11/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SENTARA NURSING CENTER PORTSMOUTH | 4201 GREENWOOD DRIVE PORTSMOUTH, VA 23701 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 314 | Continued From page 49 | F 314 | | |

The August 2016 TAR (treatment adminsitration record) evidenced the wound care specialist current treatment order dated 7/27/16 that read, Cleanse sacral wound with normal saline, apply algisite M (calcium alignate dressing) and dry dressing every day. The treatment was scheduled to be changed on the day shift.

The August TAR evidenced initialed entries by the nurses that the dressing was changed every day.

On 8/10/16 at 3:30 p.m., a dressing change observation of Resident #3's pressure sore was conducted with the licensed practical nurse (LPN#10) and wound care specialist. The nurse established a clean barrier, placed the dressing supplies on top of it, washed her hands and put on clean gloves. The sacral dressing was observed saturated with drainage and was dated as last changed on 8/8/16. The nurse was asked what was the dressing change frequency, she stated, "Once a day".

Further review of the TAR for August evidenced an inaccurate entry. The nurse initialed on 8/9/16 that the dressing was changed.

The above findings was shared with the interim Administrator and the interim Director of Nursing during an end of day meeting conducted on 8/10/16 at 6:10 p.m.

A follow up interview with the DON was conducted on 8/11/16. The DON stated, "The nurse documented it was done and it wasn't." The DON stated the nurse was an agency nurse. The DON provided a copy of an email sent to the agency dated 8/10/16 at 9:24 p.m. The subject

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495201 | A. BUILDING _____ B. WING _____ | 08/11/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SENTARA NURSING CENTER PORTSMOUTH | 4201 GREENWOOD DRIVE PORTSMOUTH, VA 23701 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 314 | Continued From page 50<br>was DNR Staff (do not return). Listed on this email was the nurse who failed to change the dressing on 8/9/16 for Resident #3. The email read in part that this nurse along with another nurse were not allowed to come back to the facility due to failure to provide a dressing change. | F 314 | | |
| F 323 SS=D | 483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES<br><br>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, resident interview, staff interview and clinical record review the facility staff failed to ensure the resident environment remained free of accident hazards for 1 of 25 residents in the survey sample, Resident #17.<br><br>The facility failed to ensure Resident #17's cleaning products were stored in a manner to prevent accidents.<br><br>The findings included:<br><br>Resident #17 was admitted to the facility on 12/11/15 with diagnoses to include end stage kidney disease requiring dialysis three times a week and chronic obstructive pulmonary disease (COPD). | F 323 | F323<br><br>The facility staff must ensure the resident environment remains free of accident hazards.<br><br>1. Resident #17's cleaning products were secured in a locked cabinet on 8/11/16.<br><br>2. All residents are at risk if cleaning products are not properly stored.<br><br>3. All rooms were checked on 8/25/16 for any unsafe products kept at bedside. Any items identified have been removed or securely stored. Staff was inserviced on 8/29-9/3/16 to review safe storage of hazardous chemicals.<br><br>4. The Director of Environmental Services will conduct weekly audits X 6 weeks on 10 rooms to confirm any hazardous chemicals | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495201 | A. BUILDING _____ B. WING _____ | 08/11/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SENTARA NURSING CENTER PORTSMOUTH | 4201 GREENWOOD DRIVE PORTSMOUTH, VA 23701 |

| (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 |
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| F 323 | Continued From page 51 | F 323 | | |

The current MDS (Minimum Data Set) with an assessment reference date of 6/30/16 coded the resident as scoring a 15 out of a possible 15 on the Brief Interview for Mental Status (BIMS), indicating the resident had intact cognition.

On 8/9/16 at 2:50 p.m., the resident was interviewed. The observation of the multiple cleaning products, such as disinfectant sprays on a of a dresser drawer was shared. Resident #17 stated he purchased the cleaning products himself when he goes out of the facility. He stated that when the nurses empty urine and stool into the toilet there is splatter left behind. He also stated housekeeping does not do a good job cleaning the bathroom. The resident's closet drawer was observed to have a lock. The resident was asked if there were any wandering resident's that enter his room. The resident stated, "Yes", and named a resident who resided on another unit. Resident #17 stated this resident has come into his room several times and slept on his bed, the roommate who was in his own bed at this time substantiated this statement.

On 8/10/16 at 10:15 a.m., the cleaning products stored on top of the dresser drawer were no longer there. On the resident's bedside drawer were two bottles of opened isopropyl alcohol, a 32 ounce and 16 ounce bottle. On top of the roommates closet was a spray bottle of Virex spray (a cleaning product).

On 8/11/16 at 3:20 p.m., the resident was observed at the bedside. The resident was asked about the cleaning products. He stated they were locked up inside his closet. The isopropyl alcohol bottles remained at the bedside. The resident

are stored safely. The results of this audit will be presented to the QAPI committee for additional oversight.

5. Date certain: 9/19/16.

Please cross reference 12VAC 5-371-220 (A, C.1) Nursing Services

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495201 | A. BUILDING _____ B. WING _____ | 08/11/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| SENTARA NURSING CENTER PORTSMOUTH | 4201 GREENWOOD DRIVE PORTSMOUTH, VA 23701 |

| (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 |
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| F 323 | Continued From page 52<br>stated he uses the isopropyl alcohol on his face after shaving as a deep cleaner as it reduces the "bumps".<br><br>The above findings was shared with the Administrator and the Director of Nursing during an end of day meeting conducted on 8/10/16 at 6:10 p.m. They stated the resident's cleaning supplies should be stored and locked in his closet.<br><br>The facility was provided an opportunity to provide any additional information for consideration.<br><br>No additional information was provided prior to exit. | F 323 | | |
| F 406 SS=E | 483.45(a) PROVIDE/OBTAIN SPECIALIZED REHAB SERVICES<br><br>If specialized rehabilitative services such as, but not limited to, physical therapy, speech-language pathology, occupational therapy, and mental health rehabilitative services for mental illness and mental retardation, are required in the resident's comprehensive plan of care, the facility must provide the required services; or obtain the required services from an outside resource (in accordance with §483.75(h) of this part) from a provider of specialized rehabilitative services.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on resident interview, staff interview and clinical record review the facility staff failed to provide specialized rehabilitative services to meet the needs of 1 of 25 residents in the survey | F 406 | F406<br><br>The facility staff must provide specialized rehabilitative services to meet the needs of the residents.<br><br>1. Resident #3 was evaluated by physical therapy on 8/12/16 and had an order initiated for a podus boot to manage foot drop.<br><br>2. All residents with foot drop are at risk.<br><br>3. A 100% review was completed on all residents with foot drop to assess for the need to implement orthotic devices. Licensed staff was inserviced on 8/29-9/3/16 | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495201 | A. BUILDING _____ B. WING _____ | 08/11/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| SENTARA NURSING CENTER PORTSMOUTH | 4201 GREENWOOD DRIVE PORTSMOUTH, VA 23701 |

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|---|---|---|---|---|

F 406 Continued From page 53
sample, Resident #3.

The rehabilitative services department failed to follow through with Resident #3's request for an orthotic device on 5/9/16. The device was to prevent and or minimize contracture and or worsening left foot drop (plantarflexion contractures).

The findings included:

Resident #3 was admitted to the facility on 2/19/16 with a diagnoses of functional quadriplegia.

CMS (Center for Medicare and Medicaid Services) definition of functional quadriplegia "refers to complete immobility due to severe physical disability or frailty." Conditions such as cerebral palsy, stroke, pressure ulcers, contractures, advanced dementia, etc. can also cause functional paralysis that may extend to all limbs hence, the diagnosis functional quadriplegia.

The current MDS (Minimum Data Set) with an assessment reference date of 5/18/16 coded the resident as scoring a 15 out of 15 on the Brief Interview for Mental Status (BIMS), indicating the resident's cognition was intact. Section G. Functional Status coded the resident as having functional limitation of range of motion that interfered with daily functions to both upper and lower extremities (arms and legs).

On 8/9/16 at 4:25 p.m., an interview was conducted with the resident. The resident stated she had asked the therapy department for a brace to prevent the left foot drop from getting

F 406
regarding notation of therapy recommendations, obtaining physician orders for orthotic devices, and, placement of ordered devices.

4. The Rehabilitation Director will audit 5 residents' weekly X 6 weeks to assure devices are being utilized as ordered. The results of this audit will be presented to the QAPI committee additional oversight.

5. Date certain: 9/19/16.

Please cross reference 12VAC 5-371-290 (A) Specialized Rehabilitation

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495201 | A. BUILDING _____ B. WING _____ | 08/11/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| SENTARA NURSING CENTER PORTSMOUTH | 4201 GREENWOOD DRIVE PORTSMOUTH, VA 23701 |

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| F 406 | Continued From page 54 | F 406 | | |

worse. Both of the resident's feet were observed to have foot drop, the left foot had a notable inversion.

When ligaments are stretched beyond their normal limits, ankle injuries, of various degrees result. Two types of ankle injuries, known as Inversion and Eversion, affect ankle joints that are stretched excessively to the sides. Inversion occurs in more than 90% of the cases. Inversion occurs with the foot rolls over that the sole of the foot increasingly faces the opposing foot.

Specialized therapy notes were reviewed to include the Physical Therapy (PT) Evaluation & Plan of Treatment for the certification period of 4/20/16 through 6/15/16. The treatment plan included the diagnoses of muscle weakness (generalized), and contractures of both knees. Treatment approaches included orthotic management and training. The resident's goal was listed as," I want to be able to get out of bed and get myself around." The potential for achieving the goals was," good secondary to the resident motivation and participation in POC (plan of care) but limited to anxiety and chronic pain."

The PT evaluation dated 4/20/16 included lower extremity range of motion (ROM). Both legs had limited ROM; the left greater than the right. An inversion of the left ankle was noted with the foot able to be brought into neutral (normal position) with passive range of motion (PROM). The therapist did not assess plantarflexion contractures to either foot.

The Assessment Summary read, in part: Clinical Impressions: Pt (patient) demonstrates decrease

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495201 | A. BUILDING _____ B. WING _____ | 08/11/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SENTARA NURSING CENTER PORTSMOUTH | 4201 GREENWOOD DRIVE PORTSMOUTH, VA 23701 |

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|---|---|---|---|---|
| F 406 | Continued From page 55 | F 406 | | |

active range of motion/ increased contracture tone in both lower extremities limiting functional bed mobility, transferability and ability to position pt in wheelchair.

A PT note with a date of service of 5/9/16 read, in part: ...passive heel cord stretch both feet 5 (repetitions) x 10 (sets)-20 second hold each time to improve joint lubrication and flexibility. Pt asked several times for PT to please stop stretching her heelcords as it's painful. Comments:...Pt states she would like to get a brace for L (left) foot that will stabilize L foot in neutral position; PT verbalized to pt that this will be looked into.

On 8/10/16 at approximately 6:00 p.m., the above findings was shared with the Rehabilitative Services Coordinator (RSC). She stated she would look into this and get back to this surveyor.

On 8/11/16 at 12:30 p.m., the Rehabilitative Services Coordinator (RSC) provided additional information. The RSC stated, "From looking back in here (therapy notes) and our conversation it (the brace) was clearly not addressed". She further stated the PT who documented the 5/9/16 notes was from another sister facility that came over to assist during that time frame. The RSC stated the physical therapist did not communicate to the other therapist or herself in a note so that the next person could follow up. The RSC stated if a recommendation had been communicated she would have known as she is the person responsible for ordering therapy supplies. The RSC stated the resident had been previously using Prevalon boots and those had been discontinued. She stated Prevalon boots "do not have the rigid support...it is more a positioning aid

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495201 | A. BUILDING _____ B. WING _____ | 08/11/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SENTARA NURSING CENTER PORTSMOUTH | 4201 GREENWOOD DRIVE PORTSMOUTH, VA 23701 |

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| F 406 | Continued From page 56 | F 406 | | |

to prevent breakdown". The RSC also stated the resident was screened this morning by another PT. She stated a fax was sent to the physician for an order to trial an orthotic positioning device for the foot drop (plantarflexion contractures) this morning.

The PT screen dated 8/11/16 read, in part: Pt screen completed to determine benefit of contracture management and possible use of a L'nard boot to improve ROM (range of motion) in ankles. Pt exhibits approximately plantarflexion contractures (foot drop) of 45-50 degrees in B (both) ankles at rest, as well as increased INV (inversion) on L (left) side. Pt may benefit from multipodus boot of L'nard device in conjunction with other interventions such as modalities and stretching program. However, it must be noted that pt. has hx (history) of poor pain tolerance, which has limited her participation in functional activities with therapy, and this condition is chronic, so while ROM may improve, potential for improvement with functional activities is limited.

A plantar flexion contracture involves the foot, toes and ankle and prevents normal foot movement. A contracture occurs when the muscles, ligaments, tendons and skin shorten and tighten causing restriction of movement in that area. Plantar flexion contractures often occur in people who are bedridden, or confined to a wheelchair. Early intervention helps in reducing the possible permanent damage of a plantar contracture. A contracture is less likely to develop if the feet receive adequate range of motion, exercise, proper positioning and stretching during an immobile period or on a regular basis if a chronic illness is involved. Range of motion exercises performed by a physical therapist,

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495201 | A. BUILDING _____ B. WING _____ | 08/11/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SENTARA NURSING CENTER PORTSMOUTH | 4201 GREENWOOD DRIVE PORTSMOUTH, VA 23701 |

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|---|---|---|---|---|
| F 406 | Continued From page 57<br>caregiver or as part of a self-care routine are essential in the prevention of contractures. The Research and Training Center on Independent Living recommends providing support for the feet and frequently repositioning the body through the day as part of a preventive routine.<br><br>Treatment of a Contracture: Approximately eight muscles are involved in plantar flexion movement of the foot. If a contracture has developed in these muscles medical intervention is necessary. Casting, splinting or surgery may be required to stretch the effected muscles and ligaments. Surgery is performed in severe cases that have not responded to other treatment. | F 406 | | |
| F 425 SS=D | 483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH<br><br>The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.<br><br>A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.<br><br>The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. | F 425 | F425<br><br>The facility staff must ensure expired biologicals are discarded.<br><br>1. The expired vials of insulin were discarded on 8/10/16.<br><br>2. All residents receiving insulin are at risk.<br><br>All insulin vials were checked for appropriate dates and discarded if necessary. Licensed nursing staff was inserviced on 8/29-9/3/16 regarding this policy and staff expectations to discard medications the day they expire. Daily medication cart and refrigerator checks have been | |

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|---|---|---|---|
| | 495201 | A. BUILDING _____ B. WING _____ | 08/11/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| SENTARA NURSING CENTER PORTSMOUTH | 4201 GREENWOOD DRIVE PORTSMOUTH, VA 23701 |

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|---|---|---|---|---|
| F 425 | Continued From page 58 | F 425 | | |

This REQUIREMENT is not met as evidenced by:
Based on observation and staff interview the facility staff failed to discard expired biologicals that were stored along side current medications inside 1 of 2 medication refrigerators.

The findings included:

On 8/10/16 at 10:55 a.m., a medication room inspection was conducted on unit 2. Stored inside the medication refrigerator were two expired multi-dose vial of Lantus insulin. The expired insulin was found stored along side other current insulin vials. One of the Lantus vials was dated as opened on 6/24/16 (expired on 7/22/16), and the other dated opened on 7/9/16 (expired on 8/6/16).

The unit 2 nurse manager was interviewed following the medication room inspection. She was asked, "Once opened how long is Lantus good for?" She stated Lantus is good for 28 days after opening it and should be discarded. She stated, "It is my expectation that each nurse that gives it, it is within the parameters."

The pharmacy policy titled "Vials and Ampules of Injectable Medications" with a revision date of 7/8/14 read, in part: Insulin-All insulins stored at room temperature or in the refrigerator expire 28 days after opening.

The above findings was shared with the interim Administrator and the interim Director of Nursing during an end of day meeting conducted on 8/10/16 at 6:10 p.m.

assigned to licensed nursing staff to assure no expired medications remain available for inadvertent administration.

3. The Clinical Manger will audit assigned checks weekly to assure staff compliance. The results of this audit will be presented to the QAPI committee for additional oversight.

4. Date certain: 9/19/16.

Please cross reference 12VAC 5-371-300 (B) Pharmaceutical Services

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495201 | A. BUILDING _____ B. WING _____ | 08/11/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SENTARA NURSING CENTER PORTSMOUTH | 4201 GREENWOOD DRIVE PORTSMOUTH, VA 23701 |

| (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 |
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| F 431 SS=D | 483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS | F 431 | F431 | |

The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.

Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.

In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.

The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.

This REQUIREMENT is not met as evidenced by:
Based on observations during the inspection of

The facility staff must ensure that a licensed nurse maintains possession of the key to the controlled substances locked container, and that controlled substances requiring refrigeration are stored in the locked box for controlled substances on the medication refrigerator.

1. The key to the locked box in the unit refrigerator was replaced on 8/12/16, and, the lorazepam oral concentrate for resident #14 was discarded on 8/12/16.

2. All residents on oral lorazepam are at risk.

3. Licensed nursing staff was inserviced on the policy and procedure regarding Storage of Medications on 8/29-9/3/16. Daily medication cart and refrigerator checks have been assigned to the licensed nursing staff to assure medications are stored appropriately

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495201 | A. BUILDING _____ B. WING _____ | 08/11/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SENTARA NURSING CENTER PORTSMOUTH | 4201 GREENWOOD DRIVE PORTSMOUTH, VA 23701 |

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|---|---|---|---|---|
| F 431 | Continued From page 60 | F 431 | | |

the medication room, staff interviews and review of the facility's policy the facility staff failed to ensure a licensed nurse for the (name of unit) maintained possession of the key to the controlled substance refrigerator locked box and the facility staff failed to ensure a controlled substance which required refrigeration was stored inside the controlled substances locked box affixed inside the medication refrigerator.

The findings included:

Resident #14 was originally admitted to the facility 6/13/14 and readmitted 2/16/16 after an acute hospital stay. The current diagnoses include hospice care related to systolic heart failure, chronic kidney disease, osteoarthritis, hypertension, endometrial neoplasia, and cardiovascular disease.

The significant change Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 7/26/16 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 11 out of a possible 15. This indicated Resident #14's cognitive abilities for daily decision making were moderately impaired. The 7/26/16 MDS also revealed Resident # 14 had no mood or behavior problems, was incontinent of bowels and bladder and required total care of 2 persons with toileting. Resident #14 required limited assistance of 1 person with eating, total care of 1 person with bed mobility, transfers, locomotion, personal hygiene, bathing, and dressing.

Resident #14 had a physician's order dated 7/13/16 for Lorazepam 0.5 milliliters (1 milligram) by mouth/sublingually (under tongue) every four

F 431

4. The Clinical Manger will audit assigned checks weekly to assure staff compliance. The results of this audit will be presented to the QAPI committee for additional oversight.

5. Date certain: 9/19/16.

Please cross reference 12VAC 5-371-300 (A/B) Pharmaceutical Services

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495201 | A. BUILDING _____ B. WING _____ | 08/11/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SENTARA NURSING CENTER PORTSMOUTH | 4201 GREENWOOD DRIVE PORTSMOUTH, VA 23701 |

| (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 431 | Continued From page 61 | F 431 | | |

hours as needed for anxiety/agitation.

On 8/12/16 at 11:05 a.m. during inspection of the medication refrigerator on the (name of unit) the key to the controlled substance locked box could not be located. Registered Nurse (RN) #101 stated multiple times there is nothing in the locked box; it hasn't been used in a long time. This comment was confirmed by 3 other licensed nurses at the nurse's station. After trying many keys to open the lock and approximately 55 minutes later the Director of Plant Operations cut the lock off the controlled substances locked box located in the refrigerator. Licensed Practical Nurse (LPN) # 75 opened and inspected the locked box and there was only a paper with names of medications on it in the locked box.

Inside the controlled substances locked box on 1 of 3 medication carts was a 30 milliliter bottle of Lorazepam Concentrate (a scheduled IV controlled medication with a potential for abuse and/or diversion. Lorazepam is prescribed to slow activity in the brain to allow for relaxation). The Lorazepam label was dated 7/14/16 and the manufacturer's expiration date was 7/2017.

The Lorazepam Oral Concentrate packaging insert located inside the box and the storage instructions written in bold print on the side of the medication box instructs users to protect the medication from light, store the medication at 2 - 8 degrees Celsius or 36 - 46 degrees Fahrenheit and to discard opened bottles after 90 days.

The surveyor asked LPN #2 if the medication cart had the capability of maintaining the medication at 36 - 46 degrees Fahrenheit and LPN #2 stated; no. LPN #2 also stated the medication was inside

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495201 | A. BUILDING _____ B. WING _____ | 08/11/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SENTARA NURSING CENTER PORTSMOUTH | 4201 GREENWOOD DRIVE PORTSMOUTH, VA 23701 |

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|---|---|---|---|---|
| F 431 | Continued From page 62 | F 431 | | |

the medication narcotic box when the cart was accepted at the beginning of the shift (she had not obtained it from the refrigerator since starting the shift). LPN #2 was also asked to observe the reconciliation record for the bottle of Lorazepam Concentrate. The reconciliation record revealed the medication had been administered to Resident #14 on 8/8/16 at 3:30 a.m.

The facility's policy titled "Medications - Controlled Substances" with a revision date of 11/12/14 stated "Drugs listed as schedule II, III, and IV shall be subject to special handling, storage, disposal and recordkeeping. The policy states at #2 all schedule II, III, and IV shall be kept under lock and key. A single dose count/shift count sheet is completed for each drug. The single dose count/shift sheet must contain ... count of the remaining amount (#of pills or cubic centimeters), signature of the nurse administering the medication, date and shift time when the shift count occurs, the signature of the nurse going off duty and counting, signature of the nurse coming on duty and counting, count of the remaining amount (#of pills or cubic centimeters), at the end of the shift".

The above findings were shared with the Administrator and Director of Nursing on 8/11/16 at approximately 7:00 p.m. The Director of Nursing stated the bottle of Lorazepam Concentrate had been removed from the medication cart and destroyed. No additional information was provided regarding the facility's procedure for managing the key to the refrigerated narcotic lock box prior to the survey teams exit but the Administrator stated in the event the staff is unable to open the refrigerated narcotic lock box the Director of Plant Operations

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495201 | A. BUILDING _____ B. WING _____ | 08/11/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| SENTARA NURSING CENTER PORTSMOUTH | 4201 GREENWOOD DRIVE PORTSMOUTH, VA 23701 |

| (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 |
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| F 431 | Continued From page 63 is available anytime necessary to open it. | F 431 | F514 | |
| F 514 SS=D | 483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE | F 514 | The facility staff must ensure the accuracy of clinical records. | |

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 staff interview and clinical record review the facility staff failed to ensure a clinical record was accurate for 1 of 25 residents in the survey sample, Resident #3.

The August 2016 TAR (Treatment Administration Record) was inaccurate for the application of a dressing change for Resident #3 on 8/9/16.

The findings included:

Resident #3 was admitted to the facility on 2/19/16 with diagnoses to include lupus, seizure disorder and a chronic stage IV pressure sore.

Lupus is a chronic, autoimmune disease that can damage any part of the body (skin, joints, and/or

1. The medical record for resident #3 was corrected on 8/25/16 to accurately reflect the provision of wound care.

2. All residents with treatment orders are at risk.

3. A 100% audit was conducted on 8/15/16 to assure dressing changes had been done as ordered. Licensed nursing staff was inserviced on the wound care policy on 8/24/16, and, 8/29-9/3/16.

4. The Clinical manager will conduct weekly audits on 10% of all residents with wound care orders to assure dressing changes are being conducted. Dressings will be monitored for current dates. All audits will be forwarded to the DON. Audits will be summarized and presented to the QAPI committee for additional oversight.

5. Date certain: 9/19/16

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|---|---|---|---|
| | 495201 | A. BUILDING _____ B. WING _____ | 08/11/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| F 514 | Continued From page 64 | F 514 | Please cross reference 12VAC 5-371-360 (E) Clinical Records | |

organs inside the body). Chronic means that the signs and symptoms tend to last longer than six weeks and often for many years. www.lupus.org

The current MDS (Minimum Data Set) with an assessment reference date of 5/18/16 coded the resident as scoring a 15 out of 15 on the Brief Interview for Mental Status (BIMS), indicating the resident's cognition was intact. Section M. Skin Condition coded the resident as having one stage IV pressure sore.

The MDS describes a stage IV pressure sore as: Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar (dead tissue) may be present on some parts of the wound bed. Often include undermining and tunneling.

The August 2016 TAR evidenced the physician current treatment order dated 7/27/16 that read, Cleanse sacral wound with normal saline, apply algisite M and dry dressing every day. The treatment was scheduled to be changed on the day shift.

The August TAR evidenced initialed entries by the nurses that the dressing was changed every day.

On 8/10/16 at 3:30 p.m., a dressing change observation of Resident #3's pressure sore was conducted with the licensed practical nurse (LPN #10).
The nurse established a clean barrier, placed the dressing supplies on top of it, washed her hands and put on clean gloves. The sacral dressing was observed saturated with drainage and was dated as last changed on 8/8/16. The nurse was asked what was the dressing change frequency, she stated, "Once a day."

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|---|---|---|---|---|
| F 514 | Continued From page 65 | F 514 | | |

Further review of the TAR for August 2016 evidenced the inaccurate entry. The nurse initialed on 8/9/16 that the dressing was changed.

The above findings was shared with the interim Administrator and the interim Director of Nursing during an end of day meeting conducted on 8/10/16 at 6:10 p.m.

A follow up interview with the DON was conducted on 8/11/16. The DON stated, "The nurse documented it was done and it wasn't." The DON stated the nurse was an agency nurse. The DON provided a copy of an email sent to the agency dated 8/10/16 at 9:24 p.m. The subject was DNR Staff (do not return). Listed on this email was the nurse who failed to change the dressing on 8/9/16 for Resident #3. The email read that this nurse along with another nurse were not allowed to come back to the facility due to failure to provide a dressing change.

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| F 518 SS=D | 483.75(m)(2) TRAIN ALL STAFF-EMERGENCY PROCEDURES/DRILLS | F 518 | F518 |

The facility must train all employees in emergency procedures when they begin to work in the facility; periodically review the procedures with existing staff; and carry out unannounced staff drills using those procedures.

This REQUIREMENT is not met as evidenced by:
Based on staff interviews, the facility failed to ensure all staff were competent in emergency procedures.

The facility must ensure all staff is competent in emergency procedures.

1. The staff involved has been informed of the location of the pull stations and extinguishers.

2. All residents are at risk if staff is not competent in emergency procedures.

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| F 518 | Continued From page 66<br>Two of eight staff interviewed for emergency preparedness failed to verbalize competency in emergency procedures.<br><br>The findings include:<br><br>On 6/10/16 interviews were conducted to assess the staff's competency in emergency procedures. Three supervisory staff and five direct care staff were selected at random, and interviewed separately by various survey team members. Two of the eight staff interviewed failed to verbalize competency in emergency procedures.<br><br>A direct care staff, certified nurse aide (CNA #1), an employee was interviewed on 8/10/16 at 11:15 a.m. She was asked, What would you do if you discovered a fire in a resident room? She responded by saying, "Call for help...I don't remember...you don't want to scream down the hallway...pull the call light?...you pull the alarm." When asked where the fire alarms were located, she stated, "Let me get it together...she then had to ask another employee where the fire alarms where located. When asked if there was a fire where would you aim the fire extinguisher? She stated, "Aim at the sides". When asked where is the safest place to maintain residents during a tornado? She replied, " Not close to windows...the shower room?" The CNA was not able to answer where the emergency power outlets where located.<br><br>On 8/11/16 at 7:05 p.m., a supervisory staff, the unit 2 nurse manager was interviewed. She was asked where the fire alarms where located on unit 2. She stated, " I believe they are located behind the fire doors". This was incorrect. The fire alarms on unit 2 where located on the end of | F 518 | 3. Staff were inserviced on the policy and procedure for Fire Precautions on 8/29-9/3/16 regarding the location of pull stations and extinguishers. The Maintenance department will conduct fire drills and inservices twice monthly X 3 months to include emergency preparedness, locations of pull stations, locations of extinguishers, and, staff responsibilities.<br><br>4. The Administrator will conduct 1 audit weekly X 6 weeks to assess staffs preparedness for emergencies. Audits will be summarized and presented to the QAPI committee for additional oversight.<br><br>5. Date certain: 9/19/16<br><br>Please cross reference 12VAC 5-371-190 (A) Safety and Emergency Procedures | |

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| F 518 | Continued From page 67<br>each hallway by the exit doors, and across from the nurses station.<br><br>A request of the facility's general fire plan was made on 8/11/16.<br><br>No additional information, to include the general fire plan, was submitted for review prior to exit. | F 518 | | |