| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 495395 | A. BUILDING _____ B. WING _____ | C 04/11/2018 |

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| HARBOR'S EDGE | ONE COLLEY AVENUE NORFOLK, VA 23510 |

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| E 000 | Initial Comments<br><br>An unannounced Medicare/Medicaid standard survey was conducted 04/09/18 through 04/11/18. One complaint was investigated during the survey. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow.<br><br>The census in this 30 certified bed facility was 26 at the time of the survey. The survey sample consisted of 15 current Resident reviews and 3 closed record reviews. | E 000 | | |
| F 000 | INITIAL COMMENTS<br><br>An unannounced Medicare/Medicaid standard survey was conducted 04/09/18 through 04/11/18. One complaint was investigated during the survey. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow.<br><br>The census in this 30 certified bed facility was 26 at the time of the survey. The survey sample consisted of 15 current Resident reviews and 3 closed record reviews . | F 000 | | |
| F 657 SS=D | Care Plan Timing and Revision<br>CFR(s): 483.21(b)(2)(i)-(iii)<br><br>§483.21(b) Comprehensive Care Plans<br>§483.21(b)(2) A comprehensive care plan must be-<br>(i) Developed within 7 days after completion of the comprehensive assessment.<br>(ii) Prepared by an interdisciplinary team, that includes but is not limited to--<br>(A) The attending physician. | F 657 | | 5/9/18 |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 05/10/2018

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| F 657 | Continued From page 1<br>(B) A registered nurse with responsibility for the resident.<br>(C) A nurse aide with responsibility for the resident.<br>(D) A member of food and nutrition services staff.<br>(E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.<br>(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.<br>(iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.<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 review and revise the plan of care of 1 of 18 residents in the final survey sample, Resident # 3.<br><br>The findings included<br><br>The facility staff failed to revise the care plan for Resident # 3 to reflect that he did not have a Foley catheter.<br><br>Resident # 3 is an 86-year-old-male who was originally admitted to the facility on 9/18/14 with a readmission date of 3/27/18. Diagnoses included but were not limited to: benign prostatic hyperplasia, hypertension, polymyalgia, and abscess of epididymis or testis. | F 657 | 1. The plan of care for Resident #3 was corrected<br>immediately to ensure accuracy.<br>2. Plans of care for all of the residents with orders<br>for indwelling catheters have been audited and<br>any discrepancies have been corrected.<br>3. The interdisciplinary team and the nursing team<br>will be educated on the importance of reviewing<br>and updating the plans of care on a regular basis.<br>4. Director of Nursing or Designee will audit<br>plans of care for correctness within 72 hours of | |

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| F 657 | Continued From page 2<br><br>On 4/10/18 at 9:32 pm, the surveyor observed Resident # 3 in the hallway traveling via motorized scooter without difficulty. Resident # 3 was well groomed wearing a tan pants, grey shirt, and grey shoes. There was no catheter drainage bag observed on Resident # 3 at this time.<br><br>The clinical record for Resident # 3 was reviewed on 4/10/18 at 2:08 pm. The most recent MDS (minimum data set) assessment was a significant change assessment with an ARD (assessment reference date) of 1/20/18. Section C of the MDS assesses cognitive patterns. In Section C0500, the facility staff coded that Resident # 3 had a BIMS (brief interview for mental status) score of 9/15, which indicated moderate cognitive impairment. Section H of the MDS assesses bladder and bowel. In Section H0100, the facility staff documented that Resident # 3 had an indwelling catheter.<br><br>The current plan of care for Resident # 3 was initiated on 3/27/18. The plan of care had a problem area documented as "Resident # 3 has DX (diagnosis) of neurogenic bladder indwelling Foley catheter. Resident pulls on Foley at times." Interventions included but were not limited to: "Foley Catheter FR (French) # 16/ 10cc (cubic centimeters) indwelling, connected to bedside drainage bag."<br><br>Upon review of the current physician's orders, the surveyor did not locate any orders for a Foley catheter for Resident # 3.<br><br>On 4/11/18 at 10:53 am, the surveyor interviewed CNA (certified nursing assistant) #1 and asked if Resident # 3 had a Foley catheter. CNA # 1 | F 657 | admission as well as daily to ensure they reflect<br>any MD order changes. | |

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| F 657 | Continued From page 3<br>stated, "He used to have one, but he doesn't have it anymore."<br><br>On 4/11/18 at 9:03 am during an interview with Resident # 3, this surveyor did not observe a catheter drainage bag and when asked if he had a catheter Resident # 3 stated that he did not have a catheter.<br><br>On 4/11/18 at 2:40 pm, the administrative team was made aware of the findings as stated above.<br><br>No further information regarding this issue was provided to the survey team prior to the exit conference on 4/11/18. | F 657 | | |
| F 684 SS=D | Quality of Care<br>CFR(s): 483.25<br><br>§ 483.25 Quality of care<br>Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices.<br>This REQUIREMENT is not met as evidenced by:<br>Based on staff interview and clinical record review, the facility staff failed to ensure that 1 of 18 residents in the final survey sample received services in accordance with physician's orders, Resident # 25.<br><br>The findings included<br><br>The facility staff failed to obtain daily weights as | F 684 | 1. No resident was adversely affected by the deficient practice.<br>2. All of the clinical records for residents with orders for daily weights have been audited and discrepancies identified.<br>3. The nursing team will be educated on | 5/8/18 |

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| F 684 | Continued From page 4<br>ordered by the physician for Resident # 25.<br><br>Resident # 25 is a 99-year-old-female who was admitted to the facility on 3/15/18. Diagnoses included but were not limited to: right hip intertrochanteric fracture, chronic diastolic heart failure, hypertension, and hypothyroidism.<br><br>The clinical record for Resident # 25 was reviewed on 4/10/18 at 11:26 am. The most recent MDS (minimum data set) assessment was a 14-day assessment with an ARD (assessment reference date) of 3/29/18. Section C of the MDS assesses cognitive patterns. In Section C 0500, the facility staff documented that Resident #25 had a BIMS (brief interview for mental status) score of 15/15, which indicated that she was cognitively intact.<br><br>The current plan of care for Resident # 25 was reviewed and revised on 3/27/18. The facility staff has documented a problem area as "Resident # 25 is at nutritional risk related to therapeutic diet." Interventions included but were not limited to: "Monitor weight per MD (medical doctor) orders."<br><br>Resident # 25 had current orders that were signed by the physician on 3/15/18 for "Daily weights due to history of heart failure and daily Lasix consumption-every morning."<br><br>Upon review of the weights for Resident #25, this surveyor did not locate weights in the clinical record for 3/24/18, 3/26/18, 4/1/18, and 4/7/18.<br><br>On 4/10/18 at 12:15 pm, the surveyor spoke with the director of nursing about the missing weights for Resident # 25. The director of nursing stated that she knew that there was a problem with | F 684 | the<br>importance of obtaining daily weights per MD<br>orders.<br>4. Unit Clerk will maintain the list of residents on daily weights and will ensure those are being taken. Director of Nursing or Designee will conduct daily audits of the weights to ensure that all residents with orders for daily weights are done and weights are accurate. Results of the audit will be reported to the Quality Assurance and Performance Improvement Committee monthly and as needed. | |

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| F 684 | Continued From page 5<br>weights in the facility and that she was working on making improvements.<br><br>On 4/11/18 at 2:40 pm, the administrative team was made aware of the findings as stated above.<br><br>No further information regarding this issue was provided to the survey team prior to the exit conference on 4/11/18. | F 684 | | |
| F 686 SS=D | Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii)<br><br>§483.25(b) Skin Integrity<br>§483.25(b)(1) Pressure ulcers.<br>Based on the comprehensive assessment of a resident, the facility must ensure that-<br>(i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and<br>(ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, resident interview, clinical record review, and facility document review, the facility staff failed to ensure that 1 of 18 residents in the final survey sample received treatment and services consistent with physician's orders to promote healing of pressure ulcers, Resident # 25.<br><br>The findings included: | F 686 | 1. The heelz up device for Resident #25 was put in<br>place and staff was in-services the same day.<br>2. All of the residents with orders for preventative<br>pressure reducing devices have been checked to<br>ensure device presence and proper placement. | 5/9/18 |

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| F 686 | Continued From page 6<br>The facility staff failed to implement interventions to prevent the development of 2 Stage 2 pressure ulcers and failed to ensure that heelz up was applied as ordered by physician for Resident # 25.<br><br>Resident # 25 is a 99-year-old-female who was admitted to the facility on 3/15/18. Diagnoses included but were not limited to: right hip intertrochanteric fracture, chronic diastolic heart failure, hypertension, and hypothyroidism.<br><br>The clinical record for Resident # 25 was reviewed on 4/10/18 at 11:26 am. The most recent MDS (minimum data set) assessment was a 14-day assessment with an ARD (assessment reference date) of 3/29/18. Section C of the MDS assesses cognitive patterns. In Section C 0500, the facility staff documented that Resident #25 had a BIMS (brief interview for mental status) score of 15/15, which indicated that she was cognitively intact. Section G of the MDS assesses functional status. In Section G0110 activities of daily living was assessed. For bed mobility and transfers, the facility staff documented that Resident # 25 is 3/3, which indicated that Resident # 25 required extensive assistance of 2 or more people. Section M of the MDS assesses skin conditions. Section M0210 assesses unhealed pressure ulcer(s). The question was asked, "Does the resident have one or more unhealed pressure ulcers(s) at Stage 1 or higher?" The facility staff documented "1" which indicated "yes." Section M 0300 assesses the current number of unhealed pressure ulcer(s) at Stage 1 or higher. M0300 B Stage 2, the facility staff documented that Resident #25 had 2 Stage 2 pressure ulcers. Facility staff also documented that the Stage 2 areas were not present upon | F 686 | 3. All nursing staff will be educated on resident<br>treatments and services consistent with physician<br>orders.<br>4. Director of Nursing or Designee will perform audits every shift on residents with orders for pressure reducing devices to ensure plan of care is being followed. Results of the audit will be reported to the Quality Assurance and Performance Improvement Committee<br>monthly and as needed. | |

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| F 686 | Continued From page 7 | F 686 | | |

admission, and documented the date of the oldest Stage 2 pressure ulcer was 3/26/18.

Upon review of the Braden Scale for Resident # 25, that was completed upon admission, the facility staff documented that Resident # 25 had a Braden score of 17, which indicated "low risk."

The current plan of care for Resident # 25 was reviewed and revised on 3/27/18. The facility staff documented a problem area "Resident # 25 is at risk for skin breakdown due to incontinence and needs help for bed mobility due to her generalized weakness, poor endurance, and easily fatigues." Interventions include but were not limited to "Encourage frequent position change", "consult dietitian as needed" and "monitor skin during baths weekly."

Resident # 25 had current physician's orders that were signed by the physician on 3/25/18 that included but is not limited to: "Float both heels with heelz up while in bed every shift." The physician wrote orders on 3/26/18 that stated "Fluid filled blister to right heel- apply skin prep every shift", and "Fluid filled blister to left heel- apply skin prep every shift."

Upon further review of the clinical record, this surveyor did not locate any dietary notes that had been written to address dietary interventions to promote wound healing.

On 4/10/18 at 3:12 pm, the surveyor entered Resident # 25's room to speak with her. Resident # 25 was observed lying in bed and heels were resting on the mattress. The heelz up device was not in place on bed and was observed in a chair next to Resident # 25's bed.

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| F 686 | Continued From page 8 | F 686 | | |

On 4/11/18 at 8:33 am, the surveyor observed two staff members pulling Resident # 25 up in bed so that she would be positioned properly in bed to eat her breakfast. Resident # 25 gave the surveyor permission to look at her heels. The surveyor observed an area on the right heel that was circular in shape and about the size of a 50-cent piece. The area was noted to be hardened and dark purple in color. The surveyor also observed an area on the left heel that was circular in shape and about the size of a dime. The area was noted to be light brown in color. Resident # 25 asked the surveyor what was going on with her heels. Resident # 25 then stated, "People keep looking at my heels but I don't know what is going on with them." The surveyor explained her observations to Resident # 25. Resident # 25 then stated to the surveyor, "You see what just happened, how they came in here and got me all fixed up, well that doesn't happen all the time."

According to the facility policy on "Wound Care Assessment and Documentation," Documented under "I. Assessment of Residents at Risk:
A. Identify resident who are particularly prone to the development of pressure ulcers. This includes: (but is not limited to)
Residents with an alteration in mobility
10. Residents who score 17 or below on skin assessment tool."

Documented under "II. Pressure Ulcer Prevention," includes but is not limited to:
"3. Use of heelz up cushion to support heels or residents and decrease shearing and pressure (physician order required)
12. Provision and assurance that the resident

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| F 686 | Continued From page 9<br>receives optimum nutrition."<br><br>Also documented within the policy in Section V, which addresses the Braden Scale includes but is not limited to<br>"A. 15 PLUS = low risk<br>Interventions to include but not limited to:<br>1. Dietitian Review<br>2. Frequent Repositioning<br>3. Floating heels"<br><br>On 4/11/18 at 2:40 pm, the administrative staff was made aware of the findings as stated above.<br><br>No further information regarding this issue was provided to the survey team prior to the exit conference on 4/11/18. | F 686 | | |
| F 690 SS=D | Bowel/Bladder Incontinence, Catheter, UTI<br>CFR(s): 483.25(e)(1)-(3)<br><br>§483.25(e) Incontinence.<br>§483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain.<br><br>§483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that-<br>(i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary;<br>(ii) A resident who enters the facility with an indwelling catheter or subsequently receives one | F 690 | | 5/21/18 |

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| F 690 | Continued From page 10<br>is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and<br>(iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible.<br><br>§483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, staff interview, and clinical record review, the facility staff failed to ensure that 1 of 18 resident's in the final survey sample received appropriate care and treatment to prevent urinary tract infections, Resident # 15.<br><br>The findings included<br><br>The facility staff failed to ensure that Resident # 15 received catheter care and failed to ensure that catheter tubing was secured to facilitate the flow of urine preventing kinking of the tubing and position below the level of the bladder.<br><br>Resident # 15 is a 92-year-old-male who was originally admitted to the facility on 3/6/18, with a readmission date of 3/27/18. Diagnoses included but were not limited to: urinary tract infection, urinary retention, clostridium difficile, and malignant neoplasm of the prostate.<br>The clinical record for Resident # 15 was | F 690 | 1. Resident #15 clinical record was corrected and<br>nursing staff ensured that catheter care protocol<br>was being properly followed.<br>2. All residents with orders for indwelling catheters have been checkedto ensure that<br>facility policy and MD protocol are being followed.<br>3. Facility indwelling catheter policy has been<br>updated to include detailed instructions on catheter placement and daily care. New standing<br>orders have been added for catheter securement<br>and check for every shift. All nursing staff will be<br>educated on proper catheter care, including | |

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| F 690 | Continued From page 11<br>reviewed on 4/10/18 at 1:54 pm. The current plan of care for Resident # 15 was initiated on 3/26/18. The facility staff documented a problem area "Resident # 15 has indwelling catheter use with potential for infection diagnosis urinary retention with 3 failed voiding trials, diagnosis benign prostatic hyperplasia." Interventions included but were not limited to: "Secure catheter to leg to avoid tension on urinary meatus." and "Provide catheter care per protocol."<br><br>The physician signed the current physician's orders for Resident # 15 on 3/27/18. This surveyor did not locate any orders for catheter care.<br><br>On 4/11/18 at 10:27 am, Resident # 15 gave the surveyor permission to look at his indwelling catheter. Upon observation of the indwelling catheter, this surveyor observed a #14 Fr (French) catheter with 10 ml (milliliter) bulb. The stat lock was not secured to the resident's leg and was connected to the catheter that was positioned upward along the left thigh of Resident # 15 promoting the flow of urine back into the bladder. The tubing that connects the Foley catheter to the urinary drainage bag was observed curled underneath of the left leg of Resident # 15.<br><br>On 4/11/18 at 2: 00 pm, the surveyor spoke with the director of nursing to ask about catheter care for Resident # 15. The director of nursing reviewed the current physician's orders along with the surveyor and agreed that Resident # 15 did not have any current orders for catheter care. Director of nursing stated, "I will have to get that updated." | F 690 | proper tubing securement and positioning.<br>4. Director of Nusing and/or Designee will perform audits every shift on residents with orders for indwelling catheter to ensure that stat lock or leg band is in place. Results of the audit will be reported to the Quality Assurance and Performance Improvement Committee monthly and as needed. | |

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|---|---|---|---|
| | 495395 | A. BUILDING _____ B. WING _____ | C 04/11/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| F 690 | Continued From page 12<br>On 4/11/18 at 2:40 pm, the administrative team was made aware of the findings as stated above.<br><br>No further information was provided to the survey team prior to the exit conference on 4/11/18. | F 690 | | |
| F 761 SS=D | Label/Store Drugs and Biologicals<br>CFR(s): 483.45(g)(h)(1)(2)<br><br>§483.45(g) Labeling of Drugs and Biologicals<br>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.<br><br>§483.45(h) Storage of Drugs and Biologicals<br><br>§483.45(h)(1) 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.<br><br>§483.45(h)(2) 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.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, staff interview, and facility document review, the facility staff failed to ensure that drugs were stored and labeled according to | F 761 | 1. The improperly labeled medication was discarded and reordered immediately. There were | 5/21/18 |

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|---|---|---|---|---|
| F 761 | Continued From page 13<br>accepted professional principles.<br><br>The findings included<br><br>The facility staff failed to ensure that 1 of 2 medication carts was locked when unattended, and failed to ensure that Budesonide inhalation suspension was dated when opened on 1 of 2 medication carts.<br><br>On 4/09/18 at 6:51 pm, the surveyor observed a medication cart # 2 unlocked and unattended. On 4/9/19 at 6:53 pm, RN (registered nurse) #1 came into the hallway and the surveyor asked him if he was responsible for the medication cart. RN #1 stated, "Yes what's wrong with it?" RN # 1 looked at the medication cart, stated "Oh God", and immediately locked the medication cart.<br><br>According to the facility policy on "Medication Administration" Procedure includes but is not limited to "XXIII. Never leave medication cart open and unattended."<br><br>On 4/10/18 at 10:07 am, the surveyor checked the medication cart # 1. The surveyor observed a foil package of Budesonide Inhalation suspension in medication cart # 1 that was opened and undated. The surveyor spoke with RN # 2 about the opened undated pouch. The surveyor asked RN # 2 what the expiration date on the Budesonide Inhalation Suspension was. RN # 2 stated that they would look at the date on the vial. The surveyor brought to RN # 2's attention that according to the manufacturer's instructions on the box, the medication can be stored for 2 weeks after opening the protective foil. The surveyor asked RN # 2 if there is no date opened, how anyone is supposed to know when the two | F 761 | no adverse effects to the resident as a result of this<br>deficient practice.<br>RN #1 was immediately in-serviced on keeping<br>the medication cart locked when unattended.<br>2. The Director of Nursing performed medication<br>cart audit to identify and discard any medications<br>that were not properly labeled the night of the<br>finding on 4/9/2018.<br>3. Nursing staff was reeducated on facility medication administration policy and medication<br>labeling in accordance with manufacturer's<br>instructions.<br>4. Director of Nursing or Designee will perform medication cart audits daily. Results of the audits will be reported to the Quality Assurance and Performance Improvement Committee monthly and as needed. | |

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| F 761 | Continued From page 14<br>weeks are up. RN voiced understanding.<br><br>On 4/11/18 at 2:40 pm, the facility staff was made aware of the findings as stated above.<br><br>No further information regarding this issue was presented to the survey team prior to the exit conference on 4/11/18. | F 761 | | |
| F 812 SS=E | Food Procurement,Store/Prepare/Serve-Sanitary<br>CFR(s): 483.60(i)(1)(2)<br><br>§483.60(i) Food safety requirements.<br>The facility must -<br><br>§483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities.<br>(i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.<br>(ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices.<br>(iii) This provision does not preclude residents from consuming foods not procured by the facility.<br><br>§483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, staff interview and facility document review it was determined that the facility staff failed to store, prepare, distribute and serve food in accordance with professional standards for food service safety in the facility kitchen. | F 812 | 1. No resident was adversely affected by the<br>deficient practice.<br>2. The deficient practice was corrected immediately to ensure that no resident is affected | 5/11/18 |

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| F 812 | Continued From page 15<br><br>The Findings Included:<br><br>On April 9, 2018 at 6 p.m., the surveyor made an initial tour of the dining room and small kitchen located on the second floor. The surveyor observed three Residents sitting in the dining room and eating their dinner. The surveyor observed a male dietary staff member walk from the kitchen into the dining room and then returned into the kitchen. The surveyor observed that the male dietary staff member had a mustache and a goatee. The surveyor did not observe that the male staff member had on a mustache or goatee guard. The surveyor continued to tour the kitchen and observed that food was still being kept hot on the steam table and was available for residents to consume.<br><br>On April 9, 2018 at 6:10 p.m. the surveyor informed the male dietary staff member that he had facial hair and asked shouldn't your facial hair be covered? The male dietary staff member stated "Yes" and said he would get a beard/mustache guard.<br><br>On April 10, 2018 at 12:50 p.m., the surveyor notified the Administrator (Adm) that a male dietary staff member did not have beard guard on yesterday evening when we first entered the building. The surveyor notified the Adm that the male dietary staff member had a mustache and a goatee. The surveyor notified the Adm that the male staff member walked from the kitchen into the dining room and then back into the kitchen. The surveyor notified the Adm that food was available and was being kept hot on the steam table. The surveyor requested the policy and procedure for handling and storage of food. | F 812 | and that food safety requirements are followed.<br>The employee involved was in-serviced the next<br>day after occurence.<br>3. All dietary staff will be reeducated on the faclity<br>hair restraint policy.<br>4. Dietary Manager or Designee will monitor for compliance at every meal service and throughout working hours.<br>Results of the audit will be reported to the Quality Assurance and Performance Improvement Committee monthly and as needed. | |

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|---|---|---|---|---|
| F 812 | Continued From page 16<br><br>On April 10, 2018 at 1:49 p.m., the Adm hand delivered a policy and procedure titled, "Dining Services Sanitation Hair Restraints." The policy and procedure read in part ... "Policy: Employees are required to wear hair restraints that effectively keep their hair from containing food, clean equipment, utensils, and lines. Procedure: I. Employees who come in contact with food, clean equipment, utensils, and linens shall wear hair restraints such as hats, hair coverings or nets and beard guards."<br><br>No additional information was provided prior to exiting the facility as to why the male dietary staff failed to wear a mustache/beard/goatee guard while working in the kitchen. | F 812 | | |
| F 842 SS=E | Resident Records - Identifiable Information<br>CFR(s): 483.20(f)(5), 483.70(i)(1)-(5)<br><br>§483.20(f)(5) Resident-identifiable information.<br>(i) A facility may not release information that is resident-identifiable to the public.<br>(ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so.<br><br>§483.70(i) Medical records.<br>§483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are-<br>(i) Complete;<br>(ii) Accurately documented;<br>(iii) Readily accessible; and | F 842 | | 5/21/18 |

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| F 842 | Continued From page 17<br>(iv) Systematically organized<br><br>§483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is-<br>(i) To the individual, or their resident representative where permitted by applicable law;<br>(ii) Required by Law;<br>(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;<br>(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.<br><br>§483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.<br><br>§483.70(i)(4) Medical records must be retained for-<br>(i) The period of time required by State law; or<br>(ii) Five years from the date of discharge when there is no requirement in State law; or<br>(iii) For a minor, 3 years after a resident reaches legal age under State law.<br><br>§483.70(i)(5) The medical record must contain-<br>(i) Sufficient information to identify the resident;<br>(ii) A record of the resident's assessments;<br>(iii) The comprehensive plan of care and services provided; | F 842 | | |

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| F 842 | Continued From page 18<br>(iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;<br>(v) Physician's, nurse's, and other licensed professional's progress notes; and<br>(vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.<br>This REQUIREMENT is not met as evidenced by:<br>Based on staff interview and clinical record review it was determined that the facility staff failed to ensure a complete and accurate clinical records for the residents' of the facility.<br><br>The facility staff failed to ensure that the monthly Drug Regimen Reviews (DRR's) completed by the pharmacy were contained in the clinical records of the facility residents'.<br><br>The Findings Included:<br><br>On April 10, 2018 at 8 a.m., the survey team started to review the clinical records of the Residents' that were assigned to each individual surveyor. The survey team noted that the clinical records failed to produce monthly Drug Regimen Reviews (DRR's) completed by the pharmacy.<br><br>On April 10, 2018 at 12:35 p.m., the survey team notified the Interim Director of Nursing (IDON) that review of the residents' clinical records failed to produce documentation that the monthly DRR's being completed by the pharmacy. The survey team reviewed several Residents' clinical records with the IDON. This surveyor pointed out that the clinical records failed to produce documentation that the monthly DRR's were completed the pharmacy. The IDON stated that she would look and see what she could find. | F 842 | 1. There were no adverse effects as aresult of this deficient practice.<br>2. All of the active clinical records were audited and discrepancies identified.<br>3. The contracted pharmacist will be educated on performing Drug Regimen Reviews within the electronic health record software.<br>4. Director of Nursing or Designee will audit all Drug Regimen Reviews monthly to ensure compliance. Results of the audit will be reported to the Quality Assurance and Performance Improvement Committee monthly and as needed. | |

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|---|---|---|---|---|
| F 842 | Continued From page 19 | F 842 | | |

Within a few moments, the IDON approached the survey team and informed the survey team that the pharmacy vendor sent the files to the facility every month when the DRR's were completed. The IDON stated that the files were on a computer in a special file folder and that only the administration team had access to the files. The IDON stated that the supervisor that worked the night shift was supposed to scan each residents' DRR and put the scanned DRR's in the appropriate Resident electronic record. The IDON stated that she was the Interim DON and had just taken the position in March of 2018. The IDON stated that when she took the position as the IDON that she made sure that the March 2018 DRR's were in the residents' clinical records. The surveyor notified the DON that the survey team had a look back period of one year for the DRR's. The survey team informed the IDON that when the clinical records were reviewed the monthly DRR's were not in the clinical record. The IDON stated that the monthly DRR's were not included in the residents' clinical records as the files/DRR's had not been scanned by the night supervisor and placed into the appropriate resident record.

On April 11, 2018 at 2:30 p.m. the survey team met with the Administrator (Adm), Assistant Administrator (AAdm) and the IDON. The survey team notified the Administrative Team (AT) that the facility staff failed to ensure complete and accurate clinical records for the facility residents'. The survey team notified the AT that the facility staff failed to ensure that the monthly pharmacy DRR's were contained in the residents' clinical records.

No additional information was provided prior to exiting the facility as to why the facility staff failed

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| | 495395 | A. BUILDING _____ B. WING _____ | C 04/11/2018 |

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| F 842 | Continued From page 20<br>to ensure complete and accurate clinical records for the residents' of the facility. The facility staff failed to ensure that monthly DRR's were contained in the clinical record. | F 842 | | |
| F 880 SS=D | Infection Prevention & Control<br>CFR(s): 483.80(a)(1)(2)(4)(e)(f)<br><br>§483.80 Infection Control<br>The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.<br><br>§483.80(a) Infection prevention and control program.<br>The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:<br><br>§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;<br><br>§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:<br>(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;<br>(ii) When and to whom possible incidents of | F 880 | | 5/21/18 |

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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| F 880 | Continued From page 21<br>communicable disease or infections should be reported;<br>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;<br>(iv)When and how isolation should be used for a resident; including but not limited to:<br>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and<br>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.<br>(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and<br>(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.<br><br>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.<br><br>§483.80(e) Linens.<br>Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.<br><br>§483.80(f) Annual review.<br>The facility will conduct an annual review of its IPCP and update their program, as necessary.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and facility document review, the facility staff failed to provide an environment that prevents the transmission of communicable diseases and infection in 1 of 1 rooms on contact isolation. | F 880 | 1. No residents have been adversely affected by the deficient practice.<br>2. All of the rooms on the unit have been checked | |

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| F 880 | Continued From page 22<br><br>The findings included<br><br>The facility staff failed to ensure that soap was available to wash hands prior to leaving the room of a resident on contact isolation.<br><br>On 4/11/18 at 10:27 am, the surveyor was conducting interview and observations with Resident # 15. Resident # 15's diagnoses included but were not limited to clostridium difficile. Upon concluding the observation and interview, the surveyor removed the personal protective equipment and went into the bathroom to wash hands prior to leaving the room. This room had an automatic soap dispenser that was located on the sink next to the faucet. The surveyor placed her hands underneath the soap dispenser to obtain soap to wash her hands. No soap was dispensed from the dispenser. The surveyor observed a bottle of soap on the counter next to the sink with a long clear hose affixed to the top. The surveyor attempted to remove the top off of the soap to obtain soap but was unsuccessful. The surveyor looked underneath the sink and observed that there was no soap connected to the automatic soap dispenser.<br><br>According to the facility policy on "Clostridium Difficile" Implementation procedures include but are not limited to "5. When caring for residents with diarrhea or fecal incontinence, staff will maintain vigilant handwashing with soap and water, rather than alcohol-based hand rubs, for the removal of Clostridium spores from hands."<br><br>On 4/11/18 at 2:40 pm, the administrative team was made aware of the findings as stated above. | F 880 | to ensure proper functionality of soap dispensers.<br>3. All of the malfunctioning soap dispensers will be replaced.<br>4. Housekeeping staff will ensure that soap dispensers are functional in each room daily. Results of the audit will be reported to the Quality Assurance and Performance Improvement Committee monthly and as needed. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495395 | A. BUILDING _____ B. WING _____ | C 04/11/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| HARBOR'S EDGE | ONE COLLEY AVENUE NORFOLK, VA 23510 |

| (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 880 | Continued From page 23<br>No further information regarding this issue was presented to the survey team prior to the exit conference on 4/11/18. | F 880 | | |