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

PRINTED: 05/02/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495186	A. BUILDING _____ B. WING _____	04/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETH SHOLOM HOME OF EASTERN VI	6401 AUBURN DR VIRGINIA BEACH, VA 23464

(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
E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted on 04/17/18 through 04/20/18. Corrections are required for compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities. The Life Safety Code report will follow. The census in this bed facility at the time of the survey was 120. The survey sample consisted of 27 current and closed records.	E 000		
E 007 SS=C	EP Program Patient Population CFR(s): 483.73(a)(3)* [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following:] (3) Address patient/client population, including, but not limited to, persons at-risk; the type of services the [facility] has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession plans.** *Note: ["Persons at risk" does not apply to: ASC, hospice, PACE, HHA, CORF, CMCH, RHC, FQHC, or ESRD facilities.] This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility staff failed to provide documentation that the facility's Emergency Preparedness Plan included delegation of authority for continuity of operations..	E 007		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Rebecca Moraley RN, LNHA | TITLE: Administrator | (X6) DATE: 5/9/18

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495186	A. BUILDING _____ B. WING _____	04/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETH SHOLOM HOME OF EASTERN VI	6401 AUBURN DR VIRGINIA BEACH, VA 23464

(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
E 007	Continued From page 1 The findings included: During an interview on 4/20/18 at 11:24 a.m. with the Administrator, she was asked to provide the facilities continuity of operations, including delegation of authority. The administrator stated the facility's Emergency Preparedness Plan did not include a delegation of authority for continuity of operations.	E 007		
E 015 SS=C	Subsistence Needs for Staff and Patients CFR(s): 483.73(b)(1) [(b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually.] At a minimum, the policies and procedures must address the following: (1) The provision of subsistence needs for staff and patients whether they evacuate or shelter in place, include, but are not limited to the following: (i) Food, water, medical and pharmaceutical supplies (ii) Alternate sources of energy to maintain the following: (A) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions. (B) Emergency lighting. (C) Fire detection, extinguishing, and alarm systems. (D) Sewage and waste disposal.	E 015	**CFR(s): 483.73(b)(1)** **1.** No residents were cited as a result of the failure to have a policy and procedure for sewage disposal service. The Administrator initiated contact with sewage management companies on 4/23/18. **2.** All residents have the potential to be affected by this finding. **3.** Facility will partner with (2) sewage management companies and update the EPP. All responsible staff will be in-serviced on the process and their roles and responsibilities by the Staff Development Coordinator or designee by the compliance date. **4.** The EPP policy and procedure for sewage disposal service will be reviewed quarterly by the EPP committee. **5.** Our corrective action plan will be in compliance by May 31st, 2018.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495186	A. BUILDING _____ B. WING _____	04/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETH SHOLOM HOME OF EASTERN VI	6401 AUBURN DR VIRGINIA BEACH, VA 23464

(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

E 015 Continued From page 2

E 015

*[For Inpatient Hospice at §418.113(b)(6)(iii).]
Policies and procedures.
(6) The following are additional requirements for hospice-operated inpatient care facilities only. The policies and procedures must address the following:
(iii) The provision of subsistence needs for hospice employees and patients, whether they evacuate or shelter in place, include, but are not limited to the following:
(A) Food, water, medical, and pharmaceutical supplies.
(B) Alternate sources of energy to maintain the following:
(1) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions.
(2) Emergency lighting.
(3) Fire detection, extinguishing, and alarm systems.
(C) Sewage and waste disposal.
This REQUIREMENT is not met as evidenced by:
Based on record review and staff interview, the facility staff failed to have Emergency Preparedness policies and procedures for sewage disposal services and fire watch process.

The findings included:

During a review of the emergency preparedness plan with the administrator on 4/20/18 at 11:26 a.m. she was asked for documentation for fire watch process and sewage disposal services. The administrator stated she "did not have documentation of the facility having a fire watch process or sewage disposal services."

E 018 Procedures for Tracking of Staff and Patients

E 018

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495186	A. BUILDING _____ B. WING _____	04/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETH SHOLOM HOME OF EASTERN VI	6401 AUBURN DR VIRGINIA BEACH, VA 23464

(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
E 018 SS=C	Continued From page 3 CFR(s): 483.73(b)(2) [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually.] At a minimum, the policies and procedures must address the following:] (2) A system to track the location of on-duty staff and sheltered patients in the [facility's] care during an emergency. If on-duty staff and sheltered patients are relocated during the emergency, the [facility] must document the specific name and location of the receiving facility or other location. *[For PRTFs at §441.184(b), LTC at §483.73(b), ICF/IIDs at §483.475(b), PACE at §460.84(b):] Policies and procedures. (2) A system to track the location of on-duty staff and sheltered residents in the [PRTF's, LTC, ICF/IID or PACE] care during and after an emergency. If on-duty staff and sheltered residents are relocated during the emergency, the [PRTF's, LTC, ICF/IID or PACE] must document the specific name and location of the receiving facility or other location. *[For Inpatient Hospice at §418.113(b)(6):] Policies and procedures. (ii) Safe evacuation from the hospice, which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s) and primary and alternate means of	E 018	**CFR(s):483.73(b)(2)** **1.** No residents were cited as a result of the failure to provide documentation for location of residents at alternate sites. A preliminary resident tracking form was developed on 4/23/18. **2.** All residents have the potential to be affected by this finding. **3.** Facility Administration will conduct periodic mock communication and documentation drills utilizing the resident tracking form. The EPP will be updated to include a designated employee responsible for maintaining documentation of residents at alternate sites. All responsible staff will be in-serviced on the process and their roles and responsibilities by the Staff Development Coordinator or designee by the compliance date. **4.** Drill results and documentation of resident tracking will be reviewed and analyzed quarterly by the EPP committee. **5.** Our corrective action plan will be in compliance by May 31st, 2018.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495186	A. BUILDING _____ B. WING _____	04/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETH SHOLOM HOME OF EASTERN VI	6401 AUBURN DR VIRGINIA BEACH, VA 23464

(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
E 018	Continued From page 4	E 018		

communication with external sources of assistance.
(v) A system to track the location of hospice employees' on-duty and sheltered patients in the hospice's care during an emergency. If the on-duty employees or sheltered patients are relocated during the emergency, the hospice must document the specific name and location of the receiving facility or other location.

*[For CMHCs at §485.920(b):] Policies and procedures. (2) Safe evacuation from the CMHC, which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s); and primary and alternate means of communication with external sources of assistance.

*[For OPOs at § 486.360(b):] Policies and procedures. (2) A system of medical documentation that preserves potential and actual donor information, protects confidentiality of potential and actual donor information, and secures and maintains the availability of records.

*[For ESRD at § 494.62(b):] Policies and procedures. (2) Safe evacuation from the dialysis facility, which includes staff responsibilities, and needs of the patients.
This REQUIREMENT is not met as evidenced by:
Based on record review and staff interview, the facility staff failed to provide documentation for the location of residents at alternate sites. The facility failed to provide documentation that staff have been trained on the system to track the location of on-duty staff and sheltered patients who may be relocated during an emergency.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495186	A. BUILDING _____ B. WING _____	04/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETH SHOLOM HOME OF EASTERN VI	6401 AUBURN DR VIRGINIA BEACH, VA 23464

(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
E 018	Continued From page 5 The findings included: During review of the facilities emergency preparedness plan on 4/20/18 at 11:55 a.m. the administrator was asked to provide documentation that facility staff have been trained on the facilities system to track the location of on-duty staff and sheltered resident who are relocated during an emergency. The administrator stated, "We have not trained our staff on the tracking system."	E 018		
E 024 SS=C	Policies/Procedures-Volunteers and Staffing CFR(s): 483.73(b)(6) [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. At a minimum, the policies and procedures must address the following:] (6) [or (4), (5), or (7) as noted above] The use of volunteers in an emergency or other emergency staffing strategies, including the process and role for integration of State and Federally designated health care professionals to address surge needs during an emergency. *[For RNHCIs at §403.748(b):] Policies and procedures. (6) The use of volunteers in an emergency and other emergency staffing strategies to address surge needs during an emergency.	E 024	**CFR(s): 483.73(b)(6)** **1.** No residents were cited as a result of the failure to develop policies and procedures for the use or non-use of volunteers during an emergency. The EPP committee met and discussed a preliminary process with the Volunteer Coordinator and Recreation Therapy Director on 4/23/18. **2.** All residents have the potential to be affected by this finding. **3.** Facility will develop a policy for the use or non-use of volunteers during an emergency and update the EPP. All responsible staff and volunteers will be in-serviced on the process and their roles and responsibilities by the Staff Development Coordinator or designee by the compliance date. **4.** The EPP policy for the use or non-use of volunteers during an emergency will be reviewed quarterly by the EPP committee. **5.** Our corrective action plan will be in compliance by May 31st, 2018.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495186	A. BUILDING _____ B. WING _____	04/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETH SHOLOM HOME OF EASTERN VI	6401 AUBURN DR VIRGINIA BEACH, VA 23464

(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
E 024	Continued From page 6 This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility staff failed to develop policies and procedures for the use or non use of volunteers during an emergency. The findings included: During an interview on 4/20/18 at 12: 02 P.M. with the Administrator, she stated the facility has volunteers who assist residents daily, however, the facility had not developed policies and procedures for the use of volunteers during emergency preparedness activities.	E 024		
E 025 SS=C	Arrangement with Other Facilities CFR(s): 483.73(b)(7) [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. At a minimum, the policies and procedures must address the following:] *[For Hospices at §418.113(b), PRFTs at §441.184,(b) Hospitals at §482.15(b), and LTC Facilities at §483.73(b):] Policies and procedures. (7) [or (5)] The development of arrangements with other [facilities] [and] other providers to receive patients in the event of limitations or cessation of operations to maintain the continuity of services to facility patients.	E 025	**CFR(s): 483.73(b)(7)** **1.** No residents were cited as a result of the failure to have written agreement between other providers and to receive residents in the event of an emergency. The signed agreement/memorandum of understanding (MOU) was obtained by the Administrator on 4/17/18. **2.** All residents have the potential to be affected by this finding. **3.** Facility will obtain partnership and written agreements/memorandum of understanding with other providers. The EPP will be updated and all responsible staff will be in-serviced on the process and their roles and responsibilities by the Staff Development Coordinator or designee by the compliance date. **4.** The signed agreement/memorandum of understanding (MOU) will be reviewed quarterly	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495186	A. BUILDING _____ B. WING _____	04/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETH SHOLOM HOME OF EASTERN VI	6401 AUBURN DR VIRGINIA BEACH, VA 23464

(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
E 025	Continued From page 7 *[For PACE at §460.84(b), ICF/IIDs at §483.475(b), CAHs at §486.625(b), CMHCs at §485.920(b) and ESRD Facilities at §494.62(b):] Policies and procedures. (7) [or (6), (8)] The development of arrangements with other [facilities] [or] other providers to receive patients in the event of limitations or cessation of operations to maintain the continuity of services to facility patients. *[For RNHCIs at §403.748(b):] Policies and procedures. (7) The development of arrangements with other RNHCIs and other providers to receive patients in the event of limitations or cessation of operations to maintain the continuity of non-medical services to RNHCI patients. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility staff failed to have a written agreement between other providers and to receive residents in the event of an emergency. The findings included: During an interview and review of the facilities emergency preparedness plan on 4/20/18 at 12:27 P.M. the administrator was asked if the facility had developed written agreements with other facilities to receive residents in the event of limited or cessation of operation of the facility, as well as, to send residents to other facilities. The administrator stated, the facility had a verbal agreement with a facility out of town but no written arrangements had been signed and agreed upon.	E 025	**Continued from page 7** by the EPP committee and changes will be made as necessary. **5.** Our corrective action plan will be in compliance by May 31st, 2018.	
E 026	Roles Under a Waiver Declared by Secretary	E 026		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495186	A. BUILDING _____ B. WING _____	04/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETH SHOLOM HOME OF EASTERN VI	6401 AUBURN DR VIRGINIA BEACH, VA 23464

(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
E 026 SS=C	Continued From page 8 CFR(s): 483.73(b)(8)	E 026	**CFR(s): 483.73(b)(8)**	

[(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. At a minimum, the policies and procedures must address the following:]

(8) [(6), (6)(C)(iv), (7), or (9)] The role of the [facility] under a waiver declared by the Secretary, in accordance with section 1135 of the Act, in the provision of care and treatment at an alternate care site identified by emergency management officials.

*[For RNHCIs at §403.748(b):] Policies and procedures. (8) The role of the RNHCI under a waiver declared by the Secretary, in accordance with section 1135 of Act, in the provision of care at an alternative care site identified by emergency management officials.

This REQUIREMENT is not met as evidenced by:

Based on record review and staff interview, the facility staff failed to develop emergency preparedness policies and procedures for providing care and services at alternate care sites during emergencies.

The findings included:

During a review of the facilities emergency preparedness plan on 04/20/18 at 12:48 p.m. the administrator was asked for the emergency

1. No residents were cited as a result of the failure to develop emergency preparedness policies and procedures for providing care and services at alternate care sites during an emergency. The EPP committee met and discussed a preliminary policy and procedure on 4/232/18.

2. All residents have the potential to be affected by this finding.

3. Facility will develop a policy and procedure for providing care and services at alternate care sites during an emergency. The EPP will be updated and all responsible staff will be in-serviced on the process and their roles and responsibilities by the Staff Development Coordinator or designee by the compliance date.

4. The policy and procedure for providing care and services at alternate care sites during an emergency will be reviewed quarterly by the EPP committee.

5. Our corrective action plan will be in compliance by May 31st, 2018.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495186	A. BUILDING _____ B. WING _____	04/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETH SHOLOM HOME OF EASTERN VI	6401 AUBURN DR VIRGINIA BEACH, VA 23464

(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
E 026	Continued From page 9 preparedness policy and procedure that specifically addressed the facility's role in providing care at an alternate site. The administrator stated, the facility did not have a policy and procedure that addresses the care and services that would be provided at an alternate care site.	E 026		
E 036 SS=C	EP Training and Testing CFR(s): 483.73(d) (d) Training and testing. The [facility] must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually. *[For ICF/IIDs at §483.475(d):] Training and testing. The ICF/IID must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually. The ICF/IID must meet the requirements for evacuation drills and training at §483.470(h). *[For ESRD Facilities at §494.62(d):] Training, testing, and orientation. The dialysis facility must develop and maintain an emergency	E 036	**CFR(s): 483.73(d)** **1.** No residents were cited as a result of the failure to develop an emergency preparedness written training and testing program based on the emergency preparedness plan. The Administrator contacted Relias Training on 4/7/18 to determine the availability of a written training and testing program. **2.** All residents have the potential to be affected by this finding. **3.** Facility will develop a written training and testing program based on the emergency plan for all staff. The EPP will be updated and all responsible staff will be in-serviced on the training and testing program by the Staff Development Coordinator or designee by the compliance date. **4.** The written training and testing program will be reviewed quarterly by the EPP committee. The Staff Development Coordinator or designee will provide a training compliance report quarterly during EPP meetings. **5.** Our corrective action plan will be in compliance by May 31st, 2018.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495186	A. BUILDING _____ B. WING _____	04/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETH SHOLOM HOME OF EASTERN VI	6401 AUBURN DR VIRGINIA BEACH, VA 23464

(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
E 036	Continued From page 10 preparedness training, testing and patient orientation program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training, testing and orientation program must be reviewed and updated at least annually. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility staff failed to develop an emergency preparedness written training and testing program that is based on the emergency preparedness plan. The findings included: During review of the facility's emergency preparedness plan on 04/20/18 at 1:20 p.m. the administrator was asked for a training and testing program that was based on the faculties emergency preparedness plan. The administrator stated, she "did not have a training and testing program based on the emergency plan."	E 036		
E 039 SS=C	EP Testing Requirements CFR(s): 483.73(d)(2) (2) Testing. The [facility, except for LTC facilities, RNHCIs and OPOs] must conduct exercises to test the emergency plan at least annually. The [facility, except for RNHCIs and OPOs] must do all of the following: "[For LTC Facilities at §483.73(d):] (2) Testing. The LTC facility must conduct exercises to test the emergency plan at least annually, including	E 039	**CFR(s): 483.73(d)(2)** 1. No residents were cited as a result of the failure to analyze the response of drills, table top exercises or emergency events. The EPP committee conducted an analysis of a table exercise for hurricane preparedness on 4/23/18. 2.All residents have the potential to be affected by this finding. 3. Facility will develop a written plan for analyzing the response to emergency drills. The EPP will	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495186	A. BUILDING _____ B. WING _____	04/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETH SHOLOM HOME OF EASTERN VI	6401 AUBURN DR VIRGINIA BEACH, VA 23464

(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
E 039	Continued From page 11 unannounced staff drills using the emergency procedures. The LTC facility must do all of the following:] (i) Participate in a full-scale exercise that is community-based or when a community-based exercise is not accessible, an individual, facility-based. If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in a community-based or individual, facility-based full-scale exercise for 1 year following the onset of the actual event. (ii) Conduct an additional exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based. (B) A tabletop exercise that includes a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed. *[For RNHCIs at §403.748 and OPOs at §486.360] (d)(2) Testing. The [RNHCI and OPO] must conduct exercises to test the emergency plan. The [RNHCI and OPO] must do the following: (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically relevant emergency scenario, and a set	E 039	**Continued from page 11** be updated and all responsible staff will be in-serviced on the process and their roles and responsibilities by the Staff Development Coordinator or designee by the compliance date. 4. The EPP committee will analyze the response of drills, table top exercises or emergency events quarterly. 5. Our corrective action plan will be in compliance by May 31st, 2018.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495186	A. BUILDING _____ B. WING _____	04/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETH SHOLOM HOME OF EASTERN VI	6401 AUBURN DR VIRGINIA BEACH, VA 23464

(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
E 039	Continued From page 12 of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (ii) Analyze the [RNHCI's and OPO's] response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed. This REQUIREMENT is not met as evidenced by: The facility staff failed to analyze the response of drills, table top exercises or emergency events. The findings included: During review of the facilities emergency preparedness plan on 4/20/18, including the facility's table top exercise, documentation of all drills and emergency events, the facility failed to have documentation for analyzing the facility's response. During an interview with the administrator on 04/20/18 at 1:25 p.m. she stated the facility had not analyzed the response to the drills, tabletop exercise or emergency events.	E 039		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid Standard survey was conducted 04/17 /18 through 04/20/18. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care and the Virginia State Long Term Care requirements. No complaints were investigated during the survey. The Life Safety Code will follow. The census in this 120 bed certified facility was 90 at the time of the survey. The survey sample	F 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495186	A. BUILDING _____ B. WING _____	04/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETH SHOLOM HOME OF EASTERN VI	6401 AUBURN DR VIRGINIA BEACH, VA 23464

(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	Continued From page 13 consisted of 27 current resident reviews and closed records.	F 000		
F 641 SS=B	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on observations, clinical record review, staff interviews, and facility document review, the facility staff failed to accurately code a quarterly Minimum Data Set (MDS) for one of 27 residents in the survey sample (Resident #27). The facility staff failed to accurately code a Quarterly MDS assessment for Resident #37 to include Oxygen therapy. The Finding include: Resident #37 was admitted on 10/22/2017 with a diagnosis of *Chronic Obstructive Pulmonary disease. *Chronic obstructive pulmonary disease makes it hard for a resident to breath. Source: (https://medlineplus.gov/copd.html). The most recent Minimum Data Set (MDS) was a quarterly assessment with an Assessment Reference Date (ARD) date of 1/3/2018. The Brief Interview for Mental Status (BIMS) was a 5 out of a possible 15 which indicated that Resident #37 had severe cognitive impairment. The Person-Centered Comprehensive Care Plan	F 641	**CFR (s): 483.20 (g)** **1.** Resident #37's MDS and supporting documentation was reviewed. A corrected MDS that included the use of oxygen was completed for this resident on 4/20/18. **2.** All residents who require oxygen therapy have the potential to be affected. An audit was conducted on 4/20/18 by Nursing Administration on all residents utilizing oxygen and their MDS's were reviewed for accuracy and corrections made as necessary. **3.** All residents utilizing oxygen therapy will be reviewed weekly during Standards of Care meetings. The Central Supply Clerk will also provide a weekly report on all residents utilizing oxygen therapy and/or discontinuation of oxygen therapy to the MDS Coordinators. All responsible staff will be in-serviced on the process and their roles and responsibilities by the Staff Development Coordinator or designee by the compliance date. **4.** Weekly audits on MDS's of residents receiving oxygen therapy will be conducted by the DON or designee to ensure accurate coding of oxygen therapy. Results will be reported during weekly QAPI meetings. **5.** Our corrective action plan will be in compliance by May 31st, 2018.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495186	A. BUILDING _____ B. WING _____	04/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETH SHOLOM HOME OF EASTERN VI	6401 AUBURN DR VIRGINIA BEACH, VA 23464

(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 641	Continued From page 14	F 641		

initiated on 10/23/2014 identified that Resident #37 had COPD: Impaired gas exchange. Interventions: Oxygen per as ordered. Change tubing and mask/nasal cannula weekly per facility protocol.

Resident #3's7 Treatment Administration Record (TAR) was reviewed on 4/18/18. The order was renewed on 3/20/2018 to increase Oxygen to 3L(liters) via nasal cannula to maintain O2 (oxygen) saturation > 95% for disease of chronic obstructive pulmonary disease.

On 4/19/2018 at 2:30 p.m. an interview was conducted with MDS coordinator's #22 and #23 concerning Resident #37's oxygen therapy. MDS coordinator #22 was asked if she was aware that Resident #37 was on oxygen. MDS Coordinator #22 stated, "Yes." Surveyor asked was Resident #37 coded for oxygen on her last MDS. MDS Coordinator #23, stated "I am the one who did not code that correctly." MDS Coordinator #23 stated, "We will be doing a correction for the MDS dated 1/3/2018." A modified MDS was provided on 4/19/2018 at approximately 4:00 p.m.

The Facilities policy and Procedures titled "Care Area Assessments" with a revision date of May 2017, documented the following:

Care Area Assessments (CAAs) will be used to help analyze data obtained from the MDS and to develop individualized care plans. CAA's are the link between assessment and care planning.

3. The IDT will employ tools and resources during the CAA process, including evidence-based research and clinical practice guidelines, along with the sound clinical decision making and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495186	A. BUILDING _____ B. WING _____	04/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETH SHOLOM HOME OF EASTERN VI	6401 AUBURN DR VIRGINIA BEACH, VA 23464

(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 641 Continued From page 15

problem-solving.

On 4/20/2018 at 3:30 p.m. a pre-exit interview was conducted with the Administrator, the DON. The above findings were shared. The facility did not present any further information about the findings.

F 641

F 657 Care Plan Timing and Revision
SS=D CFR(s): 483.21(b)(2)(i)-(iii)

§483.21(b) Comprehensive Care Plans
§483.21(b)(2) A comprehensive care plan must be-
(i) Developed within 7 days after completion of the comprehensive assessment.
(ii) Prepared by an interdisciplinary team, that includes but is not limited to--
(A) The attending physician.
(B) A registered nurse with responsibility for the resident.
(C) A nurse aide with responsibility for the resident.
(D) A member of food and nutrition services staff.
(E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.
(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.
(iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.
This REQUIREMENT is not met as evidenced

F 657 **CFR (s): 483.21 (b)(2)(i)-(iii)**

1. Resident #12's care plan was reviewed and updated by the Unit Manager on 4/20/18 to reflect the use of oxygen therapy.

2. All residents who require oxygen therapy have the potential to be affected. An audit was conducted on 4/20/18 by Nursing Administration on all residents utilizing oxygen and their care plans were reviewed for accuracy and updated as necessary.

3. All residents utilizing oxygen therapy will be reviewed weekly during Standards of Care meetings. The Central Supply Clerk will also provide a weekly report on all Residents utilizing oxygen therapy and/or discontinuation of oxygen therapy to the Unit Managers. All responsible staff will be in-serviced on the process and their roles and responsibilities by the Staff Development Coordinator or designee by the compliance date.

4. Weekly audits on care plans will be conducted by the Unit Managers to ensure accurate documentation of oxygen therapy on residents care plans. Results will be reported during weekly QAPI meetings.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495186	A. BUILDING _____ B. WING _____	04/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETH SHOLOM HOME OF EASTERN VI	6401 AUBURN DR VIRGINIA BEACH, VA 23464

(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 657	Continued From page 16	F 657	**Continued from page 16**	

by:
Based on observations, clinical record review, staff interviews, and facility document review, the facility staff failed to revise person-centered comprehensive care plan for 1of 27 sample residents (Resident #12).

The facility staff failed to revise Resident #12's person-centered comprehensive care plan to include Oxygen therapy.

The finding include:

Resident #12 was readmitted on 02/22/2012 with diagnosis to include but not limited to Bipolar Disorder, Dementia, Hypothyroidism.

The most recent Minimum Data Set (MDS) for Resident #12 was a quarterly with Assessment Reference Date (ARD) of 1/17/2018. The Brief Interview for Mental Status (BIMS) was a 6 out of a possible 15, which indicated that resident #12 has severe cognitive impairment.

Resident #12's Physicians Order was reviewed on 4/18/2018. An order dated 3/22/2018 was written to administer Oxygen 2Liter/min via nasal cannula: Every day at 7:00 am -3:00 pm; 3:00 pm -11:00 pm; 11:00 pm - 7:00 am.

The Person-Centered Comprehensive Care Plan initiated on 5/14/2016 for Resident #12 listed the focus as Pneumonia, intervention: administer oxygen as ordered prn (resolved 5/14/2016). On 3/10/2017 a focus was added for cold symptoms/upper respiratory symptoms, intervention: may use PRN Oxygen for comfort. On 4/13/2017 person-centered comprehensive care plan listed focus Hospice Care, end of life

5. Our corrective action plan will be in compliance by May 31st, 2018.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495186	A. BUILDING _____ B. WING _____	04/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETH SHOLOM HOME OF EASTERN VI	6401 AUBURN DR VIRGINIA BEACH, VA 23464

(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 657	Continued From page 17	F 657		

care -HPCT Hospice. Goals: Resident will maintain the highest quality of life during the review. Interventions: Administer medications per order, provide support for family and Patient as needed, report changes in condition to Hospice company.

A nursing note dated 4/13/2018 at 9:37 p.m. documented Resident #12 on 2Liters/min via nasal cannula.

On 4/20/2018 at 9:38 a.m. an interview was conducted with Unit Manager (UM #15). UM #15 was asked, "Who is responsible to update care plans?" UM #15 stated, "Any nurse can update a care plan. Whoever takes the order should update the care plan." UM #15 was also asked, "Should Resident #12's care plan be updated to include Oxygen therapy?" UM #15 stated, "Yes, we have been having in-services about updating of care plans."

On 4/20/2018 at 9:58 a.m. an interview was conducted with Director of Nursing (DON) #2 concerning the updating of care plans. DON #2 stated "All nurses are responsible to update care plans." The DON was asked, "Should resident #12's care plan been updated to include Oxygen?" The DON #2 stated, "I thought the Oxygen was care planned under the focus of Hospice for Resident #12."

On 4/20/2018 at approximately 11:00 a.m. an interview was conducted with the Administrator #1 and DON #2 concerning Quality Assessment and Assurance (QAA) and Quality Assurance and Performance Improvement (QAPI) Plan Review. Administrator #1 was asked for any identified issues that the facility has or is experiencing.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495186	A. BUILDING _____ B. WING _____	04/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETH SHOLOM HOME OF EASTERN VI	6401 AUBURN DR VIRGINIA BEACH, VA 23464

(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 657	Continued From page 18 Administrator #1 stated" One identified issue is the lack of care plans revision. Each department has been identified with this issue." The Facilities policy and Procedures titled "Care Plan, Comprehensive Person-Centered" with a revision date of November 2017, documented the following: A comprehensive, person-centered care plan that includes measurable objective and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. Number 13. Assessments of residents are ongoing and care plans are revised as information about the residents and the resident's condition changes. On 4/20/2018 at 3:30 p.m. a pre-exit was conducted with the Administrator, the DON. The above findings were shared. No further information was shared at this time.	F 657		
F 698 SS=E	Dialysis CFR(s): 483.25(l) §483.25(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 staff interviews and record review, the facility staff failed to obtain a written agreement with the dialysis center and failed to maintain communication with the dialysis center providing services for 1 of 27 residents in the survey	F 698	**CFR (s): 483.25 (I)** **1.** For resident # 87, the Administrator obtained a written agreement from the dialysis center providing service for this resident on 4/19/18. **2.** All residents on dialysis have the potential to be affected. An audit was initiated by Nursing Administration on 4/19/18 and there were no other residents on dialysis in the facility. **3.** Upon admission, the Admissions Director or designee will initiate a written agreement with dialysis center providing services to the resident. The Medical Records Clerk will ensure the written agreement was obtained and scanned into the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495186	A. BUILDING _____ B. WING _____	04/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETH SHOLOM HOME OF EASTERN VI	6401 AUBURN DR VIRGINIA BEACH, VA 23464

(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 698	Continued From page 19 sample (Resident #87).	F 698	**Continued from page 19**	

Findings included:

Resident #87 was admitted to the facility on 3/28/2018. Diagnoses included, but were not limited too, hypertension, GERD (gastroesophageal reflux disease), syncope with collapse, unspecified systolic (congestive) heart failure, End Stage Renal Disease (ESRD), dependence on renal dialysis, and gout.

Resident #87 had an Admission Minimum Data Set (MDS) completed on 4/4/18. The assessment indicated resident #87 has a BIMS (Brief Interview for Mental Status) assessment score of 10, indicating moderate cognitive impairment. Section O0100 J. indicated the resident received dialysis services. Resident #87's functional status was coded as limited assistance needed for self-performance and staff assistance of one staff member for bed mobility, transfers, locomotion on and off the unit, dressing, toilet use, and personal hygiene.

A care plan dated 3/28/18 indicated: Focus - Dehydration/Fluid imbalance: Risk for R/T (related to) fluid restriction, variable PO (by mouth) intake, CHF (congestive heart failure), ESRD with hemodialysis, medication regimen/potentials side effects. Goal - Resident will receive adequate hydration during this review period. Interventions - Medications as ordered, Encourage PO fluids within the fluid restriction, Labs as ordered, Determine resident preferences, Monitor vitals per protocol. Focus - Resident requires dialysis chronic kidney disease. Goals - Resident will be without complications related to dialysis during this review period.

resident's medical record. All responsible staff will be in-serviced on the process and their roles and responsibilities by the Staff Development Coordinator or designee by the compliance date.
4. A weekly audit will be conducted by the Medical Records Clerk to ensure compliance and results will be reported to Nursing Administration weekly.
5. Our corrective action plan will be in compliance by May 31st, 2018.

CFR (s): 483.25 (I)
1. For resident # 87, the Unit Manager obtained recent records from the dialysis center providing services to this resident and ensured they were scanned into the resident's medical record.
2. All residents on dialysis have the potential to be affected. An audit was initiated by Nursing Administration on 4/19/18 and there were no other residents on dialysis in the facility.
3. A dialysis communication form will be created and implemented for all residents on dialysis. Licensed nursing staff and unit secretaries will be responsible for ensuring dialysis communication forms are sent and returned with appropriate documentation. All responsible staff will be in-serviced on the process and their roles and responsibilities by the Staff Development Coordinator or designee

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495186	A. BUILDING _____ B. WING _____	04/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETH SHOLOM HOME OF EASTERN VI	6401 AUBURN DR VIRGINIA BEACH, VA 23464

(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 698	Continued From page 20	F 698	**Continued from page 20**	

Interventions - Monitor and document intake and output each shift, Diet per order, Fluid restriction per order, Monitor for fluid volume overload and report, Monitor and Report difficulty breathing, wet lung sounds and wheezing, Monitor bruit and thrill each shift and pm - Report concerns to MD/NP/PA (medical doctor/nurse practitioner/physician assistant).

Physician order review included: Diet NAS (no added salt) regular consistency, Fluid restriction 960cc/24hr Dietary (480ml/day) 160 ml with breakfast, 160 ml with lunch, 160 ml with dinner. Nursing (480ml/day) 7a/7p = 240ml, 7p/7a = 240ml. Advance Directive -Full Cardiopulmonary Resuscitation (CPR). Dialysis Monday, Wednesday, Friday, and Saturday. Laboratory - weekly labs: CBC and BMP. Monitoring - daily weights before breakfast. Monitoring - Monitor I&O's every shift due to primary diagnosis of CHF. Monitoring - Monitor Bruit and thrill to LUE fistula every shift and before/after dialysis.

On 04/18/18 at 9:10 AM Resident #87 was observed well groomed, sitting on the side of her bed eating breakfast. Resident #87 had dialysis four times each week Monday, Wednesday, Friday, and Saturday.

The medical record was reviewed on 04/18/18 at 11:00 AM. There was no communication noted between the dialysis center and the facility. During staff Interview with Unit Manager LPN #18 when asked about communication with the dialysis center she stated she had no notes from the dialysis center for resident #87. The LPN #18 stated "we should have communication with her dialysis center. This is something we can work on."

by the compliance date.

4. A weekly audit will be conducted by Unit Managers to ensure compliance and results will be reported during weekly Standards of Care meetings.

5. Our corrective action plan will be in compliance by May 31st, 2018.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495186	A. BUILDING _____ B. WING _____	04/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETH SHOLOM HOME OF EASTERN VI	6401 AUBURN DR VIRGINIA BEACH, VA 23464

(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 698	Continued From page 21	F 698		

On 04/18/18 at 11:22 AM, LPN #18 obtained faxed copies dated 4/18/18 at 11:21 AM, consisting of two pages of Nurse Practitioner's assessments and 9 pages of lab reports for resident #87 from the dialysis center after the facility requested communication from the dialysis provider.

On 4/19/18 at 09:30 AM, during a review of the facility contracts provided to the survey team, there was no written agreement between the facility and the dialysis center that was providing hemodialysis for resident #87.

On 4/19/18 at 10:00 AM, during an interview with the administrator, the surveyor asked for a copy of the current dialysis contract used to cover services provided by the specific dialysis center for Resident #87.

On 04/19/18 at 11:00 Am, the Administrator was asked a second time for the dialysis contract and she stated she had requested a copy of the contract be faxed to her.

On 04/19/18 at 1:06 PM, the Administrator was asked to provide a copy of the faxed contract which was received by facility on 4/19/18 at 11:01AM with signature/execution date of 4/19/18, effective date February 12, 2018.

On 04/19/18 at 1:55 PM the Administrator was asked about the date the contract was signed. The Administrator stated that she had faxed over a month ago and requested the dialysis center to please sign it.

The administrator stated that the dialysis center

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495186	A. BUILDING _____ B. WING _____	04/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETH SHOLOM HOME OF EASTERN VI	6401 AUBURN DR VIRGINIA BEACH, VA 23464

(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 698 Continued From page 22

"was supposed to send over information for the resident each week too, but they didn't."

On 04/19/18 at 02:20 PM the Administrator was asked who was responsible to follow up and maintain contracts for services. The Administrator responded "the CEO, CFO, and the attorneys as well as myself for corrections as needed."

A review of the policy for "End-Stage Renal Disease, Care of a Resident with" dated March 19, 2018 noted: 4. Resident's care and communication will be managed between Beth Sholom and the dialysis center, All written communications will be scanned into the resident's record.

Pre-exit was conducted 4/20/18 at 3:24pm with the administrator and DON to review above information. No further information was provided.

F 698

F 761 SS=E Label/Store Drugs and Biologicals
CFR(s): 483.45(g)(h)(1)(2)

§483.45(g) Labeling of Drugs and Biologicals
Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.

§483.45(h) Storage of Drugs and Biologicals

§483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.

F 761 **CFR (s): 483.45 (g)(h)(1)(2)**

1. For resident # 63, the Unit Manager removed both medications from the resident's room and placed on the medication cart on 4/17/18, and the resident and responsible party were educated on the facility policy for self-administration of medication.
2. All residents who have medications ordered have the potential to be affected. Rounds were performed by all Unit Managers on 4/17/18 to determine if any other residents had medications at bedside for self-administration. Assessments and education was provided as necessary.
3. The facility policy for "Self-Administration of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495186	A. BUILDING _____ B. WING _____	04/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETH SHOLOM HOME OF EASTERN VI	6401 AUBURN DR VIRGINIA BEACH, VA 23464

(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 761	Continued From page 23	F 761	**Continued from page 23**	

§483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.
This REQUIREMENT is not met as evidenced by:
Based on observation, record review, resident interview, and staff interviews, the facility staff failed to obtain a physician's order for self-administration of medications for 1 of 27 residents in the survey sample (Resident#63), and failed to ensure medications obtained from outside of the facility were properly labeled and stored.

1. The facility staff failed to obtain a physician's order for self-administration of Pepto-Bismol and Tylenol for Resident #63.

2. Facility staff failed to date multiple bottles of medication after opening on two of three medication carts inspected, and one medication room.

3. The facility staff failed to ensure 1 open multi-dose vial of Aplisol (tuberculin skin test serum) was dated correctly when opened.

A review of the facility policy for: "Bulk Medications, Dispensing of" dated February 2017 notes: 4. Date and time each container when opened.

Medication" will be reviewed and updated as necessary. All residents and families will be informed of the "Self-Administration of Medication" policy upon admission and as needed. All licensed nurses will be in-serviced on the process and their roles and responsibilities by the Staff Development Coordinator or designee by the compliance date.
4. Weekly rounds will be conducted by Unit Managers to determine if residents have medications at bedside for self-administration. For residents who wish to self-administer medication, an appropriate assessment will be conducted and medications will be kept on the medication cart. Audit results will be reviewed during weekly Standards of Care.
5. Our corrective action plan will be in compliance by May 31st, 2018.

CFR (s): 483.45 (g)(h)(1)(2)
1. No residents were cited as a result of failure of staff to date medication bottles after opening. The noted opened and undated medication bottles were discarded and reordered from the pharmacy.
2. All residents who use bottled medications have the potential to be affected. An audit was conducted on 4/19/18 by all Unit Managers and all opened and undated medication bottles were discarded and reordered.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495186	A. BUILDING _____ B. WING _____	04/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETH SHOLOM HOME OF EASTERN VI	6401 AUBURN DR VIRGINIA BEACH, VA 23464

(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 761	Continued From page 24	F 761	**Continued from page 24**	

The findings included:

1. Resident #63 was admitted to the facility on 12/6/2017 with diagnoses that included but not limited to, Respiratory failure, COPD (Chronic Obstructive Pulmonary Disease), Hypertension, Retention of urine, Polyneuropathy, Protein-calorie malnutrition, GERD (gastroesophageal reflux disease), and Anxiety.

Resident #63 had a Quarterly Minimum Data Set (MDS) assessment completed on 4/5/18. The assessment indicated resident #63 had a BIMS (Brief Interview for Mental Status) assessment score of 15, indicating no cognitive impairment. Resident #63's functional status was coded as limited assistance needed for self-performance and staff assistance of one staff member for bed mobility, transfers, locomotion on and off the unit, dressing, toilet use, and personal hygiene.

Resident #63's care plan initiated on 12/6/17 had been reviewed and updated periodically. There was no care plan for self-administration of medications.

On 04/17/18 at 11:20 AM, resident #63 was observed with unsecured medications on her over bed table. Open bottles of un-labeled Pepto-Bismol and Tylenol were on resident's over bed table.

On 04/17/18 at 1:30 PM Resident #63 was interviewed and she stated the "staff moved her meds to her bedside table" and she "takes them by herself." Observed in the drawer were the open bottles of Pepto-Bismol and Tylenol.

On 04/17/18 at 3:00 PM the Pepto-Bismol and

3. The facility policy "Dispensing of Bulk Medications" will be reviewed and updated as necessary. All licensed nurses will be required to date medication bottles when they are opened. All licensed nurses will be in-serviced on the process and their roles and responsibilities by the Staff Development Coordinator or designee by the compliance date.
4. The Staff Development Coordinator will conduct weekly checks on all medication carts and med rooms to ensure all opened medication bottles are properly dated. Results will be reported weekly during Standards of Care Meetings.
5. Our corrective action plan will be in compliance by May 31st, 2018.

CFR (s): 483.45 (g)(h)(1)(2)

1. No residents were cited as a result of staff failing to correctly date an open multi-use vial of Tuberculin skin test serum. The noted vial of Tuberculin was discarded and reordered from the pharmacy.
2. All residents who require administration of Tuberculin have the potential to be affected. An audit of all vials of Tuberculin was conducted on 4/19/18 and no further opened vials were dated incorrectly.
3. The facility policy "Medication Administration" will be reviewed and updated as necessary.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495186	A. BUILDING _____ B. WING _____	04/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETH SHOLOM HOME OF EASTERN VI	6401 AUBURN DR VIRGINIA BEACH, VA 23464

(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 761	Continued From page 25	F 761	**Continued from page 25**	

Tylenol were again observed at the bedside.

On 04/17/18 at 03:10 PM, a review of the medical record and physician's orders noted that there was no physician order for Pepto-Bismol, and no order for self-administration of medications.

On 04/18/18 at 1:15 PM during an interview with the unit manager LPN #18 she stated she had met with resident #63 and told her she cannot bring medications from home.

2. On 04/19/18 12:03 PM during observation of the medication cart (Low side cart) used by LPN #12 on Blue Unit, the following items open and undated:
10 Polyethylene glycol 255gr powder bottles,
2 Polyethylene glycol 527gr bottles,
1 Diphenhist liquid 473ml bottle,
1 Milk of Magnesia 473ml bottle,
1 Bismatrol 236ml bottle,
1 Mintox 355ml bottle.

On 04/19/18 at 12:11 PM, the medication cart (High side cart) used by LPN #13 on the Blue Unit was observed and noted the following items open and undated:
4 Polyethylene glycol 255gr powder bottles,
2 Polyethylene glycol 527gr powder bottles,
3 Milk of Magnesia 473ml bottle,
1 bottle Lactulose liquid,
1 bottle Potassium Chloride oral solution USP 10%,
3 bottles of Chlorhexidine Gluconate 0.12% oral rinse.

Staff interviews on 4/19/18 at 12:15 PM with LPN #12 and LPN #13 were conducted. When asked about open yet undated bottles of medication

All licensed nurses will be required to correctly date Tuberculin vials when they are opened. All licensed nurses will be in-serviced on the process and their roles and responsibilities by the Staff Development Coordinator or designee by the compliance date.
4. The Staff Development Coordinator will conduct weekly checks on all vials of Tuberculin to ensure all opened vials are properly dated. Results will be reported weekly during Standards of Care Meetings.
5. Our corrective action plan will be in compliance by May 31st, 2018.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495186	A. BUILDING _____ B. WING _____	04/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETH SHOLOM HOME OF EASTERN VI	6401 AUBURN DR VIRGINIA BEACH, VA 23464

(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 761	Continued From page 26	F 761		

found in the medication carts they responded that they should be dated when they are opened. When asked who's job it was to date the medications when opened they responded, "the nurse is to date the bottle when they open the bottle with the date it is opened." LPN #12 and LPN #13 were asked what they would do with these open/undated bottles of medication. They responded that they would notify the DON, destroy these medications, and re-order them for the residents.

Pre-exit conference was conducted 4/20/18 at 3:24pm with the administrator and DON to review above information.

A review of the facility policy for: "Bulk Medications, Dispensing of" dated February 2017 notes: 4. Date and time each container when opened.
3. On 04/19/18 at 12:27 P.M. the medication room on the blue unit was observed with LPN (Licensed Practical Nurse) #13 and Unit Manager LPN #15. One open multi-dose vial of tuberculin purified Protein Derivative, Diluted Aplisol LOT #307583 EXPIRATION DATE 08/19 was identified and open dated 4/28/18. Unit Manager LPN #15 was asked what was the written date on vial. LPN #15 stated, "It appears to say 4/28/18." LPN #15 asked if that would be correct open date and LPN #15 stated, "Obviously not because today is the only April 19th. LPN #15 was then asked what date should be on the vial, and when does the vial expire after it is opened. LPN #15 stated, "The date the vial is opened and 30 days after it is opened."

Aplisol: is a sterile aqueous solution of a purified protein fraction for intradermal administration as

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495186	A. BUILDING _____ B. WING _____	04/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETH SHOLOM HOME OF EASTERN VI	6401 AUBURN DR VIRGINIA BEACH, VA 23464

(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 761	Continued From page 27	F 761		

an aid in the diagnosis of tuberculosis. www.fda.gov/downloads, Food and Drug Administration

The facility Pharmacy medication insert for Aplisol was reviewed and documented in part, as follows:
Aplisol Injection (tuberculin test)
Storage Recommendations: Store in refrigerator at 36 to 46 degrees Fahrenheit. protect from light. Vials in use more than 30 days should be discarded.

On 04/19/18 at 2:24 P.M. and interview was conducted with the Director of Nursing (DON). The DON was made aware of open Aplisol vial and the date on the vial. The DON was asked what would she have expected the nurses to do when vials were opened. The DON stated, "If the date is incorrect they need to discard it and reorder from the pharmacy and when they open a new vial they should date the vial when opened."

The facility policy titled "Dispensing of Bulk Medications" last revised February 2017 was reviewed and is documented in part, as follows:

Policy Statement: To provide a means of dispensing bulk medications safely.
Policy Interpretation and Implementation:
4. Date and time each container opened.

On 4/20/18 at 4:23 P.M. a pre-exit interview was conducted with the Administrator and the Director of Nursing where the above information was shared. The Director of Nursing stated, "I educated the nurse that opened the vial it was the Staff Development Coordinator and she put the date on the vial it was going to expire to remind her. It should have been the date it was opened."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495186	A. BUILDING _____ B. WING _____	04/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETH SHOLOM HOME OF EASTERN VI	6401 AUBURN DR VIRGINIA BEACH, VA 23464

(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 761	Continued From page 28	F 761		

Prior to exit no further information was shared.

F 812 SS=F Food Procurement,Store/Prepare/Serve-Sanitary
CFR(s): 483.60(i)(1)(2)

§483.60(i) Food safety requirements.
The facility must -

§483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities.
(i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.
(ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices.
(iii) This provision does not preclude residents from consuming foods not procured by the facility.

§483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.
This REQUIREMENT is not met as evidenced by:
Based on observation, resident interview, staff interview, facility documentation review, the facility staff failed to store and prepare food in a sanitary manner.

The findings included:

On 4/17/18 at approximately 11:15 AM during the initial Kitchen tour, the Dietary Manager was asked the use by date on one 5 pound package of Mozzarella cheese in the walk-in refrigerator. The Dietary Manager looked for an expiration

F 812

CFR(s): 483.60(i)(1)(2)

1. No residents were cited as a result of the failure to have cheese labeled with a use by date. The Food Service Director immediately discarded the cheese on 4/17/18.
2. All residents have the potential to be affected by this finding. On 4/17/18, the Food Service Director checked all foods in the refrigerator and discarded any foods that were not labeled with a use by date.
3. All staff responsible for food procurement, store/prepare/serve food will be educated on the policy and procedure for dating foods by the dietary manager by the compliance date.
4. Weekly compliance audits will be conducted by the Food Service Director or designee and reported by the Food Service Director weekly during Standards of Care meetings.
5. Our corrective action plan will be in compliance by May 31, 2018.

CFR(s): 483.60(i)(1)(2)

1. No residents were cited as a result of dietary staff #24 and #25 not having their mustache and beard completely covered. Both staff members immediately corrected the placement of their beard nets on 4/18/18.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495186	A. BUILDING _____ B. WING _____	04/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETH SHOLOM HOME OF EASTERN VI	6401 AUBURN DR VIRGINIA BEACH, VA 23464

(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 812	Continued From page 29	F 812	**Continued from page 29**	

date on the cheese and she did not find one. The Dietary Manager stated she still had the box the cheese came in. The Dietary Manager was asked if all boxes that food product came in were saved and she stated, "No." The Dietary Manager was asked if it was her expectation for her staff to go in search of boxes to find out the use by date and she stated, "No." There was not posting observed in the walk in refrigerator of "Use by dates."

On 4/18/18 at approximately 10:50 AM, the Dietary Manager showed the box the cheese came in. The Dietary Manager again was asked if it was her expectation for dietary staff to go in hunt of boxes to determine a use by date. The Dietary Manager stated, "No." The Dietary Manager showed a sticker that included spaces for the dietary aide to document date and time food opened and a "use by date." The Dietary Manager was asked if the Kitchen is currently using these stickers or any specific way to determine "use by" dates. The Dietary Manager stated, "No."

On 4/18/18 at approximately 10:55 AM, the Dietary Cook #24 was observed preparing food with his mustache not covered with a hair net. On 4/18/18 at approximately 11:30 AM, Dietary employee #25 was observed preparing food with his mustache and partial beard not covered with a hairnet.

The Dietary Manager #26 was asked if she saw anything wrong after each occurrence of seeing a Dietary employee preparing food. Initially, the Dietary Manager said nothing. The Dietary Manager was asked to look at their face. At that time, the Dietary Manager directed both

2. All Residents have the potential to be affected by this finding. On 4/18/18, all dietary staff were observed to ensure proper placement of beard and hair nets.
3. All staff responsible for food procurement, store/prepare/serve food will be educated by the Food Service Director on the policy and procedure for proper wearing hair/beard nets by the compliance date.
4. Weekly compliance audits will be conducted by the Food Service Director or designee and reported weekly during Standards of Care meetings.

5. Our corrective action plan will be in compliance by May 31, 2018.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495186	A. BUILDING _____ B. WING _____	04/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETH SHOLOM HOME OF EASTERN VI	6401 AUBURN DR VIRGINIA BEACH, VA 23464

(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 812	Continued From page 30	F 812		

employees to cover their mustache hair with their net.

The Facility Policy and Procedure with a revision date of 1/2017, and tiled, "Preventing Foodborne Illness - Employee Hygiene and Sanitary Practices" documented the following:

"Hair nets are caps and/or beard restraints must be worn to keep hair from contacting exposed food, clean equipment, utensils and linens."

According to the Food and Drug Administration 2017 Food Code, section 3-501.17(A) Ready-to-Eat, Time/Temperature Control for Safety Food "...refrigerated, READY-TOEAT, TIME/TEMPERATURE CONTROL FOR SAFETY FOOD prepared and held in a FOOD ESTABLISHMENT for more than 24 hours shall be clearly marked to indicate the date or day by which the FOOD shall be consumed on the PREMISES, sold, or discarded when held at a temperature of 5°C (41°F) or less for a maximum of 7 days..." Mozzarella cheese is not a soft cheese listed as exempt from date marking (due to high moisture percentage).

The facility administration was informed of the findings during a pre-exit meeting on 4/20/18 at approximately 3:24 PM. The facility did not present any further information about the findings.

F 842 SS=D Resident Records - Identifiable Information
CFR(s): 483.20(f)(5), 483.70(i)(1)-(5)

§483.20(f)(5) Resident-identifiable information.
(i) A facility may not release information that is resident-identifiable to the public.
(ii) The facility may release information that is

F 842 **CFR (s): 483.20 (f)(5), 483.70 (i)(1)-(5)**

1. Resident #88's Lidoderm patch was removed by a licensed nurse on 4/18/18 and a correction was added to the MAR to reflect that the patch was not removed on 4/17/18.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495186	A. BUILDING _____ B. WING _____	04/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETH SHOLOM HOME OF EASTERN VI	6401 AUBURN DR VIRGINIA BEACH, VA 23464

(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 842	Continued From page 31	F 842	**Continued from page 31**	

resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so.

§483.70(i) Medical records.
§483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are-
(i) Complete;
(ii) Accurately documented;
(iii) Readily accessible; and
(iv) Systematically organized

§483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is-
(i) To the individual, or their resident representative where permitted by applicable law;
(ii) Required by Law;
(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;
(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.

§483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.

2. All residents with orders for medication patches have the potential to be affected. An audit on all residents with medication patches was conducted on 4/19/18 to ensure accuracy of Resident's MAR's.
3. Licensed nurses will be responsible for accurately documenting on MAR's and adding corrections as necessary and appropriate. All licensed nurses will be in-serviced on how to add corrections to electronic MAR documentation by the Staff Development Coordinator or designee by the compliance date.
4. Weekly spot checks of residents with medication patches and accurate MAR documentation will be conducted by Unit Managers to ensure accuracy. Audit results will be reviewed during weekly Standards of Care meetings.
5. Our corrective action plan will be in compliance by May 31st, 2018.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495186	A. BUILDING _____ B. WING _____	04/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETH SHOLOM HOME OF EASTERN VI	6401 AUBURN DR VIRGINIA BEACH, VA 23464

(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 842	Continued From page 32	F 842		

§483.70(i)(4) Medical records must be retained for-
(i) The period of time required by State law; or
(ii) Five years from the date of discharge when there is no requirement in State law; or
(iii) For a minor, 3 years after a resident reaches legal age under State law.

§483.70(i)(5) The medical record must contain-
(i) Sufficient information to identify the resident;
(ii) A record of the resident's assessments;
(iii) The comprehensive plan of care and services provided;
(iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;
(v) Physician's, nurse's, and other licensed professional's progress notes; and
(vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.
This REQUIREMENT is not met as evidenced by:
Based on staff interviews, resident observation, clinical record review, and facility documentation review, the facility staff failed ensure the clinical record was accurate for one (1) of 27 residents (Resident #88) in the survey sample.

The facility staff failed to ensure the Resident's Medication Administration Record (MAR) for April 2018 was accurate for the removal of Resident #88's Lidocaine Patch.

The findings included:

Resident #88 was admitted to the facility on 03/30/18. Diagnosis for Resident #88 included but not limited to *Pain (unspecified).

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495186	A. BUILDING _____ B. WING _____	04/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETH SHOLOM HOME OF EASTERN VI	6401 AUBURN DR VIRGINIA BEACH, VA 23464

(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 842	Continued From page 33	F 842		

*Pain is an unpleasant sensation that can range from mild, localized discomfort to agony (https://www.medicinenet.com).

The current Minimum Data Set (MDS), a comprehensive assessment with an Assessment Reference Date (ARD) of 4/06/18 coded the resident with a 15 out of a possible score of 15 on the Brief Interview for Mental Status (BIMS) indicating no cognitive impairment. The resident required extensive assistance of one with toilet use, personal hygiene and bathing, limited assistance of one with bed mobility and transfers. In addition, the MDS under section J (Health Conditions) was coded for pain management.

During the medication pass and tour on 4/18/17 with License Practical Nurse (LPN) #17 on the skilled unit, the LPN removed two Lidocaine 5% topical patches from the medication cart. Resident #88 positioned himself to his right side; the LPN removed a Lidocaine 5 % topical patch from his left hip dated 4/17/18. The resident then positioned himself on his left side; the LPN removed a Lidocaine 5% topical patch from his right hip dated 4/17/18.

The review of Resident #88's physician orders for April 2018 revealed the following order: Lidocaine 5% topical patch - apply two patches by topical route daily to bilateral hips. Protocol: on in the AM (9:00 a. m.) and OFF in the PM (9:00 p.m.).

Review of clinical record revealed: nurse signed off on 4/17/18 at 9:45 p.m., that she had removed Lidocaine patches from left and right hip.

The review of Resident's #88's Medication

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495186	A. BUILDING _____ B. WING _____	04/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETH SHOLOM HOME OF EASTERN VI	6401 AUBURN DR VIRGINIA BEACH, VA 23464

(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 842	Continued From page 34	F 842		

Administration Audit Report for April 17, 2018 revealed the following: License Practical Nurse (LPN) #11 had signed off at approximately 9:45 p.m., that she had removed the Lidocaine patch from Resident #88's left and right hip.

An interview was conducted with the Director of Nursing (DON) on 4/19/18 at approximately 1:20 p.m., who stated, "I expect for the nurses to sign off on the Medication Record after their treatments are done."

On 4/21/18 at approximately 8:50 a.m., an interview was conducted with LPN #11 who stated, "Well, when I took him to the bathroom, I didn't see a patch so I thought they had rolled up and fell off; I forgot to go back and sign off that I did not remove his Lidocaine patches, that is my fault."

The above information was shared with Administration staff during a pre-exit meeting on 4/20/18. No additional information was provided.

The facility's policy titled Charting and Documentation (Revision Date: 5/17).
-Policy statement: All services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional or psychosocial condition, shall be documented in the resident's medical record. The medical record should facilitate communication between the interdisciplinary tem regarding he resident is condition and response to care.

Policy Interpretation and Implementation include but not limited to,
-Documentation in the medical record will be

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495186	A. BUILDING _____ B. WING _____	04/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETH SHOLOM HOME OF EASTERN VI	6401 AUBURN DR VIRGINIA BEACH, VA 23464

(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 842	Continued From page 35 objective (on opinionated or speculative), complete, and accurate.	F 842		
F 921 SS=E	Safe/Functional/Sanitary/Comfortable Environ CFR(s): 483.90(i) §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observations, clinical record review, staff interviews, and facility documentation review, the facility staff failed to maintain a sanitary environment for four residents in a survey sample of 27 Residents (#37, #11, #68, #67). 1. The facility staff failed to clean Oxygen concentrator filters for resident #37. 2. The facility staff failed to clean Oxygen concentrator filters for resident #11. 3. The facility staff failed to clean Oxygen concentrator filters for resident #68. 4. The facility staff failed to maintain Resident #67's wheelchair in a sanitary condition. The findings include: 1. Resident # 37 was originally admitted on 10/24/2014 with a diagnosis of *Chronic Obstructive Pulmonary Disease. *Chronic obstructive pulmonary disease makes it hard for a resident to breath. Source:	F 921	**CFR (s): 483.90 (i)** 1. Residents #11, #37 and #68's oxygen concentrator filters were thoroughly cleaned and replaced. 2. All residents who utilize oxygen via concentrators have the potential to be affected. The Unit Managers conducted an audit on 4/19/18 on all oxygen concentrator filters for cleanliness and cleaned or replaced the filters as necessary. 3. The facility policy for the maintenance of oxygen equipment will be updated to include regular cleaning and/or replacing of oxygen concentrator filters. Unit secretaries will be responsible for cleaning the oxygen concentrator filters weekly during replacement of oxygen supplies. All responsible staff will be in-serviced on the process and their roles and responsibilities by the Staff Development Coordinator or designee by the compliance date. 4. Audits will be conducted by the Staff Development Coordinator and/or Central Supply Clerk and results will be reported during weekly Standards of Care meetings. 5. Our corrective action plan will be in compliance by May 31st, 2018. **CFR (s): 483.90 (i)** 1. Resident #67's wheelchair was thoroughly	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495186	A. BUILDING _____ B. WING _____	04/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETH SHOLOM HOME OF EASTERN VI	6401 AUBURN DR VIRGINIA BEACH, VA 23464

(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 921	Continued From page 36 (https://medlineplus.gov/copd.html).	F 921	**Continued from page 36**	

The most recent Minimum Data Set (MDS) was a quarterly assessment with an Assessment Reference Date (ARD) date of 1/3/2018. The Brief Interview for Mental Status (BIMS) was a 5 out of a possible 15 which indicated that Resident #37 had severe cognitive impairment.

The Person-Centered Comprehensive Care Plan initiated on 10/23/2014 identified that Resident #37 had chronic obstructive pulmonary disease. Impaired gas exchange. Interventions: Oxygen per as ordered. Change tubing and mask/nasal cannula weekly per facility protocol.

On 4/17/2018 at approximately 11:45 a.m. an observation was made of resident #37's Oxygen concentrator filter. The filter was covered with dust particles.

On 4/17/2018 at 4:15 p.m. an observation was made of resident #37's Oxygen concentrator filter. The filter was covered with dust particles.

On 4/18/2018 at 9:15 a.m. an observation was made of resident #37's Oxygen concentrator filter. The filter was covered with dust particles.

Resident #37's Treatment Administration Record (TAR) was reviewed on 4/18/18. The order was renewed on 3/20/2018 to increase Oxygen to 3 Liter via nasal cannula to maintain O2 saturation > 95% for disease of chronic obstructive pulmonary disease.

On 4/19/2018 at 11:42 a.m. an interview was conducted with Licensed Practical Nurse (LPN) #14. LPN #14 was asked, "What is your process

cleaned by the Unit Manager on 4/23/18.
2. All residents who require the use of mobility devices have the potential to be affected. Nursing Administration conducted an audit on 4/23/18 of all wheelchairs and Geri chairs for cleanliness.
3. The facility policy "Cleaning and Disinfection of Resident Wheelchairs and Geri chairs" will be reviewed and updated to include regularly scheduled power washing of wheelchairs and Geri chairs. All nursing, environmental services and maintenance staff will be in-serviced on the process and their roles and responsibilities by the Staff Development Coordinator or designee by the compliance date.
4. All licensed nursing staff will be responsible for monitoring the cleanliness of mobility devices daily. Weekly spot checks will be conducted by Nursing Administration and results will be reviewed by the Staff Development Coordinator during weekly Standard of Care meetings.
5. Our corrective action plan will be in compliance by May 31st, 2018.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495186	A. BUILDING _____ B. WING _____	04/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETH SHOLOM HOME OF EASTERN VI	6401 AUBURN DR VIRGINIA BEACH, VA 23464

(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 921	Continued From page 37	F 921		

for cleaning the oxygen concentrator's filter?" LPN #14 stated, "We clean the filters." When asked if the concentrator filter for Resident #37 been cleaned, LPN # 14, stated, "No, it has not been cleaned. I will get on it today."

On 4/19/2018 at approximately 1:15 p.m. an interviewed was conducted with Unit Manager (LPN) #15 concerning cleaning of the oxygen concentrator's filters. LPN #15 stated, "The unit secretary changes them on Fridays with the tubing."

On 4/20/2018 at 3:30 p.m. a pre-exit was conducted with the Administrator, the Director of Nursing (DON). The above findings were with Administrator and DON. At 3:36 p.m. the Administrator stated, "And, I would agree regarding the dirty Oxygen filters." The facility did not present any further information about the findings.

2. Resident # 11 was readmitted on 1/11/2018 with a diagnoses of *Pulmonary fibrosis, Shortness of breath and Chronic Obstructive Pulmonary disease.

*Pulmonary fibrosis is a condition were the lungs becomes scarred over time. This tissue gets thick and stiff. That makes it hard for someone with this diagnosis to catch their breath. Source: (https://medlineplus.gov/pulmonaryfibrosis.html)

The most recent Minimum Data Set (MDS) was a significant change assessment with an Assessment Reference Date (ARD) date of 3/7/2018. The Brief Interview for Mental Status (BIMS) was a 10 out of a possible 15 which indicated that Resident #11 had moderate

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495186	A. BUILDING _____ B. WING _____	04/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETH SHOLOM HOME OF EASTERN VI	6401 AUBURN DR VIRGINIA BEACH, VA 23464

(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 921	Continued From page 38	F 921		

cognitive impairment.

The Person-Centered Comprehensive Care Plan initiated on 10/23/2014 identified that Resident #11 had COPD: Impaired gas exchange. Pulmonary fibrosis since 2012, on 6 Liter per minute home oxygen. Interventions: Oxygen per as ordered. Change tubing and mask/nasal cannula weekly per facility protocol. My utilize oxygen concentrator when in plaza and in room.

Resident #11's Treatment Administration Record (TAR) was reviewed. The order for 6L/min was initiated on 4/3/2018, Oxygen to 6 Liter per minute via nasal cannula.

On 4/17/2018 at approximately 11:45 a.m. an observation was made of resident #11's oxygen concentrator filter. The filter was covered with dust particles.

On 4/17/2018 at 4:15 p.m. an observation was made of resident #11's oxygen concentrator filter. The filter was covered with dust particles.

On 4/18/2018 at 9:15 a.m. an observation was made of resident #11's oxygen concentrator filter. The filter was covered with dust particles.

On 4/19/2018 at 11:42 a.m. an interview was conducted with Licensed Practical Nurse (LPN) #14. LPN #14 was asked, "What is your process for cleaning the oxygen concentrator's filter?" LPN #14 stated, "We clean the filters." When asked if the concentrator filter for Resident #37 been cleaned, LPN # 14, stated, "No, it has not been cleaned. I will get on it today."

On 4/19/2018 at approximately 1:15 p.m. an

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495186	A. BUILDING _____ B. WING _____	04/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETH SHOLOM HOME OF EASTERN VI	6401 AUBURN DR VIRGINIA BEACH, VA 23464

(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 921	Continued From page 39	F 921		

interviewed was conducted with Unit Manager (LPN) #15 concerning cleaning of the oxygen concentrator's filers. She stated, "The unit secretary changes them on Fridays with the tubing."

On 4/20/2018 at 3:30 p.m. a pre-exit was conducted with the Administrator, and the DON. The above findings were shared. At 3:36 p.m. the Administrator stated, "And I would agree regarding the dirty Oxygen filters." The facility did not present any further information about the findings.

3. Resident #68 was admitted on 11/20/2017 with a diagnosis of *Cardiomyopathy.

*Cardiomyopathy, the heart muscle becomes enlarged, thick, or rigid. In rare cases, the muscle tissue in the heart is replaced with scar tissue. Source: (https://www.nhlbi.nih.gov/health-topics/cardiomyopathy).

The most recent Minimum Data Set (MDS) was a quarterly assessment with an Assessment Reference Date (ARD) date of 2/4/2018. The Brief Interview for Mental Status (BIMS) was a 5 out of a possible 15 which indicated that Resident #68 had severe cognitive impairment.

The Person-Centered Comprehensive Care Plan initiated on 11/21/2017 identified a focus area as chronic obstructive pulmonary disease: Impaired gas exchange. Interventions: oxygen as ordered (continuous O2). Change tubing and mask/nasal cannula weekly per facility protocol.

Resident #68's Treatment Administration Record

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495186	A. BUILDING _____ B. WING _____	04/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETH SHOLOM HOME OF EASTERN VI	6401 AUBURN DR VIRGINIA BEACH, VA 23464

(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 921	Continued From page 40	F 921		

(TAR) was reviewed. The order for 2 Liter per minute via nasal cannula was renewed on 3/12/2018.

On 4/17/2018 at approximately 11:45 a.m. an observation was made of resident #68's oxygen concentrator filter. The filter was covered with dust particles.

On 4/17/2018 at 4:15 p.m. an observation was made of resident #68 Oxygen concentrator filter. The filter was covered with dust particles.

On 4/18/2018 at 9:15 a.m. an observation was made of resident #68's oxygen concentrator filter. The filter was covered with dust particles.

On 4/19/2018 at 11:42 a.m. an interview was conducted with Licensed Practical Nurse (LPN) #14. LPN #14 was asked, "What is your process for cleaning the oxygen concentrator's filter?" LPN #14 stated, "We clean the filters." When asked if the concentrator filter for Resident #37 been cleaned, LPN # 14, stated, "No, it has not been cleaned. I will get on it today."

On 4/19/2018 at approximately 1:15 p.m. an interviewed was conducted with Unit Manager (LPN) #15 concerning cleaning of the oxygen concentrator's filers. She stated, "The unit secretary changes them on Fridays with the tubing."

The Facilities policy and Procedures titled "Oxygen Concentrators, Care/Maintenance of" with a revision date of May 2017, documented the following:

While a concentrator is being used by a resident,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495186	A. BUILDING _____ B. WING _____	04/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETH SHOLOM HOME OF EASTERN VI	6401 AUBURN DR VIRGINIA BEACH, VA 23464

(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 921	Continued From page 41	F 921		

the unit secretary will be responsible for washing the filter with hot water on both sides weekly while changing tubing on Fridays. Filters will be dry before replacing.
Filters may be washed more frequently as needed.
Replace filter if unable to clean.

On 4/20/2018 at 3:30 p.m. a pre-exit was conducted with the Administrator, and the DON. The above findings were shared. At 3:36 p.m. the Administrator stated, "And I would agree regarding the dirty Oxygen filters." The facility did not present any further information about the findings.

4. Resident # 67 was a 90 year old admitted to the facility on 1/14/14 with diagnoses to include Alzheimer's Disease and Osteoporosis.

The most recent comprehensive Minimum Data Set (MDS) assessment was an Annual assessment with an Assessment Reference Date (ARD) of 12/27/17. The Brief Interview for Mental Status (BIMS) indicated that Resident #67 was moderately cognitively impaired in daily decision making and had long and short memory issues. Under Section G0600 Mobility Devices Resident #67 was coded as normally uses a wheelchair.

On Tuesday 04/17/18 at 12:15 PM, Resident #67 was observed up in her wheelchair eating in the main dining room with daughter and spouse present. The wheelchair was observed with large amounts of dust and heavy debris on the wheels and on the metal bars under the wheelchair.

On Tuesday 04/17/18 at 12:45 PM an interview was conducted with Resident #67's Daughter/Power of Attorney in the resident's

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495186	A. BUILDING _____ B. WING _____	04/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETH SHOLOM HOME OF EASTERN VI	6401 AUBURN DR VIRGINIA BEACH, VA 23464

(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 921	Continued From page 42	F 921		

room. Resident #67's daughter was asked if she had any concerns about her mother's wheelchair. Resident #67's daughter stated, "It's filthy they never clean it."

On Wednesday 04/18/18 at 09:15 AM, Resident #67 was observed up in her wheelchair with spouse at her side. The resident's wheelchair remained dirty.

On Thursday 04/19/18 at 10:30 AM, Resident#67 was observed in her room up in her wheelchair. The wheelchair was observed still dirty.

On Friday 04/20/18 at 9:12 AM, Resident #67's wheelchair was observed in her bathroom and was still dirty. Her spouse stated, "Oh they haven't cleaned it, it's still dirty."

On Friday 04/20/18 at 9:20 AM, the Sholom Unit Manager LPN (Licensed Practical Nurse) #16 was asked to walk to Resident #67's room. While in room LPN #16 was asked to look at Resident #67's wheelchair and see if she saw anything wrong with it. LPN #16 stated, "It's dirty and needs to be cleaned, we have a wheelchair cleaning schedule." LPN #16 copied the unit wheelchair cleaning schedule which was observed taped at the nurse's station in view.

The 11-7 Wheelchair Cleaning Schedule for the Sholom Unit was reviewed and is documented that Resident #67's room was scheduled to be cleaned on Thursday night.

The facility's policy titled "Cleaning and Disinfection of Resident Wheelchairs and Gerichairs" was reviewed and is documented in part, as follows:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495186	A. BUILDING _____ B. WING _____	04/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETH SHOLOM HOME OF EASTERN VI	6401 AUBURN DR VIRGINIA BEACH, VA 23464

(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 921	Continued From page 43	F 921		

Policy Statement: Resident-care equipment , including durable medical equipment will be cleaned and disinfected according to current CDC (Center for Disease Control) and the OSHA (Occupational Safety and Health Administration) Bloodborne Pathogens Standard.

Policy Interpretation and Implementation:
4. Wheelchairs and gerichairs will be cleaned in the shower room on resident's days. Disinfectants will be used for cleaning wheelchairs and gerichairs. If chairs are extremely soiled, environmental services will pressure wash.

On 4/20/18 at 4:23 P.M. a pre-exit interview was conducted with the Administrator and the Director of Nursing where the above information was shared.

Prior to exit no further information was shared.