STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495201	A. BUILDING _____ B. WING _____	C 06/30/2016

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

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F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid Abbreviated Standard Survey was conducted 06/28/2016 through 06/30/2016. One complaint was investigated during the survey. Corrections are required for compliance with the following 42 CFR Part 483 Federal Long Term Care requirements. The census in this 124 dually certified facility was 107 at the time of the survey. The survey sample consisted of 3 current Residents (Residents #1, 2, 3).	F 000		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, staff interview, facility documentation review and clinical record review, the facility staff failed to provide appropriate supervision to prevent elopement for one resident (Resident #1) of a 3 resident survey sample. The findings included: Resident #1 was a 55 year old male originally admitted to the facility on 12/19/2013 and his most recent readmission was 12/26/15. Diagnoses included, but were not limited to CVA	F 323	Past noncompliance: no plan of correction required.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 07/29/2016

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 323	Continued From page 1 (cerebral vascular accident-stroke), ASHD (arteriosclerotic heart disease-narrowing of the arteries), Mild Vascular Dementia with Behaviors, Hypothyroid, Fracture of the right hip 12/25/16, use of tobacco and a history of ETOH (drinking alcohol) abuse. Review of Resident #1's clinical record revealed a Comprehensive Significant Change MDS (minimum data set-an assessment protocol) with an ARD (assessment reference date) of 01/06/16 which coded the resident's BIMS (brief interview mental status) score as a 13 out of a possible score of 15. This indicated that the resident was cognitively intact. No behaviors were coded for the ARD. He was further coded as having clear speech and that he usually understood and usually understands verbal information. He was coded as being independent for bed mobility, transferring from different surfaces. locomotion on and off the unit, dressing, eating, toileting, personal hygiene and bathing. The resident was also coded as being continent of both bladder and bowel. Further review noted the resident was coded as not having any behaviors refusing care, refusing medications, or of wandering. Review of the resident's most recent Quarterly MDS with an ARD of 04/06/16 noted that the resident had a BIMS score of 11 out of 15 which would indicate that he had moderately impaired cognition and required supervision for all of his ADLs (activities of daily living) for the aforementioned assessment period. Additionally the resident was coded as having clear speech but would only sometimes understand and be understood. Further review noted the resident was also coded as not having any behaviors such as refusing care, refusing medications, or of	F 323		

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F 323	Continued From page 2 wandering. Review of the resident's current care plan noted the following: Wanderguard placed to lower extremity due to elopement attempt with fluctuation in condition. In the past made attempts to leave facility and at times not easily redirected. 6/24/16 resident noncompliant with wearing wanderguard. During the Entrance Conference conducted on 06/28/16 at approximately 1:45 p.m. with the acting DON (director of nurses) ASM (Administrative Staff member) #2 she stated that currently the Acting Administrator was the Corporate Vice President Administrative Staff Member (ASM #1). Continuing the conversation with ASM #2 she stated, "I have only been in the facility since 05/2016. ASM #2 was asked if any residents had eloped and she stated: "Yes. Resident #1 (name) on 06/22/16." She was then asked what action had been taken and she stated: "We were informed by staff about 8:30 a.m., that the resident had not been available to receive his morning medications. We conducted a facility and grounds search without finding the resident. The police department was then contacted of the missing resident incident and a police report was filed." She further stated that they immediately started an investigation by reviewing all of the external security building camera. ASM #2 was then asked to submit any additional information regarding the incident. ASM #2 added that she has had several occasions to talk to Resident #1 during her Administrative placement in 05/2016, and found him to be alert, oriented and answered questions appropriately when given time. She stated, "He gets frustrated when he is not able to speak more	F 323		

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F 323	Continued From page 3	F 323		

quickly or when he cannot recall the word that he wants to use." She added: "I was called to the front lobby when the police returned with Resident #1 on 06/23/16 at approximately 2:45 p.m. I asked the police officer where they had found him and he stated that they had not found him but Resident #1 came to their police station and asked for assistance to get back to the facility. "

On 06/28/16 at approximately 2:37 p.m., an observation was made of Resident #1 on his unit. He was in his wheelchair with shower supplies in his lap self-propelling very quickly toward the shower room on the unit. Resident #1 was stopped and an introduction was made by this surveyor. When asked if he would have time to discuss his life in the facility he stated clearly: "Sure, but I need to take a shower. Could we make it later?" The resident then proceeded to the shower room.

An interview was conducted on 06/28/16 at approximately 2:57 p.m., with RN (registered nurse) #1. When asked about the elopement incident of Resident #1 she stated: "I was doing my orientation to be the new Unit Manager. The staff just thought that Resident #1 was out in the smoking area where he is allowed to go independently. After the search which was initiated by ASM #2 we realized that he was not on the premises." She further stated: "After we couldn't locate Resident #1 we started a visual check to be done by the CNAs (certified nursing assistant) on every shift."

On 06/29/16 at approximately 3:47 p.m., an interview was conducted with ASM #1 and ASM #2. ASM #1 reiterated what ASM #2 had stated

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F 323	Continued From page 4 in the 1:45 p.m., Entrance Conference. He further stated that Risk Management was already doing an internal investigation regarding the incident of 06/22/16. ASM #1 further stated: "During our investigation we found out that a facility staff member saw the resident get onto the bus but did not inform anyone. We have since addressed the responsibility of all facility staff that they are mandatory reporters and anything unusual occurrence must be reported immediately." Review of the nursing notes did not indicate that the resident had attempted to elope. Documentation was found that he went on leave on 11/26/15 and also on 12/24/15 with his family. On 12/25/15 a nursing note revealed that he had increased pain in his right upper leg area after returning from his family outing. An x-ray was ordered and the results revealed a fractured hip and was sent to the hospital for treatment. He returned to the facility on 12/26/15 after surgical revision for therapy. The note revealed that the resident had a fall going up some stairs at his family home while on leave 12/25/15. A nursing note dated 06/23/16 at 3 p.m. noted: "Pt (patient) returned to facility by police officer. Pt ambulatory. States he went to the police station to ask for assistance with transportation back to the facility. VS (vital signs) checked by CNA (certified nursing assistant)-all WNL (within normal limits). Food and fluids offered and consumed. Elopement assessment completed and wander guard applied to left ankle and to bottom of wheelchair cushion. This writer spoke to patient and asked that he allow us to assist him with future outings. Patient agreed. Staff will continue to observe pt frequently. "	F 323		

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F 323	Continued From page 5	F 323		

A nursing note dated 06/24/16 at 12:42 p.m. noted the following: "Late entry for 06/23/16- At approx. 14:50 (2:50 p.m.) Resident returned to the facility escorted by a police officer, resident is ambulating per his normal gait, laughing, no signs of distress noted. Resident is assisted to his room. This nurse present in room during skin assessment. 3 cm (centimeter) x 3 cm abrasion to right elbow. is not open or draining, surrounding skin intact. No other signs of injury noted. Respirations are regular, non-labored. Resident able to assist with dressing and undressing. Shower offered. Resident declines, states, "I am just tired. Maybe later."

A Physicians Progress note dictated on 06/23/16, noted no changes in the resident's medical status. "Interim History: Resident #1 (name) is a 54 YOWM (year old white male) with PMH (prior medical history) of L (left) MCA (middle cerebral artery) ischemic Stroke resulting in Chronic R (right) sided weakness, Vascular dementia, HLD (high cholesterol), Atypical chest pain, Hypothyroidism, ETOH (drinking alcohol) abuse, Depression. Patient recently left nursing home on his own will. After speaking with him today, he reports it was because he needed new pants. Advised patient to make us aware of his needs so we can help him appropriately. Patient understands. He reports he sought out the police to bring him back to the facility. He also is very familiar with how the bus system works. Patient now has a wanderguard in place, psych (psychiatric) consult and increase in Seroquel. He denies chest pain and shortness of breath, dizziness, fever, n/v (nausea/vomiting). He reports a good appetite and denies any sores. He reports a good mood, denies any racing

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F 323	Continued From page 6 thoughts, or thoughts of suicide or homicidal ideation." An interview was conducted on 06/29/16 at approximately 9:40 a.m., with Resident #1. He spoke clearly but slowly and stated he remembered meeting this surveyor the previous day. When asked how his life had been he stated: "When I first came here I had just had a stroke. I couldn't talk and my right side wasn't working. That was in December of 2013." He was then asked if he could relate what happened when he left the facility recently. He stated: "Yeah, it was a couple of days ago. I needed some different clothes and I know that if I went to the Salvation Army in Norfolk because I used to live around there I could get some so I got onto a bus and went there. I have just become my own responsible party with the help of the people here because I could never get a hold of my brother to bring me some money. They are even getting me a free cell phone." He continued: "After I got my stuff and had talked to my friends for a while I got on a bus to come back. I had asked someone which one (bus) and they told me the wrong one. I tried again but still had the same problem. I was tired and it was getting late so I decided to sleep in the woods because I knew where I was and I had done it before when I was living there." He further stated: "When I woke up I walked to the police station and told them I needed to get back to where I lived in Portsmouth so they brought me back here." The resident was then asked if he had informed anyone that he was going to get some clothes he stated: "No. It was real early and they were busy I knew how to get there and could get back by myself." The resident was then asked if he had a wanderguard on his leg and he stated: "Yeah. When I came back they put it on.	F 323		

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F 323	Continued From page 7 I cut it off because I didn't want it. It's my right." Observations were made during the survey of Resident #1 ambulating throughout the facility with the use of a long walking stick. It was noted his gait was steady, right upper extremity flaccid and right hand contracted. Resident #1 was social and smiling. He spoke to this surveyor by name and thanked this surveyor for visit. Attempts were made on 06/28/16 and 06/30/16 to meet with the Social Service Director but she was unavailable. Review of the facility's Adverse Events policy and procedure dated 01/13/2015 noted: "Elopement occurs when a resident leaves the premises or a safe area without authorization and/or the necessary supervision to do so and under circumstances that place the Resident's health, safety, or welfare at risk." ASM #2 supplied the requested Initial Investigative Findings for the incident elopement incident on 06/22/16. The review noted the following time line: " 06/22/16 5:45 a.m.-patient arrives in lobby and exits front door. Patient proceeds to wander East (right), and hangs around new exit door of Unit 1. (reviewed tape from external building camera) 06/22/16 5:52 a.m.-patient proceeds East towards the store on the corner and rounds corner and not seen until approximately 6:22 a.m. (reviewed tape from external building camera) 06/22/16 6:45 a.m.-A staff member arrived at facility via a bus and identified patient waiting at	F 323		

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F 323	Continued From page 8 bus stop. Staff member indicated that they thought patient had permission to leave and had no reason to question him. (The bus stop is located in front of the facility.) 06/22/16 7:01 a.m.-Patient is seen at bus stop boarding bus. Bus departs at approximately 7:02 a.m. (reviewed tape from external building camera) 06/22/16 8:30-9:00 a.m.-Not able to locate resident. Staff conducted a room to room search as well as searching the grounds. Police notified of incident and report filed. Roommate interviewed and had not seen or spoken to resident that morning. Patient in different room-a friend of the resident, when asked if he knew where Resident #1 was. He informed a nurse that Resident #1 had indicated he was going to the (named location) to get clothing then to (different named location) to shop. Management staff went to the named locations to locate patient and was unsuccessful. Brother-first listed emergency contact-notified and only asked how long he had to gather his brother's belongings as he assumed he would be "kicked out." He also stated that he would let facility know if he heard from his brother. Bus Driver interviewed to verify resident got on the bus-he had and had paid the fare. 06/22/16 5:50 p.m. FRI (facility reported incident) initiated and filed with the State Agency, APS (adult protective services). Social media and Phone Record search conducted. Media notification issued. FAX copies submitted for verification of entry and revealed that reporting had been done per statement.	F 323		

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F 323	Continued From page 9 06/23/16 9:07 a.m.-phone records reviewed to see whom Resident #1 may have been in contact with prior to leaving the building 06/23/16 Patient returned via police at 1500 (3:00 pm. Patient arrived at Police Department for assistance. Patient appeared to be in good health. Nursing Assessment to be initiated. " Review of Resident #1's Care Plan documented: Current: Wanderguard placed to lower extremity due to elopement 06/22/16. In the past made attempts to leave facility and at times not easily redirected. 06/24/16 resident noncompliant with wearing wanderguard. Interventions: Provide cues for safety. Provide safe environment for wandering-every shift, Educate as needed Resident was advised to make facility staff aware of needs and care plan updated. ASM #2 also submitted the following plan of correction (6/28/16) for review: Proof of an immediate mandatory all nursing staff inservice for elopement on 06/22/16. Proof of the Elopement Policy and Procedure for the Dining Services Department on 06/23/16. Proof of implementation and continuation of visual checks for every resident every shift by CNA (certified nursing assistant) started on 06/22/16 and continuing to current date an initiated as policy. Proof of Elopement Risk Assessments for all residents in the facility starting on 06/23/16 and completed on 06/28/16.	F 323		

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F 323	Continued From page 10 Proof of written warning for the staff member's supervisor who witnessed the resident waiting at the bus stop 06/22/16. Proof of free cell phone application submitted for Resident #1 on 06/28/2016 at 12:43 p.m. An emergency QA (Quality Assurance) meeting was conducted 6/28/16 (prior to survey) and follow up at next scheduled meeting. The plan of care was accepted as past non compliance. Administration consisting of the Acting Administrator, the Acting DON and the Corporate Director of Regulatory Division were informed of the findings at a briefing. No additional information was submitted for review.	F 323		