STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495149	A. BUILDING _____ 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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
F 000	Initial Comments An unannounced State Licensure Inspection was conducted 08/2/16 through 08/04/16. The facility was not in compliance with the Virginia Rules and Regulations for the Licensure of Nursing Facilities. Two complaints were investigated during the survey. The census in this 120 bed facility was 115 at the time of the survey. The survey sample consisted of 20 current Resident reviews (Residents #1 through 20) and 3 closed record reviews (Residents #21 through 23).	F 000	Preparation and/or execution of the Plan of Correction does not constitute admission or agreement of the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The Plan of Correction is prepared and/or executed solely because it is required by the provision of Federal and State law. This plan of correction is the facility's credible allegation of compliance.	
F 001	Non Compliance The facility was out of compliance with the following state licensure requirements: This RULE: is not met as evidenced by: 12VAC 5-371-250 Resident assessment and care planning. Cross Referenced to F278 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 J Therapeutic diets cross reference to F tag 367 12 VAC 5-371-271(A) Social Services Please Cross Reference F 250	F 001	12VAC 5-371-250 Resident Assessment and care planning. Cross Reference to F278. 12VAC 5-371-370A/B Maintenance and Housekeeping. Cross Reference to F323. 12VAC 5-371-370 A Maintenance and Housekeeping. Cross Reference to F465. 12VAC 5-371-340 Dietary and Food Service Program. J Therapeutic Diets. Cross Reference to F367. 12VAC 5-371-271(A) Social Services. Cross Reference to F250 12VAC 5-371-250 (A.D.) Resident Assessment. Cross Reference F278.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	Interim Exec. Dir	8/26/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495149	A. BUILDING _____ 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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
F 001	Continued From Page 1	F 001	**12VAC 5-371-220(D)**	

12 VAC 5-371-250 (A.D.) Resident Assessment
Please Cross Reference F 271

12 VAC 5-371-220 (D) Nursing Services:
Based on family interview, staff interview, clinical record review and facility document review the facility staff failed to ensure 2 residents in the survey sample of 23 received twice weekly showers, Resident #2 and Resident #18.

1. Resident #2 was provided 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 dependent on staff for full-body baths/ showers.

Review of the certified nurse aides (CNAs) 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 one shower for the month of July, on Friday 7/1/16.

Review of the shower schedule evidenced the resident was scheduled to receive twice weekly showers on Tuesdays and Fridays during the 3-11 shift.

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

Resident #2 and #18 showers were completed.

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 showers are documented and report non compliance in the daily nursing department start up meeting.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495149	A. BUILDING _____ 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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
F 001	Continued From Page 2	F 001	**4.) The Facility will monitor its performance to make sure solutions are sustained.** The Director of Nursing, Assistant Director of Nursing or Nurse Manager will audit a minimum of 10% of the Care Tracker documentation weekly for four weeks, then monthly for three months, to validate completion and documentation of resident showers. 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. 09/08/16**	

The certified nurse aide (CNA #2) assigned to care for Resident #2 was interviewed on 8/4/16 at 2:30 p.m. She stated the resident was scheduled for showers on the 3-11 shift. The CNA stated the resident is not resistant to care. The CNA stated resident showers are documented into the kiosk (ADL tracker) once they are given. CNA #2 also stated when a resident is given a shower or refuses a shower it is documented 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 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)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495149	A. BUILDING _____ 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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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 shift.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495149	A. BUILDING _____ 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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
F 001	Continued From Page 4	F 001		

exit.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495149	A. BUILDING _____ B. WING _____	C 08/04/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER- PORTSMOUTH	900 LONDON BOULEVARD PORTSMOUTH, VA 23704

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 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 complaints were investigated during the survey. The census in this 120 bed facility was 115 at the time of the survey. The survey sample consisted of 20 current Resident reviews (Residents #1 through 20) and 3 closed record reviews (Residents #21 through 23).	F 000	Preparation and/or execution of the Plan of Correction does not constitute admission or agreement of the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The Plan of Correction is prepared and/or executed solely because it is required by the provision of Federal and State law. This plan of correction is the facility's credible allegation of compliance.	
F 250 SS=D	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on staff interviews and clinical record review the facility staff failed to pursue medically-related social services for 1 of 23 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	F 250	**F 250** **1.) How the Corrective Action was accomplished for those residents found to have been affected.** Resident #2 has received their glasses For Resident #2 staff was educated on the process for management of ophthalmology services. **2.) How the facility will identify other residents having the potential to be affected by the deficient practice.** Residents with order for ophthalmology services have the potential to be affected. The Social Services Director, Social Services Assistant or Nursing Manager will audit the medical record of residents with orders for ophthalmology services to validate receipt of glasses for applicable residents. **3.) The Following Measures will be put into place or systematic changes made to ensure that the deficient practice will not recur.**	

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

Executive Dir. | 8/26/16

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495149	A. BUILDING _____ B. WING _____	C 08/04/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER- PORTSMOUTH	900 LONDON BOULEVARD PORTSMOUTH, VA 23704

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 250	Continued From page 1	F 250	The Director of Clinical Education, Director of Clinical Education Assistant will educate Social Services, Business Office Manager, Interdisciplinary Care Plan Team and Nursing Staff on the process for management of ophthalmology services.	

on 7/12/16. The business office further delayed the process by not submitting an adjustment to the Department of Medical Assistance Services (DMAS) until 7/27/16.

The findings included:

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. Under Section B. Hearing, Speech, and Vision the resident was coded as having impaired vision-sees large print, but not able to see newspapers/books.

On 8/3/16 at 1:50 p.m., CNA #2 (certified nurse aide) assigned to Resident #2 was interviewed. She was asked about the resident's use of glasses and stated, "She really needs them...I've been waiting a long time for those glasses...She (the resident) can see better with them...I 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."

On 8/3/16 at 6:25 p.m., the unit two nurse manager was interviewed. She was asked how long had Resident #2's glasses been missing and what was the status on obtaining new ones. She stated, "Since April or May, I want to say May...she was seen by the eye doctor...as far as I know we are waiting for a prescription." The unit manager stated a physician order could be

The Social Services Director, Social Worker Assistant or Nursing Manager will arrange ophthalmology services for residents with applicable orders.

The Nurse Unit Managers will update C.N.A Care Cards to indicate the use of prescription eye glasses.

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

The Social Services Director, Social Worker Assistant or Nursing Manager will audit 100% of the in house resident's 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.

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

5.) Date Corrective Action will be completed.

Compliance Date is 09/08/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495149	A. BUILDING _____ B. WING _____	C 08/04/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER- PORTSMOUTH	900 LONDON BOULEVARD PORTSMOUTH, VA 23704

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 250	Continued From page 2	F 250		

obtained within an hour, and could be pursued through fax or telephone.

Review of the clinical record evidenced the resident was evaluated by the contracted eye care services physician on three occasions since January 2016:
1. The resident was evaluated on 1/4/16 for a chief complaint of irritated, red eyes, with mattering. The resident was prescribed an eye gel (Lotemax) and diagnosed with dry eye syndrome of both eyes. The resident was to be followed up in April for a corneal evaluation.
2. On 4/4/16 the resident was re-evaluated and an eyeglass prescription was obtained.
3. On 7/27/16 the resident was re-evaluated for dry eye syndrome, a follow-up was scheduled for 1/2017.

Further investigation included an interview with the Business Office Administrator (BOA) on 8/3/16 at 6:25 p.m. The BOA stated she received the remission of payment request from the eye vision services in her office on 5/24/16 in the amount of $159.98 for a pair of eyeglasses for Resident #2. The payment request was dated 4/4/16. She stated she did not receive this document until 5/24/16 (per the time stamp on the right corner of the document). She stated the unit secretary is provided with the all follow up documentation after each eye appointment evaluation, and disperses the documentation to the appropriate staff for further action. The BOA could not state why her office received the payment request 7 weeks after it was requested. The BOA continued 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495149	A. BUILDING _____ B. WING _____	C 08/04/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER- PORTSMOUTH	900 LONDON BOULEVARD PORTSMOUTH, VA 23704

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

F 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 SS=D 483.20(g) - (j) ASSESSMENT 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.

F 278

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495149	A. BUILDING _____ B. WING _____	C 08/04/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER- PORTSMOUTH	900 LONDON BOULEVARD PORTSMOUTH, VA 23704

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 278	Continued From page 4 that portion of the assessment. 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 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. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on observations, resident interview, staff interviews, facility documentation review, clinical record review, and in the course of a complaint investigation, the facility failed to ensure that the Minimum Data Set (MDS) were accurate for two of 23 residents in the survey sample, Residents #2 and #6. 1. The facility staff dashed (-) the quarterly MDS (Minimum Data Set) with an assessment reference date (ARD) of 5/30/16 in Sections C, D, E, and J for Resident #6 instead of locating resident assessments to assess his Cognitive, Mood, Behaviors, and Health Conditions over the 7 days look back period. 2. The facility staff failed to ensure the quarterly MDS (Minimum Data Set) with an assessment	F 278	**4.) The Facility will monitor its performance to make sure solutions are sustained.** The Director of Nursing, Assistant Director of Nursing or Nurse Manager will audit a minimum of 3 MDS weekly to determine the accuracy of coding for sections C, D, E, J and P. 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	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495149	A BUILDING _____ B WING _____	C 08/04/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER- PORTSMOUTH	900 LONDON BOULEVARD PORTSMOUTH, VA 23704

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 278	Continued From page 5	F 278		

reference date (ARD) of 5/24/16 Section P. Restraints was accurate for Resident #2.

The findings included:

1. Resident #6 was admitted to the facility on 8/28/15. Diagnoses for Resident #6 included but are not limited to Quadriplegia (total or partial loss of all limbs and torso) and Manic Depressive Bipolar Disorder.

Resident #6's Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 5/30/16 coded Resident #6 as being "Understood" in the ability to express ideas and wants.

Section C "Cognitive Patterns" were dashed in the following sections:

C0200 Repetition of Three Words

C0300 Temporal Orientation

C0400 Recall

C0500 Summary Score

C0600 Should the Staff Assessment for Mental Status (C0700-C1000 be Conducted?

C0700 Short-Term Memory

C0800 Long-Term Memory

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495149	A. BUILDING _____ B. WING _____	C 08/04/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER- PORTSMOUTH	900 LONDON BOULEVARD PORTSMOUTH, VA 23704

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 278	Continued From page 6 C0900 Memory/Recall Ability C1000 Cognitive Skills for Daily Decision Making Section D "Mood" were dashed in the following sections: D0100 Should Resident Mood Interview be Conducted? D0200 Resident Mood Interview sections A through I D0300 Total Severity Score D0500 Staff Assessment of Resident Mood sections A through J. D0600 Total Severity Score Section E "Behavior" were dashed in the following sections: E0100 Potential Indicators of Psychosis E0200 Behavioral Symptom - Presence and Frequency sections A through C E0800 Rejection of Care - Presence and Frequency E0900 Wandering - Presence and Frequency Section J "Health Conditions" were dashed in the following sections: J0300 Pain Presence J0400 Pain Frequency	F 278		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495149	A. BUILDING _____ B. WING _____	C 08/04/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER- PORTSMOUTH	900 LONDON BOULEVARD PORTSMOUTH, VA 23704

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 278	Continued From page 7	F 278		

J0500 Pain Effect on Function sections A and B

J0600 Pain Intensity sections A and B

J0700 Should the Staff Assessment for Pain be Conducted?

J0800 Indicators of Pain or Possible Pain in the last 5 days

J0850 Frequency of Indicator of Pain or Possible Pain in the last 5 days

J1100 Shortness of Breath (dyspnea)

Resident #6's care plan Focus "I sometimes have behaviors which include: refusal of care refused to be seen by wound care physician. Leaving facility in wheelchair smoking on sidewalk. Leaving building with IV ABT (intravenous antibiotic) attached to PICC (peripherally inserted central catheter) line. Sections E of the Quarterly MDS with an ARD of 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.

Resident #6's care plan Focus "Potential for drug related complications associated with use of psychotropic medications related to: Anti-Psychotic medication" initiated on 7/17/16. Resident #6's diagnoses on his Quarterly MDS with ARD of 5/30/16 included a diagnosis of Manic Depressive Bipolar. Sections E of the Quarterly MDS with an ARD of 5/30/16 were

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495149	A. BUILDING _____ B. WING _____	C 08/04/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER- PORTSMOUTH	900 LONDON BOULEVARD PORTSMOUTH, VA 23704

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 278	Continued From page 8	F 278		

dashed.

Resident #6 was interviewed on 8/4/16 at approximately 10:45 a.m.. Resident #6's cognition was intact as he was alert and oriented to person, time and place. Sections C (Cognitive Skills) of the Quarterly MDS with an ARD of 5/30/16 were dashed.

An interview on 8/3/16 at approximately 10:37 a.m. with Registered Nurse (RN) #1. RN #1 was asked why the Quarterly MDS sections with an ARD date of 5/30/16 were all dashed. RN #1 stated, "The RAI manual will not let you update sections after you enter it and accept it." When asked how a Resident's care can be generated from the assessment, RN #1, stated, "You can read the nurses notes."

A second interview on 8/4/16 at approximately 2:55 p.m. RN #1, was asked again about the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 5/30/16 sections C, D and J being dashed. RN #1 was asked if the following sections should have been completed in the timeframe (7 days look back) allowed and because Resident #6 had not been discharged or hospitalized, RN #1 stated, "Yes."

The RAI MDS 3.0 manual states at chapter 3 page 4: Almost all MDS 3.0 items allow a dash (-) value to be entered and submitted to the MDS Quality Improvement and Evaluation System (QIES) Assessment Submission and Processing System (ASAP). A dash value means an item has not been assessed. The most often occurs

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495149	A. BUILDING _____ B. WING _____	C 08/04/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER- PORTSMOUTH	900 LONDON BOULEVARD PORTSMOUTH, VA 23704

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 278	Continued From page 9	F 278		

when a resident is discharged before an item has been assessed. Dashed values allow a partial assessment to be submitted when an assessment is required for payment purposes. There are 4 date items (A2400C, O0400A6, O0400B6, O0400C6) that use a dash-filled value to indicate the even has not yet occurred.

The RAI MDS 3.0 manual states at chapter 2 page 13: OBRA -Required Tracking Records and Assessments are federally mandated, and therefore, must be performed for all residents of Medicare and/or Medicaid certified nursing homes...They include ... Assessments: ... Quarterly.

The facility administration consisting of the Administrator and the Director of Nursing was informed of the findings during a meeting on 8/4/16 at approximately 4:00 p.m. The facility did not present any further information about the findings.

2. The facility staff failed to ensure the quarterly MDS (Minimum Data Set) with an assessment reference date of 5/24/16 Section P. Restraints was accurate for Resident #2.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495149	A. BUILDING _____ B. WING _____	C 08/04/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER- PORTSMOUTH	900 LONDON BOULEVARD PORTSMOUTH, VA 23704

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 278	Continued From page 10	F 278		

decision making skills. Section P. Restraints coded the resident as having a limb restraint used while in a chair or out of the bed.

A review of the clinical record evidenced a physician order dated 5/14/15 that read, in part: Please provide patient with one-sided hinged padded lap board to be placed on patient wheelchair for patients convenience and assist with self positioning. Ask patient to open the lap-board every 2-3 hours for repositioning and weight shifting.

During the survey day of 8/2/16, 8/3/16 and 8/4/16 the resident was observed in various areas such as the unit dining/activity room and the resident room to be in a wheelchair with a one-sided hinged padded lap board.

On 8/4/16 the certified nurse aide (CNA#2) assigned to care for the resident was interviewed. She stated the resident seems to be more independent with the padded lap tray in use. She stated the resident is able to reach for cups placed on it and is able to participate with independent captivities better due to having them being closer in reach. During this time the resident was able to demonstrate pulling the hinged padded lap tray up and down after demonstration and verbal prompting.

On 8/3/16 at 6:40 p.m., the Director of Resident Assessments was interviewed. The quarterly MDS section P. Restraints was reviewed. She stated, "It is incorrect...I will modify it".

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495149	A. BUILDING _____ B. WING _____	C 08/04/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER- PORTSMOUTH	900 LONDON BOULEVARD PORTSMOUTH, VA 23704

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 278	Continued From page 11 Additional information was not provided prior to exit.	F 278	**F 312** **1.) How the Corrective Action was accomplished for those residents found to have been affected.** Resident #2 and #18 showers were completed. 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 showers are documented and report non compliance in the daily nursing department start up meeting.	
F 312 SS=E	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. 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	F 312		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495149	A. BUILDING _____ B. WING _____	C 08/04/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER- PORTSMOUTH	900 LONDON BOULEVARD PORTSMOUTH, VA 23704

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 312	Continued From page 12	F 312	**4.) The Facility will monitor its performance to make sure solutions are sustained.**	

dependent on staff for full-body baths/ showers.

Review of the shower schedule evidenced the resident was scheduled to receive twice weekly showers on Tuesdays and Fridays during the 3-11 shift.

A review of the certified nurse aides (CNAs) documentation on the ADL (activities of daily living) electronic tracker for the month of July 2016 was conducted. The ADL tracker evidenced the resident received one shower for the month of July, on Friday 7/1/16.

The certified nurse aide (CNA #2) assigned to care for Resident #2 was interviewed on 8/4/16 at 2:30 p.m. She stated the resident was scheduled for showers on the 3-11 shift. The CNA stated the resident is not resistant to care. The CNA stated resident showers are documented into the kiosk (ADL tracker) once they are given. CNA #2 also stated when a resident is given a shower or refuses a shower it is documented on the assignment sheet.

A request for the assignment sheets for the month of July 2016 was made. 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 the assignment sheets 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

The Director of Nursing, Assistant Director of Nursing or Nurse Manager will audit a minimum of 10% of the Care Tracker documentation weekly for four weeks, then monthly for three months, to validate completion and documentation of resident showers.

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. 09/08/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495149	A. BUILDING _____ B. WING _____	C 08/04/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER- PORTSMOUTH	900 LONDON BOULEVARD PORTSMOUTH, VA 23704

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 312	Continued From page 13	F 312		

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 shower schedule evidenced the resident was scheduled to receive twice weekly showers on Tuesdays and Fridays during the 7-3 shift.

Review of the certified nurse aides (CNAs) 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 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 on the assignment sheet.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495149	A. BUILDING _____ B. WING _____	C 08/04/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER- PORTSMOUTH	900 LONDON BOULEVARD PORTSMOUTH, VA 23704

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

F 312 Continued From page 14

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 exit.

F 314 SS=D 483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES

Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.

This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview, clinical record review and facility document review the facility staff failed to provide the necessary care

F 312 F 314

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

Resident #1 no longer resides at the facility.

Competency evaluation was completed with the Treatment Nurse

Nurses were educated on the policy and procedures on dressing change and infection control.

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

Residents with pressure ulcers have the potential to be affected.

The Director of Clinical Education, Director of Clinical Education Assistant or designee will complete wound treatment competencies with licensed nurses.

F 314

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 continue to provide education on Wound Treatment competencies upon hire and annually.

The Director of Clinical Education or Assistant Director of Clinical Education will perform competency evaluation with nurses on pressure ulcer dressing change.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495149	A. BUILDING _____ B. WING _____	C 08/04/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER- PORTSMOUTH	900 LONDON BOULEVARD PORTSMOUTH, VA 23704

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 15 and services to promote healing and prevent infection during a pressure ulcer/sore dressing change for 1 resident out of 24 in the survey sample, Resident #1. The nurse failed to change gloves and implement hand hygiene after cleaning the wound bed, the nurse continued to use the same gloves to continue application of the treatment and dressing. The findings included: Resident #1 was admitted to the facility on 10/13/15 and readmitted on 2/25/16 with diagnoses to include coronary artery disease, 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 impaired cognition. Section M. Skin Conditions coded the resident as having a stage IV pressure ulcer/sore. A stage IV pressure ulcer is described on the MDS as: Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar (dead tissue) may be present on some parts of the wound bed. Often include undermining and tunneling. The comprehensive plan of care date initiated 2/11/16 included actual pressure ulcer. The goal was that the wound would heal without complications. One of the interventions listed to obtain the goal was for treatments as ordered.	F 314	**4.) The Facility will monitor its performance to make sure solutions are sustained.** The Director of Nursing, Assistant Director of Nursing or Nurse Manager will audit a minimum of 10% of residents with pressure ulcers dressing change weekly 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 prevent infection during pressure ulcer dressing change for residents. Findings will be reported to 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	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495149	A. BUILDING _____ B. WING _____	C 08/04/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER- PORTSMOUTH	900 LONDON BOULEVARD PORTSMOUTH, VA 23704

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 16	F 314		

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495149	A BUILDING _____ B WING _____	C 08/04/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER- PORTSMOUTH	900 LONDON BOULEVARD PORTSMOUTH, VA 23704

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 17	F 314		

The wound nurse was interviewed on 8/3/16 at 7:15 p.m. The observation of failing to change gloves after cleaning the wound and using these same gloves to apply the clean dressing was shared. The wound nurse stated, "The whole goal is to prevent infection or cross-contamination". When asked if appropriate infection control practices were maintained during the dressing change she stated, "Not in missing that step...No..." When asked why she would store gloves inside her scrub top she stated that she normally has a box of gloves with her that she takes into the resident rooms. She stated a box of gloves was not available for use inside the treatment cart.

The facility's Clean Dressing Change Competency list included the following steps:
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...
14. Remove gloves, perform hand hygiene, and put on clean gloves
15. Apply prescribed medication...
16. Apply prescribed dressing...

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.

A meeting was conducted with the Administrator

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495149	A. BUILDING _____ B. WING _____	C 08/04/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER- PORTSMOUTH	900 LONDON BOULEVARD PORTSMOUTH, VA 23704

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314 SS=E	Continued From page 18 and the Director of Nursing on 8/4/16 at 2:55 p.m. The above findings was shared. F 323 483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility documentation review the facility staff failed to ensure a safe environment free from the hazard of an unlocked biohazard storage room and free from accident hazard for 1 Resident of 23 residents (Resident #17). 1. Facility staff failed to ensure the biohazard storage room was locked on unit II. 2. The facility staff failed to provide an environment free from accident hazards by not ensuring that Resident 17's wheel chair alarm was in place on 8/3/16 when Resident #17 was found on floor after a fall. The findings included: 1. During general observations with the Maintenance Director on 8/3/16 at approximately 3:30 p.m. the biohazard storage room on unit II was observed to be unlocked with no staff near	F 314	F323 **1.) How the Corrective Action was accomplished for those residents found to have been affected.** The Biohazard storage room is locked. A new door closure was placed on the door for automatic secure/closure. A secured key is in place for staff use. For Resident #17, an alarm was placed on chair on 08/03/16. For Resident #17 a fall risk assessment, care plan and care card were updated. **2.) How the facility will identify other residents having the potential to be affected by the deficient practice.** All residents in the vicinity of the biohazard doors had the potential to be affected. Residents at risk for falls have the potential to be affected. The Nurse Unit Managers or Nurse Manager will review the medical records of residents identified as being at risk for falls to validate those interventions are implemented.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495149	A. BUILDING _____ B. WING _____	C 08/04/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER- PORTSMOUTH	900 LONDON BOULEVARD PORTSMOUTH, VA 23704

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 19	F 323	**3.) The Following Measures will be put into place or systematic changes made to ensure that the deficient practice will not recur.**	

the door. The Maintenance Director was observed getting his keys out but not needing to use the keys to unlock the door as the door was unlocked. On a second observation at 8/3/16 at approximately 4:00 p.m. the biohazard storage room on unit II was unlocked with no staff near the door. On a third observation on 8/4/16 at 9:50 a.m. the door was locked. On a fourth observation on 8/4/16 at 2:00 p.m. the door to the biohazard storage room was unlocked with no staff near the door. After this writer freely opened the unlocked door to the biohazard storage room at 2:00 p.m., a staff member who had witnessed the observation was observed locking the door at 2:05 p.m..

On 8/4/16 at approximately 2:05 p.m. LPN #1 (Licensed Practical Nurse), the Unit II Manager, was interviewed. LPN #1 explained that the Biohazard storage room contained bio-hazard red boxes with used sharps (needles), dirty linen and trash. LPN #1 also stated, "It [the door to the biohazard storage room] should be locked at all times. She went on to explain, "Ideally, everyone should have a key, there may be individuals that do not have a key ...like new employees not issued yet or an employee that left key at home." Finally, LPN #1 stated, "I do periodic checks on the door and will educate staff [to lock the door]."

On 8/4/16 at 3:30 p.m. LPN #1 returned and stated, "I figured out with the Maintenance Director that the door [to the biohazard storage room] was not being pulled closed all the way." LPN #1 also explained, "The Maintenance Director made sure when the door gets pulled closed that it locks and will make sure staff has keys to open."

The Director of Clinical Education, Assistant Director of Clinical Education or Nurse Manager will provide education to staff on the guidelines for falls precautions.

The Interdisciplinary Team will develop and implement an individualized plan of care to address the residents identified risks.

The Nurse Unit Managers and IDCPT Department Managers or Nurse Manager designee will validate placement of applicable interventions during observational facility rounds.

The Director of Clinical Education, Assistant Director of Clinical Education or Nurse Manager designee will educate the staff on the guidelines for Environmental Safety, to include maintaining the security of all applicable doors. The Staff will validate that the Biohazard / Soiled Utility room is secure when exiting. The Maintenance Director, Assistant Maintenance Director will validate security of Biohazard / Soiled Utility rooms daily time five days per week.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495149	A. BUILDING _____ B. WING _____	C 08/04/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER- PORTSMOUTH	900 LONDON BOULEVARD PORTSMOUTH, VA 23704

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 20 On 8/4/16 at approximately 4:00 p.m. the Maintenance Director stated, "I made sure door [biohazard 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	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495149	A. BUILDING _____ B. WING _____	C 08/04/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER- PORTSMOUTH	900 LONDON BOULEVARD PORTSMOUTH, VA 23704

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 21	F 323		

Resident #17 was coded as having 1 fall since admission on the Quarterly MDS with no evidence of any injury.

Resident #17's current 4/13/16 Care Plan documented a focus area of "At risk for falls related to: Use of medication, new environment. 7/8/16 Fall without injury, 7/29/16 Fall without injury, 8/3/16 Fall without injury. Interventions documented included but were not limited to: chair/bed alarm: initiated 7/29/16; Staff to assist with toileting after meals: initiated 7/12/16, Footwear to prevent slipping while OOB (out of bed): revised 7/11/16, and Grab Bar: revised on 7/11/16."

Resident #17's 7/29/16 Fall documentation note documented "chair alarm in place."

Resident #17's Treatment Administration Record (TAR) for July 2016 showed no documentation for placement of either a chair alarm or bed alarm. Resident #17's August TAR documented "Monitor placement and function of chair alarm each shift" beginning 8/4/16.

An observation was made on 8/3/16 at approximately 4:23 p.m. three Laundry Staff members walking past Resident #17's room comment, "she fell". Immediately, LPN (Licence Practical Nurse) #10 locked the medication cart and went into Resident #17's room. Resident #17 was observed to be sitting on the floor with legs outstretched in front of her between her bed and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495149	A. BUILDING _____ B. WING _____	C 08/04/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER- PORTSMOUTH	900 LONDON BOULEVARD PORTSMOUTH, VA 23704

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 22	F 323		

beside the bathroom door. LPN #10 began a head to toe assessment of Resident #17. Resident #17 stated when asked if she was hurt, "Nowhere except my pride. I didn't hit my head. I hit my butt. My knees are really sore. They were sore before my fall. I was coming out of there (pointed to the bathroom)." Resident #17 was observed to be wearing pull up briefs and non slip shoes. The staff assessed Resident #17 then she was assisted with the sit to stand lift into bed. LPN #10 notified Resident #17's daughter of the fall and stated the Physician was notified.

Resident #17's "RESIDENT CARDEX INFO" card documented the following: bed/chair alarm, assist x 1, grab-bars, offer toileting before bedtime/chair alarm.

On 8/3/16 at approximately 5:06 p.m. LPN #1 was observed taking a chair alarm from new package and placing it in Resident #17's wheel chair. LPN #1 stated, "I saw it (wheel chair alarm) Friday (7/29/16). LPN when asked if wheel chair alarm was in wheel chair prior to her placing the new one on stated, "No." CNA #1 stated, "Maybe it (wheel chair alarm) got moved when chair got washed." CNA #1 was asked when wheel chair was last washed and she stated, "I don't know."

On 8/3/16 at approximately 5:20 p.m. with the surveyor assessed Resident #17's bed and found bed alarm to be in place. The Corporate Consultant asked LPN #10 if Resident #17 had been in the bed or wheel chair prior to ambulating to the bathroom, LPN #10 stated, "She was in the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495149	A. BUILDING _____ B. WING _____	C 08/04/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER- PORTSMOUTH	900 LONDON BOULEVARD PORTSMOUTH, VA 23704

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 23 wheel chair." The facility Guideline titled "Falls Management Guideline" with an effective date of 10/21/15 documented to following: "...Assure that the appropriate fall interventions are in place prior to the resident's admission. Newly admitted/readmitted residents are assessed for fall risk by means of the Clinical Health Status tool. The Immediate Plan of Care At Risk - Falls Risk is initiated.... Residents at risk for falls are care planned with individualized interventions." The facility administration consisting of the Administrator and the Director of Nursing was informed of the findings during a meeting on 8/4/16 at approximately 4:00 p.m. The facility did not present any further information about the findings.	F 323		
F 367 SS=E	483.35(e) THERAPEUTIC DIET PRESCRIBED BY PHYSICIAN Therapeutic diets must be prescribed by the attending physician. This REQUIREMENT is not met as evidenced by: Based on the investigation of a complaint, observation, staff and resident interviews and clinical record review it was determined for three of 23 residents in the survey sample that facility staff failed to serve therapeutic diets for Residents #'s 8, 19 and 20. A therapeutic diet is defined as a diet ordered by a physician as part of treatment for a disease or clinical condition, or to	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 physician. Resident #20 no longer resides at the facility Nursing and Dietary staff were educated 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 medical records, tray cards and meals to validate compliance with therapeutic diet as ordered.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495149	A. BUILDING _____ B. WING _____	C 08/04/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER- PORTSMOUTH	900 LONDON BOULEVARD PORTSMOUTH, VA 23704

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 367	Continued From page 24	F 367	**3.) The Following Measures will be put into place or systematic changes made to ensure that the deficient practice will not recur.**	

eliminate or decrease specific nutrients in the diet or to increase specific nutrients in the diet. Therapeutic diets also include a change in the texture of the food (mechanically altered diet).

The findings included:

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 cognitively intact with a brief interview for mental status of 15 out of 15.

Resident #8's functional status was compromised by a right tibia (bone in lower leg) fracture that did not heal well and prevented her from being weight bearing. This resident required the extensive assistance of one staff with bed mobility, transfer, toilet use and hygiene. Once up in a wheelchair she was able to locomotion on and off the unit. Limited assistance was required with eating.

Review of the clinical record evidenced the resident was prescribed a renal diet by her physician to help manage her chronic kidney failure. Resident #8 required dialysis three times a week to provide her body with what her kidneys were unable to do.

Kidneys are two organs in the lower back are the bodies filtration system cleaning wastes and extra

The Dietary Manager, Assistant Dietary Manager or designee will observe tray line for meal services.

The Tray Card will be read to the cook at the beginning of the tray line.

The Tray Card will be checked against the meal as plated at the end of the tray line 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.

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

The Dietary Manager, Assistant Dietary Manager or designee will monitor tray line for accuracy of therapeutic diets daily for four weeks, then weekly for three months to validate accuracy.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495149	A. BUILDING _____ B. WING _____	C 08/04/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER- PORTSMOUTH	900 LONDON BOULEVARD PORTSMOUTH, VA 23704

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 367	Continued From page 25	F 367		

fluids from the body and producing and balancing chemicals, in advanced kidney failure dialysis fills this function.

A complaint being investigated during this survey alleged that therapeutic diets were not being served as ordered by the physician. Resident #8 was interviewed on 8/3/16 after lunch when she returned from dialysis. The resident stated that she frequently did not receive her ordered renal diet.

On 8/3/16 the evening meal was observed for temperatures and plating starting at 4:55 p.m. The main entrees were cheese ravioli, with hamburgers, hot dogs and grilled cheese sandwiches as the alternates. The "spread sheet" was reviewed which shows the dietary staff the food items and amounts to be included in each therapeutic diet such as puree, controlled carbohydrate and renal dialysis.

Following the kitchen observation the evening meal was observed in the dining areas and resident rooms.

Resident #8's meal along with the "meal ticket" was observed. The meal ticket, from the kitchen and used to plate her food, evidenced she was to receive "cold cereal, a baked chicken breast, cottage cheese, a dinner roll, a fruit salad and broccoli." When the surveyor entered Resident #8's room and requested to observe her tray (still covered) the resident stated that she had not yet looked at the tray but added it will not be right.

Observation of the tray evidenced that the resident received what was on the spread sheet for a regular diet (cheese ravioli, and garlic

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495149	A. BUILDING _____ B. WING _____	C 08/04/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER- PORTSMOUTH	900 LONDON BOULEVARD PORTSMOUTH, VA 23704

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 367	Continued From page 26	F 367		

bread) and did not have the added items of cold cereal and cottage cheese.

The resident's tray was also observed the following day 8/4/16 for lunch. The dialysis diet only varied one item from the regular menu of pepper cubed steak with cream pepper sauce. The cream pepper 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.

Following lunch the dietary manager was interviewed and made aware of the observations. He stated that the night before chicken breasts were available but was unable to say why they were not on the tray line and available for serving. He was not aware that the diet sheet for that day was incorrect for the diet the resident's were to receive.

2. Resident #19 did not receive the correct therapeutic diet for two of two meals observed. This resident was admitted to the facility 3/12/16. Resident
#19's diagnoses included, anemia, malnutrition, diabetes and chronic renal failure.

Review of the resident's physician's diet order evidenced he was to receive a puree textured dialysis/renal diet. The quarterly MDS with an assessment reference date of 6/3/16 evidenced this resident was unable to complete the brief interview for mental status, and a mechanically altered therapeutic diet was needed. The

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495149	A. BUILDING _____ B. WING _____	C 08/04/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER- PORTSMOUTH	900 LONDON BOULEVARD PORTSMOUTH, VA 23704

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 367	Continued From page 27	F 367		

resident's activities of daily living, including eating, required the extensive assistance of one or two persons.

Observation of the evening meal on 8/3/16 evidenced Resident #19 received pureed cheese ravioli rather than the baked chicken listed on the spread sheet menu. The resident's diet card evidenced he was a "dialysis" pureed with fluid restrictions. However, the meal printed on the slip evidenced he was to receive the cheese ravioli.

The lunch meal was observed on 8/4/16; Resident #19 received the pepper steak with the pepper cream sauce as printed on the diet slip. The master spread sheet evidenced the pepper sauce was to be omitted for dialysis/renal diets.

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.

3. Resident #20 did not receive the correct therapeutic diet for two of two meals observed. This resident was admitted to the facility 7/13/16, she was 76 years old. Resident #20's diagnoses included congestive heart failure, diabetes and end stage renal disease.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495149	A. BUILDING _____ B. WING _____	C 08/04/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER- PORTSMOUTH	900 LONDON BOULEVARD PORTSMOUTH, VA 23704

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

F 367 Continued From page 28

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.

Observation of the evening meal on 8/3/16 evidenced Resident #20 received cheese ravioli rather than the baked chicken listed on the spread sheet menu. The resident's diet card evidenced he was a "dialysis" regular (texture). Printed on the slip evidenced she was to receive the baked chicken and cottage cheese.

The lunch meal was observed on 8/4/16, Resident #20 received the pepper steak with the pepper cream sauce as printed on the diet slip. The master spread sheet evidenced the pepper sauce was to be omitted for dialysis/renal diets.

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 SS=D 483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH

F 367

F 425

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

Medication was disposed of in the sharps container

Nurses were educated on the Medication Destruction for Non controlled Medications.

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

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495149	A. BUILDING _____ B. WING _____	C 08/04/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER- PORTSMOUTH	900 LONDON BOULEVARD PORTSMOUTH, VA 23704

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 425	Continued From page 29	F 425	**4.) The Facility will monitor its performance to make sure solutions are sustained.**	

The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.

A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.

The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility.

This REQUIREMENT is not met as evidenced by:
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

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

The Director of Clinical Education or designee will conduct medication observation with nurses weekly times four weeks, then monthly times three months to validate compliance with Medication Destruction for Non controlled medication.

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

5.) Date Corrective Action will be completed.

Compliance Date is 09/08/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495149	A. BUILDING _____ B. WING _____	C 08/04/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER- PORTSMOUTH	900 LONDON BOULEVARD PORTSMOUTH, VA 23704

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 425	Continued From page 30	F 425		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495149	A. BUILDING _____ B. WING _____	C 08/04/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER- PORTSMOUTH	900 LONDON BOULEVARD PORTSMOUTH, VA 23704

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 425	Continued From page 31 approved drug destruction product.	F 425	F 441 **1.) How the Corrective Action was accomplished for those residents found to have been affected.** Resident #1 no longer resides at the facility. Resident #10 Wound has healed on 08/10/16. Competency Evaluation was completed with treatment nurse. Nurses were educated on appropriate infection control practices during wound care dressing change to prevent cross contamination and infection. **2.) How the facility will identify other residents having the potential to be affected by the deficient practice.** Residents with wounds have the potential to be affected. Audits completed by the Director of Nursing, Assistant Director of Nursing of Nurse Managers. **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 will provide education to the nurses on appropriate infection control practices during dressing change to prevent cross contamination and infection. The Director of Clinical Education, Assistant Director of Clinical Education will continue to perform competency evaluation with nurses on wound dressing change.	
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program 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 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. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495149	A. BUILDING _____ B. WING _____	C 08/04/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER- PORTSMOUTH	900 LONDON BOULEVARD PORTSMOUTH, VA 23704

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 32	F 441	**4.) The Facility will monitor its performance to make sure solutions are sustained.**	

This REQUIREMENT is not met as evidenced by:
Based on observation, staff interviews, clinical record review and facility document review the facility staff failed to implement appropriate infection control practices to prevent cross-contamination and infection during a dressing change for 2 of 23 residents in the survey sample, Resident #1 and #10.

1. During a dressing change observation of the arterial ulcers on Resident #1's left foot and ankle area, the nurse failed to change gloves and implement appropriate hand hygiene after cleaning the wounds.

2. During a dressing change observation of a MASD (moisture associated skin damage) wound on Resident #10's coccyx, the nurse failed to change gloves and implement appropriate hand hygiene after cleaning the wound base. The nurse then touched the calcium alginate dressing and inserted it into the wound base using the same gloves.

The findings included:

Resident #1 was admitted to the facility on 10/13/15 and readmitted on 2/25/16 with diagnoses to include coronary artery disease, 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

The Director of Nursing, Assistant Director of Nursing or Nurse Manager will audit a minimum of 10% of residents with wound dressing change weekly for four weeks, then monthly for three months, to validate that the nurse is implementing appropriate infection control practices to prevent cross contamination and infection during dressing change.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495149	A. BUILDING _____ B. WING _____	C 08/04/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER- PORTSMOUTH	900 LONDON BOULEVARD PORTSMOUTH, VA 23704

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 33	F 441		

impaired cognition. Section M. Skin Conditions coded the resident as having 2 arterial ulcers.

Arterial insufficiency ulcers (also known as Ischemic ulcers or Ischemic wounds) are mostly located on the lateral surface of the ankle or the distal digits. They are commonly caused by peripheral artery disease (PAD). U.S. National Library of Medicine.

The comprehensive plan of care date initiated 3/9/16 included altered skin integrity non-pressure related to arterial wound. The goal was that the wound would heal without complication. One of the interventions listed to obtain the goal was for treatments as ordered.

The Wound Care Specialist Evaluation dated 7/27/16 read, in part:
1. Arterial wound of the right ankle, size 3.0 x 2.0 x 0.2 cm (centimeters), 10% necrotic (dead tissue) and 90% granulation (healthy tissue). Wound progress: Improved.
2. Arterial wound of the right, lateral (side) foot, size 5.0 x 2.0 x not measurable cm. 20% thick adherent black necrotic tissue, 65% granulation tissue and 15% skin. Wound progress: Improved.
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) and apply a dry dressing.

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495149	A. BUILDING _____ B. WING _____	C 08/04/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER- PORTSMOUTH	900 LONDON BOULEVARD PORTSMOUTH, VA 23704

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 34	F 441		

observed setting up a barrier on the bedside table, wash her hands, then removed necessary dressing supplies from the treatment cart, removed gloves and washed her hands. The nurse then removed gloves from inside her scrub top pocket. The nurse then removed a pair of scissors from her scrub top pocket, cleansed the scissors with an alcohol prep pad. The wound 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495149	A. BUILDING _____ B. WING _____	C 08/04/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER- PORTSMOUTH	900 LONDON BOULEVARD PORTSMOUTH, VA 23704

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 35	F 441		

same gloves when applying a clean dressing was shared. The wound nurse stated, "The whole goal is to prevent infection or cross-contamination." When asked if appropriate infection control practices were maintained during the dressing change she stated, "Not in missing that step...No..." When asked why she would store gloves inside her scrub top, she stated that she normally has a box of gloves that she takes inside the resident room with her. She stated a box of gloves was not available for use inside the treatment cart.

The facility's Clean Dressing Change Competency list included the following steps:
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...
14. Remove gloves, perform hand hygiene, and put on clean gloves
15. Apply prescribed medication...
16. Apply prescribed dressing...

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.

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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495149	A. BUILDING _____ B. WING _____	C 08/04/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER- PORTSMOUTH	900 LONDON BOULEVARD PORTSMOUTH, VA 23704

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 36	F 441		

on Resident #10's coccyx, the wound the nurse failed to change gloves and implement appropriate hand hygiene after cleaning the wound base. The nurse then touched the calcium alginate dressing and inserted it into the wound base using the same 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.

The current MDS (Minimum Data Set) a quarterly with an assessment reference date of 7/1/16 coded the resident as having long and short-term memory deficits and severely impaired daily decision making skills. The resident was incontinent of both bladder and bowel. The resident did not have any skin problems during this assessment.

A Wound Evaluation Flow Sheet dated 7/22/16 evidenced the resident was identified on this date as having a MASD to the coccyx area.

The physician ordered treatment dated 7/23/16 instructed the staff to: Clean the wound with normal saline, pat dry, cut Calcium Alginate to fit site, place onto wound bed and cover with a dry dressing every day and as needed.

Alginate Dressings are composed of calcium alginate, a gelatinous and water-insoluble substance. When in contact with a wound, the calcium alginate in the dressing reacts with sodium chloride from the wound. This turns the dressing into a hydrophilic gel that maintains a moist environment for the wound. Good for exudating wounds and helps in debridement and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495149	A. BUILDING _____ B. WING _____	C 08/04/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER- PORTSMOUTH	900 LONDON BOULEVARD PORTSMOUTH, VA 23704

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 37	F 441		

sloughing of wounds. Do not use on low exudating wounds as this will cause dryness and scabbing. Dressings should be changed daily. www.nursingcenter.com

A dressing change observation was conducted on 8/2/16 at 2:55 p.m., with the wound nurse. After placing the wound supplies on the bedside table the nurse washed her hands and then placed on gloves obtained from inside her scrub pocket. After cleansing the wound bed with saline soaked 4x4 gauzes and padding the wound site dry, the nurse grabbed a pre-cut piece of alginate and placed into directly onto the wound. The nurse failed to remove her gloves and implement appropriate hand hygiene prior to applying the treatment. The nurse then removed her gloves and put on new gloves and removed the soiled dressings from the room.

The wound nurse was interviewed on 8/3/16 at 7:15 p.m. The observation of failing to change gloves after cleaning the wound and using the same gloves when applying the alginate dressing was shared. The wound nurse stated, "The whole goal is to prevent infection or cross-contamination". When asked if appropriate infection control practices were maintained during the dressing change she stated, "Not in missing that step...No..." When asked why she would store gloves inside her scrub top she stated that she normally has a box of gloves that she takes inside the resident room with her. She stated a box of gloves was not available for use inside the treatment cart.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495149	A. BUILDING _____ B. WING _____	C 08/04/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER- PORTSMOUTH	900 LONDON BOULEVARD PORTSMOUTH, VA 23704

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 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... 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... 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. 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.	F 441	F 465 **1.) How the Corrective Action was accomplished for those residents found to have been affected.** All three dryers were cleaned and debris removed as of 08/26/16. Staff was educated on keeping dryers safe and free from caked on debris on the dryer drums **2.) How the facility will identify other residents having the potential to be affected by the deficient practice.** All Residents had the potential to be affected. **3.) The Following Measures will be put into place or systematic changes made to ensure that the deficient practice will not recur.** Dryers will be checked daily five times a week to ensure they are safe and sanitary operating condition. The facility is pursuing having the dryer drums replaced on the dryers 4.) The Facility will monitor its performance to make sure solutions are sustained. 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. An audit will be completed daily five times per week for four weeks and then monthly for three months and finding reported to the QAPI committee until compliance is achieved and maintained.	
F 465 SS=F	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.	F 465		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495149	A. BUILDING _____ B. WING _____	C 08/04/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER- PORTSMOUTH	900 LONDON BOULEVARD PORTSMOUTH, VA 23704

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 465	Continued From page 39 This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility documentation review the facility staff failed to maintain equipment in a safe and sanitary operating condition. Specifically, the facility staff failed to maintain all three facility dryers in a safe (unknown substances melted on the inside of dryer bins) and sanitary (free from debris caked on the inside of each dryer) condition. The findings included: During the routine general observation of the laundry room on 8/3/16 at approximately 1:45 p.m. one empty dryer was observed with melted substance caked on debris, brown and black in color on the dryer drum. On 8/3/16 at approximately 2:30 p.m. with the Housekeeping Manager, Maintenance Director, Housekeeping Director, and two laundry staff (Others #7 and #8) present, all three facility dryers were observed with caked on melted unknown substances with brown, black, and white residue. In an interview on 8/3/16 at 2:00 p.m. with a laundry/housekeeping staff (others #6) he stated, "Things get burned on [the dryers] and we can't get this off." In an interview on 8/3/16 at approximately 2:35 p.m. with the Maintenance Director, Housekeeping Director, and District Housekeeping Director it was agreed that unknown substances were present and melted onto all three dyer bins. The Housekeeping Manager stated, "It could be a diaper" and he added, "We could try and clean". He reached into a dryer he pulled out a wad of hard white	F 465	**5.) Date Corrective Action will be completed.** Compliance Date is 09/08/16	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495149	A. BUILDING _____ B. WING _____	C 08/04/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER- PORTSMOUTH	900 LONDON BOULEVARD PORTSMOUTH, VA 23704

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 465	Continued From page 40	F 465		

plastic-like substance and stated, "I am not sure what this is and we could call the cleaning company for dryer maintenance." In the same interview when asked how long this debris has been in the dryers, the Housekeeping Director stated, "I have only been here for about a month and its been like that since I've started." He also stated, "I'm not saying that's good [the melted debris] but [when it comes to safety] I concentrate on cleaning the lint."

In an interview with another laundry/housekeeping staff member (Others #7) on 8/3/16 at 3:30 p.m. she stated, "Sometimes nursing plastic gloves get caught in the dryer but no fires." On 8/3/16 at approximately 4:00 p.m. Housekeeping/Laundry (others #8) staff stated, "I have been here 3 to 4 months and the dryers have been like that."

On 8/3/16 at 6:30 p.m. the Housekeeping Director stated, "I called [the cleaning/maintenance company for the dryers] and there are two options once it gets that bad [either] take the whole drum out or power wash." He finally added, we are looking into this to clean the dyers.

The facility staff was asked to provide a policy regarding maintenance of the dryer. No policy was presented by the facility staff regarding the cleaning and maintenance of the dyers. The facility staff only presented a daily and hourly log for cleaning the lint trap of the dryers.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495149	A. BUILDING _____ B. WING _____	C 08/04/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER- PORTSMOUTH	900 LONDON BOULEVARD PORTSMOUTH, VA 23704

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE