PRINTED: 01/20/2016 FORM APPROVED OMB NO. 0938-0391

CENTER	S FOR MEDICARE	& MEDICAID SERVICES	,,,,,,	<u> </u>	<u> </u>	MB NO. 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495392	B. WING	:		C 01/13/2016
		1 45932		***************************************	REET ADDRESS, CITY, STATE, ZIP CODE	1 01710/2010
	ROVIDER OR SUPPLIER A NSG CENTER-WIN	DERMERE		160	4 OLD DONATION PKWY RGINIA BEACH, VA 23454	
(X4) tD	SUMMARY STA	ATEMENT OF DEFICIENCIES	10		PROVIDER'S PLAN OF CORRECTIO	
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC (DENTIFYING INFORMATION)	PREF TAG		EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	
F 000	INITIAL COMMEN	TS	F	000		
	standard survey wa 1/13/16. Two comp during the survey. compliance with the Federal Long Term deficiencies are ide The census in this at the time of the s consisted of 3 residence.	Medicare/Medicald abbreviated as conducted 1/11/16 through plaints were investigated Corrections are required for e following 42 CFR Part 483 Care requirements. Corrected entified on the 2587B report. 90 certified bed facility was 80 urvey. The survey sample dents, 2 current Resident			Past noncompliance: no plan of correction required.	
		#1 through 2) and 1 closed				•
	record review (Res	ident #3).			,	
F 225	483.13(c)(1)(ii)-(iii) INVESTIGATE/RE	, (c)(2) - (4) PORT	F	225	A professional and the second	
00.10	The facility must no	DIVIDUALS of employ individuals who have				
	mistreating resider had a finding enter registry concerning of residents or mis and report any kno court of law agains indicate unfitness f	of abusing, neglecting, or have led into the State nurse aide abuse, neglect, mistreatment appropriation of their property; wiedge it has of actions by a let an employee, which would for service as a nurse aide or of the State nurse aide registry lities.				
	involving mistreatn	nsure that all alleged violations nent, neglect, or abuse, f unknown source and				
	misappropriation o immediately to the	f resident property are reported administrator of the facility and accordance with State law				
	through establishe	d procedures (including to the etilication agency)				
L	v Hacktop's no penin	DENSUPPLIER REPRESENTATIVES SIG	NATURE		TITLE ,	(X6) DATE
	MIMAL	MUL		H	dministrator	1-25-2016
other safegu	ialds provide sufficient pr i dale of survey whether (ing the date these docum	oteclion to the patients. (See Instruction is amythed	ns.) Exci Par oursi	eputori Ioa bom	on may be excused from correcting providi nursing homes, the findings stated above nes, the above findings and plans of correc- re cited, an approved plan of correction is	tion are disclosable 14

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RECEIVED Event ID: 1LK211 Facility ID: VX0276

If continuation sheet Page 1 of 25

JAN 26 2016

PRINTED: 01/20/2016 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA-(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED IDENTIFICATION NUMBER: A. BUILDING C ele disconsissabilità i colo conti d'administrato de dicina describación de la como en contra como en contra c A del como disconsista de la colonia de l 495392 B. WING 01/13/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1604 OLD DONATION PKWY SENTARA NSG CENTER-WINDERMERE VIRGINIA BEACH, VA 23454 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PREFIX PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) (X5) COMPLETION DATE (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX TAG TAG F 225 Continued From page 1 F 225 The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not mel as evidenced by: Based on staff interviews, clinical record review, Past noncompliance: no plan of facility document review and during the course of correction required. a complaint investigation the facility staff failed to report an injury of unknown origin (IUO) immediately to the Administrator and other officials in accordance with State Law for 1 of 3 residents in the survey sample, Resident #1. Resident #1 was found to have first and second degree thermal burns to the right inner and outer thigh areas, right lower abdomen and right knee on 12/25/15. The facility staff failed to immediately notify the Administrator of the IUD and the State Survey and Certification Agency until 12/28/15. The findings included:

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Resident #1 an 86 year old was admitted to the facility on 9/14/15 following a hospitalization requiring skilled services. The resident's

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RS FOR MEDICARE	& MEDICAID SERVICES	·	****	OMB NO. 0938-0391
	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	€		(X3) DATE SURVEY COMPLETED
	495392	B. WING		C 01/13/2016
PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	
A NSG CENTER-WINI	DERMERE	1	1604 OLD DONATION PKWY	
			VIRGINIA BEACH, VA 23454	
(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFIX TAG	PROVIDER'S PLAN OF CORF X (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE COMPLETION
diagnosis included to with behavioral distribution of the current MDS (Massessment references identified as scoring Brief Interview for Mindicating the resident cognition. The resident in th	Non-Alzheimer's Dementia urbances. Alinimum Data Set) with an oce date of 12/3/15 coded the a 5 out of a possible 15 on the dental Status (BIMS), and had severely impaired then thad received the alion Seroquel 12.5 mg ring the seven days of the The resident was wheelchair above-the-knee amputation.	F 2	25	
12/28/15. The FRI of unknown origin note aide) on Resident # approximately 11:27 described as "Blister The resident stated lieg." The Administroccurrence was brother than the process of the state of t	lescribed an injury of d by a CNA (certified nurse of signs of this right thigh on 12/25/15 at pm. The injury was asintact and some open." I'she spilled coffee on her ator documented, "This ught to the attention of the			
3:00 pm. He stated, on herselfshe did r they were changing I (12/28/15) and met v Party/RP) to recap w coffee machine in the turned off Sunday (1). The Director of Nursinurse manager were	"the patient spilled coffee not teil the nursing staff until ner! found out on Monday with the son (Responsible hat had happenedthe edining room was initially 2/27/15). Ing (DON) and the unit one interviewed on 1/11/16 at			
	PROVIDER OR SUPPLIER A NSG CENTER-WINIT SUMMARY STA (EACH DEFICIENCY REGULATORY OR LS Continued From particular of the current MDS (Nassessment references in the company of the compa	PROVIDER OR SUPPLIER A NS G CENTER-WINDERMERE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC (DENTIFYING INFORMATION)	I OP DEFICIENCIES DE CORRECTION (X1) PROVIDER SUPPLIER 495392 RA NSG CENTER-WINDERMERE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC (DENTIFYING INFORMATION) Continued From page 2 diagnosis included Non-Alzheimer's Dementia with behavioral disturbances. The current MDS (Minimum Data Set) with an assessment reference date of 12/3/15 coded the resident as scoring a 5 out of a possible 15 on the Brief Interview for Mental Status (BIMS), indicating the resident had severely impaired cognition. The resident had received the antipsycholic medication Seroquel 12.5 mg (milligrams) dally during the seven days of the assessment period. The resident was wheelchair bound due to a left above-the-knee amputation. A Facility Reported Incident (FRI) was sent to the State Survey and Certification Agency on 12/28/15. The FRI described an injury of unknown origin noted by a CNA (certified nurse aide) on Resident #1's right thigh on 12/25/15 at approximately 11:27 pm. The injury was described as "Bilistersintact and some open." The resident stated "she spilled coffee on her leg." The Administrator documented, "This occurrence was brought to the attention of the administrator on 12/28/15 at approx. 9:15 am." The Administrator was interviewed on 1/11/16 at 3:00 pm. He stated, "the pattent spilled coffee on herselfshe did not tell the nursing staff until they were changing her! found out on Monday (12/28/15) and met with the son (Responsible Party/RP) to recap what had happenedthe coffee machine in the dining room was initially turned off Sunday (12/27/15). The Director of Nursing (DON) and the unit one nurse manager were interviewed on 1/11/16 at 3:45 pm. The DON stated, "I was notified of the	A 95392 PROVIDER OR SUPPLIER AN SIGNATION DENTIFICATION NUMBER AN SIGNATION OF CORRECTION A 95392 PROVIDER OR SUPPLIER AN SIGNATION DERMERE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCIES CIEVA STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 2 diagnosis included Non-Alzheimer's Dementla with behavioral disturbances. The current MDS (Minimum Data Set) with an assessment reference date of 12/3/15 coded the resident as scoring a 5 out of a possible 15 on the Brief Interview for Mental Slatus (BIMS), indicating the resident had severely impaired cognition. The resident had received the antipsychotic medication Seroquel 12.5 mg (milligrams) daily during the seven days of the assessment period. The resident was wheelchair bound due to a left above-the-knee amputation. A Facility Reported Incident (FRI) was sent to the State Survey and Certification Agency on 12/28/15. The FRI described an injury of unknown origin noted by a CNA (certified nurse aide) on Resident #1's right thigh on 12/25/15 at approximately 11:27 pm. The injury was described as "Bilistersintact and some open." The resident stated "she spilled coffee on her leg." The Administrator documented, "This occurrence was brought to the attention of the administrator on 12/28/15 at approx. 9:15 am." The Administrator was interviewed on 1/11/16 at 3:00 pm. He stated, "the pattent spilled coffee on herselfshe did not tell the nursing staff until they were changing herI found out on Monday (12/28/15) and met with the son (Responsible Party/RP) to recap what had happenedthe coffee machine in the clining room was initially turned off Sunday (12/27/15). The Director of Nursing (DON) and the unit one nurse manager were interviewed on 1/11/16 at 3:45 pm. The DON stated, "was notified of the

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Facility ID: VA0276

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CENTE	HS FOR MEDICARE	E & MEDICAID SERVICES			(<u>)MB NC</u>). 0938-039°
	POP DEFICIENCIES	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILD		CONSTRUCTION		TE SURVEY MPLETED
,		495392	B, WING			01	C I/13/2016
NAME OF	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
SENTAR	RA NSG CENTER-WIN	IUCDWEBE	1	}	04 OLD DONATION PKWY		
What I as a	N New Agents a new Assesser	DEMMENT		VIF	RGINIA BEACH, VA 23454		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	DBE	(X5) COMPLETION DATE
F 225	Continued From pa	age 3	F.	226			
	of unit one manage homeshe (the uni	er), she called me at lit one manager) Instructed the lervisor to turn off the coffee	٠ -				
	notified of the them through a phone ca evening(12/27/15) of threatening to call A Services) in respon- phone call the DON nursing manager or manager) had not b	manager stated she was mal burns by one of the nurses all on Sunday due to Resident #1's son APS (Adult Protective ase to the injuries. Prior to this N, the Administrator and the n weekend duty (the unit one been informed of the injury of ermal burns) identified by the			-		
	next day during mor The DON stated the could be combative stating the resident, drinks at a time and wheelchair and betweelchair and betweelchair and between the DON stated and the DON	ween her legsthey slosh." Investigation was initiated on ity was unable to determine					
	the thermal burns or on 1/11/16 at 5:30 pi arrived on duty she in in a wheelchair in the resident's room. CN the resident was "go the second unit. The happened between t staffshe (the reside	nurse aide #1) who discovered in 12/25/15 was interviewed om. She stated when she first observed the resident sitting he hallway outside the NA #1 stated later she noted one for a little while down on here was some altercation that the resident and another lent) swung at a pregnant ere called because of the					

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Eveni ID: 1LK211

Facility ID: VA0276

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CENTERS	S FOR MEDICARE	& MEDICAID SERVICES					O. 0938-039
STATEMENT OF	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	LTIPLE CONS		(X3) DA	ATE SURVEY DMPLETED
		495392	B. WING	~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~		0,	C 1/13/2016
	OVIDER OR SUPPLIER	DERMERE		1804 OL	ADDRESS. CITY, STATE, ZIP ID DONATION PKWY IA BEACH, VA 23454	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO (ROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
the away site of the contract	the police left she as approximately 7:00 was assisting the residence observed the "brigh area. She ashappened, the residence on myself	reness." CNA#1 stated after assisted the resident to bed at pm. She stated when she esident with putting on a gown burn" to the resident's right ked the resident how this dent responded, "I spilled I happened the day before". I e notified the nurse who then ent. The resident to the emergency of the discovery of the blisters. I the first emergency of 12/26/15 at 00:13 am. The art: "thermal burns to the dieg after spilling coffee on D. Blisters ruptured at this dieg after spilling coffee on D. Blisters ruptured at this dieg after spilling coffee on the dieg after spilling coffee on D. Blisters ruptured at this dieg after spilling coffee on the dieg after spilling coffee on D. Blisters ruptured at this dieg after spilling coffee on the ERPatient likely requires burn with (name of second ED) and for evaluation by burn team." If at the second ED on the resident was ond degree burns. The EDapprox 3-4% TBSA (total		225			

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Event ID:1LK211

Facility ID: VA0276

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		OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	.(X2).MUI A. BUILO		CONSTRUCTION		TE SURVEY MPLETED
				A. OUILL	,mu _			С
samin merali	yn mento megas		495392	B WING		o por filosoficios com en 1993 en prese ncionem proprieta (se presenta en 1964), en esta en 1963, en esta en 19 Mario esta en 1965, en 1965,	01	/13/2016
		ROVIDER OR SUPPLIER NSG CENTER-WINI	DERMERE		18	STREET ADDRESS, CITY, STATE, ZIP CODE 1804 OLD DONATION PKWY VIRGINIA BEACH, VA 23454		
	(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE FRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE	(X5) COMPLETION DATE
	F 225	degree burns with t x 1.5 cm (centimete with few scattered a (redness), small ap	ge 5 Ihigh & knee with 1st and 2nd ne larger areas measuring 6.5 if) 6.5 x 4.5 cm, and 8 x 3 cm areas of 1st degree erythema prox 3-4 cm area on the RLQ at abdomen 1st degree	Fí	225			
		The resident was seen in the burn clinic on 1/4/16. The burn clinic notes read, in part:" Mental health: Occasional anxiety and dementia causing altered mental statusshe is awake, alert, and oriented slightly confused extremely feistyright lower extremity has a 4% total body surface area burn involving her thigh, knee and calf that is varied stages of healing from epithelialization to an area on her proximal medial knee that is significantly granulated with some pseudo eschar (dead tissue) that is present. The treatment was changed to Silvadene dressing changes with thorough cleansing with chiorhexidine and premedicating with morphine one hour prior to the daily dressing changes.						
	On 1/13/16 at 11:58 am, a second interview was conducted with the DON. The failure of the staff to notify the Administrator and the State Survey and Certification Agency immediately of an injury of unknown origin involving 1st and 2nd degree burns was shared. The DON stated, "They should have called to let us know immediately."							
		of abuse, neglect, n injury of unknown or stated the facility im correction to address follows:	ire have been no allegations isappropriation of property or igin since 12/25/15. She plemented a plan of as this identified deficiency as the way inserviced on 1/4/16					

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Event ID: 1LK211 Fecility ID: VA02

Fecility ID: VA0276

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JAN 26 2015

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CENTERS FOR MEDICARE & MEDICARD SERVICES					<u> DMB NO. 0938-0391</u>
	TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDERUSUPPLIERUCLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION ING	(X3) DATE SURVEY COMPLETED
					С
NAME OF	rnal large on cum iro	485392	B. WING		01/13/2016
NAME OF	PROVIDER OR SUPPLIER		- 1	STREET ADDRESS, CITY, STATE, ZIP CODE	
SENTAR	RA NSG CENTER-WIN	DERMERE		1604 OLD DONATION PKWY	
131 41 193	CHARLE CTA	TELELY OF OPPOPELMING		VIRGINIA BEACH, VA 23454	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORRECTI X (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	DBE COMPLETION
F 225	Continued From pa	ge 6	F 2	25	
	on the facility policy	titled Abuse: Investigation,			
	Protection and Rep				
	2. I he nursing man	ager on duty will call the kends to ensure all incidences			
	have been correctly				
	3. The findings will !	be discussed in QAPI (Quality			
ı		ance Improvement) on a			
	monthly basis. Date of compliance	1 <i>iAi</i> 16			
	mata o. outriplication	ti ti i to		•	
		ed Abuse: Investigation,			
	Protection and Repo	orling revised 1/13/15 read, in			
		with state regulations and the			
	Code of Virginia, Life	e Care employees will		·	
	immediately report a	il incidents of alleged			
		esident mistreatment, neglect njuries of unknown sources			
	and misappropriatio	n of resident property to their			
	supervisor, the DON				
	COMPLAINT DEFIC	CIENCY-PAST NON			
	COMPLIANCE				
	483.20(d)(3), 483.10		F 2	30	
SS=D	PARTICIPATE PLAN	INING CARE-REVISE CP			
	The resident has the	right, unless adjudged	1.	Resident's #1 care plan has been	revised
	incompetent or other	wise found to be		to include management of the un	safe behavior
	incapacitated under	the laws of the State, to	2.	All residents that demonstrate uns	afe behaviors
	participate in plannin	g care and treatment or		have the potential to be affected t	v this deficient
	changes in care and	ireaiment.		practice.	1 mmiletbill
	A comprehensive car	re plan must be developed	3.	The Clinical Manger (designee) wi	l identify all
	within 7 days after th	e completion of the		residents with unsafe behaviors ar	d verify that
	comprehensive asse	ssment; prepared by an		there is an appropriate plan of care	to manage
		i, that includes the attending ed nurse with responsibility		the behavior(s).	
	p	THE THE PERSON AS A STREET OF THE PERSON AS			

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Event ID: 1LK211

Facility ID: VA0278

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CENTE	KS FUR MEDICAKE	E & MICHICAID SEKVICES			<u> </u>
	TOP DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDII	IFLE CONSTRUCTION	(X9) DATE SURVEY COMPLETED C
va vastri jastrijeni	relien er kurkurkurken å verkene en om om optorer f	495392	B. WING_		01/13/2016
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
SENTAR	A NSG CENTER-WIN	DERMERE		1604 OLD DONATION PKWY VIRGINIA BEACH, VA 23454	
(X4) ID PREFIX TAG	(EACH DEFICIENC	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC (DENTIFYING (NFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETION
F 280	disciplines as deter and, to the extent p the resident, the re- legal representative	ige 7 d other appropriate staff in mined by the resident's needs, tracticable, the participation of sident's family or the resident's and periodically reviewed am of qualified persons after	F 28	. Clinical Manager (designee) will president newly exhibiting unsafe in the standards of care meeting and then twice a month for two pathere is plan of care to manage to Report finds to QAPI.	behavior weekly for four weeks
	by: Based on observal record review and of complaint investigate revise a care plant of 3 residents in the first service and second degree inner and outer thing and right knee. The of coffee spillage. To with behavioral distributions of placing and right knee. The of coffee spillage. To with behavioral distributions are second degree inner and outer thing and right knee. The of coffee spillage. To with behavioral distributions are second degree inner and outer thing and right knee. The of coffee spillage. The of coffee spillage. The with behavioral distributions are second degree inner and outer thing and right knee. The of coffee spillage. The of coffee spillage.	NT is not met as evidenced tion, staff interviews, clinical during the course of a tion the facility staff failed to o include unsafe behaviors for the survey sample, Resident entified to have unsafe graultiple beverage cups filled everages to include coffee in and tucked inside the xt to her thighs while heelchair throughout the sident was found to have first thermal burns to the right the areas, right lower abdomen thermal burns were a result the resident had dementia urbances and poor safety			
	The findings include	80;			

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Resident #1 an 86 year old was admitted to the

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Facility ID: VA0276

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CENTE	RS FOR MEDICARE	E & MEDICAID SERVICES). 0938-0391
STATEMENT	TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPL/ER/CLIA IDENTIFICATION NUMBER:	1 '		CONSTRUCTION	(X3) DAT	TE SURVEY MPLETED
		495392	B. WING			01	C /13/2016
	PROVIDER OR SUPPLIER EA NSG CENTER-WINI			160	REET ADDRESS, CITY, STATE, ZIP CODE 64 OLD DONATION PKWY RGINIA BEACH, VA 23454		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES LY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	ıx	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROPOLICIENCY)	D BE	(X5) COMPLETION CA:E
F 280	requiring skilled ser diagnosis included I with behavioral district the current MDS (Nassessment references ident as scoring Brief Interview for Mindicating the reside cognition. The reside cognition. The reside cognition. The reside cognition and the reside cognition and the reside cognition and the reside cognition. The reside cognition and the reside cognition and the reside (milligrams) dally duassessment period. The residence of the cognition of the residence of the reside	following a hospitalization rvices. The resident's Non-Alzheimer's Dementia		280			
	3:00 pm. He stated on herselfshe did a they were changing came to check the s 12/29/15. The vend dispensing hot water degrees to 175 degreat that time he decid machine off perman was known to place (independently obtain	er temperature from 191 rees. The Administrator stated ded to keep the coffee nently. He stated Resident #1					

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Facility IO: VA0276

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CENTER	43 FUR MEDICARE	& MICHICHIO SEVAICES			טא מאט	. 0330-0391
	OF DEFICIENCIES OF CORRECTION	(X1)-PROVIDER/SUPPLIER/CLIA	A. BUILD	TIPLE CONSTRUCTION	COM	E SURVEY MPLETED
Maran - tang	. Na statiske franchistorien en skrevet i muse	495392	B. WING		and the state of the state of	C /13/2016
	PROVIDER OR SUPPLIER A NSG CENTER-WIN	DERMERE		STREET ADDRESS, CITY, STATE, ZIP CO 1504 OLD DONATION PKWY VIRGINIA BEACH, VA 23454		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		SHOULD BE	(X5) COMPLETION DATE
F 280	wheelchair.	ng about the facility in her	F 2	280		Fs.
	nurse manager was 3:45 pm. The DON refused care, could coffee everyday, st multiple cups of dri in the wheelchair as would slosh." She placed on the resid December but the reultiple cups of between the wheelche resident's leg. brought in a cup wit resident recognizes	sing (DON) and the unit one re interviewed on 1/11/16 at I stated the resident often be combative and drank ating the resident, " takes nks at a time and places them nd between her legsthey stated a cup holder was ent's wheelchair sometime in esident continued to place verages to include coffee chair arm rests and between She stated the son had h a lid. The DON stated the her son but does not s name and has poor safety				•
	placed on the whee placed cups on her The 7 am-3 pm nur was interviewed on stated, "She (Resid twoshe had spiller juicethe nurse attend the resident sw teft arm, I grabbed to around away from me in the gut and spolice to see if we detaining order) and detaining order) and see the see if we detain the see	rsing supervisor for 12/25/15 1/12/16 at 2:30 pm. He ent #1) was seen on unit d a couple of cups of empted to remove the cups ung at her hilting her on her he wheelchair arm and swung the nurse and the resident hilt cratched my arm! called the ould get a TDO (temporary if a record of her violent				
	behaviorshe had to cup holder, one on t	ive cups of juices, one in the the inside of each wheelchair between her legs and one on				

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Event ID: 1LK211

Facility ID: VA0276

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CENTE	NO FUR WILLIUMNE	G WIEDIGAID SERVICES				TIME LACT	. 0530-0391
	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	COM	E BURVEY APLETED
		495392	B. WING	i		1	C /13/2016
NAME OF	PROVIDER OR SUPPLIER		·	STRI	EET ADDRESS, CITY, STATE, ZIP CODE		
0001740	4 bloom more) 7000 155ttt	سا تحلس و و نسمت تس		1604	4 OLD DONATION PKWY		
SENIAR	A NSG CENTER-WIN	DEKMEKE	į	VIR	GINIA BEACH, VA 23454		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROVIDERICIENCY)	DBE	(X5) COMPLETION DATE
F 280	Continued From pa	ne 10	. 5	280			
. 200	•	ere was no coffee"	4 4	LUU			
	me amirestbut in	ere was no conee					
	On 1/13/16 at 0:52	am, the Food Service					
		interviewed. He stated he					
		ent on an almost daily basis					
		obtain not only juice but coffee					
	from the self service	e machines. He stated, "She					
		ng it between her legsshe					
		o let you take the cups to the					
		he would have a cup of					
	something in betwe 90% of the time."	en her legs I would say 80 to					
	au 70 or the time.						
	was observed in be was asked about th burned myself with her right leg. When obtained the coffee don't know where the resident was observed the interview was strumbler with a lid and on the sink, away from the sind, away from the approximately 30 m	orn, on initial tour the resident of and awake. The resident is incident. She stated, "I coffee" the resident pointed to asked where she had from she yelled abruptly, "I ley got the coffee from." The red agitated at that point and opped. A clear plastic id straw was observed empty om the residents reach. A served on the residents night is residents reach with I of clear fluid inside it. The resident arm rest.					
	sent to the emergen discovery of the bils resident arrived at the department (ED) on ED notes read, in partight thigh, knee and self this am at-0800	evidenced the resident was locy department following the ters on 12/25/15. The left is emergency 12/26/15 at 00:13 am. The left is emergency in the emergency in the emergency in the emergency in the emergency department in the emergency depa					

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Facility ID: VA0276

Event ID: ILK211

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	T-OF-DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILD	TIPLE CONSTRUCTION		ATE SURVEY OMPLETED C
 — end brigktigsterkeit in 	e e majeri fette fatte fatte e e e e e e e e e e e e e e e e e e	495392	B. WING		0	1/13/2016
	PROVIDER OR SUPPLIER IA NSG CENTER-WINI	DERMERE		STREET ADDRESS, CITY, STATE, ZIP CODE 1604 OLD DONATION PKWY VIRGINIA BEACH, VA 23454		WE I THE THE STATE OF THE STATE
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		ULD EE	(X5) COMPLETION DATE
F 280	scrub. Discussed will transfer patient In my opinion, this i lay person (who posknowledge of health result in serious jed impairment of bodily dysfunction of bodily both 1st and 2nd delower extremity), will (transfer) to (initial of the resident arrived 12/26/15 at 02:33 at diagnosed with seconde read, in part:" body surface area) in Non-circumferential The burns were cleaded in the burns were cleaded in the second applied. The reside facility with a recompany of the resident was as practitioner on 12/26 described as: Right thigh & knee with the larger areas (centimeter) 6.5 x 4. scattered areas of 15 (redness), small applications.	Patient likely requires burn ith (name of second ED) and for evaluation by burn team. is a condition that a prudent is sesses an average in and medicine) may expect to pardy, or cause serious y function, or serious y organsPt (patient) with it (g (degree) burns to rie (right if tx (treat) pain and txfer of second ED) for burn care." If at the second ED on in. The resident was ond degree burns. The ED inapprox 3-4% TBSA (total 2nd degree burn. (did not go around the leg) in and, treated with Bacitracin all and a dressing was int was discharged back to the mendation to have a follow up with the burn clinic. Is sessed by the nurse is measuring 6.5 x 1.5 cm is cm, and 8 x 3 cm with few	F 2			
		Assessment & Treatment				

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is awake, delusional, confused and

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER;	(X2) MUL	TIPLE CONSTRUCTION	{X:	D) DATE SURVEY COMPLETED
		495392	B. WING			C
	PROVIDER OR SUPPLIER IA NSG CENTER-WIN	1		STREET ADDRESS, CITY, STATE, ZIP COD 1604 OLD DONATION PKWY VIRGINIA BEACH, VA 23454	E	01/13/2016
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG		IOULD BE	
F 280	staff when touched. hitting staff states "I why." She is currer (by mouth) qd (ever is not sufficient to a physical aggression. A nurses note dated part:Resident was had several cops of resident and floor in assist her with the o from resident to ass and resident raised to closed meal cart out onto the floor" A nurses note datedreminded son of in juice machine and pa and coffee and plac resident spilling bey mobilizes wheelchai floorAsked son to resident could use." A nurses note dated placed to son to requ resident to use to dr fluids from drink ma down hallway and w	conlinues to be violent with When asked why she is they are aggravating me that's ally on Seroquel 12.5 mg pory day). This dose of Seroquel leviate delusions or stop	F 2	280		
	in part: Resident at f setting the alarm off.	d 12/28/15 at 1:42 pm, read, ront door throughout this shift Resident was asked to or and attempted to be				

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-		FOF-DEFICIENCIES——— DF CORRECTION	(X1)-PROVIDER/SUPPLIER/CLIA- IDENTIFICATION NUMBER:	(X2) MULTII A. BUILDIN	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
ı	in was to the trivial	en er en vedestå didfinet flytter skelet er med sterre	495392	B. WING _		C
		PROVIDER OR SUPPLIER A NSG CENTER-WIND	DERMERE		STREET ADDRESS. CITY, STATE, ZIP CODE 1604 OLD DONATION PKWY VIRGINIA BEACH, VA 23454	01/13/2016
herromento (Marrows and American	(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETION
	F 323 SS=G	at this nurse when a resident was seen to in the cup. This nurse spilled coffee on floor monitor. Review of the reside evidence a revised or resident's unsafe be cups of hot and cold of the wheelchair and legs. On 1/13/16 at 11:58 conducted with the Extremely's care proceed if the resident been revised to inclusive stated, "It should complete the complete that the complete the complete that the complete the resident been revised to inclusive stated, "It should complete the complete that the	at continued to swing both fists asked to move. later this shift to have a cup on tap. Nothing se was told that resident had for in dinning (sic) area. Will ent's plan of care failed to care plan to include the chavior of placing multiple is beverages along the inside m rests and between her am, a second interview was DON. The failure to revise lan was shared. When is care plan should have to these identified behaviors if have been."	F 281		
		by:	is not met as evidenced in, staff interviews, clinical ring the course of a		Past noncompliance: no plan of correction required.	

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PRINTED: 01/20/2016 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY DENTIFICATION NUMBER: COMPLETED A. BUILDING 495392 B. WING 01/13/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1604 OLD DONATION PKWY SENTARA NSG CENTER-WINDERMERE VIRGINIA BEACH, VA 23454 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (KS) COMPLETION (EACH DEFICIENCY MUST BE FRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX PREFIX DATE DEFICIENCY) F 323 Continued From page 14 F 323 complaint investigation the facility staff failed to provide an environment free of accident hazards over which the facility has control and provide supervision to prevent an avoidable accident for 1 of 3 residents in the survey sample, Resident #1. Resident #1 was found to have first and second degree thermal burns to the right inner and outer thigh areas, right lower abdomen and right knee on 12/25/15. The thermal burns were a result of coffee spillage. The resident was known by the facility to have dementia, poor safety awareness and unsafe behaviors such as placing multiple beverage cups filled with cold and hot beverages such as coffee in between her legs and tucked inside the wheelchair arms next to her thighs while ambulating in the wheelchair throughout the facility. The resident obtained these beverages independently from two self serve beverage machines located on Unit two and the main dining room. The findings included: Resident #1 an 86 year old was admitted to the facility on 9/14/15 following a hospitalization requiring skilled services. The resident's diagnosis included Non-Alzheimer's Dementia with behavioral disturbances.

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The current MDS (Minimum Data Set) with an assessment reference date of 12/3/15 coded the resident as scoring a 5 out of a possible 15 on the

Brief Interview for Mental Status (BIMS), indicating the resident had severely impaired cognition. The resident had received the antipsychotic medication (Seroquel 12.5 mg (milligrams) daily during the seven days of the assessment period. The resident was wheelchair

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	19 LOLLMEDIOWIC	& WEDICAID SERVICES				WIR NO	<u>. 0938-039</u> 7
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A BUILDI		LE CONSTRUCTION	CDV	resurvey MPLETED
Contract Ship with	Pitagon en Propositioneren etablige en mendesen.	495392	B WING) 1 to		100000000000000000000000000000000000000	/13/2016
NAME OF F	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE	***************************************	1072070
SENTAR	A NSG CENTER-WIN	DERMERE			1604 OLD DONATION PKWY /IRGINIA BEACH, VA 23454		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	ĸ	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOUL) CROSS REFERENCED TO THE APPROF DEFICIENCY)	38 C	(X5) COMPLETION DATE
F 323	Continued From pa	ge 15	F 3:	23			
	bound due to a left	above-lhe-knee amputation.					
	State Agency Office described an injury by a CNA (certified right thigh on 12/25, pm. The injury was and some open". T coffee on her leg." documented, "This	Incident (FRI) was sent to the on 12/28/15. The FRI of unknown origin was noted nurse aide) on Resident #1's //15 at approximately 11:27 described as "Blistersintact the resident stated "she spilled The Administrator occurrence was brought to the inistrator on 12/28/15 at					
	3:00 pm. He stated on herselfshe did they were changing (12/28/15) and met Party/RP) to recap v coffee machine in the turned off Sunday (1 vendor came to che dispenser on 12/29/the hot water tempe 175 degrees. He fur machine contains a that is mixed with the He stated after the hwas decreased the todispensed was 174 action he stated the was made inoperable stated the residents coffee during off hou Administrator stated machine had been kere stated and the stated the residents coffee during off hou Administrator stated machine had been kere stated in the stated the residents coffee during off hou Administrator stated machine had been keresidents.	ras interviewed on 1/11/16 at , "the patient spilled coffee not tell the nursing staff until her! found out on Monday with the son (Responsible what had happenedthe he dining room was initially 12/27/15). He stated the ck the self serve coffee 15. The vendor lurned downerature from 191 degrees to rither stated the coffee pouch of cold liquid coffee hot water when dispensed not water temperature setting emperature of the coffee degrees. As corrective self serve coffee machine e effective 12/28/15. He now have to ask staff for in meal times. The the self serve coffee ept on unit two inside the self serve coffee machine was serve coffee machine was					

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moved from the Coastal Cafe to the main dining

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CENTER	42 FOR MEDICARE	a MEDICAID SERVICES			NAIS INC. CONSULTORS
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED
		495392	B. WING		C 01/13/2016
			L	STREET ADDRESS, CITY, STATE, ZIP CODE	1 21/13/2010
NAME OF	PROVIDER OR SUPPLIER				
SENTAR	A NSG CENTER-WIN	DERMERE		1604 OLD DONATION PKWY	
				VIRGINIA BEACH, VA 23454	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	FROVIDERS PLAN OF CORRECTIC ((EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	BE COMPLETION
F 323	to Thanksgiving). It was known to place (independently obtainable processed in the legs while move wheelchair. The Adassigned staff in the supervision to reside and activities held in the Director of Nurnurse manager was 3:45 pm. The DOM injury on Sunday (1 of unit one manage homeshe (the unit he 3-11 pm nurse coffee machine." The unit one nurse notified of the them through a phone cathreatening to call A Services) in responevening (12/27/15).	vations were completed (prior de further stated Resident #1 ecups of beverages ained from the self service to coffee dispenser) between any about the facility in her dining room to provide tent's outside of meal times	F 3:		
	the injury of unknow DON stated, "I notif	vn origin (thermal burns). The fied the Administrator the next meeting (12/28/15).			
	The DON stated the could be combative stating the resident "takes multiple cup them in the wheeld legsthey would significant them in the wheeld legsthey would significant them in the wheeld legsthey would significant the whole the country would significant the whole	e resident often refused care, and drank coffee everyday, was known and observed to s of drinks at a time and place hair and between her osh." She stated a cup holder resident's wheelchair			

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	1-OF-DEFIGIENCIES DF CORRECTION	(X1) PROVIDERSUPPLIENCLIA DENTIFICATION NUMBER:	-(X2) MU A. BUILI	LTIPLE CON	(X3) DATE SURVEY————————————————————————————————————	
es servers ra	etarin televijas vinnas konnentrini aritot	495392	B. WING			C 01/13/2016
	PROVIDER OR SUPPLIER A NSG CENTER-WINI	DERMERE		1604 0	T ADDRESS, CITY, STATE, ZIP CODE OLD DONATION PKWY NIA BEACH, VA 23454	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC :DENTIFYING INFORMATION)	PREF TAG		PROVIDERS PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	DE COMPLETION
F 323	continued to place include coffee between the reson had brought in stated the resident not remember the safety awareness. The DON stated the holder for the reside son to bring in a cup There were no othe or trialed to correct multiple beverages in between the wheelchair arms wheelchair through cincreased supervisic safety for the reside the Coastal Cafe. The unit manager si placed on the wheel placed cups on her in the thermal burns or on 1/11/16 at 5:30 p arrived on duty she wheelchair in the haroom. CNA #1 state "gone for a little whill There was some attresident) swung at a were called because	aber but the resident multiple cups of beverages to een the wheelchalr arm rests sident's leg. She stated the a cup with a lid. The DON recognizes her son but does taffs name and has poor a facility had obtained a cup ent's wheelchair and asked the with a lid for the resident. In interventions implemented the unsafe behavior of placing ups filled with cold and hot en her legs and tucked inside while ambulating in the out the facility. There was no on implemented to promote int while in the dining room or lated after the cup holder was chair the resident, "Still ap." surse aide #1) who discovered in 12/25/15 was interviewed in 12/25/15 wa		323		

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CENTE	RS FOR MEDICARE	E & MEDICAID SERVICES		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		TAIR MA	<i>J.</i> 0938-0391		
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		495392	B. WING			01	C /13/2016		
NAME OF	PROVIDER OR SUPPLIER	<u></u>	'''''	STR	REET ADDRESS, CITY, STATE, ZIP CODE		·		
were the ball		t ar to hell the hells.	1	160	4 OLD DONATION PKWY				
SENIAR	RA NSG CENTER-WIN	DERMEKE		VIR	RGINIA BEACH, VA 23454				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES LY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	ς	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROVIDENCY)	.O BE	(X5) COMPLETION DATE		
F 323	was assisting the re	pm. She stated when she resident with putling on a gown	F 3	23					
	thigh area. She as happened, the resi coffee on myselfi	"burn" to the resident's right sked the resident how this ident responded, "I spilled it happened the day before,"							
	assessed the resid								
	was Interviewed on stated, "She (Resid twoshe had spille juicethe nurse att and the resident sw	rising supervisor for 12/25/15 in 1/12/16 at 2:30 pm. He ident #1) was seen on unit ied a couple of cups of itempted to remove the cups wung at her hitting her on her ithe wheelchair arm and swung							
	it around away from me in the gut and s police to see if we detaining order) an	m the nurse and the resident hit scratched my armI called the could get a TDO (temporary nd a record of her violent I five cups of julces, one in the							
	cup holder, one on arm rests and one	the inside of each wheelchair between her legs and one on here was no coffee"							
	assigned to care for interviewed. She s with morning care to clothes and clothes stated. "I stayed on	pm, the day shift CNA #2 or Resident #1 on 12/25/15 was stated she assisted the resident by handing the resident wash is to change into. The CNA in the left side of the bed							
	leg" The CNA was redness to the residence she stated, "No." I on the left side of the position to have ha	cick you real fast with that right as asked if she noted any ident's right leg at that time and She stated because she was he bed she was not in a aid full visual access to the							
		h area. She stated the ee everyday and would go to							

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		TO MEDICANO OCITATOLO	,			
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	-(X2) MU A. BUILI		ONSTRUCTION	(X3) DATE SURVEY COMPLETED
znegogovánkom negos						C
	a status de tra lagrandes a la seguitation	495392	B. WING	-	A CONTRACTOR OF THE CONTRACTOR	01/13/2016
NAME OF F	PROVIDER OR SUPPLIER			STRE	ET ADDRESS, CITY, STATE, ZIP CODE	
SENTAR	A NSG CENTER-WINI	neeweee		1604	OLD DONATION PKWY	
JEN IMIN	~ ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	ber fine fine fine fine fine fine fine fine		VIR	GINIA BEACH, VA 23454	
(x4) IO PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S FLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION
F 323	unit two to get it wh located on that unit removed the reside wet with urine as th inconlinent care fro observe any coffee stated the resident wheelchair and ami	en the coffee machine was The CNA stated she had ont's linen due to them being e resident had refused m the night shift. She did not stains on the linen. CNA #2 does not get into the bulate in the hallways as she y, she indicated the resident	F	323		
	(FSD) was interview the resident on an a the day obtain not deservice machin habit of placing it be adamantly refused table to help hersl something in betwee 90% of the time." The Resident #1's therm machine was made unplugging the elect coffee bag from instated he maintains the spare keys inside the resident if from the kitches were inserviced on plans include having serve coffee machine FSD stated there is the facility and it is the facility did not have	am, the Food Service Director yed. He stated he observed almost daily basis throughout only juice but coffee from the es. He stated, "She has a stween her legsshe to let you take the cups to the he would have a cup of en her legs I would say 80 to he FSD stated as a result of nal burns the self serve coffee inoperable on 12/28/15 by trical cord, removing the side of it and locking it. He the key on his key chain and the kitchen. He stated the lot have access to these keys. dent's request coffee the staffen. He stated the kitchen staff 12/28/15. The FSD stated the githe vendor remove the self he from the dining room. The only one coffee machine in ocated inside the kitchen. The me of the burn injury the lids available for the cups at and coffee beverage stations.				

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MUL1 A. BUILO:		E CONSTRUCTION .		TE SURVEY MPLETED C
		495392	B, WING			01	/13/2016
NAME OF	PROVIDER OR SUPPLIER			_	TREET ADDRESS, CITY, STATE, ZIP CODE		
SENTAR	A NSG CENTER-WIN	DERMERE			604 OLD DONATION PKWY IRGINIA BEACH, VA 23454		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDERS PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	DBE	(X5) COMPLETION DATE
F 323	Plan dated 10/1/15 is awake, delusiona uncooperative. She staff when touched hitting staff states "why." She is currer (by mouth) qd (ever is not sufficient to a physical aggression. A nurses note dated part:Resident was had several cops of resident and floor in assist her with the of from resident to assand resident raised to closed meal cart out onto the floor	for the cups. Assessment & Treatment read, in part: (Resident name) at, confused and continues to be violent with When asked why she is they are aggravating me that's atty on Seroquel 12.5 mg pory day). This dose of Seroquel lleviate delusions or stop at 11/13/15 read, in a spouring coffee in cups and a coffee that were spilling on a formed resident was going to coffee and went to take coffee that it staff. Resident went opened it up and pulled trays at 11/24/15 read, in part: incidents of resident going to couring several cups of juice aing (sic) wheelchair and then the couring in cup with a lid that	F 3	23			
	she becomes agitat and throws the fluid	then (sic) try to assist resident ed and refuses or try's (sic) s on staff.					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/OLIA AND PLAN OF CORRECTION NUMBER:		-(X2) MUL A. BUILD		(X3) DATE SURVEY COMPLETED		
AMMIN THEORY	on presentate #5555 (Montrich Charmiton	495392	B. WING			C 01/13/2016
	PROVIDER OR SUPPLIER A NSG CENTER-WIN	DERMERE		1604	EET ADDRESS, CITY, STATE, ZIP CODE 4 OLD DONATION PKWY GINIA BEACH, VA 23454	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID FREFI TAG		PROVIDER'S PLAN OF CORRECTI JEACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	DBE COMPLETION
	in part: Resident at setting the alarm of move away from do redirected. Resider at this nurse when a resident was seen to the cup. This nurse pilled coffee on flormonitor. Review of the reside evidence a revised resident's unsafe be cups of hot and coto of the wheelchair ar On 1/11/16 at 3:05 pwas observed in bewas asked about the burned myself with a burned myself with the right leg. When obtained the coffee don't know where the resident was observed the interview was strumbler with a lid an on the sink, away from Another pink sip cup residents night stand reach with approximinside it. The resider	ed 12/28/15 at 1:42 pm, read, front door throughout this shift. Resident was asked to our and attempted to be not continued to swing both fists asked to move. later this shift to have a cup on lap. Nothing se was told that resident had or in dinning (sic) area. Will ent's plan of care failed to care plan to include the chavior of placing multiple di beverages along the inside ms and between her legs. In on initial tour the resident di and awake. The resident e incident. She stated, "I coffee" (the resident pointed to asked where she had from she yelled abruptly, "I ley got the coffee from." The led agitated at that point and opped. A clear plastic di straw was observed empty om the residents reach. In was observed on the di, away from the residents lately 30 ml of clear fluid int's wheelchair was observed in the resident of attached to the right.	F3	323		
	On 1/12/16 and 1/13 approximately 2:00 p	1/16 from 10:00 am to om, the resident remained in c cup remained on the sink,				

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CENTERS FOR MEDICARE & MEDICAID SERVICES		~~~		OMB NO. 0938-0391			
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495392	B. WING			01	C /13/2016
NAME OF	PROVIDER OR SUPPLIER			STR	REET ADDRESS, CITY, STATE, ZIP CODE	***************************************	**************************************
CCAITAD	A NSG CENTER-WIN	neossene		160	4 OLD DONATION PKWY		
SCHIMA	A Mag GEM 15K-Milai	DERMERC		VIR	KGINIA BEACH, VA 23454		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION!	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 323	Continued From pa	ge 22	F3	23			
	the pink sip cup ren	nained on the dresser drawer unt of clear fluid as seen on					
	sent to the emerger discovery of the blis the first emergency at 00:13 am. The E "thermal burns to after spilling coffee Blisters ruptured at Given morphine in troom)Patient likely Discussed with (nar transfer pallent for my opinion, this is a person (who posses health and medicine serious jeopardy, or bodily function, or serogansPt with both burns to rie (right love	evidenced the resident was not department following the iders. The resident arrived at department (ED) on 12/26/15 iD notes read, in part: the right thigh, knee and leg on self this am at-0800. this time. Pain improved, he ER (emergency y requires burn scrub, me of second ED) and will evaluation by burn team. In condition that a prudent lay sees an average knowledge of a) may expect to result in cause serious impairment of erious dysfunction of bodily in 1st and 2nd deg (degree) wer extremity), will tx (treat) ifer) to (initial of second ED)					
	12/26/15 at 02:33 ardiagnosed with seconderead, in part:" body surface area) 2 Non-circumferential The burns were cleased to unit gram topic applied. A follow up clinic was to be schefor a visit in 2 days for healing. The resident	at the second ED on m. The resident was ond degree burns. The ED approx 3-4% TBSA (total 2nd degree burn. (did not go around the leg). aned, treated with Bacitracin at and a dressing was appointment with the burn eduled as soon as possible or burn care and to ensure nt was discharged from the 12/26/15 back to the facility.					

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CENTER	45 FUR MEDICARE	A MEDICAID SERVICES			QIVID 110. 0300-0031
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	A. BUILD	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495392	B. WING		C 01/13/2016
7	PROVIDER OR SUPPLIER A NSG CENTER-WIN	F		STREET ADDRESS. CITY. STATE, ZIP CO 1604 OLD DONATION PKWY VIRGINIA BEACH, VA 23454	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFII TAG		SHOULD BE COMPLETION
F 323	Continued From pa	ige 23	F3	323	
	practitioner on 12/2 described as: Right thigh & knee with the larger area (centimeter) 6.5 x 4 scattered areas of (redness), small ap (right lower quadraterythema. The resident was s 1/4/16. The burn of Mental health: Occursing altered mealert, and oriented reistyright lower esurface area burn in calf that is varied stepithelialization to a knee that is signific pseudo eschar (deeremoving a signification to a signification of the survey dead tissue (dead tissue pseudo eschar that granulation. This a deepest burn that a was changed to Sill thorough cleansing premedicating with daily dressing chan During the initial to the survey days of serve coffee machimain dining room.	ssessed by the nurse 18/15. The burns were with 1st and 2nd degree burns is measuring 6.5 x 1.5 cm 1.5 cm, and 8 x 3 cm with few 1.5 cm, and 8 x 3 cm with few 1.5 cm, and 8 x 3 cm with few 1.5 cm, and 8 x 3 cm with few 1.5 cm, and 8 x 3 cm with few 1.5 cm 1.5 cm, and 8 x 3 cm with few 1.5 cm 1.5			

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		AND HUMAN SERVICES & MEDICAID SERVICES			FOR	D: 01/20/2010 MAPPROVED O. 0938-039
STATEMENT	OI- DEFICIENCIES PCORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	IPLE CONSTRUCTION NG		ATE SURVEY OMPLETED
		495392	B WING_		0	1/13/2016
NAME OF F	PROVIDER OR SUPPLIER	<u> </u>	·	STREET ADDRESS, CITY, STATE, ZIP CODE		
SENTAR	A NSG CENTER-WIN	DERMERE		1604 OLD DONATION PKWY VIRGINIA BEACH, VA 23454		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 1 MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 323	areas. One coffee the kitchen. The plan of correctl accidents from the included: 1. The self service immediately turned 2. The machine was 12/28/15. 3. Employees will of through the kitchen staff vithe self service coff 12/28/15. 5. The vendor was self service coffee in the facility was in companied.	any of the resident common machine was located inside ion to prevent further self serve coffee machine coffee machine	F 3:	23		

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