

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/22/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495309	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/02/2017
NAME OF PROVIDER OR SUPPLIER THORNTON HALL NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 827 NORVIEW AVENUE NORFOLK, VA 23509		
(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 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 5/31/17 through 6/2/17. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. Three complaints were investigated during the survey. The census in this 60 certified bed facility was 53 at the time of the survey. The survey sample consisted of 15 current Resident reviews (Residents #1 through 14 and Resident 17) and 5 closed record reviews (Residents #15, 16 and 18 through 20).	F 000			
F 164 SS=E	PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS CFR(s): 483.10(h)(1)(3)(i); 483.70(i)(2) 483.10 (h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. (h)(3)The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. §483.70 (i) Medical records.	F 164		7/14/17	

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

TITLE

(X6) DATE

Electronically Signed

06/20/2017

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495309	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/02/2017
NAME OF PROVIDER OR SUPPLIER THORNTON HALL NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 827 NORVIEW AVENUE NORFOLK, VA 23509		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 164	<p>Continued From page 1</p> <p>(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-</p> <p>(i) To the individual, or their resident representative where permitted by applicable law;</p> <p>(ii) Required by Law;</p> <p>(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;</p> <p>(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. This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, resident interview, staff interview, facility documentation review, clinical record review, and in the course of a complaint investigation, the facility staff failed to ensure privacy of 3 Resident records (Residents #10, #11 and #12) during observation of medication pass by leaving their MAR (Medication Administration Record) open for view of anyone that would pass.</p> <p>The findings included:</p> <p>1. Resident #10 was admitted to the facility on 2/5/14. Diagnoses for Resident #10 included but</p>	F 164	<p>LPN was re-educated regarding leaving MAR screen unlocked while unattended during medication pass for residents #10, # 11, & #12 on 5/31/17. Residents #10, 11 and 12's health information is maintained in a confidential manner. On 6/1/17, facility observation rounds conducted by DCS for other nurses leaving Computer screen unlocked when unattended potentially causing visualization of protected health information. The director of Clinical Services or designee to provide re-education regarding privacy and confidentiality of</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495309	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/02/2017
NAME OF PROVIDER OR SUPPLIER THORNTON HALL NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 827 NORVIEW AVENUE NORFOLK, VA 23509		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 164	<p>Continued From page 2</p> <p>are not limited to: glaucoma (1).</p> <p>Resident #10's Quarterly Minimum Data Set (MDS - an assessment protocol) with an Assessment Reference Date of 4/14/17 coded Resident #10 with a BIMS (Brief Interview for Mental Status) score of 5, indicating a severe cognition impairment.</p> <p>During the Medication Pass task on 5/31/17 at approximately 4:29 p.m., LPN (Licensed Practical Nurse) #3 was observed after gathering medications to administer, walked away from the Medication Administration Record (MAR) twice leaving it open for anyone passing to observe medications that Resident #10 was prescribed. During this time three non nursing staff passed by the MAR.</p> <p>The Facility Policy and Procedure titled: "Notice of Privacy Practices" with an effective Date of 11/30/14 documented the following: "The Facility Responsibilities: The Facility is responsible to Maintain the privacy of the resident health information."</p> <p>LPN #3 stated at approximately 5:00 p.m., "I shouldn't keep it (MAR) open as it shows others info."</p> <p>An interview with the Regional Director of Clinical Services on 6/1/17 at approximately 3:15 p.m. was conducted. When asked if it was an expectation to close the MAR, the Regional Director of Clinical Services stated: "Yes."</p> <p>The facility administration was informed of the findings during a meeting on 6/1/17 at approximately 3:05 p.m. The facility did not</p>	F 164	<p>records to staff. Director of Clinical service to review proper procedures with license staff on ensuring privacy and confidentiality of the MAR.</p> <p>The Director of Clinical Services or designee to conduct random observation of LPN/RN at med pass and a Quality Monitor to be performed 3 times per week for 4 weeks on each shift to ensure compliance with ensuring resident privacy then 1 time weekly for 1 month then quarterly thereafter. Quality Monitoring schedule to be modified based on findings of Quality Reviews. The results of the Quality Monitoring to be reviewed at the monthly Quality Assurance Performance Improvement (QAPI) meetings for review, analysis, and further recommendations.</p>		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/22/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495309	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/02/2017
NAME OF PROVIDER OR SUPPLIER THORNTON HALL NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 827 NORVIEW AVENUE NORFOLK, VA 23509		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 164	<p>Continued From page 3</p> <p>present any further information about the findings.</p> <p>2. Resident #11 was admitted into the facility on 5/3/16. Diagnoses for Resident #11 included but were not limited to Blindness and Hip pain.</p> <p>Resident #11's Quarterly Minimum Data Set (MDS - an assessment protocol) with an Assessment Reference Date of 4/30/17 coded Resident #11 with a BIMS (Brief Interview for Mental Status) score of 5, indicating a severe cognition impairment.</p> <p>During the Medication Pass task on 5/31/17 at approximately 4:45 p.m., LPN (Licensed Practical Nurse) #3 was observed after gathering medications to administer, walked away from the Medication Administration Record (MAR) twice leaving it open for anyone passing to observe medications that she was on. The first time the LPN walked away was to assess the Resident's pain level, and the second time was to administer the Resident the pain medication.</p> <p>The Facility Policy and Procedure titled: "Notice of Privacy Practices" with an effective Date of 11/30/14 documented the following: "The Facility Responsibilities: The Facility is responsible to Maintain the privacy of the resident health information."</p> <p>An interview with the Regional Director of Clinical Services on 6/1/17 at approximately 3:15 p.m. was conducted. When asked if it was an expectation to close the MAR, the Regional Director of Clinical Services stated: "Yes."</p> <p>The facility administration was informed of the</p>	F 164			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495309	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/02/2017
NAME OF PROVIDER OR SUPPLIER THORNTON HALL NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 827 NORVIEW AVENUE NORFOLK, VA 23509		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 164	<p>Continued From page 4</p> <p>findings during a meeting on 6/1/17 at approximately 3:05 p.m. The facility did not present any further information about the findings.</p> <p>3. Resident #12 was admitted into the facility on 4/7/17. Diagnoses included but were not limited to: Diabetes (2) and Seizure (3) disorder.</p> <p>Resident #12's Quarterly Minimum Data Set - (MDS an assessment protocol) with an Assessment Reference Date of 2/27/17, coded Resident #12 as having short and long term memory problems.</p> <p>On 5/31/17 at approximately 4:10 p.m., LPN (Licensed Practical Nurse) #3 was observed to go into Resident #12's room without knocking prior to entering to assess a blood sugar level. When LPN #3, left the Medication cart, she left the computer screen open for anyone passing by to see Resident #12's health information (medications). During this time three non nursing staff passed by the MAR.</p> <p>The Facility Policy and Procedure titled: "Notice of Privacy Practices" with an effective Date of 11/30/14 documented the following: "The Facility Responsibilities: The Facility is responsible to Maintain the privacy of the resident health information."</p> <p>An interview with the Regional Director of Clinical Services on 6/1/17 at approximately 3:15 p.m. was conducted. When asked if it was an expectation to close the MAR, the Regional Director of Clinical Services stated: "Yes."</p> <p>The facility administration was informed of the</p>	F 164			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495309	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/02/2017
NAME OF PROVIDER OR SUPPLIER THORNTON HALL NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 827 NORVIEW AVENUE NORFOLK, VA 23509		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 164	Continued From page 5 findings during a meeting on 6/1/17 at approximately 3:05 p.m. The facility did not present any further information about the findings. Definitions: (1) Glaucoma: Medline Plus documented: Glaucoma is a group of diseases that can damage the eye's optic nerve. It is a leading cause of blindness in the United States. (2) Diabetes: Medline Plus Documents: Diabetes is a disease in which your blood glucose, or blood sugar, levels are too high. Glucose comes from the foods you eat. Insulin is a hormone that helps the glucose get into your cells to give them energy. With type 2 diabetes, the more common type, your body does not make or use insulin well. Without enough insulin, the glucose stays in your blood. (3) Seizure disorder: Medline Plus documented: Seizures are symptoms of a brain problem. They happen because of sudden, abnormal electrical activity in the brain. When people think of seizures, they often think of convulsions in which a person's body shakes rapidly and uncontrollably. Not all seizures cause convulsions. There are many types of seizures and some have mild symptoms. Seizures fall into two main groups. Focal seizures, also called partial seizures, happen in just one part of the brain. Generalized seizures are a result of abnormal activity on both sides of the brain.	F 164			
F 241 SS=E	DIGNITY AND RESPECT OF INDIVIDUALITY CFR(s): 483.10(a)(1) (a)(1) A facility must treat and care for each	F 241		7/14/17	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495309	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/02/2017
NAME OF PROVIDER OR SUPPLIER THORNTON HALL NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 827 NORVIEW AVENUE NORFOLK, VA 23509		
(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 241	<p>Continued From page 6</p> <p>resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life recognizing each resident's individuality. The facility must protect and promote the rights of the resident. This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, resident interview, staff interview, facility documentation review, clinical record review, and in the course of a complaint investigation, the facility staff failed for 4 of 20 residents (Residents #9, #10, #11 and #12) in the survey sample to ensure dignity during observation of a medication pass by entering the Resident's rooms without knocking prior.</p> <p>The findings included:</p> <p>1. Resident #9 was admitted to the facility on 2/28/17. Diagnoses for Resident #9 included but are not limited to Diabetes (1).</p> <p>Resident #9's Quarterly Minimum Data Set (MDS - an assessment protocol) with an Assessment Reference Date of 5/25/17 coded Resident #9 with a BIMS (Brief Interview for Mental Status) score of 10 of 15 indicating a moderate impairment in cognition.</p> <p>During the Medication Pass observation on 5/31/17 at approximately 5:08 p.m., LPN (Licensed Practical Nurse) #3, was observed to go into Resident #9's room to perform a glucometer test (check blood sugar). LPN #3 walked into the Resident's room the first time and did not knock on the door prior to entering. The glucometer test required repeating and the LPN exited the room to obtain more supplies. When</p>	F 241	<p>LPN was re-educated regarding proper way to enter a resident's room to ensure privacy prior to administration of medications. Staff knocks prior to entering rooms.</p> <p>On 6/1/17 ED and DCS/designees conducted Resident interviews with interviewable residents to ensure staff knocks before entering. Follow up based on findings entering resident rooms. The director of Clinical Services or designee to provide re-education on dignity and respect of individuality and the importance of knocking on resident room doors to facility staff. Random Quality Monitoring to be performed to monitor that staff members knock prior and ask permission to enter resident rooms. The Director of Clinical Services or designee to conduct random observation Quality Monitoring 3 times per week on each shift for 4 weeks, then 1 time weekly for 1 month then quarterly thereafter. Quality Monitoring schedule modified based on Quality Monitoring findings. The results of the Quality Monitoring to be reviewed at the Quality Assurance Performance Improvement meetings for review, analysis, and further recommendations.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495309	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/02/2017
NAME OF PROVIDER OR SUPPLIER THORNTON HALL NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 827 NORVIEW AVENUE NORFOLK, VA 23509		
(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 241	<p>Continued From page 7</p> <p>LPN #3 reentered the room, she did not knock before entering. Once the LPN had the glucometer result, she exited the Resident's room to check the MAR (Medication Administration Record) for Insulin orders. The LPN obtained two types of insulin and walked into the resident's room and after hearing the surveyor knock prior to entering, left the resident and walked to the door and knocked and then returned to Resident 9's bedside to administer the insulin.</p> <p>An interview with Resident #9 on 6/1/17 at approximately 2:00 p.m. was conducted. Resident #9 was asked how she felt when staff come into her room and don't knock. She stated that sometimes they knock and sometimes they don't. She stated that she has somewhat gotten used to it.</p> <p>An interview with the Regional Director of Clinical Services on 6/1/17 at approximately 3:15 p.m. was conducted. When asked if it was her expectation for a staff member to knock on the door prior to entering, she stated, "Yes."</p> <p>The Facility provided the Policy and Procedure titled, "Privacy" with an effective date 11/30/14 when asked for a policy related to knocking on doors prior to walking in. The Policy documented the following: "The nursing home staff will recognize that residents and their families need a place of privacy."</p> <p>Medicare.gov documents: Nursing home residents have certain rights and protections under the law. The nursing home must list and give all new residents a copy of these rights. These resident rights include, but aren't limited to:</p>	F 241			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495309	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/02/2017
NAME OF PROVIDER OR SUPPLIER THORNTON HALL NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 827 NORVIEW AVENUE NORFOLK, VA 23509		
(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 241	<p>Continued From page 8</p> <p>The right to be treated with dignity and respect.</p> <p>The facility administration was informed of the findings during a meeting on 6/1/17 at approximately 3:05 p.m. The facility did not present any further information about the findings.</p> <p>(1) Diabetes: Medline Plus Documents: Diabetes is a disease in which your blood glucose, or blood sugar, levels are too high. Glucose comes from the foods you eat. Insulin is a hormone that helps the glucose get into your cells to give them energy. With type 2 diabetes, the more common type, your body does not make or use insulin well. Without enough insulin, the glucose stays in your blood.</p> <p>2. Resident #10 was admitted to the facility on 2/5/14. Diagnoses for Resident #10 included but are not limited to glaucoma (1).</p> <p>Resident #10's Quarterly Minimum Data Set (MDS - an assessment protocol) with an Assessment Reference Date of 4/14/17 coded Resident #10 with a BIMS (Brief Interview for Mental Status) score of 5, indicating a severe cognition impairment.</p> <p>An observation was made of LPN (Licensed Practical Nurse) #3 entering Resident 10's room on 5/31/17 at approximately 4:29 p.m. LPN #3 entered the room without knocking to administer eye drops.</p> <p>An interview with Resident #10 was conducted on 5/1/17 at approximately 2:15 p.m. Resident #10 did not answer questions.</p>	F 241			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/22/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495309	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/02/2017
NAME OF PROVIDER OR SUPPLIER THORNTON HALL NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 827 NORVIEW AVENUE NORFOLK, VA 23509		
(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 241	<p>Continued From page 9</p> <p>An interview with the Regional Director of Clinical Services on 6/1/17 at approximately 3:15 p.m. was conducted. When asked if it was her expectation for a staff member to knock on the door prior to entering, she stated, "Yes."</p> <p>The Facility provided the Policy and Procedure titled, "Privacy" with an effective date 11/30/14 when asked for a policy related to knocking on doors prior to walking in. The Policy documented the following: "The nursing home staff will recognize that residents and their families need a place of privacy."</p> <p>(1) Glaucoma: Medline Plus documented: Glaucoma is a group of diseases that can damage the eye's optic nerve. It is a leading cause of blindness in the United States.</p> <p>3. Resident #11 was admitted into the facility on 5/3/16. Diagnoses for Resident #11 included but were not limited to: Blind and Hip pain.</p> <p>Resident #11's Quarterly Minimum Data Set (MDS - an assessment protocol) with an Assessment Reference Date of 4/30/17 coded Resident #11 with a BIMS (Brief Interview for Mental Status) score of 5, indicating a severe cognition impairment.</p> <p>An observation was made of LPN (Licensed Practical Nurse) #3 entering Resident 11's room on 5/31/17 at approximately 4:45 p.m. to assess the resident's pain level and did not knock on the door prior to entering the blind resident's room.</p>	F 241			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495309	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/02/2017
NAME OF PROVIDER OR SUPPLIER THORNTON HALL NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 827 NORVIEW AVENUE NORFOLK, VA 23509		
(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 241	<p>Continued From page 10</p> <p>After assessing Resident's pain level, the LPN exited the room to return a few minutes later without knocking prior to entering to administer an analgesic (pain medication) to the resident.</p> <p>Resident #11 was asked how she felt when staff come into her room without prior notice, Resident #11 stated, "I don't know."</p> <p>An interview with the Regional Director of Clinical Services on 6/1/17 at approximately 3:15 p.m. was conducted. When asked if it was her expectation for a staff member to knock on the door prior to entering, she stated, "Yes."</p> <p>The Facility provided the Policy and Procedure titled, "Privacy" with an effective date 11/30/14 when asked for a policy related to knocking on doors prior to walking in. The Policy documented the following: "The nursing home staff will recognize that residents and their families need a place of privacy."</p> <p>Medicare.gov documents: Nursing home residents have certain rights and protections under the law. The nursing home must list and give all new residents a copy of these rights. These resident rights include, but aren't limited to: The right to be treated with dignity and respect.</p> <p>The facility administration was informed of the findings during a meeting on 6/1/17 at approximately 3:05 p.m. The facility did not present any further information about the findings.</p> <p>4. Resident #12 was admitted into the facility on 4/7/17. Diagnoses included but were not limited to: Diabetes (1) and Seizure disorder (2).</p>	F 241			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/22/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495309	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/02/2017
NAME OF PROVIDER OR SUPPLIER THORNTON HALL NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 827 NORVIEW AVENUE NORFOLK, VA 23509		
(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 241	<p>Continued From page 11</p> <p>Resident #12's Quarterly Minimum Data Set - (MDS an assessment protocol) with an Assessment Reference Date of 2/27/17, coded Resident #12 as having short and long term memory problems.</p> <p>On 5/31/17 at approximately 4:10 p.m., LPN (Licensed Practical Nurse) #3 was observed walking into Resident 12's room without knocking to obtain a glucose check.</p> <p>On 6/1/17 at approximately 2:50 p.m., Resident #12 was asked how she felt when staff enter her room without knocking. She stated: "I don't know."</p> <p>An interview with the Regional Director of Clinical Services on 6/1/17 at approximately 3:15 p.m. was conducted. When asked if it was her expectation for a staff member to knock on the door prior to entering, she stated, "Yes."</p> <p>The Facility provided the Policy and Procedure titled, "Privacy" with an effective date 11/30/14 when asked for a policy related to knocking on doors prior to walking in. The Policy documented the following: "The nursing home staff will recognize that residents and their families need a place of privacy."</p> <p>Medicare.gov documents: "Nursing home residents have certain rights and protections under the law. The nursing home must list and give all new residents a copy of these rights. These resident rights include, but aren't limited to: The right to be treated with dignity and respect."</p> <p>The facility administration was informed of the</p>	F 241			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495309	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/02/2017
NAME OF PROVIDER OR SUPPLIER THORNTON HALL NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 827 NORVIEW AVENUE NORFOLK, VA 23509		
(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 241	Continued From page 12 findings during a meeting on 6/1/17 at approximately 3:05 p.m. The facility did not present any further information about the findings. (1) Diabetes: Medline Plus Documents: Diabetes is a disease in which your blood glucose, or blood sugar, levels are too high. Glucose comes from the foods you eat. Insulin is a hormone that helps the glucose get into your cells to give them energy. With type 2 diabetes, the more common type, your body does not make or use insulin well. Without enough insulin, the glucose stays in your blood. (2) Seizure disorder: Medline Plus Documents: Seizures are symptoms of a brain problem. They happen because of sudden, abnormal electrical activity in the brain. When people think of seizures, they often think of convulsions in which a person's body shakes rapidly and uncontrollably. Not all seizures cause convulsions. There are many types of seizures and some have mild symptoms. Seizures fall into two main groups. Focal seizures, also called partial seizures, happen in just one part of the brain. Generalized seizures are a result of abnormal activity on both sides of the brain.	F 241			
F 309 SS=D	PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING CFR(s): 483.24, 483.25(k)(l) 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial	F 309		7/14/17	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495309	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/02/2017
NAME OF PROVIDER OR SUPPLIER THORNTON HALL NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 827 NORVIEW AVENUE NORFOLK, VA 23509		
(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 309	<p>Continued From page 13</p> <p>well-being, consistent with the resident's comprehensive assessment and plan of care.</p> <p>483.25 Quality of care 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, including but not limited to the following:</p> <p>(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.</p> <p>(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility staff failed to follow physician orders for two residents (Resident #15 and #9) in the survey sample of 20 residents.</p> <p>The findings included:</p> <p>1. The facility staff failed to follow physician discharge orders.</p>	F 309	<p>Resident #15 was discharged from the facility on 10/6/16. A medical record review of new admissions for the past 30 days was completed by Assistant Director of Nursing /designees for accuracy of transcription of physician orders. Follow up based on findings. DCS or designee to re-educate licensed staff on transcription of physicians</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495309	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/02/2017
NAME OF PROVIDER OR SUPPLIER THORNTON HALL NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 827 NORVIEW AVENUE NORFOLK, VA 23509		
(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 309	<p>Continued From page 14</p> <p>Resident #15 was admitted to the facility on 8/29/16 with diagnoses which included epilepsy and epileptic syndromes, convulsions, cerebral amyloid angiopathy, non-traumatic intracerebral hemorrhage, hypertension, Chronic viral hepatitis C, venous insufficiency chronic (peripheral), inguinal hernia, gastro-esophageal reflux, history of urinary infections, dementia with behavioral disturbance, and Alzheimer's.</p> <p>Resident #15's hospital discharge orders included the following prescribed medications: Start taking these medications: "Amlodipine 5 mg (milligrams) (also known as Norvasc) take one tab by mouth once a day. (antihypertensive) Lamotrigine 25 mg tabs (commonly known as Lamictal) take one tab by mouth once a day. (anticonvulsant) Levetiracetam 100 mg/ml (commonly known as Keppra) take 10 ml (milliliter) by mouth every 12 hours for 30 days. Replaces levetiracetam 750 mg tabs. (anticonvulsant) Quetiapine 25 mg tabs (commonly known as Seroquel) take 1 tab by mouth once a day. (antipsychotic) Quetiapine 25 mg tabs (commonly known as Seroquel) take 1 tab by mouth every night at bedtime." *Notice: This list has 2 medications that are the same as other medications prescribed for you. Read the directions carefully, and ask your doctor or other care provider to review them with you.</p> <p>Continue taking these medications: Famotidine 20 mg tabs (commonly known as Pepcid) take 1 tab by mouth once a day.(antacid and antihistamine)</p>	F 309	<p>discharge orders. 24 Hour Chart check to be completed by 11-7 shift to ensure new admissions have had physician orders accurately transcribed. New admissions medical records to be reviewed in Morning Clinical Meeting for accuracy of transcription of physician orders. DCS or designee to Quality Monitor resident with discharge orders to ensure accuracy weekly times 4 weeks then monthly. Quality Monitoring schedule modified based on findings. . The results of the Quality Monitoring to be reviewed at the monthly Quality Assurance Performance Improvement meetings for review, analysis, and further recommendations.</p> <p>Resident # 9 Keppra was available and was given the next scheduled dosage on 6/1/17 and continues to receive Keppra as ordered by physician. LPN was re-educated regarding medication administration policy and procedure. Physician was notified, blood level drawn. The resident experienced no ill effects with missed dose of medication. A review of current residents Medication Administration Records (MAR) was completed. Three additional residents were with orders for Keppra were identified. These residents received their medication as ordered. Director of Clinical Services or designee to Quality monitor MARs daily for omissions of medications not given per physician's orders. Director of Clinical service or designee to provide</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495309	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/02/2017
NAME OF PROVIDER OR SUPPLIER THORNTON HALL NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 827 NORVIEW AVENUE NORFOLK, VA 23509		
(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 309	<p>Continued From page 15</p> <p>Losartan 100 mg tabs take one tab by mouth once a day. (antihypertensive)</p> <p>STOP taking these Medications: Divalproex DR 25 mg tab (commonly known as DEPAKOTE). (used to treat seizure disorders and manic depression) Docusate Sodium 100 mg caps (Commonly known as Colace) (stool softener) Levetiracetam 750 mg tabs (commonly known as KEPPRA) replaced by levetiracetam 100 mg/ml one a day 50 plus po (by mouth).</p> <p>A review of the Medication Administration Record (MAR) for the month of August 2016 indicated Resident #15 received one dose of divalproex sodium tablet delayed release 250 mg give one tab tablet by mouth two times a day related to other persistent mood (Affective disorders).</p> <p>Quetiapine 25 mg tabs take 0.5 tabs by mouth once a day was not indicated as given on the MAR as ordered by the physician.</p> <p>A physician's admission note dated 8/30/16 indicated: Resident #15 had a history of Alzheimer's disease, more moderate to severe at this point. History of a previous spontaneous intracerebral hemorrhage, thought to be due to angiod angiopathy and having some behaviors at home.</p> <p>Resident has apparently been unable to be maintained at home and has presented to the hospital with status epilepticus. She had difficult to control seizures and she required ever increasing doses of Keppra. She has actually been placed on Depakote for behavioral abnormalities and was thought that this might be</p>	F 309	<p>re-education to licensed staff on policy of medication administration.</p> <p>Director of clinical Services or designee to preform random quality monitoring on all shifts for 2 months and then once monthly for 3 months then quarterly there after. Quality monitoring schedule modified based on Quality Monitoring findings. The results of the Quality Monitoring to be reviewed at the monthly Quality Assurance meetings for review, analysis, and further recommendations.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495309	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/02/2017
NAME OF PROVIDER OR SUPPLIER THORNTON HALL NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 827 NORVIEW AVENUE NORFOLK, VA 23509		
(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 309	<p>Continued From page 16</p> <p>causing elevation of her ammonia level, thus it was discontinued and the patient was switched. She has been discharged on the following medication which include:</p> <p>Keppra 12.5 mg every 12 hours of 1000 mg/ml Seroquel 25 mg Norvasc 5 mg a day Flomax 0.4 mg She in on Keflex for five more days Losartan 100 mg a day Pepcid 20 mg a day</p> <p>There is a confusion in the discharge medication in that she was on Lamictal 25 mg a day, but apparently, this was not included in the discharge stuff. Keflex every 12 hours was also not included, but she has been on ceftriaxone. We will continue the keflex. We will continue the lamotrigine. The dose of keppra is different on the discharge summary versus the medication list from the hospital. We will have to review this.</p> <p>During an interview with the Physician on 6/2/17 at 9:45 A.M. he stated, Resident #15 had a mix up with the discharged medications and the medications when admitted. He was not sure of all the medications and needed to look at the closed record.</p> <p>During an interview with the Administrator on 6/1/17 at 3:15 P.M. she was asked if Resident #15 had received all medications per physician's orders and she stated, to the best of her understanding, the Physician Assistant could answer that question better. During an interview on 6/2/17 at 10: 50 A.M. with the Physician Assistant, she stated, the medications orders from the hospital were reviewed. and changes were made.</p>	F 309			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495309	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/02/2017
NAME OF PROVIDER OR SUPPLIER THORNTON HALL NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 827 NORVIEW AVENUE NORFOLK, VA 23509		
(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 309	Continued From page 17 2. The facility failed to administer Keppra per physician orders. Resident #9 was admitted to the facility on 2/28/17. Diagnoses for Resident #9 included but are not limited to: Seizure disorder (1), Depression (2) and Diabetes (3). Resident #9's Quarterly Minimum Data Set (MDS - an assessment protocol) with an Assessment Reference Date of 5/25/17 coded Resident #9 with a BIMS (Brief Interview for Mental Status) score of 10 of 15 indicating a moderate impairment in cognition. On 5/31/17 at approximately 5:08 p.m. LPN #3 was preparing to give evening medications and could not find Keppra (4). LPN #3 stated that she would call the pharmacy to order more. LPN #3 documented in the MAR that Keppra was not available. LPN #3 left the Medication cart and went to the Nurse's station and called Pharmacy to notify that Keppra was needed. LPN #3 went back to the Medication Cart to gather the remaining evening medications. During this time the ADON (Assistant Director of Nurses) came and found the Keppra and left. LPN #3, at that time began looking for Keppra on the Medication Administration Record (MAR) and after several unsuccessful attempts to find Keppra, stated, "I can't find it so it must have been discontinued." At that time, LPN #3, placed the Keppra back into the cart and went into the Resident's room to administer the other medications. On 6/1/17, an observation was made of the	F 309			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495309	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/02/2017
NAME OF PROVIDER OR SUPPLIER THORNTON HALL NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 827 NORVIEW AVENUE NORFOLK, VA 23509		
(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 309	<p>Continued From page 18 completed 5/31/17 MAR. LPN #3 had entered a code that the Resident refused the evening medication Kepra dose.</p> <p>Resident #9's Clinical Records documented the following Medical Doctor's order:</p> <p>"3/1/17 Kepra Tablet 750 mg (milligrams) Give 1 tablet by mouth two times a day related to Major Depressive Disorder."</p> <p>The facility administration was informed of the findings during a meeting on 6/1/17 at approximately 3:05 p.m. The facility did not present any further information about the findings.</p> <p>Definitions:</p> <p>(1) Seizure disorder: Medline Plus Documents: Seizures are symptoms of a brain problem. They happen because of sudden, abnormal electrical activity in the brain. When people think of seizures, they often think of convulsions in which a person's body shakes rapidly and uncontrollably. Not all seizures cause convulsions. There are many types of seizures and some have mild symptoms. Seizures fall into two main groups. Focal seizures, also called partial seizures, happen in just one part of the brain. Generalized seizures are a result of abnormal activity on both sides of the brain.</p> <p>(2) Depression: Medline Plus Documents: Depression is a serious medical illness. It's more than just a feeling of being sad or "blue" for a few days. If you are one of the more than 19 million teens and adults in the United States who have depression, the feelings do not go away. They</p>	F 309			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495309	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/02/2017
NAME OF PROVIDER OR SUPPLIER THORNTON HALL NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 827 NORVIEW AVENUE NORFOLK, VA 23509		
(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 309	Continued From page 19 persist and interfere with your everyday life. Symptoms can include Feeling sad or "empty" Loss of interest in favorite activities Overeating, or not wanting to eat at all Not being able to sleep, or sleeping too much Feeling very tired Feeling hopeless, irritable, anxious, or guilty Aches or pains, headaches, cramps, or digestive problems Thoughts of death or suicide Depression is a disorder of the brain. There are a variety of causes, including genetic, biological, environmental, and psychological factors (3) Diabetes: Medline Plus Documents: Diabetes is a disease in which your blood glucose, or blood sugar, levels are too high. Glucose comes from the foods you eat. Insulin is a hormone that helps the glucose get into your cells to give them energy. With type 2 diabetes, the more common type, your body does not make or use insulin well. Without enough insulin, the glucose stays in your blood. (4) Keppra: Medline Plus documented: Levetiracetam is used in combination with other medications to treat certain types of seizures in adults and children with epilepsy. Levetiracetam is in a class of medications called anticonvulsants. It works by decreasing abnormal excitement in the brain.	F 309			
F 323 SS=G	FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES CFR(s): 483.25(d)(1)(2)(n)(1)-(3) (d) Accidents. The facility must ensure that -	F 323		6/20/17	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495309	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/02/2017
NAME OF PROVIDER OR SUPPLIER THORNTON HALL NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 827 NORVIEW AVENUE NORFOLK, VA 23509		
(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 323	Continued From page 20 (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on staff interviews, clinical record review and facility document review the facility staff failed to implement interventions consistent with the resident's needs, goals and person-centered care plan to reduce an avoidable accident for 2 of 20 residents in the survey sample, Resident #17 and #15. 1. On 5/11/17 Resident #17 was manually transferred from the bed to a shower chair with two staff when the resident's legs gave out. The resident was lowered to the floor and the resident's right leg got caught underneath her which resulted in a fracture to the right ankle	F 323	Past noncompliance: no plan of correction required.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495309	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/02/2017
NAME OF PROVIDER OR SUPPLIER THORNTON HALL NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 827 NORVIEW AVENUE NORFOLK, VA 23509		
(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 323	<p>Continued From page 21</p> <p>resulting in harm. The staff failed to implement the appropriate transfer approach to prevent injuries per the resident's person-centered plan of care. The resident was to have been transferred using a mechanical lift (Hoyer).</p> <p>2. The facility staff failed to provide supervision for Resident #15 to prevent a fall.</p> <p>The findings included:</p> <p>1. Resident #17's last admission date to the facility was 2/5/13. The resident's diagnoses included Alzheimer's and contracture (1) of both the left and right knees.</p> <p>The MDS (Minimum Data Set) a quarterly with an assessment reference date of 4/6/17 coded the resident as scoring a 3 out of a possible 15 on the Brief Interview for Mental Status (BIMS), indicating the resident's cognition was severely impaired. The resident was coded as requiring two person physical assistance with transfers.</p> <p>The comprehensive person-centered care plan initiated on 12/20/15 identified the resident has an ADL (Activities of Daily Living) Self Care Performance Deficit due to Alzheimer's and contractures. The goal was that the resident will receive appropriate staff support with all ADLs. One of the interventions listed was to transfer the resident with a mechanical lift.</p> <p>The Progress Notes dated 5/11/17 timed for 10:26 am, read, "Resident has a hematoma (2) to right outer ankle. Blue in color. Resident c/o (complaint of) pain. NP (Nurse Practitioner) notified and order was given for x-ray of right ankle,. Resident was medicated prn (as needed)</p>	F 323			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495309	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/02/2017
NAME OF PROVIDER OR SUPPLIER THORNTON HALL NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 827 NORVIEW AVENUE NORFOLK, VA 23509		
(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 323	<p>Continued From page 22 for pain. Mobile X-ray called."</p> <p>The Progress Notes dated 5/11/17 timed for 9:54 pm, authored by the night shift Licensed Practical Nurse (LPN#5) read, in part: "At 0630 (6:30 am) when transferred resident to the chair to get shower, resident can't keep her balance, the CNA (Certified Nurse Aide #4) needed to slide her to sit on the floor..."</p> <p>The Progress Notes dated 5/11/17 timed for 11:00 pm, read, in part: "NP (name) made aware of X-ray of (R) ankle Incomplete fracture of medial malleolus (ankle). Patient to have a splint until seen by Ortho. blue boot used as immobilizer tonight..."</p> <p>The Radiology Report dated 5/11/17 Conclusion read: Findings suggesting recent incomplete fracture of the medial malleolus.</p> <p>On 5/12/17 the resident was sent to the ER (Emergency Room) for an Orthopedic evaluation. The resident was evaluated and discharged back to the facility the same day. The discharge diagnosis was closed nondisplaced fracture of lateral malleolus of right fibula. The resident's discharge instructions were for a splint, no boot, and to continue the PRN Ibuprofen 600 mg (milligrams) by mouth every six (6) hours as needed for pain and to schedule a follow up appointment with the Orthopedic physician.</p> <p>The follow up appointment with the Orthopedic physician occurred on 5/18/17. The resident was placed in a cast and was to have another follow up in 3 weeks for removal of the cast.</p> <p>In response to the fall, the facility faxed a Facility</p>	F 323			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495309	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/02/2017
NAME OF PROVIDER OR SUPPLIER THORNTON HALL NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 827 NORVIEW AVENUE NORFOLK, VA 23509		
(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 323	<p>Continued From page 23</p> <p>Reported Incident (FRI) to the appropriate agencies to include the State Survey Agency and initiated an investigation.</p> <p>The facility's follow up investigation report dated 5/18/17 , authored by the Administrator, documented the resident was being transferred from the bed to the shower chair when the residents legs gave out. The resident was then lowered to the ground and subsequently sustained an incomplete fracture of the right ankle. In response to the incident a 100% quality review was completed on all residents transfer/mobility status. Direct care staff were re-educated on proper low lift technique and how to identify what means and mode of transfer for residents' plan of care. Lift competency skills review were initiated with all direct care staff.</p> <p>An interview was conducted with the Director of Clinical Services (DCS) on 6/1/17 at approximately 4:00 pm. The DCS was asked about the resident's fall with injury. She stated that the resident was a total lift transfer and required the use of a mechanical lift. She stated the CNA (Certified Nurse Aide #4) who transferred the resident that morning had knowledge that the resident required a Hoyer (mechanical) lift yet transferred the resident without one. The DCS stated that when interviewing CNA #4 she denied knowing the resident was a Hoyer lift and stated she had not been educated on the facility's Low Lift policy. The DCS stated all staff are educated on the facility's Low Lift policy during orientation. The DCS stated the resident had a red sticker at the entrance of the resident's room that identified her as a total lift (TL) at the time of the fall. The DCS also stated the resident's transfer requirements</p>	F 323			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/22/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495309	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/02/2017
NAME OF PROVIDER OR SUPPLIER THORNTON HALL NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 827 NORVIEW AVENUE NORFOLK, VA 23509		
(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 323	<p>Continued From page 24</p> <p>are also noted in the CNA Kardex that is maintained on the tablets used daily by the direct care staff. When asked what was the root cause of the fall that resulted in the fracture, she stated, "Used the wrong lift". When asked if a Hoyer lift was available and operational for staff use at the time of the fall, she stated, "Yes". Both CNA #4 and LPN #5 were given a final written warning due to utilizing "an unapproved lift when getting a resident out of bed. Resident fell fracturing her ankle". The DCS stated LPN #5 failed to inform the oncoming staff of the fall and failed to fill out an incident report.</p> <p>On 6/1/17 at 2:45 pm, the direct care staff (CNA #6) assigned to care for Resident #17 today was interviewed. The CNA was asked how is the resident transferred, she stated, "A two (2) person Hoyer lift". When asked why the resident was a total Hoyer lift she stated, "She (the resident) can't weight-bear because both of her legs are contracted". When asked if she was aware of how the resident fell she stated, "(Name of CNA #4) tried to use the sit to stand".</p> <p>On 6/1/17 at 3:10 pm, a second CNA was interviewed (CNA #5). She was asked how Resident #17 was transferred. She stated that the resident has been a "Hoyer lift transfer for at least the last two years". She stated a sit to stand lift would not be appropriate for Resident #17 due to the resident's contractures and inability to weight-bear.</p> <p>On 6/2/17 at 9:45 am, CNA #4 was interviewed on the phone. She stated she was preparing the resident for a shower. While transferring the resident from the bed to the shower chair her and the charge nurse (LPN #5) grabbed the resident</p>	F 323			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495309	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/02/2017
NAME OF PROVIDER OR SUPPLIER THORNTON HALL NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 827 NORVIEW AVENUE NORFOLK, VA 23509		
(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 323	<p>Continued From page 25</p> <p>under both arms. They could not complete the transfer and lowered the resident to the floor. The CNA stated, "(Name of LPN #5) couldn't bear the resident's weight...she couldn't lift her..." Another CNA came into the room to assist with transferring the resident from the floor to the shower chair. CNA #4 stated she took the resident to the shower room and completed the shower. Afterwards the resident was then transferred to the bed with the use of a sit to stand and assistance of another CNA. CNA #4 stated she was not aware the resident was a Hoyer lift and further stated, "I have never seen anyone use a lift (mechanical-Hoyer) with the resident, they normally use a 2 person lift with her". She stated, "The Hoyer lift would have been a better transfer".</p> <p>A telephone call was placed to LPN #5 on 6/2/17 at 10:00 am., for an interview. The phone was not answered.</p> <p>The resident had been observed several times during the survey in bed with her eyes closed, on 6/1/17 and 6/2/17. Observed on the resident's name plate was a sticker with the symbol TL (total lift).</p> <p>The facility's Low Lift Program with a revision date of 01/11 Purpose read: Improve working conditions by eliminating 85%-90% of all manual resident transfers by utilizing mechanical lifting devices and aids, and to provide appropriate training for all employees on proper body mechanics and lifting techniques. Under Procedure read, in part: (3) The transfer requirement should be documented on the resident's care plan. (4) A sticker should be placed on each resident's nameplate. The sticker</p>	F 323			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495309	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/02/2017
NAME OF PROVIDER OR SUPPLIER THORNTON HALL NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 827 NORVIEW AVENUE NORFOLK, VA 23509		
(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 323	<p>Continued From page 26</p> <p>should include one of the following symbols-IND-individual, 1-Assist of One, 2-Assist of two, S/SST-Invacare Sit to Stand with Standing Sling, S/STR-Invacare Sit to Stand with Transfer Sling, TL-Invacare Total Lift (Hoyer).</p> <p>The 5 Point Corrective Action Plan dated 5/12/17 included the following with a corrective action completion date of 5/19/17 read as follows:</p> <ol style="list-style-type: none"> 1. Identified staff members were not using lifts that are required to safely transfer residents. 2. All residents had a new mobility assessment performed. Identifying lift dots placed outside rooms bedside room numbers. 3. All staff members were re-educated on policy of a low lift facility and no resident is to be transferred without lift identified. Staff members were also in-serviced on kardex and how to verify lift necessary. 4. 100% compliance by 5/19/17 with all staff members able to verbalize proper use of all lifts. Also the staff has been in-serviced regarding appropriate transfer status for each resident. 5. Each staff member will have completed a lift competency and safe transfer techniques. Audit will be conducted on all three shifts on proper technique 1 time a week (total of 3 audits per week) for 30 days and random checks for 1 month after and will have annual competency thereafter. <p>Based on the aforementioned interviews with facility staff, review of the corrective action plan and that the deficient practice did not reoccur after 5/19/17 or exist during the current survey, it was determined the facility met Past Non Compliance for this specific regulatory requirement.</p>	F 323			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495309	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/02/2017
NAME OF PROVIDER OR SUPPLIER THORNTON HALL NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 827 NORVIEW AVENUE NORFOLK, VA 23509		
(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 323	<p>Continued From page 27</p> <p>The following medical Definitions were obtained from Taber's Cyclopedic Medical Dictionary Edition #20:</p> <p>(1) Contracture-Fibrosis of connective tissue in skin, fascia, muscle, or a joint that prevents normal mobility of the related tissue or joint.</p> <p>(2) Hematoma- A swelling comprising a mass of extravasated blood (usually clotted) confined to an organ, tissue, or space and caused by a break in a blood vessel.</p> <p>2. The facility staff failed to provide Resident #15 with supervision to prevent a fall.</p> <p>Resident #15 was admitted to the facility on 8/29/16 with diagnoses of convulsions, epilepsy, non-traumatic interceder hemorrhage, hypertension Hepatitis C, venous insufficiency, gastro-esophageal reflux disease dementia, History of Urinary Tract Infections, Dementia, Alzheimer's and muscle weakness.</p> <p>A review of the closed clinical records indicated: Resident #15 had a fall on 9/5/16-(resident fell out of bed) possible have 1 on 1 supervision, to ensure residents safety. 9/7/16 (resident found on floor by CNA) (certified nursing assistant). request lab work. 9/30/16 resident found on floor on right side in pink solarium in front of w/c. Unwitnessed fall. No visibly apparent injuries. Found unattended. Fall with pain to right hip x-ray requested to rule out fracture. X-ray determined no fracture.</p> <p>The clinical records indicated the physician as well as family were contacted after each incident.</p> <p>An Initial Minimum Data Set dated 9/5/16 assessed this resident in the area of hearing as</p>	F 323			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495309	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/02/2017
NAME OF PROVIDER OR SUPPLIER THORNTON HALL NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 827 NORVIEW AVENUE NORFOLK, VA 23509		
(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 323	<p>Continued From page 28</p> <p>adequate. This resident was able to make her self understood sometimes and sometimes she was able to understand others. This resident was not able to complete the Brief Interview for Mental Status (BIMS). This resident was assessed as having short and long memory problems. This resident was assessed as having behaviors which impacted others. In the area of Activities of Daily Living (ADL'S) this resident was coded as requiring Extensive assistance of one person physical assist in the areas of Transfer, walk in room, locomotion on unit, dressing, eating toilet use and personal hygiene. This resident was assessed as having a history of falls.</p> <p>A Care Plan dated 8/30/16 indicated focus-Impaired balance, Alzheimer, restlessness and agitation. Interventions- Assitive devices (wheelchair). Explain all procedures/tasks before starting and converse with resident while providing care. Monitor and report decline in abilities. Screen for physical therapy, occupational therapy and speech therapy. Resident requires assistance to turn and reposition in bed. Transfer with assistance.</p> <p>Focus- potential for fall related injury history of seizures, falls, Alzheimer, non compliant. Interventions- Resident needs a safe environment with even floors free from spills and/or clutter, adequate glare-free light; a working and reachable call light, bed in low position at night, hand rails on walls, persona items within reach. Wear appropriate footwear when ambulation or mobilizing in wheelchair. Needs activities that minimize the potential for falls while proving diversion and distraction Non-drug interventions-enjoys sitting at the nurses station and watching everyone "buzz around".</p>	F 323			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/22/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495309	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/02/2017
NAME OF PROVIDER OR SUPPLIER THORNTON HALL NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 827 NORVIEW AVENUE NORFOLK, VA 23509		
(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 323	Continued From page 29 A Four Point Falls Plan- indicated: "Resident with poor safety awareness was left unsupervised in pink solarium." Interventions include providing supervision at all times for residents with high fall risk. During an interview on 6/3/17 at 11:15 A.M. with the administrator, she stated Resident #15 was very restless and would get up unassisted." The facility staff failed to provide Resident #15 with supervision to prevent a fall.	F 323			
F 441 SS=D	Complaint Deficiency INFECTION CONTROL, PREVENT SPREAD, LINENS CFR(s): 483.80(a)(1)(2)(4)(e)(f) (a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: (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 (facility assessment implementation is Phase 2); (2) Written standards, policies, and procedures for the program, which must include, but are not	F 441		7/14/17	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495309	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/02/2017
NAME OF PROVIDER OR SUPPLIER THORNTON HALL NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 827 NORVIEW AVENUE NORFOLK, VA 23509		
(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 441	Continued From page 30 limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (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 (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. (4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. (e) Linens. Personnel must handle, store,	F 441			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495309	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/02/2017
NAME OF PROVIDER OR SUPPLIER THORNTON HALL NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 827 NORVIEW AVENUE NORFOLK, VA 23509		
(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 441	<p>Continued From page 31</p> <p>process, and transport linens so as to prevent the spread of infection.</p> <p>(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility documentation review, clinical record review, and in the course of a complaint investigation:</p> <ol style="list-style-type: none"> The facility staff failed for one of 20 residents in the survey sample (Resident #10) to ensure that correct hand hygiene/handwashing was utilized during the administration of eye drops during observation of medication pass. The facility staff failed to store medical supplies in a clean environment and manner to prevent the potential for indirect transmission of infection due to potentially contaminated single use medical equipment. <p>The findings included:</p> <ol style="list-style-type: none"> Resident #10 was admitted to the facility on 2/5/14. Diagnoses for Resident #10 included but are not limited to: glaucoma (1). <p>Resident #10's Quarterly Minimum Data Set (MDS - an assessment protocol) with an Assessment Reference Date of 4/14/17 coded Resident #10 with a BIMS (Brief Interview for Mental Status) score of 5, indicating a severe cognition impairment.</p> <p>During the Medication Pass task on 5/31/17 at</p>	F 441	<p>LPN was re-educated regarding the proper handwashing technique between the administrations of eye drops. DCS/designee conducted med pass observations with nurses to ensure eye drops are administered following proper infection control practices. Follow up based on findings of med pass observations. The director of Clinical Services or designee to provide a re-education on the correct hand hygiene/handwashing procedure for resident care. Random Quality Monitoring to be performed to ensure that staff members are washing their hands appropriately. The Director of Clinical Services or designee to conduct random observations 3 times per week on each shift for 4 weeks, then 1 time weekly for 1 month then quarterly. Quality Monitoring schedule modified based on Quality Monitoring findings. The results of the Quality Monitoring to reviewed at the monthly Quality Assurance meetings for review, analysis, and further recommendations.</p> <p>Facility Staff removed and disposed of all</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495309	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/02/2017
NAME OF PROVIDER OR SUPPLIER THORNTON HALL NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 827 NORVIEW AVENUE NORFOLK, VA 23509		
(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 441	<p>Continued From page 32</p> <p>approximately 4:29 p.m., LPN (Licensed Practical Nurse) #3 entered Resident #10's room without washing her hands. She then proceeded to put on clean gloves and instilled one drop of Timolol (2) 0.5% eye drop into the Resident's Right eye. The LPN then walked to the sink, removed her gloves and put on clean gloves without washing her hands and returned to Resident #10 and instilled one drop of Timolol 0.5% eye drop into the Resident's Left eye.</p> <p>Resident #10's Clinical Record documented a 10/1/15 physician order for Timolol Maleate Solution 0.5% instill 1 drop in both eyes one time a day related to Unspecified Glaucoma.</p> <p>An interview with the Regional Director of Clinical Services on 6/1/17 at approximately 3:15 p.m. was conducted. When asked if it was an expectation to wash hands after removing gloves and prior to the administration of the Left eye drop, the Regional Director of Clinical Services stated: "Yes."</p> <p>Review of the Facility Performance Improvement Quality Indicator titled: "Infection Control Program - General" with a revision date of 3/14 documented: "Handwashing procedures are consistent with the Center for Disease Control Guidelines. Hand washing practiced between resident contact after removal of gloves as indicated."</p> <p>The facility administration was informed of the findings during a meeting on 6/1/17 at approximately 3:05 p.m. The facility did not present any further information about the findings.</p> <p>Definitions:</p>	F 441	<p>stored medical supplies and soiled, dry towels from under the cabinet in the nourishment room. Cabinet under the sink were secured shut to prevent storage.</p> <p>Facility rounds were conducted of facility's nourishment room cabinets for improper storage of medical supplies and soiled articles. Follow up based on findings. Cabinets under sinks were secured shut in facility nourishment rooms.</p> <p>All medical supplies were disposed of from nourishment room and soiled and dry towels. Maintenance director inspected sink pipes to ensure no leakage. Maintenance director installed a lock on cabinet doors to ensure no storage under sink on 6/1/17.</p> <p>Maintenance Director or designee to re-educate staff regarding appropriate storage of medical supplies.</p> <p>Maintenance director or designee to quality monitor cabinet storage 2 times a week for 1 month and 1 time a week for 1 month then monthly. Quality Monitoring schedule modified based on findings. The results of the quality monitoring to be reviewed at the monthly Quality Assurance meetings for review, analysis, and further recommendations.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495309	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/02/2017
NAME OF PROVIDER OR SUPPLIER THORNTON HALL NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 827 NORVIEW AVENUE NORFOLK, VA 23509		
(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 441	<p>Continued From page 33</p> <p>(1) Glaucoma: Medline Plus documented: Glaucoma is a group of diseases that can damage the eye's optic nerve. It is a leading cause of blindness in the United States</p> <p>(2) Timolol: Medline Plus documented: Ophthalmic (eye) timolol is used to treat glaucoma, a condition in which increased pressure in the eye can lead to gradual loss of vision. Timolol is in a class of medications called beta-blockers. It works by decreasing the pressure in the eye.</p> <p>2. An inspection of the resident's nourishment room located on the unit was conducted on 5/31/17 at 12:10 pm. Stored underneath the sink were three opened boxes of medical supplies to include:</p> <ol style="list-style-type: none"> 1. Two (2) boxes of tube feeding E (electronic) pump Safety Screw Spike Sets 2. One box of tube feeding Safety Spike Plus Pump Sets with Y adapter <p>In between these opened boxes were two bath towels that appeared to have been placed there to soak up water from the sink drain. The towels were soiled and dry. The sink drain at this time did not appear to be leaking.</p> <p>The Unit Manager was asked to come into the nourishment room at this time. She also observed the medical supply boxes and stated she was unaware of them being stored there. She indicated medical supplies are stored in the medical supply room.</p> <p>On 6/1/17 at 4:50 pm, an end of day wrap up meeting was conducted with the Administrator,</p>	F 441			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/22/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495309	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/02/2017
NAME OF PROVIDER OR SUPPLIER THORNTON HALL NURSING AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 827 NORVIEW AVENUE NORFOLK, VA 23509		
(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 441	Continued From page 34 the Regional Director of Clinical Services, the Director of Clinical Services and the Unit Manager in attendance. The above findings was shared. The Administrator stated medical supplies should be stored in the medical supply storage room. The Administrator also stated the facility does not have a policy that speaks specifically on the storage of medical supplies.	F 441		