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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIE IDENTIFICATION NUI		1	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
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F 000	conducted 08/2/16 was not in complian Regulations for the	nced State Licensure Inspection was 8/2/16 through 08/04/16. The facility ompliance with the Virginia Rules and for the Licensure of Nursing Facilities. ints were investigated during the			Preparation and/or execution of the of Correction does not constitute admission or agreement of the profithe truth of the facts alleged or conclusions set forth in the stater deficiencies. The Plan of Correcti prepared and/or executed solely it is required by the provision of Fand State law.	ovider nent of on is because			
	time of the survey. of 20 current Resid	120 bed facility was a The survey sample of the survey sample of the surveys (Resider closed record reviews bugh 23).	consisted nts #1		This plan of correction is the facil credible allegation of compliance  12VAC 5-371-250 Resident Ass and care planning. Cross Refere F278.  12VAC 5-371-370A/B Maintenant	essment			
F 001	Non Compliance	on Compliance ne facility was out of compliance with the llowing state licensure requirements:			Housakeeping, Cross Reference 12VAC 5-371-370 A Maintenance	to F323.			
					Housekeeping. Cross Reference F465.				
	This RULE: is not met as evidenced by: 12VAC 5-371-250 Resident assessment and care				12VAC 5-371-340 Dietary and F Service Program. J Therapeutic Cross Reference to F367.				
	planning. Cross Re	eferenced to F278			12VAC 5-371-271(A) Social Ser Cross Reference to F250	vices.			
	12 VAC 5-371-370A/B Maintenence and Housekeeping. Cross-reference to F-323 12VAC 5-371-370 A Maintenence and Housekeeping. Cross reference to F465 12 VAC 5 371340 DIETARY AND FOOD SERVICE PROGRAM				12VAC 5-371-250 (A.D.) Reside Assessment. Cross Reference F	nt 278.			
	J Therapeutic diets	cross reference to F	tag 367						
	12 VAC 5-371-271( Please Cross Refer								

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

TITLE

(X6) DATE

FURTHER SECTION STATE FORM

DPGH11 If continuation sheet 1 of 5

PRINTED: 08/18/2016

FORM APPROVED State of Virginia STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER: AND PLAN OF CORRECTION COMPLETED A. BUILDING 495149 B. WING 08/04/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 900 LONDON BOULEVARD **GOLDEN LIVINGCENTER- PORTSMOUTH** PORTSMOUTH, VA 23704 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE SUMMARY STATEMENT OF DEFICIENCIES (X4) ID ID (X5)(EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX PREFIX COMPLETE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) F 001 Continued From Page 1 F 001 12VAC 5-371-220(D) 1.) How the Corrective Action was 12 VAC 5-371-250 (A.D.) Resident Assessment accomplished for those residents Please Cross Reference F 271 found to have been affected. Resident #2 and #18 showers were 12 VAC 5-371-220 (D) Nursing Services: completed. Based on family interview, staff interview, clinical The Director of Clinical Education record review and facility document review the educated the nursing staff immediately facility staff failed to ensure 2 residents in the on the shower/bathing process/schedule. survey sample of 23 received twice weekly showers, Resident #2 and Resident #18. 2.) How the facility will identify other residents having the potential to be affected by the deficient practice. 1. Resident #2 was provided one shower from 7/1/16 through 8/4/16. All residents have the potential to be affected. 2. Resident #18 was provided three showers from The Nurse Unit Managers or Nurse 7/1/16 through 8/4/16. Manager will review the assignment sheet and Care Tracker record of The findings included: residents to validate documentation of shower as rendered. 1. Resident #2 was admitted to the facility on 3.) The Following Measures will be put 11/7/12 with a diagnosis of unspecified dementia into place or systematic changes without behavioral disturbance. made to ensure that the deficient practice will not recur. The current MDS (Minimum Data Set) a guarterly with an assessment reference date of 5/24/16 The Director of Clinical Education, Director of Clinical Education Assistant or coded the resident as having long and short-term Nurse Manager will provide education to memory deficits with severely impaired daily the nursing staff regarding the shower decision making skills. The resident was totally process. dependent on staff for full-body baths/ showers. The resident Shower preference is Review of the certified nurse aides (CNAs) placed on the assignment sheet. documentation on the ADL (activities of daily The C.N.A will initial on the assignment living) electronic tracker was reviewed for the sheet for completion of shower or month of July 2016. The ADL tracker evidenced document refusal of shower. the resident received one shower for the month of July, on Friday 7/1/16. Charge nurses will initial on assignment sheet after verification that shower was Review of the shower schedule evidenced the completed. resident was scheduled to receive twice weekly The Nurse Unit Managers or Nurse showers on Tuesdays and Fridays during the 3-11 Manager will verify in Care Tracker that shift. showers are documented and report non

compliance in the daily nursing

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PRINTED: 08/18/2016 **FORM APPROVED** State of Virginia STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER-COMPLETED A. BUILDING 495149 B. WING 08/04/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE GOLDEN LIVINGCENTER- PORTSMOUTH 900 LONDON BOULEVARD PORTSMOUTH, VA 23704 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5)PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) F 001 Continued From Page 2 F 001 4.) The Facility will monitor its performance to make sure solutions The certified nurse aide (CNA #2) assigned to are sustained. care for Resident #2 was interviewed on 8/4/16 at The Director of Nursing, Assistant 2:30 p.m. She stated the resident was scheduled Director of Nursing or Nurse Manager will for showers on the 3-11 shift. The CNA stated the audit a minimum of 10% of the Care resident is not resistant to care. The CNA stated Tracker documentation weekly for four resident showers are documented into the kiosk weeks, then monthly for three months, to (ADL tracker) once they are given. CNA #2 also validate completion and documentation stated when a resident is given a shower or of resident showers. refuses a shower it is documented on the assignment sheet. Findings will be reported to the QAPI committee monthly for three months or A request for review of the assignment sheets for until compliance is achieved and maintained. the month of July 2016 was requested. A folder was provided with the assignments. The folder was incomplete and only had assignment sheets 5.) Date Corrective Action will be from 7/1/16 through 7/18/16. A review of these completed, 09/08/16 assignments evidenced there was no documentation of showers provided or refused for Resident #2. The above findings was shared with the

Administrator and the Director of Nursing on 8/4/16 at 2:55 p.m.

2. Resident #18 was admitted to the facility on 9/4/15 with Hospice services and a diagnosis of dementia with behavioral disturbances.

The current MDS (Minimum Data Set) a quarterly with an assessment reference date of 6/9/16 coded the resident as having long and short-term memory deficits with moderately impaired daily decision making skills. The resident was totally dependent on staff for full-body baths/showers.

On 8/3/16 at 5:00 p.m., an interview was conducted with the daughter/responsible party (RP) of Resident #18. She stated the resident is only receiving showers on Fridays.

Review of the certified nurse aides (CNAs)

PRINTED: 08/18/2016

FORM APPROVED State of Virginia STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING \_ 495149 B. WING 08/04/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **GOLDEN LIVINGCENTER- PORTSMOUTH** 900 LONDON BOULEVARD PORTSMOUTH, VA 23704 SUMMARY STATEMENT OF DEFICIENCIES (X4) (D PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) F 001 Continued From Page 3 F 001 documentation on the ADL (activities of daily living) electronic tracker was reviewed for the month of July 2016. The ADL tracker evidenced the resident received three showers for the month of July, on Wednesday 7/13/16. Wednesday 7/20/16 at 2:06 pm., and at 10:34 p.m. Review of the shower schedule evidenced the resident was scheduled to receive twice weekly showers on Tuesdays and Fridays during the 7-3 The certified nurse aide (CNA #3) assigned to care for Resident #18 was interviewed on 8/4/16 at 1:20 p.m. She stated she was not sure when the resident was scheduled for showers stating, "I think on Tuesdays and maybe Fridays on the day-shift (7-3). CNA #3 stated the nurses are responsible for placing on the assignment sheet who is scheduled for a shower. If a shower is refused it is documented in the comment section on the assignment sheet. A request for review of the assignment sheets for the month of July 2016 was requested. A folder was provided with the assignments. The folder was incomplete and only had assignment sheets from 7/1/16 through 7/18/16. A review of these assignments sheets evidenced there was no documentation of showers provided or refused for Resident #18. The above findings was shared with the Administrator and the Director of Nursing on 8/4/16 at 2:55 p.m. The DON stated the resident is receiving Hospice services. She stated she would check the Hospice CNA documentation to determine if they had provided showers to the resident.

No additional information was provided prior to

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STATEMENT AND PLAN O	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NUI	RVCLIA MBER:	a de la companya de l	CONSTRUCTION	(X3) DATE : COMPI	SURVEY LETED		
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FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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An unannounced Medicare/Medicaid standard survey was conducted 08/02/16 through 08/04/16. The facility was not in substantial compliance with the following 42 CFR Part 483 Federal Long Term Care requirement(s). Two			F	000	Preparation and/or execution of the F of Correction does not constitute admission or agreement of the provide of the truth of the facts alleged or conclusions set forth in the statement deficiencies. The Plan of Correction is prepared and/or executed solely becit is required by the provision of Federand State law.	der t of s ause	
	complaints were inv	estigated during the survey.			This plan of correction is the facility's credible allegation of compliance.		
	The census in this	120 bed facility was 115 at the			F 250		
	time of the survey. The survey sample consisted of 20 current Resident reviews (Residents #1 through 20) and 3 closed record reviews				How the Corrective Action was accomplished for those residents found to have been affected.		
		(Residents #21 through 23).			Resident #2 has received their glass	BS	
	RELATED SOCIAL		F	250	For Resident #2 staff was educated of the process for management of ophthalmology services.	on	
	services to attain or practicable physical	ovide medically-related social maintain the highest , mental, and psychosocial			2.) How the facility will identify oth residents having the potential to b affected by the deficient practice.		
	wen-being or each i	each resident.			Residents with order for ophthalmolo services have the potential to be affected.	gy	
	by: Based on staff inter review the facility st medically-related so	cial services for 1 of 23			The Social Services Director, Social Services Assistant or Nursing Managwill audit the medical record of reside with orders for ophthalmology service validate receipt of glasses for applicates residents.	ents es to	
	residents in the survey sample to meet the residents needs, Resident #2.  Resident #2 was assessed for glasses and a prescription was obtained on 4/4/16. The resident had not received the ordered glasses as of the survey end date of 8/4/16. The facility staff failed to pursue a physician order for the eye service provided on 4/4/16, until 14 weeks later				3.) The Following Measures will be into place or systematic changes made to ensure that the deficient practice will not recur.	put	

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

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.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: SL6P11

Facility ID: VA0035

INDUM END.

(X6) DATE

CENTE	RS FOR MEDICARE	& MEDICAID SERVICES				FOR	M APPROVED 0. 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	3		LE CONSTRUCTION	(X3) D	O. 0936-039 I ATE SURVEY OMPLETED
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NAME OF	PROVIDER OR SUPPLIER			1	STREET ADDRESS, CITY, STATE, ZIP CODE		
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F 250	the process by not set the pepartment of M (DMAS) until 7/27/1	siness office further delayed submitting an adjustment to Aedical Assistance Services 6.	gon d	250	The Director of Clinical Education, Director of Clinical Education Assist will educate Social Services, Busine Office Manager, Interdisciplinary Caplan Team and Nursing Staff on the process for management of ophthalmology services.	ISS Ire	
The findings included:  Resident #2 was admitted to the facil  11/7/12 with a diagnosis of unspecific  without behavioral disturbance.		mitted to the facility on osis of unspecified dementia			The Social Services Director, Social Worker Assistant or Nursing Managarrange ophthalmology services for residents with applicable orders.	er will	
•	The current MDS (M	finimum Data Set) a quarterly reference date of 5/24/16 is having long and short-term			The Nurse Unit Managers will upda C.N.A Care Cards to indicate the us prescription eye glasses.		
	memory deficits with decision making skil Speech, and Vision	severely impaired daily ls. Under Section B. Hearing, the resident was coded as			<ol> <li>The Facility will monitor its performance to make sure soluti are sustained.</li> </ol>	ons	
	having impaired visit able to see newspap	on-sees large print, but not pers/books.			The Social Services Director, Soci Worker Assistant or Nursing Manaç audit 100% of the in house residen	jer will	A CONTRACTOR OF THE CONTRACTOR
	aide) assigned to Re She was asked abouglasses and stated, been waiting a long to	8/3/16 at 1:50 p.m., CNA #2 (certified nurse le) assigned to Resident #2 was interviewed. e was asked about the resident's use of sses and stated, "She really needs themI've en waiting a long time for those glassesShe			medical records of those with orders for ophthalmology services weekly for four weeks, then monthly for three months, to validate receipt of ordered prescription eye glasses.		
	(the resident) can see better with themI told the unit manager and the unit secretary that they were missing" When asked how long the glasses had been missing she stated, "Since at least April or May."				Findings will be reported to the QA committee monthly for three month until compliance achieved and maintained.		OUTERONAL TRANSPORTED TO THE PARTY OF THE PA
		On 8/3/16 at 6:25 p.m., the unit two nurse nanager was interviewed. She was asked how			<ol><li>5.) Date Corrective Action will be completed.</li></ol>		A CONTRACTOR OF THE CONTRACTOR
•	long had Resident #2 what was the status o stated, "Since April o	L's glasses been missing and on obtaining new ones. She			Compliance Date is 09/08/16		The second secon

know we are waiting for a prescription." The unit manager stated a physician order could be

PRINTED: 08/18/2016 FORM APPROVED OMB NO. 0938-0301

CENTER	RS FOR MEDICARE	E & MEDICAID SERVICES			OMB NO. 0938-0391
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E 250	A - aliminal Planes on	•	****		
r 200	Continued From pa		F 2	50	
	obtained within an h through fax or telep	hour, and could be pursued phone.			
	resident was evaluated care services physical January 2016:  1. The resident was chief complaint of ir mattering. The resident (Lotemax) and on syndrome of both expending the properties of the	esident was re-evaluated for a follow-up was scheduled for			
	the Business Office 8/3/16 at 6:25 p.m. the remission of pay vision services in he amount of \$159.98 f Resident #2. The pay 4/4/16. She stated socument until 5/24/ the right corner of the unit secretary is provided to the appropriate staff could not state why leading the state of the state of the services of the serv	n included an interview with Administrator (BOA) on The BOA stated she received yment request from the eye er office on 5/24/16 in the for a pair of eyeglasses for payment request was dated she did not receive this 1/16 (per the time stamp on the document). She stated the evided with the all follow up reach eye appointment perses the documentation to for further action. The BOA the office received the			
	payment request / v The BOA continued	weeks after it was requested. to state that an adjustment			

for liability would need to be requested to DMAS (Department of Medical Assistance Services), the agency that administers Medicaid. This part of

### DEFAR I WENT OF HEALTH AND HUMAN SERVICES

PRINTED: 08/18/2016 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY IDENTIFICATION NUMBER: A. BUILDING COMPLETED C 495149 B. WING 08/04/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE

### GOLDEN LIVINGCENTER- PORTSMOUTH

900 LONDON BOULEVARD PORTSMOUTH, VA 23704

PRÉFIX TAG

SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

m PREFIX TAG

PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)

(X5) COMPLETION DATE

### F 250 Continued From page 3

the process could not be continued until a physician order was received for the eye vision services conducted on 4/4/16. The physician order was not obtained until 7/12/16, 14 weeks later. The BOA completed the Medicaid LTC (long term care) Communication Form DMAS-225 dated 7/26/16 and forwarded it. The BOA stated she is now waiting for an approval from DMAS. She further stated an approval or denial from DMAS generally takes 30 to 60 days. Once the approval is received, she then needs to make contact with the responsible party and request the payment of \$159.98.

The above findings was shared with the Administrator and the Director of Nursing during a meeting conducted on 8/4/16 at 2:55 p.m. The Administrator stated, "There is definitely a delay there...we need to look into this." At approximately 4:30 p.m., the Administrator requested to speak to this inspector and stated, "I spoke to the Social Worker and had her pay for the glasses to get them here quicker."

F 278 483.20(g) - (j) ASSESSMENT SS=D ACCURACY/COORDINATION/CERTIFIED

The assessment must accurately reflect the resident's status.

A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.

A registered nurse must sign and certify that the assessment is completed.

Each individual who completes a portion of the assessment must sign and certify the accuracy of

#### F 250 F 278

1.) How the Corrective Action was accomplished for those residents found to have been affected.

Resident #2 will have an MDS scheduled and completed to accurately reflect the resident's status by August 30, 2016.

Resident #6 had a modification completed on August 3, 2016 to accurately reflect Section P of the Quarterly MDS with ARD of 5/24/16.

2.) How the facility will identify other residents having the potential to be affected by the deficient practice.

The Director of Nursing, Assistant Director of Nursing or Nurse Manager will complete a review of the MDS assessments completed within the last 30 days to determine accurate coding of Sections C, D, E, J and P.

Residents identified to have inaccurate coding of Sections C, D, E, J, and P will be modified or evaluated as needed or have a new MDS scheduled to accurately reflect the resident's status.

3.) The Following Measures will be put into place or systematic changes made to ensure that the deficient practice will not recur.

The Clinical Reimbursement Specialist, Director of Resident Assessment will provide education to the Interdisciplinary Care Plan Team on the coding for Sections C, D, E, J and P.

F 278

### DEPARTIMENT OF HEALTH AND HUMAN SERVICES

CODM ADDOOR

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F 278	Continued From parthat portion of the a	ssessment.	F	278	4.) The Facility will monitor its performance to make sure solution are sustained.		and the second and th
	Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or an individual who willfully and knowingly causes another individual				The Director of Nursing, Assistant Director of Nursing or Nurse Managraudit a minimum of 3 MDS weekly to determine the accuracy of coding for sections C, D, E, J and P.	r r	
	to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment.				Findings will be reported to the QAP committee monthly for three months until compliance is achieved and maintained.		
	Clinical disagreement material and false st	nt does not constitute a latement.			5.) Date Corrective Action will be completed.		
					Compliance Date is 09/08/16		
	by: Based on observation interviews, facility do record review, and in investigation, the facility distribution in the facility distribution.	T is not met as evidenced ons, resident interview, staff ocumentation review, clinical of the course of a complaint cility failed to ensure that the MDS) were accurate for two e survey sample, Residents					
 	(Minimum Data Set) reference date (ARD E, and J for Residen resident assessment	) of 5/30/16 in Sections C, D, t #6 instead of locating s to assess his Cognitive, d Health Conditions over the					

2. The facility staff failed to ensure the quarterly MDS (Minimum Data Set) with an assessment

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F 278		ge 5 D) of 5/24/16 Section P. urate for Resident #2.	F	278			
	The findings include						
	8/28/15. Diagnoses are not limited to Q	s admitted to the facility on s for Resident #6 included but uadriplegia (total or partial loss o) and Manic Depressive	i				
	(MDS) with an Asse (ARD) of 5/30/16 co	terly Minimum Data Set essment Reference Date oded Resident stood" in the ability to express					
	Section C "Cognitive the following section	e Patterns" were dashed in os:					
	C0200 Repetition of	f Three Words					
	C0300 Temporal O	rientation					
	C0400 Recall						
	C0500 Summary S	core					i de la companion de la compan
	C0600 Should the S Status (C0700-C100	Staff Assessment for Mental 00 be Conducted?					STATE OF THE STATE
	C0700 Short-Term	Memory					ALIUSTATION
	C0800 Long-Term I	Memory					

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	LTIPLE CONSTRUCTION DING	(X3) DATE SURVEY COMPLETED
			71. 5012		C
		495149	B. WING	The second control of the desired of the desired of the second of the se	08/04/2016
	PROVIDER OR SUPPLIER  I LIVINGCENTER- PO	RTSMOUTH		STREET ADDRESS, CITY, STATE, ZIP CODE 900 LONDON BOULEVARD PORTSMOUTH, VA 23704	
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F 278	Continued From pa C0900 Memory/Re	-	F2	278	
	C1000 Cognitive S	kills for Daily Decision Making			
	Section D "Mood" w sections:	ere dashed in the following		,	
	D0100 Should Res Conducted?	ident Mood Interview be			
	D0200 Resident Mo through I	od Interview sections A			
	D0300 Total Severi	ty Score			
	D0500 Staff Assess sections A through J	ment of Resident Mood			
	D0600 Total Severi	ty Score			
	Section E "Behavior sections:	were dashed in the following			
	E0100 Potential Ind	icators of Psychosis			
	E0200 Behavioral S Frequency sections	lymptom - Presence and A through C			on a control of the c
	E0800 Rejection of 0 Frequency	Care - Presence and			
	E0900 Wandering -	Presence and Frequency			SOMEON AND AND AND AND AND AND AND AND AND AN
	Section J "Health Co following sections:	nditions" were dashed in the			The state of the s
	J0300 Pain Presenc	e			
	J0400 Pain Frequen	icv			

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CENTE	NO FUR MEDICARE	: & WEDICAID SERVICES	PPSKUISISSISSISSISSISSISSISSISSISSISSISSISSI		( )	DMB NC	D. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		ONSTRUCTION	(X3) DA	TE SURVEY MPLETED
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NAME OF I	PROVIDER OR SUPPLIER	en de la companya de La companya de la companya del la companya de	<u> </u>	STRE	ET ADDRESS, CITY, STATE, ZIP CODE	1 00	3/U4/ZU 10
COLDEN	HUMMOOTHTO DO	(Profession & & 1 and 1 a	accompany		ONDON BOULEVARD		
GOLDEN	I LIVINGCENTER- PO	RISMOUTH	en Menter		TSMOUTH, VA 23704		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPOLICIENCY)	D BE	(X5) COMPLETION DATE
F 278	Continued From pa	ge 7	F 2	78			
	J0500 Pain Effect	on Function sections A and B					
	J0600 Pain Intensi	ty sections A and B					
	J0700 Should the S Conducted?	Staff Assessment for Pain be					
	J0800 Indicators of last 5 days	00 Indicators of Pain or Possible Pain in the 5 days					
	J0850 Frequency of Pain in the last 5 da	of Indicator of Pain or Possible					
	J1100 Shortness of	f Breath (dyspnea)					
	behaviors which inc to be seen by wound facility in wheelchair Leaving building wit antibiotic) attached central catheter) line	plan Focus "I sometimes have lude: refusal of care refused d care physician. Leaving smoking on sidewalk. h IV ABT (intravenous to PICC (peripherally inserted e. Sections E of the Quarterly f 5/30/16 were dashed.					
	Resident #6's care plan Focus "Needs Pain Management and monitoring related to Spinal cord injury" initiated on 9/12/15. Sections J of the Quarterly MDS with an ARD of 5/30/16 were dashed.						
	related complication psychotropic medical Psychotic medication Resident #6's diagnosisth ARD of 5/30/16	plan Focus "Potential for drug is associated with use of ations related to: Anti- n" initiated on 7/17/16, oses on his Quarterly MDS included a diagnosis of ipolar. Sections E of the					

Quarterly MDS with an ARD of 5/30/16 were

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DA	TE SURVEY MPLETED
		495149	B. WING	- CONTRACTOR			C
NAME OF	PROVIDER OR SUPPLIER	a. Business and the second control of the se		ST	FREET ADDRESS, CITY, STATE, ZIP CODE	U	/04/2016
COLDER	N LIVINGCENTER- PC	STYTES & BONG LIVE S		Į.	0 LONDON BOULEVARD		
GOLDEI	A CIANAQCEIAI EK- KC	W. LOMOOTH		l .	ORTSMOUTH, VA 23704		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 278	Continued From pa	ge 8	F	278			restance and the second second second
	approximately 10:4 cognition was intac to person, time and	terviewed on 8/4/16 at 5 a.m Resident #6's t as he was alert and oriented place. Sections C (Cognitive erly MDS with an ARD of ed.					
	a.m. with Registere asked why the Qua ARD date of 5/30/1 stated, "The RAI masections after you easked how a Reside	/16 at approximately 10:37 ed Nurse (RN) #1. RN #1 was rterly MDS sections with an 6 were all dashed. RN #1 anual will not let you update inter it and accept it." When ent's care can be generated int, RN #1, stated, "You can es."					
	2:55 p.m. RN #1, w. Quarterly Minimum Assessment Refere sections C, D and J asked if the followin completed in the timallowed and becaus	on 8/4/16 at approximately as asked again about the Data Set (MDS) with an ence Date (ARD) of 5/30/16 being dashed. RN #1 was g sections should have been deframe (7 days look back) e Resident #6 had not been talized, RN #1 stated, "Yes."					
	page 4: Almost all N (-) value to be entered Quality Improvement (QIES) Assessment	nanual states at chapter 3 MDS 3.0 items allow a dash and submitted to the MDS and Evaluation System Submission and Processing dash value means an item					

has not been assessed. The most often occurs

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<u></u>	10 LOU MEDICAUE	A MEDICAID SERVICES				UNIB NO	J. 0938-0391
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		495149	B WING		00000000000000000000000000000000000000	l ns	C 3/04/2016
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					ONDON BOULEVARD		
GOLDEN	I LIVINGCENTER- PO	RTSMOUTH					
				FUK	TSMOUTH, VA 23704		
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F 278	Continued From pa	age 9	F 2	78			
		discharged before an item has	1 2	0			
	heen accessed Da	ashed values allow a partial					
	assessment to be s						
		lired for payment purposes.					
		ems (A2400C, O0400A6,					
		6) that use a dash-filled value					
		has not yet occurred.					
		*					
	The RAI MDS 3.0 n	nanual states at chapter 2					
		equired Tracking Records and					
		ederally mandated, and					
		performed for all residents of					
		edicaid certified nursing					
		de Assessments:					
	Quarterly.						
		tration consisting of the					
		he Director of Nursing was					
		ings during a meeting on					
		ately 4:00 p.m. The facility did					
	findings.	her information about the					
	mungs.						
	2. The facility staff f	ailed to ensure the quarterly					
	MDS (Minimum Dat	ta Set) with an assessment					
		24/16 Section P. Restraints					
	was accurate for Re	esident #2.					O CONTRACTOR OF
	Danidant 40	lmitted to the facility					
		Imitted to the facility on					WANDINAM
		osis of unspecified dementia					
	without behavioral d	nsturdance.					Miller
	The current MDS /A	/linimum Data Set) a quarterly					намини
		reference date of 5/24/16					Boscowie
		as having long and short-term					St.Aldamon
	coded the resident	22 HOVING IVING BIND SHUIT-REITH					1

memory deficits with severely impaired daily

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CENIE	KS FUK MEDICAKE	& MEDICAID SERVICES	-			OM	3 NO. 0938-0391
	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			ONSTRUCTION		3) DATE SURVEY COMPLETED
MASS Paramata		495149	B. WING	NEW TOWNS AND THE STATE OF THE	nementation and an activate and activate and activate and activate and activate and activate activate and activate activ	0000000 for transverse of	C 08/04/2016
NAME OF I	PROVIDER OR SUPPLIER	The second secon		STRE	ET ADDRESS, CITY, STATE, ZIP COE	Œ	0.010.41.00.10
GOLDEN	I LIVINGCENTER- PO	RTSMOUTH		900 L	ONDON BOULEVARD		
				POR	TSMOUTH, VA 23704		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SI- CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(XS) COMPLETION TE DATE
F 278	Continued From pa	ge 10	F 2	78		Politicia della seglia para pre di regiotamano	ence de la companya de la compa
	decision making sk	ills. Section P. Restraints as having a limb restraint used					
	physician order date Please provide patie padded lap board to wheelchair for patie with self positioning	cal record evidenced a ed 5/14/15 that read, in part: ent with one-sided hinged be placed on patient ints convenience and assist . Ask patient to open the hours for repositioning and					
	8/4/16 the resident value such as the unit dini	ay of 8/2/16, 8/3/16 and was observed in various areas ing/activity room and the in a wheelchair with a added lap board.					
	assigned to care for She stated the resident with the stated the resident is placed on it and is a independent captivit being closer in reach resident was able to	ed nurse aide (CNA#2) the resident was interviewed. lent seems to be more e padded lap tray in use. She s able to reach for cups ble to participate with ites better due to having them h. During this time the demonstrate pulling the ray up and down after verbal prompting.					
	Assessments was in	m., the Director of Resident iterviewed. The quarterly traints was reviewed. She itI will modify it".					
	The above findings v	was shared with the					STATEMENT

Administrator and the Director of Nursing during a

meeting conducted on 8/4/16 at 2:55 p.m.

#### DEPARTIMENT OF HEALTH AND HUMAN SERVICES PRINTED: 08/18/2016 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY IDENTIFICATION NUMBER: A. BUILDING\_ COMPLETED 495149 B WING NAME OF PROVIDER OR SUPPLIER 08/04/2016 STREET ADDRESS, CITY, STATE, ZIP CODE GOLDEN LIVINGCENTER- PORTSMOUTH 900 LONDON BOULEVARD PORTSMOUTH, VA 23704 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID ID PROVIDER'S PLAN OF CORRECTION PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) COMPLETION TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) F 278 Continued From page 11 F 312 F 278 1.) How the Corrective Action was accomplished for those residents Additional information was not provided prior to found to have been affected. F 312 483.25(a)(3) ADL CARE PROVIDED FOR Resident #2 and #18 showers were F 312 SS=E DEPENDENT RESIDENTS completed.

daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.

A resident who is unable to carry out activities of

This REQUIREMENT is not met as evidenced by:

Based on family interview, staff interview, clinical record review and facility document review the facility staff failed to ensure 2 dependent residents in the survey sample of 24 received showers, Resident #2 and Resident #18.

- 1. Resident #2 was provided only one shower from 7/1/16 through 8/4/16.
- 2. Resident #18 was provided three showers from 7/1/16 through 8/4/16.

The findings included:

1. Resident #2 was admitted to the facility on 11/7/12 with a diagnosis of unspecified dementia without behavioral disturbance.

The current MDS (Minimum Data Set) a quarterly with an assessment reference date of 5/24/16 coded the resident as having long and short-term memory deficits with severely impaired daily decision making skills. The resident was totally

The Director of Clinical Education educated the nursing staff immediately on the shower/bathing process/schedule.

2.) How the facility will identify other residents having the potential to be affected by the deficient practice.

All residents have the potential to be affected.

The Nurse Unit Managers or Nurse Manager will review the assignment sheet and Care Tracker record of residents to validate documentation of shower as rendered.

3.) The Following Measures will be put into place or systematic changes made to ensure that the deficient practice will not recur.

The Director of Clinical Education. Director of Clinical Education Assistant or Nurse Manager will provide education to the nursing staff regarding the shower process.

The resident Shower preference is placed on the assignment sheet.

The C.N.A will initial on the assignment sheet for completion of shower or document refusal of shower.

Charge nurses will initial on assignment sheet after verification that shower was completed.

The Nurse Unit Managers or Nurse Manager will verify in Care Tracker that Facility I showers are documented and report non t Page 12 of 42 compliance in the daily nursing department start up meeting.

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CENIE	<u>RS FOR MEDICARE</u>	& MEDICAID SERVICES			,		KM APPROVE
STATEMENT	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) C	IO. 0938-039 DATE SURVEY COMPLETED
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NAME OF	PROVIDER OR SUPPLIER	AND THE PROPERTY OF THE PROPER	1	000000	REET ADDRESS, CITY, STATE, ZIP CODE		)8/04/2016
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F 312	Continued From pa	ne 19			4.) The Facility will monitor its	HARRIE GOVERNOUS CO.	MONTH AND
		for full-body baths/ showers.	F3	12	performance to make sure solutions are sustained.	ons	
	resident was schedu showers on Tuesda shift. A review of the certii	er schedule evidenced the uled to receive twice weekly ys and Fridays during the 3-11 fied nurse aides (CNAs)			The Director of Nursing, Assistant Director of Nursing or Nurse Managaudit a minimum of 10% of the Card Tracker documentation weekly for f weeks, then monthly for three mont validate completion and documentation fresident showers.	our hs. to	
	living) electronic trac 2016 was conducted	ne ADL (activities of daily cker for the month of July d. The ADL tracker evidenced done shower for the month of 6.	•		Findings will be reported to the QAF committee monthly for three months until compliance is achieved and maintained.	?{ 3 OF	
	care for Resident #2 2:30 p.m. She state for showers on the 3 the resident is not re stated resident show kiosk (ADL tracker) of also stated when a re	aide (CNA #2) assigned to was interviewed on 8/4/16 at d the resident was scheduled -11 shift. The CNA stated sistant to care. The CNA ers are documented into the once they are given. CNA #2 esident is given a shower or a documented on the			5.) Date Corrective Action will be completed. 09/08/16		
! ! !	month of July 2016 wording the assumment of the assumment of the and only long the and only long the assignment sheets expression of the assignment of the assignment sheets expression of the assignment of the a	ignment sheets for the vas made. A folder was ignments. The folder was nad assignment sheets from 6. A review of the videnced there was no owers provided or refused for					The second secon
P	The above findings was administrator and the 1/4/16 at 2:55 p.m.	as shared with the Director of Nursing on					

2. Resident #18 was admitted to the facility on

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NAME OF I	PROVIDER OR SUPPLIER		4	STREET ADDRESS, CITY, STATE, ZIP CODE	
GOLDEN	I LIVINGCENTER- PO		der state (APPENDENCE)	900 LONDON BOULEVARD PORTSMOUTH, VA 23704	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ITEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	DRF COMPLETION
	The current MDS (Nowith an assessment coded the resident amemory deficits with decision making skill decision making skill decision making skill dependent on staff and the conducted with the conducted with the conducted with the confluence of the shown resident was schedus showers on Tuesday shift.  Review of the certification on the commentation on the commentation on the comment of July 2016.	e services and a diagnosis of avioral disturbances.  Minimum Data Set) a quarterly treference date of 6/9/16 as having long and short-term h moderately impaired daily fills. The resident was totally for full-body baths/showers.  .m., an interview was daughter/responsible party 8. She stated the resident is ers on Fridays.  er schedule evidenced the uled to receive twice weekly ys and Fridays during the 7-3 ed nurse aides (CNAs) ne ADL (activities of daily cker was reviewed for the The ADL tracker evidenced	F 3	12	
	living) electronic trac month of July 2016. the resident received	cker was reviewed for the			

on the assignment sheet.

7/20/16 at 2:06 pm., and again at 10:34 p.m.

The certified nurse aide (CNA#3) assigned to care for Resident #18 was interviewed on 8/4/16 at 1:20 p.m. She stated she was not sure when the resident was scheduled for showers stating, "I think on Tuesdays and maybe Fridays on the day-shift (7-3). CNA#3 stated the nurses are responsible for placing on the assignment sheet who is scheduled for a shower. If a shower is refused it is documented in the comment section

16 ED 91

CENT	EDS FOR MEALIF	AND HUMAN SERVICES			PRINTED: 08/18/20
STATEME	EKS FUR MEDICARE NT OF DEFICIENCIES	& MEDICAID SERVICES			FORM APPROVE
AND PLAI	V OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION ING	OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED
NAMEO	E DON'INCE OF COLUMN	495149	B. WING		c
1	F PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	08/04/2016
GOLDE	N LIVINGCENTER- PO	RTSMOUTH	***************************************	900 LONDON BOULEVARD PORTSMOUTH, VA 23704	
(X4) ID PREFIX TAG	LUNGO UCCILICIONE Y	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COORTS	ha as on more (Phill)
F 314 SS=D	was provided with the was incomplete and from 7/1/16 through assignments sheets documentation of sheets documentation and the 8/4/16 at 2:55 p.m. The seceiving Hospice is would check the Hospidetermine if they had resident.  No additional information of the second determine if they had resident.  No additional information of the second determine if they had resident, the facility makes and the second develop presentive and the second develop presentive sores received does not develop present new sores from this REQUIREMENT in this REQUIREMENT in the second development in the second developme	of the assignment sheets for 16 was requested. A folder e assignments. The folder only had assignment sheets 7/18/16. A review of these evidenced there was no owers provided or refused for was shared with the Director of Nursing on the DON stated the resident services. She stated she pice CNA documentation to provided showers to the distribution was provided prior to ST/SVCS TO SSURE SORES  The sive assessment of a sust ensure that a resident without pressure sores sure sores unless the dition demonstrates that and a resident having as necessary treatment and aling, prevent infection and in developing.	F 314	1.) How the Corrective Action was accomplished for those resident found to have been affected.  Resident #1 no longer resides at the facility.  Competency evaluation was complewith the Treatment Nurse.  Nurses were educated on the policy procedures on dressing change and infection control.  2.) How the facility will identify ot residents having the potential to affected by the deficient practice.  Residents with pressure ulcers have potential to be affected.  The Director of Clinical Education, Director of Clinical Education Assist designee will complete wound treatment.	ant or ment or ide
16	scord review and tacill	staff interview, clinical y document review the vide the necessary care			

### DEPARTIMENT OF HEALTH AND HUMAN SERVICES

CENTER	RS FOR MEDICARE	E & MEDICAID SERVICES					RM APPROVEI
STATEMENT	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) D	NO. 0938-039 DATE SURVEY COMPLETED
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GOLDEN	I LIVINGCENTER- PO	PRTSMOUTH			0 LONDON BOULEVARD ORTSMOUTH, VA 23704		
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	infection during a procharge for 1 reside sample, Resident #  The nurse failed to chand hygiene after churse continued to continue application dressing.  The findings include Resident #1 was ad 10/13/15 and readmidiagnoses to include diabetes and hyperto the significant chan with an assessment coded the resident a possible 15, indicating impaired cognition, coded the resident aulcer/sore.  A stage IV pressure MDS as: Full thicknessing may be preserved bone, tendon or must issue) may be preserved bed. Often inclunneling.	omote healing and prevent pressure ulcer/sore dressing ent out of 24 in the survey #1.  change gloves and implement cleaning the wound bed, the use the same gloves to n of the treatment and  ed:  dmitted to the facility on mitted on 2/25/16 with le coronary artery disease.	F 3	14	4.) The Facility will monitor its performance to make sure solution are sustained.  The Director of Nursing, Assistant Director of Nursing or Nurse Manager audit a minimum of 10% of residents a pressure ulcers dressing change week for four weeks, then monthly for three months, to validate that the nurse(s) is providing the necessary care and services to promote healing and preve infection during pressure ulcer dressin change for residents.  Findings will be reported to QAPI committee monthly for three months of until compliance is achieved and maintained.  5.) Date Corrective Action will be completed.  Compliance Date is 09/08/16	r will with ekly s s ent	
	was that the wound v						

complications. One of the interventions listed to obtain the goal was for treatments as ordered.

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NAME OF PROVIDER OR SUPPLIER		-	STREET ADDRESS, CITY, STATE, ZIP CODE	With the committee of t
GOLDEN LIVINGCENTER- PO	RTSMOUTH	Миноэнення полемую.	900 LONDON BOULEVARD PORTSMOUTH, VA 23704	
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### F 314 Continued From page 16

The Wound Care Specialist Evaluation dated 7/27/16 for the Stage IV pressure wound of the left buttock read, in part:
Size 0.8 x 2.5 x 1.0 cm (centimeter), undermining 5.3 cm at 3 o'clock, exudate moderate.
Granulation tissue 100%. Wound progress:
Deteriorated. The Assessment Plan was to continue with the dressing change, once daily using Dakins 0.25% (a solution used to kill germs and prevent germ growth in wounds), pack the wound bed with Dakins soaked gauze and apply a dry dressing. Deteriorated due to generalized decline of patient: Will discuss with POA (power of attorney) that patient is now declining-may need to consider Hospice or Palliative care.

Resident #1 was placed under Hospice services on 8/2/16.

A dressing change observation of the stage IV pressure ulcer was conducted on 8/3/16 at 10:35 a.m. The wound nurse was observed obtaining the necessary supplies from inside the treatment cart. The wound nurse washed her hands, obtained gloves from her scrub top pocket. After putting on gloves the nurse removed the dressing, and packing, she then cleansed the wound bed with several Dakins soaked 4x4's. The nurse then padded the wound dry with more 4 x 4 gauzes. The nurse then grabbed the packing and began to pack the wound. The nurse failed to remove her gloves and implement appropriate hand hygiene prior to packing the wound. This inspector observed there was still packing left in the wound, at this point the nurse was asked to measure the undermining. While doing so she noted that she had left some packing in the wound, and removed it. The nurse continued the dressing change.

F 314

## DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 08/18/2016 FORM APPROVED OMB NO 0938-0391

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F 314	Continued From pa	ige 17	F3	314	4	ninenininininininininininininininininin	200 Marie Para (1444 Annie 1444 A
	7:15 p.m. The obsegloves after cleaning same gloves to apposhared. The wound goal is to prevent in cross-contamination infection control prathe dressing change that stepNo" What step gloves inside the she normally has a she takes into the residues after the step of the step o	was interviewed on 8/3/16 at servation of failing to change ing the wound and using these ply the clean dressing was dinurse stated, "The whole infection or on". When asked if appropriate actices were maintained during ge she stated, "Not in missing then asked why she would her scrub top she stated that a box of gloves with her that resident rooms. She stated a not available for use inside the					
	<ol> <li>Open dressings</li> <li>Put on first pair of</li> <li>Remove soiled dr</li> <li>Dispose of glove</li> <li>Wash hands and</li> <li>Cleanse wounds</li> </ol>	or disposable gloves for disposable gloves fressing fress for put on second pair of gloves fressing fress for put on second pair of gloves fressing fresseribed solution for perform hand hygiene, and fressing fresseribed solution for perform hand hygiene, and fressing fr					
	Control and Prevent	cdc.gov (Centers for Disease tion): nd medications should be					

and medications in pockets.

maintained in clean areas separate from used supplies and equipment. Do not carry supplies

A meeting was conducted with the Administrator

CENTE	RS FOR MEDICARE	E & MEDICAID SERVICES				FORM.	APPROVE
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		90000000000		P	ORTSMOUTH, VA 23704		
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F 314	Cantin and Eram ar	- · - AA			F323	inateisvionam <del>o</del> ajustamane	
	234 Continued From page 18 and the Director of Nursing on 8/4/16 at 2:55 p.m. The above findings was shared. 23 483,66(h) FREE OF ACCIDENT EE HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident	Nursing on 8/4/16 at 2:55 p.m. swas shared.	F 31		How the Corrective Action was accomplished for those residents found to have been affected.		
F 323 SS=E		F 32	23	The Biohazard storage room is locked new door closure was placed on the dofor automatic secure/closure.	i. A oar		
environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.	environment remair	must ensure that the resident			A secured key is in place for staff use.		
	as is possible; and a adequate supervision	each resident receives			For Resident #17, an alarm was placed on chair on 08/03/16.	nt,	
			For Resident #17 a fall risk assessment care plan and care card were updated.				
	This REQUIREMENT is not met as evidenced			2.) How the facility will identify other residents having the potential to be affected by the deficient practice.	şû B		
	by: Based on observation documentation revieus	ion, staff interview, and facility we the facility staff failed to			All residents in the vicinity of the biohazard doors had the potential to be affected.	3	
	ensure a safe enviro of an unlocked bioha	onment free from the hazard azard storage room and free			Residents at risk for falls have the potential to be affected.		
	from accident hazard residents (Residents	rd for 1 Resident of 23 #17).			The Nurse Unit Managers or Nurse Manager will review the medical record of residents identified as being at risk for	ls	
	Facility staff failed storage room was local	d to ensure the biohazard ocked on unit II.			falls to validate those interventions are implemented.	)[	
( (	ensuring that Reside	om accident hazards by not ent 17's wheel chair alarm 16 when Resident #17 was					
*	The findings included	d:					ı
N	During general obs Maintenance Director     3:30 p.m. the biohaza	servations with the or on 8/3/16 at approximately ard storage room on unit II					

was observed to be unlocked with no staff near

## DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 08/18/2016

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	observed getting his use the keys to unlouse the keys to unlounlocked. On a second approximately 4:00 proom on unit II was the door. On a third a.m. the door was loobservation on 8/4/1 biohazard storage rostaff near the door. At the unlocked door that 2:00 p.m., a staff the observation was 2:05 p.m  On 8/4/16 at approxi (Licensed Practical I was interviewed. LPI Biohazard storage roboxes with used shatrash. LPN #1 also shohazard storage rotimes. She went on the should have a key, the donot have a key, the door and will edu.  On 8/4/16 at 3:30 p.m. stated, "I figured out Director that the door room] was not being LPN #1 also explained Director made sure was the door made sure was	tenance Director was is keys out but not needing to ock the door as the door was cond observation at 8/3/16 at p.m. the biohazard storage unlocked with no staff near I observation on 8/4/16 at 9:50	F 32	23 3.) The Following Measures will to into place or systematic changes made to ensure that the deficient practice will not recur.  The Director of Clinical Education, Assistant Director of Clinical Educations. The Interdisciplinary Team will develop and implement an individualized place care to address the residents identificials.  The Nurse Unit Managers and IDCP Department Managers or Nurse Manadesignee will validate placement of applicable interventions during observational facility rounds.  The Director of Clinical Education, Assistant Director of Clinical Education Nurse Manager designee will educate staff on the guidelines for Environmer Safety, to include maintaining the security of all applicable doors. The Swill validate that the Biohazard / Solled Utility room is secure when exiting. The Maintenance Director, Assistant Maintenance Director will validate security of Biohazard / Solled Utility rooms daily time five days per week.	tion or on to

keys to open."

FORM APPROVED OMB NO. 0938-0391

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### F 323 Continued From page 20

On 8/4/16 at approximately 4:00 p.m. the Maintenance Director stated, "I made sure door [biobazard storage room] will lock and will give everyone a key." He also added that he would check on the other unit, Unit I and the rest of the doors in the building.

On 8/4/16 a policy was requested from Administration regarding safety but the facility staff did not have a policy that related specifically to the biohazard storage room remaining locked.

The facility administration was informed of the findings during a briefing on 8/4/16 at approximately 5:45 p.m. The facility did not present any further information about the findings.

2. Resident #17 was admitted to the facility on 4/5/16. Diagnoses for Resident #17 included but are not limited to Alzheimer's Disease.

Resident #17's Quarterly Minimum Data Set (MDS - an assessment protocol) with an Assessment Reference Date (ARD) of 7/13/16 coded Resident #17 with a BIMS (Brief Interview for Mental Status) of 10 of 15 indicating a moderate cognitive impairment.

In addition, the Quarterly MDS coded Resident #17 as requiring limited assistance with the assistance of one staff person for transfers, walking in room, and dressing. Resident #17 was coded as requiring extensive assistance with one staff person for toilet use. Resident #17 was coded as being occasionally incontinent of urine and frequently incontinent of bowel functioning.

# F 323 4.) The Facility will monitor its performance to make sure solutions are sustained.

The Director of Nursing, Assistant Director of Nursing or Nurse Manager designee will review 10% of the medical records of residents Identified as being at risk for falls weekly for four weeks, then monthly for three months, to validate adherence to the established guidelines for Fall Precautions.

The Maintenance Director, Assistant Maintenance Director or designee will conduct audits of the Biohazard /Soiled Utility Rooms five times per week for four weeks then monthly for three months to validate security of Biohazard / Soiled Utility Rooms.

Findings will be reported to the QAPI committee monthly for three months or until compliance is achieved and maintained.

5.) Date Corrective Action will be completed.

Compliance Date is 09/08/16

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F 323	Continued From pa	ge 21	F;	323			
		coded as having 1 fall since uarterly MDS with no ury.					
	documented a focurelated to: Use of n 7/8/16 Fall without i injury, 8/3/16 Fall w documented include chair/bed alarm: init with toileting after m Footwear to preven	ent 4/13/16 Care Plan s area of "At risk for falls nedication, new environment, njury, 7/29/16 Fall without ithout injury. Interventions ed but were not limited to: liated 7/29/16; Staff to assist neals: initiated 7/12/16, t slipping while OOB (out of 6, and Grab Bar: revised on	,				
	Resident #17's 7/29 documented "chair	/16 Fall documentation note alarm in place."					
	(TAR) for July 2016 for placement of eith alarm. Resident #1	atment Administration Record showed no documentation her a chair alarm or bed 7's August TAR documented and function of chair alarm g 8/4/16.					
	members walking pa comment, "she fell". Practical Nurse) #10 and went into Resid- was observed to be	made on 8/3/16 at p.m. three Laundry Staff past Resident #17's room Immediately, LPN (Licence locked the medication cart ent #17's room. Resident #17 sitting on the floor with legs of her between her bed and					

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	head to toe assessing Resident #17 stated "Nowhere except must hit my butt. My kne sore before my fall. (pointed to the bath observed to be weathered to be we	n door. LPN #10 began a ment of Resident #17. I when asked if she was hurt, y pride. I didn't hit my head. I es are really sore. They were I was coming out of there room)." Resident #17 was ring pull up briefs and non slip sessed Resident #17 then ith the sit to stand lift into ed Resident #17's daughter of the Physician was notified.  SIDENT CARDEX INFO" card owing: bed/chair alarm, s, offer toileting before  imately 5:06 p.m. LPN #1 g a chair alarm from new g it in Resident #17's wheel d, "I saw it (wheel chair 16). LPN when asked if as in wheel chair prior to her on stated, "No." CNA #1 neel chair alarm) got moved	F:	323			
	when wheel chair wastated, "I don't know On 8/3/16 at approxisurveyor assessed Fed alarm to be in pl Consultant asked LF	med." CNA #1 was asked as last washed and she ."  imately 5:20 p.m. with the Resident #17's bed and found ace. The Corporate 'N #10 if Resident #17 had heel chair prior to ambulating					

to the bathroom, LPN #10 stated, "She was in the

### DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & P STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1)	PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT		MB NO. 0938-0391
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F 323 Continued From page 2 wheel chair."	23	F 32	3	Cardinary - Versicalin in Andréin in Anguerin in Leann-gear Peace State Chairmann Ann ann
the resident's admission admitted/readmitted resident's admisted resident risk by means of the tool. The Immediate Plack is initiated Residence planned with indivious The facility administration Administrator and the Dinformed of the findings 8/4/16 at approximately not present any further infindings.  F 367 483.35(e) THERAPEUT BY PHYSICIAN  Therapeutic diets must lattending physician.  This REQUIREMENT is by:  Based on the investigate observation, staff and reclinical record review it work of 23 residents in the sustaff failed to serve therates residents #'s 8, 19 and the sustaff failed to serve there are sidents #'s 8, 19 and the sustaff failed to serve there are sidents #'s 8, 19 and the sustaff failed to serve there are sidents #'s 8, 19 and the sustaff failed to serve the same admits a submission of the sustaff failed to serve the same admits a summission of the sustaff failed to serve the same admits a summission of the summ	etive date of 10/21/15 g: "Assure that the ations are in place prior to n. Newly sidents are assessed for e Clinical Health Status an of Care At Risk - Falls dents at risk for falls are dualized interventions."  On consisting of the eirector of Nursing was during a meeting on 4:00 p.m. The facility did information about the  IC DIET PRESCRIBED  be prescribed by the e not met as evidenced ion of a complaint, sident interviews and was determined for three ervey sample that facility expeutic diets for	F 367	F 367  1.) How the Corrective Action was accomplished for those residents found to have been affected.  Resident #8 no longer resides at the facility.  Resident #19 is currently receiving a therapeutic diet as ordered by physicial Resident #20 no longer resides at the facility  Nursing and Dietary staff were educate on therapeutic diets, tray line process and serving meals to residents.  2.) How the facility will identify other residents having the potential to be affected by the deficient practice.  Residents on therapeutic diets have the potential to be affected.  The Dietary Manager, Assistant Dietary Manager or designee will review residents with therapeutic diets medica records, tray cards and meals to valida compliance with therapeutic diet as	d e

defined as a diet ordered by a physician as part of treatment for a disease or clinical condition, or to

ordered.

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F 367	or to increase speci The peutic diets al	se specific nutrients in the diet ific nutrients in the diet. Iso include a change in the mechanically altered diet).	F 3	67	into place or systematic changes made to ensure that the deficient practice will not recur.  The Dietary Manager, Assistant Dieta Manager or designee will observe tray line for meal services.	ry	
1. Resident #8 was 48 years old at the time of the survey. Resident #8 was admitted to the facility on 2/2/15 for rehabilitation following surgery. The resident's diagnoses included end stage renal disease (also called chronic kidney disease), diabetes, cardiology, history of falls, upper extremity lymphedemia (swelling in arms), and toe amputations. The quarterly Minimum Data Set (MDS) with an assessment reference date of 7/7/2016 evidenced the resident was				The Tray Card will be read to the cook the beginning of the tray line.  The Tray Card will be checked against the meal as plated at the end of the traine for accuracy.  The Nurse or C.N.A will check the tray card against the meal before serving the meal to the resident in the Dining room and on the nursing units.	t ay / he		
	cognitively intact with status of 15 out of 15	h a brief interview for mental			4.) The Facility will monitor its performance to make sure solutions are sustained.	S	
	by a right tibia (bone not heal well and pre bearing. This resider assistance of one sta transfer, toilet use an	nd hygiene. Once un in a			The Dietary Manager, Assistant Dieta Manager or designee will monitor tray line for accuracy of therapeutic diets of for four weeks, then weekly for three months to validate accuracy.  Findings will be reported to the QAPI		
İ	wheelchair she was a the unit. Limited assi eating.	able to locomotion on and off istance was required with			committee monthly for three months o until compliance is achieved and maintained.	if	
Title of the state	Review of the clinical resident was prescrib	record evidenced the sed a renal diet by her			5.) Date Corrective Action will be completed.		

were unable to do.

physician to help manage her chronic kidney failure. Resident #8 required dialysis three times

a week to provide her body with what her kidneys

Kidneys are two organs in the lower back are the

completed.

Compliance Date is 09/08/16

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CENTER	<u>RS FOR MEDICARE</u>	<u> &amp; MEDICAID SERVICES</u>		NAME OF THE PERSON		DMB NO. 0938-0391
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F 367	Continued From pa	ıge 25	F 3	67	-	
	fluids from the body	y and producing and balancing nced kidney failure dialysis fills				
	alleged that therape served as ordered I was interviewed on returned from dialys	nvestigated during this survey eutic diets were not being by the physician. Resident #8 8/3/16 after lunch when she sis. The resident stated that not receive her ordered renal				
	temperatures and p The main entrees w hamburgers, hot do sandwiches as the a was reviewed which food items and ame	ing meal was observed for plating starting at 4:55 p.m. were cheese ravioli, with ogs and grilled cheese alternates. The "spread sheet" in shows the dietary staff the ounts to be included in each thas puree, controlled enal dialysis.				
		en observation the evening in the dining areas and				
	was observed. The and used to plate he receive "cold cereal, cottage cheese, a di broccoli." When the #8's room and reque covered) the resider	along with the "meal ticket" meal ticket, from the kitchen er food, evidenced she was to a baked chicken breast, linner roll, a fruit salad and surveyor entered Resident ested to observe her tray (still nt stated that she had not yet ut added it will not be right.				
	Observation of the tr	ray evidenced that the				от в в в в в в в в в в в в в в в в в в в

resident received what was on the spread sheet for a regular diet (cheese ravioli, and garlic

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GOLDEN	I LIVINGCENTER- PO	RTSMOUTH		900	LONDON BOULEVARD RTSMOUTH, VA 23704	<b>t</b>	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMAT(ON)	ID PREFI TAG	theidiscrimination and an annual section and	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 367	Continued From pa bread) and did not i cereal and cottage of	nave the added items of cold	F 3	67		6655	amadang digunga.
	following day 8/4/16 only varied one item pepper cubed steak	was also observed the for lunch. The dialysis diet from the regular menu of with cream pepper sauce. sauce was to be omitted.					
Review of the menu card for Resident #8 evidenced she was to receive the cream pepper sauce as well. Observation of the resident's tray at lunch evidenced the cream sauce was on the pepper steak.							
	interviewed and mad He stated that the ni were available but w were not on the tray He was not aware the	dietary manager was de aware of the observations. Ight before chicken breasts was unable to say why they line and available for serving. In the diet sheet for that day a diet the resident's were to					
	therapeutic diet for to This resident was ac Resident	not receive the correct wo of two meals observed. Imitted to the facility 3/12/16. uded, anemia, malnutrition, crenal failure.					
	evidenced he was to dialysis/renal diet. T assessment reference	nt's physician's diet order receive a puree textured he quarterly MDS with an each deach of 6/3/16 evidenced able to complete the brief					

interview for mental status, and a mechanically altered therapeutic diet was needed. The

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CENTERS FOR MEDICARE & MEDICAID SERVICES			OMB NO. 0938					
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C 267	A - D					NA466Commonosco		
F 301	Continued From pa		F 30	<i>i</i> 67				
	resident's activities of daily living, including eating, required the extensive assistance of one or two persons.							
	evidenced Resident ravioli rather than the spread sheet menu evidenced he was a restrictions. Howey	evening meal on 8/3/16 It #19 received pureed cheese he baked chicken listed on the I. The resident's diet card a "dialysis" pureed with fluid ver, the meal printed on the vas to receive the cheese						
	Resident #19 receiv pepper cream sauce The master spread	s observed on 8/4/16; ved the pepper steak with the e as printed on the diet slip. sheet evidenced the pepper nitted for dialysis/renal diets.						
	following the lunch of	with the Dietary Manager observation on 8/4/16. He resident did not receive the						
	the administrative st	neeting was conducted with taff and they were made rns, no additional information						
	therapeutic diet for the This resident was ac she was 76 years old	luded congestive heart failure,			•			

Review of the physician's orders for the resident included, "dialysis diet".

#### DEFAR TWENT OF HEALTH AND HUMAN SERVICES FRINIEM. UDI 18/2016 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY IDENTIFICATION NUMBER: A. BUILDING COMPLETED C 495149 B. WING 08/04/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 900 LONDON BOULEVARD **GOLDEN LIVINGCENTER- PORTSMOUTH** PORTSMOUTH, VA 23704 SUMMARY STATEMENT OF DEFICIENCIES Ю PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (X5) COMPLETION DATE PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE **DEFICIENCY** F 367 Continued From page 28 F 367 The admission MDS evidenced the resident had a brief interview for mental status score of 12 out of 15 indicating moderate impairment. Resident #20's functional status evidenced she required the assistance of one to two persons to complete activities of daily living. To eat, she required the limited assistance of one person. F 425 Observation of the evening meal on 8/3/16 evidenced Resident #20 received cheese ravioli 1.) How the Corrective Action was accomplished for those residents rather than the baked chicken listed on the found to have been affected. spread sheet menu. The resident's diet card evidenced he was a "dialysis" regular (texture). Medication was disposed of in the sharps Printed on the slip evidenced she was to receive container the baked chicken and cottage cheese. Nurses were educated on the Medication Destruction for Non controlled The lunch meal was observed on 8/4/16. Medications. Resident #20 received the pepper steak with the pepper cream sauce as printed on the diet slip. 2.) How the facility will identify other The master spread sheet evidenced the pepper residents having the potential to be sauce was to be omitted for dialysis/renal diets. affected by the deficient practice.

This was discussed with the Dietary Manager following the lunch observation on 8/4/16. He acknowledged the resident did not receive the renal diet.

A 8/4/16 4:30 pm meeting was conducted with the administrative staff and they were made aware of the concerns, no additional information was received.

complaint deficiency
F 425 483.60(a),(b) PHARMACEUTICAL SVC SS=D ACCURATE PROCEDURES, RPH

An immediate Audit was conducted and no other medications were found in trash.

3.) The Following Measures will be put into place or systematic changes made to ensure that the deficient practice will not recur.

The Director of Clinical Education, Assistant Director of Clinical Education educated the nurses on the Medication Destruction for Non controlled Medication policy and procedures.

F 425

Medication will be disposed of in the sharps container if resident refuses medication or if medication becomes contaminated.

PERMICIAL OF DEAFIR AND HOMAN SEKVICES CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY IDENTIFICATION NUMBER: A. BUILDING COMPLETED C 495149 B. WING 08/04/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 900 LONDON BOULEVARD **GOLDEN LIVINGCENTER- PORTSMOUTH** PORTSMOUTH, VA 23704 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID m PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX (X5) COMPLETION DATE PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 425 Continued From page 29 F 425 4.) The Facility will monitor its The facility must provide routine and emergency performance to make sure solutions drugs and biologicals to its residents, or obtain are sustained. them-under an agreement described in The Director of Clinical Education or §483.75(h) of this part. The facility may permit designee will conduct medication unlicensed personnel to administer drugs if State observation with nurses weekly times law permits, but only under the general four weeks, then monthly times three months to validate compliance with supervision of a licensed nurse. Medication Destruction for Non controlled medication. A facility must provide pharmaceutical services (including procedures that assure the accurate Findings will be reported to the QAPI acquiring, receiving, dispensing, and committee monthly for three months or administering of all drugs and biologicals) to meet until compliance achieved and the needs of each resident. maintained The facility must employ or obtain the services of 5.) Date Corrective Action will be a licensed pharmacist who provides consultation completed. on all aspects of the provision of pharmacy services in the facility. Compliance Date is 09/08/16 This REQUIREMENT is not met as evidenced The facility staff failed to implement a method of disposable of a medication consistent with applicable state and federal requirements, and standards of practice to ensure that they are unusable. The findings included:

On 8/2/15 at 5:45 p.m., a medication pass observation was conducted with an agency nurse on the "Even" medication cart located on unit one. Observed near the top of the medication cart trash was a single whole pill. The pill was removed by this inspector, the agency nurse (licensed practical nurse #11) was asked what the

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pill was. She stated, "It looks like a Naproxen". The nurse was asked if she had disposed of the medication into the trash, she stated, "No. medications should be disposed inside the sharps container".

A sharps container is a safe disposable container for needles, syringes, lancets, razors and sharp objects. The sharps container is secured on each medication cart and locked. It does not allow for accessibility or retrieval of the contents.

The pill was later identified as a Naproxen 500 mg tablet. Naproxen is an anti-inflammatory drug used to treat pain and inflammation.

The Naproxen was handed to the Director of Nursing on 8/2/16 at approximately 6:00 p.m. for disposal.

The facility pharmacy policy titled "Medication Destruction For Non-Controlled Medications" dated 6/2015 read, in part under policy read, in part: Destruction methods comply with federal and state laws for medication procedures. Procedures: A. All medications should be destroyed in a manner that they are unusable.

A meeting was conducted with the Administrator and the Director of Nursing on 8/4/16 at 2:55 p.m. The above findings was shared. The DON stated the disposal of a single pill that may have been refused or dropped on the floor during a medication pass should be discarded inside the sharps containers. She stated the sharps containers render the medications unusable and inaccessible. The DON stated bulk medications such as controlled medications are disposed of in a way that make them unusable, by using an

F 425

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STATEMEN	T OF DEFICIENCIES	VALDENARDO PERONA	T	**************************************		MR MO: 0838-0381
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F 425	Continued From page	ge 31	F	125	F 441	neaneuropspare of 60 mag (spatium) en ansistenament water 6 m god stateling manager
	approved drug dest	ruction product.	•	v ang. age	1.) How the Corrective Action wa	w.w.
F 441 SS=D	441 483.65 INFECTION CONTROL, PREVENT SED SPREAD, LINENS		F	141	accomplished for those resident found to have been affected.	15 3
The facility must es Infection Control Prosafe, sanitary and c		tablish and maintain an ogram designed to provide a comfortable environment and development and transmission			Resident #1 no longer resides at the facility.	
					Resident #10 Wound has healed or 08/10/16.	
	of disease and infec	fection.			Competency Evaluation was comple with treatment nurse.	eled
<ul> <li>(a) Infection Control Program</li> <li>The facility must establish an Infection Control</li> <li>Program under which it -</li> <li>(1) Investigates, controls, and prevents infections</li> </ul>				Nurses were educated on appropria infection control practices during wo care dressing change to prevent cro contamination and infection.	nund.	
	in the facility; (2) Decides what pro should be applied to	ocedures, such as isolation, an individual resident: and			<ol><li>How the facility will identify ot residents having the potential to l affected by the deficient practice.</li></ol>	Same .
	(3) Maintains a recor	Maintains a record of incidents and corrective ions related to infections.			Residents with wounds have the potential to be affected.	
	(b) Preventing Sprea (1) When the Infection determines that a re-	on Control Program			Audits completed by the Director of Nursing, Assistant Director of Nursin Nurse Managers.	ng of
determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.  (2) The facility must prohibit employees with a communicable disease or infected skin lesions				<ol> <li>The Following Measures will be into place or systematic changes made to ensure that the deficient practice will not recur.</li> </ol>	e put	
	from direct contact with residents or their food, if direct contact will transmit the disease.  (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.				The Director of Clinical Education, Assistant Director of Clinical Education will provide education to the nurses of appropriate infection control practices during dressing change to prevent croportion.	on l
	(c) Linens Personnel must hand transport linens so as infection.	lle, store, process and to prevent the spread of			The Director of Clinical Education, Assistant Director of Clinical Educatio will continue to perform competency evaluation with nurses on wound dressing change.	n

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F 441 Continued From pa	ige 32	F 4	4.) The Facility will monitor its performance to make sure soluti are sustained.	ons
by: Based on observation record review and facility staff failed to infection control practors-contamination dressing change for survey sample, Res  1. During a dressing arterial ulcers on Rearea, the nurse faile implement appropriateleaning the wounds  2. During a dressing MASD (moisture asson Resident #10's conchange gloves and inhygiene after cleaning nurse then touched the and inserted it into the same gloves.  The findings included Resident #1 was addingled and readmited it was addingled to the same gloves.	n and infection during a r 2 of 23 residents in the sident #1 and #10.  g change observation of the esident #1's left foot and ankle ed to change gloves and ate hand hygiene after s.  g change observation of a sociated skin damage) wound occyx, the nurse failed to implement appropriate handing the wound base. The the calcium alginate dressing he wound base using the		The Director of Nursing, Assistant Director of Nursing or Nurse Managaudit a minimum of 10% of resident wound dressing change weekly for weeks, then monthly for three mont validate that the nurse is implement appropriate infection control practic prevent cross contamination and infection during dressing change.  Findings will be reported to the QAF committee monthly for three months until compliance is achieved and maintained.  5.) Date Corrective Action will be completed.  Compliance Date is 09/08/16	ts with four ths, to ting es to

diabetes and hypertension.

The significant change MDS (Minimum Data Set) with an assessment reference date of 6/8/16 coded the resident as scoring a 7 out of a possible 15, indicating the resident had severely

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F 441	Continued From pa	ge 33	F ,	441		MONOGRAPHICAL SPECIAL	
	impaired cognition. Section M. Skin Conditions coded the resident as having 2 arterial ulcers.						
	Ischemic ulcers or I located on the latera distal digits. They are peripheral artery distribution of Medicine.  The comprehensive 3/9/16 included alternon-pressure relate was that the wound complication. One of the located of the l	plan of care date initiated red skin integrity d to arterial wound. The goal would heal without f the interventions listed to					
	The Wound Care Sp 7/27/16 read, in part 1. Arterial wound of x 0.2 cm (centimete tissue) and 90% gra Wound progress: Im 2. Arterial wound of size 5.0 x 2.0 x not radherent black necestissue and 15% skin The Assessment Pladressing change, on (a solution used to k growth in wounds) a Resident #1 was pla	the right ankle, size 3.0 x 2.0 rs), 10% necrotic (dead nulation (healthy tissue).					
	on 8/2/16.	•					Abruminen de

A dressing change observation of the arterial wounds was conducted on 8/3/16 at 4:25 p.m. The nurse performing the dressing change was the facility's wound care nurse. The nurse was

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(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CORRECTIO ( (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETION
F 441	observed setting up table, wash her han dressing supplies fr removed gloves and nurse then removed top pocket. The nu- scissors from her so	ge 34  a barrier on the bedside ds, then removed necessary om the treatment cart, d washed her hands. The d gloves from inside her scrub rse then removed a pair of crub top pocket, cleansed the ohol prep pad. The wound	F 4.	41	

nurse then cut the Kerlix dressing. The Kerlix dressing had a moderate amount of strike through (dried drainage) which the scissors came close to touching, once completed cutting the dressing the nurse then put the scissors back into her pocket. The nurse removed her gloves and washed her hands. She then placed on gloves obtained from her pocket, removed the soiled dressing from the arterial ulcer on the lateral foot, discarded it into the red bag taped to the foot board. The nurse then removed her gloves, washed her hands and the placed on gloves removed from her pocket. The nurse then cleansed the wound using several Dakins soaked 4x4 gauzes, with each wipe the nurse tossed the gauze inside the red bag. After cleansing the wound the nurse used the same gloves to apply a Dakins soaked 2x2 gauze to the surface of the wound bed, placed a dry dressing on top and then secured. The nurse then removed her gloves, washed her hands and began cleansing the arterial ankle wound. The nurse failed to change her gloves and implement appropriate hand hygiene before applying a Dakins soaked 2x2 dressing to the wound bed. The dressing change was then completed and soiled dressings were discarded.

The wound nurse was interviewed on 8/3/16 at 7:15 p.m. The observation of failing to change gloves after cleaning the wounds and using the

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F 441	Continued From pa	ge 35	F4	141			
	same gloves when shared. The wound is to prevent infection when asked if appropriatices were main change she stated, stepNo" When a gloves inside her so normally has a box the resident room was gloves was not avait treatment cart.	applying a clean dressing was nurse stated, "The whole goal on or cross-contamination." copriate infection control ntained during the dressing "Not in missing that asked why she would store crub top, she stated that she of gloves that she takes inside with her. She stated a box of lable for use inside the					
	<ul><li>7. Open dressings</li><li>8. Put on first pair o</li><li>9. Remove soiled di</li></ul>	luded the following steps: f disposable gloves ressing					
	12. Cleanse wounds	d put on second pair of gloves with prescribed solution perform hand hygiene, and dimedication					
	Control and Prevent Unused supplies an maintained in clean	d medications should be areas separate from used nent. Do not carry supplies					
		ucted with the Administrator lursing on 8/4/16 at 2:55 p.m. was shared.					- Andrews and Analysis and Anal

2. During a dressing change observation of a MASD (moisture associated skin damage) wound

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F 441	Continued From pa	ge 36	F4	.41			
	-	coccyx, the wound the nurse	• •				
	failed to change glo						
		ygiene after cleaning the					
		urse then touched the calcium					
		nd inserted it into the wound					
	base using the sam	e gloves.					
Resident #10 was admitted to the facility on 3/24/16 with diagnosis to include Alzheimer's disease, diabetes, heart failure and high blood pressure.							
	with an assessmen coded the resident memory deficits and decision making ski incontinent of both I	Minimum Data Set) a quarterly treference date of 7/1/16 as having long and short-term d severely impaired daily ills. The resident was bladder and bowel. The re any skin problems during					
		n Flow Sheet dated 7/22/16 ent was identified on this date to the coccyx area.					
	instructed the staff to normal saline, pat d	red treatment dated 7/23/16 to: Clean the wound with ry, cut Calcium Alginate to fit and bed and cover with a dry and as needed.					A CONTRACTOR OF THE PARTY OF TH
	alginate, a gelatinou substance. When in calcium alginate in t sodium chloride from	are composed of calcium is and water-insoluble contact with a wound, the he dressing reacts with in the wound. This turns the ophilic gel that maintains a					

moist environment for the wound. Good for exudating wounds and helps in debridement and

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(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	DBE COMPLETION
	exudating wounds a scabbing. Dressing: www.nursingcenter.  A dressing change (8/2/16 at 2:55 p.m., placing the wound sthe nurse washed higher obtained from the nurse grabbed a preplaced into directly of failed to remove her appropriate hand higher the nurse grabbed a preplaced into directly of failed to remove her appropriate hand higher the nurse and put on new glow dressings from the restriction. The wound nurse with the wo	ds. Do not use on low as this will cause dryness and is should be changed dailycom  observation was conducted on with the wound nurse. After supplies on the bedside table her hands and then placed on minside her scrub pocket. wound bed with saline soaked dding the wound site dry, the e-cut piece of alginate and onto the wound. The nurse of gloves and implement syglene prior to applying the set hen removed her gloves wes and removed the soiled room.  It is interviewed on 8/3/16 at ervation of failing to change if the wound and using the applying the alginate dressing bound nurse stated, "The whole	F	141		
	treatment cart.	ot available for use inside the				

The facility's Clean Dressing Change Competency list included the following steps:

FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PE AND PLAN OF CORRECTION IDI		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			The state of the s		2010 (100 (100 (100 (100 (100 (100 (100	C	
NAMEAS	CANAL CONTRACTOR CONTR	495149	B. WING	7500000000		08/04/2016	
NAME OF PROVIDER OR SUPPLIER  GOLDEN LIVINGCENTER- PORTSMOUTH				9(	TREET ADDRESS, CITY, STATE, ZIP CODE 00 LONDON BOULEVARD ORTSMOUTH, VA 23704		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL, SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETION	
F 441	Continued From page 38 7. Open dressings 8. Put on first pair of disposable gloves 9. Remove soiled dressing 10. Dispose of gloves 11. Wash hands and put on second pair of gloves 12. Cleanse wounds with prescribed solution		F 4	Action to the second se	F 465  1.) How the Corrective Action was accomplished for those residents found to have been affected.  All three dryers were cleaned and deremoved as of 08/26/16.  Staff was educated on keeping dryer		
12. Cleanse woulds with prescribed solution  14. Remove gloves, perform hand hygiene, and put on clean gloves  15. Apply prescribed medication using a clean tongue blade or Q-tip  16. Apply prescribed dressing					safe and free from caked on debris of the dryer drums  2.) How the facility will identify oth	n	
					residents having the potential to b affected by the deficient practice.	9	
	. <del>-</del>				All Residents had the potential to be affected.		
	According to www.cdc.gov (Centers for Disease Control and Prevention): Unused supplies and medications should be maintained in clean areas separate from used supplies and equipment. Do not carry supplies and medications in pockets.				<ol> <li>The Following Measures will be put into place or systematic chang made to ensure that the deficient practice will not recur.</li> </ol>	) es	
					Dryers will be checked daily five time week to ensure they are safe and sanitary operating condition.	s a	
	A meeting was conducted with the Administrator				The facility is pursuing having the dry drums replaced on the dryers	er	
	and the Director of Nursing on 8/4/16 at 2:55 p.m. The above findings was shared.			<ol> <li>The Facility will monitor its performance to make sure solutions a sustained.</li> </ol>	ire		
	483.70(h) SAFE/FUNCTIONAI E ENVIRON	/SANITARY/COMFORTABL	F4	65	The Dryer drums will be checked daily five times per week by the Housekeeping/Laundry Manager, Maintenance Director or designee to ensure they are clean and in safe working order.		
	The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.				An audit will be completed daily five times per week for four weeks and the monthly for three months and finding reported to the QAPI committee until compliance is achieved and maintaine	дагален үүдөөдө	

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MED

FORM APPROVED
OMB NO. 0938-0391

<u> </u>	<u>RS FOR MEDICARE</u>	& MEDICAID SERVICES				$\sim 10  \text{Ce}$	WAPPROVEL
STATEMENT	T OF DEFICIENCIES OF CORRECTION	DEFICIENCIES (X1) PROVIDED/GLIDDLIEB/CHA		LTIPLE DING_	CONSTRUCTION	(X3) DAT	). 0938-0391 TE SURVEY MPLETED
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NAME OF	PROVIDER OR SUPPLIER			STI	PEET ADDECK CITY OF THE PARTY O		/04/2016
201000	5 I 65 45 9 4 40 40 40 40 40 40 40 40 40 40 40 40 4				REET ADDRESS, CITY, STATE, ZIP CODE		
GULDER	I LIVINGCENTER- PO	RTSMOUTH			LONDON BOULEVARD		
AND	The state of the s			۲U	PRTSMOUTH, VA 23704		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	n ac	(X5) COMPLETION DATE
F 465	Continued From pa	ge 39 IT is not met as evidenced	F	165	5.) Date Corrective Action will be completed.	scholations (PP	e Compiled in Compiled in the American Chief American (Chief American Chief Chief American Chief
	ph:	vi is not met as evidenced			Compliance Date is 09/08/16		
	-	inn staff into in			Date is 09/08/16		
	documentation review	ion, staff interview, and facility we the facility staff failed to in a safe and sanitary					
	three facility dryers i substances melted	on the inside of dryer bins) om debris caked on the inside					
	The findings include	đ:					
	laundry room on 8/3, p.m. one empty drye substance caked on color on the dryer dryer approximately 2:30 p Manager, Maintenan Director, and two lau present, all three fac	o.m. with the Housekeeping ce Director, Housekeeping ndry staff (Others #7 and #8) ility dryers were observed If unknown substances with					
; ; ; ; ;	laundry/housekeeping 'Things get burned of get this off." In an inter papproximately 2:35 p. Director, Housekeeping Housekeeping Directous Jonknown substances Jonto all three dyer bing Janager stated, "It co	3/16 at 2:00 p.m. with a g staff (others #6) he stated, in [the dryers] and we can't erview on 8/3/16 at .m. with the Maintenance ing Director, and District or it was agreed that were present and melted is. The Housekeeping build be a diaper" and he and clean". He reached into					

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		: & MEDICAID SERVICES	T		OMB NO	O. 0938-0391	
	T OF DEFICIENCIES OF CORRECTION			LTIPLE CONSTRUCTION DING	(X3) DA	(X3) DATE SURVEY COMPLETED	
		495149	B. WING		(h)	C	
	PROVIDER OR SUPPLIER  V LIVINGCENTER- PO	RTSMOUTH		STREET ADDRESS, CITY, STATE, ZII 900 LONDON BOULEVARD PORTSMOUTH, VA 23704	P CODE	<u>8/04/2016</u>	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG		ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
	what this is and we company for dryer rinterview when asked been in the dryers, stated, "I have only and its been like the stated, "I'm not sayidebris] but [when it on cleaning the lint."  In an interview with laundry/housekeepi on 8/3/16 at 3:30 p.1 nursing plastic glove no fires." On 8/3/16 Housekeeping/Launhave been like that. On 8/3/16 at 6:30 p. Director stated, "I caleaning/maintenance and there are two or [either] take the whole finally added, we the dyers.  The facility staff was regarding maintenar was presented by the cleaning and maintefacility staff only presfor cleaning the lint to the facility administrating of the staff only presfor cleaning the lint to the facility staff only presfor cleaning the lint to the facility administrating of the staff only presfor cleaning the lint to the facility administrating of the staff only presfor cleaning the lint to the facility administrating of the staff only presfor cleaning the lint to the facility administrating of the staff only presfor cleaning the lint to the facility administrating of the staff only presfor cleaning the lint to the facility administrating of the staff only presfor cleaning the lint to the facility administrating of the staff only presfor cleaning the lint to the facility administrating of the staff only presfor cleaning the staff only presfor c	ce and stated, "I am not sure could call the cleaning maintenance." In the same ad how long this debris has the Housekeeping Director been here for about a month at since I've started." He also ng that's good [the melted comes to safety] I concentrate "  another ng staff member (Others #7) m. she stated, "Sometimes as get caught in the dryer but at approximately 4:00 p.m. adry (others #8) staff stated, "I 4 months and the dryers."  m. the Housekeeping alled [the be company for the dryers] obtions once it gets that bad alle drum out or power wash." are looking into this to clean asked to provide a policy be facility staff regarding the nance of the dryers. The sented a daily and hourly log rap of the dryers.  ation was informed of the	F 4	465			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION DING	(X3) DATE SURVEY COMPLETED	
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			PORTSMOUTH, VA 23704		
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