900 London Boulevard



Melissa Green, Administrator Portsmouth Health and Rehab 900 London Blvd Portsmouth, VA 23704 Provider Number 495149 Phone Number: 757.393.6864

Ms. Hudnall, 8/1/17

Sincerely,

Please find our 2567 with our Plan of Correction (POC) attached. If you have any questions feel free to call me at Portsmouth Health and Rehab, 757.393.6864.

Leadard &

Melissa L. Green, Administrator

AUG 0 2 2017 VDH/OLC

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

PRINTED: 07/24/2017 FORM APPROVED OMB NO. 0938-0391

CENTERS FOR IVIEDICARE & IVIEDICAID SERVICES ONIS INC. 09							
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	TIPLE CONSTRUCTION ING	(X3) DATE SURVEY COMPLETED			
	40.54.40	D W///		С			
	495149	B. WING		07/13/2017			
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE				
PORTSMOUTH HEALTH AND REHAB			900 LONDON BOULEVARD				
PORTSMOUTH REALTH AND	KENAB		PORTSMOUTH, VA 23704				
(//4) 10	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(7.10)			
	Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	PREF TAG					
TAG REGULATORY OR L	SO BENTA TAVE AN ONNIATION	IAG	DEFICIENCY)	10/71 =			

F 000 INITIAL COMMENTS

An unannounced Medicare/Medicaid standard survey was conducted 7/11/17 through 7/13/17. Two complaints were investigated. Corrections are required for compliance with the following 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow.

The census in this 120 certified bed facility was 104 at the time of the survey. The survey sample consisted of 30 residents, 24 current Resident reviews (Resident #1 through #24) and 6 closed record reviews (Resident #25 through #30).

F 156 483.10(d)(3)(g)(1)(4)(5)(13)(16)-(18) NOTICE OF SS=E RIGHTS, RULES, SERVICES, CHARGES

(d)(3) The facility must ensure that each resident remains informed of the name, specialty, and way of contacting the physician and other primary care professionals responsible for his or her care.

§483.10(g) Information and Communication. (1) The resident has the right to be informed of his or her rights and of all rules and regulations governing resident conduct and responsibilities during his or her stay in the facility.

- (g)(4) The resident has the right to receive notices orally (meaning spoken) and in writing (including Braille) in a format and a language he or she understands, including:
- (i) Required notices as specified in this section. The facility must furnish to each resident a written description of legal rights which includes -
- (A) A description of the manner of protecting

F 000



F156

- F 156 1. There is no opportunity to correct the letters that have already been sent to residents #25, #26 and #27.
 - 2. Residents that require Medicare cut letters are at risk for this practice.
 - 3. The MDS coordinators and the business office manager have been re-educated by the Administrator on ensuring the cut letters have a telephone number and a QIO number on the letters prior to being sent to a resident or the POA. An audit will be completed weekly x 12 weeks, to review any cut letters to ensure they contain all the required information.
 - 4. Results of the audit will be discussed in the monthly QAPI meeting and reeducation provided as needed

8/13/17

LABORATORY DIRECTOR'S OR PROVIDER SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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.

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

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CENTER	ENTERS FOR MEDICARE & MEDICAID SERVICES				C	MB NO	. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILD		CONSTRUCTION		E SURVEY MPLETED
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NAME OF F	PROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
PORTSN	OUTH HEALTH AND	REHAB			0 LONDON BOULEVARD DRTSMOUTH, VA 23704		
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F 156	Continued From pa personal funds, und section;	ge 1 der paragraph (f)(10) of this	F	156			
	procedures for esta including the right to	the requirements and blishing eligibility for Medicaid, o request an assessment of ction 1924(c) of the Social					
	email), and telepho. State regulatory and resident advocacy of Survey Agency, the State Long-Term Caprotection and advoservices where statin long-term care faagency for informat	addresses (mailing and ne numbers of all pertinent d informational agencies, groups such as the State State licensure office, the are Ombudsman program, the ocacy agency, adult protective e law provides for jurisdiction cilities, the local contact ion about returning to the Medicaid Fraud Control Unit;					
	complaint with the Sconcerning any sus federal nursing facil not limited to reside exploitation, misappin the facility, non-odirectives requirement information regarding (ii) Information and and local advocacy not limited to the St Long-Term Care Or	t the resident may file a State Survey Agency pected violation of state or ity regulations, including but nt abuse, neglect, propriation of resident property ompliance with the advance ents and requests for ng returning to the community. contact information for State organizations including but ate Survey Agency, the State mbudsman program section 712 of the Older					

Americans Act of 1965, as amended 2016 (42



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

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		495149	B. WING	i		C 07/13/2017
NAME OF	PROVIDER OR SUPPLIER		***************************************	STR	REET ADDRESS, CITY, STATE, ZIP CODE	
PORTSM	OUTH HEALTH AND	REHAB			RTSMOUTH, VA 23704	
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F 156	advocacy system (a as established under Disabilities Assistant 2000 (42 U.S.C. 15 [§483.10(g)(4)(ii) with November 28, 2017 (iii) Information regaligibility and covera [§483.10(g)(4)(iii) with November 28, 2017 (iv) Contact information 20(a)(20)(Act); or other No William [§483.10(g)(4)(iv) with November 28, 2017 (v) Contact information Control Unit; and [§483.10(g)(4)(v) with November 28, 2017 (vi) Information and grievances or compassible to the subsected violation facility regulations, resident abuse, negmisappropriation of facility, non-complication regarding information regarding inf	and the protection and as designated by the state, and are the Developmental nee and Bill of Rights Act of 001 et seq.) Ill be implemented beginning (Phase 2)] Arding Medicare and Medicaid age; Ill be implemented beginning (Phase 2)] Ation for the Aging and Center (established under B)(iii) of the Older Americans rong Door Program; Ill be implemented beginning (Phase 2)] Ition for the Medicaid Fraud all be implemented beginning (Phase 2)] Contact information for filing plaints concerning any of state or federal nursing including but not limited to	F	156		

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

manner accessible and understandable to residents, resident representatives:

Event ID: TD2W11

Facility ID: VA0035

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CENTER	CENTERS FOR MEDICARE & MEDICAID SERVICES				C	MB NO. 0938-0391
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		495149	B. WING			C 07/13/2017
NAME OF F	PROVIDER OR SUPPLIER	1		STR	REET ADDRESS, CITY, STATE, ZIP CODE	
PORTSM	OUTH HEALTH AND	REHAB			LONDON BOULEVARD RTSMOUTH, VA 23704	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETION
F 156	Continued From pa	ge 3	F	156		
	and telephone num agencies and advor Survey Agency, the protective services jurisdiction in long-t of the State Long-T program, the protection and communant the Medicaid F (ii) A statement that complaint with the Sconcerning any susfederal nursing facilimited to resident a misappropriation of facility, and non-condirectives requirem	addresses (mailing and email), bers of all pertinent State cacy groups, such as the State State licensure office, adult where state law provides for term care facilities, the Office ferm Care Ombudsman ction and advocacy network, aity based service programs, raud Control Unit; and the resident may file a State Survey Agency spected violation of state or lity regulation, including but not abuse, neglect, exploitation, resident property in the mpliance with the advanced ents (42 CFR part 489 subpart information regarding returning				
	written information, applicants for admi- information about h Medicare and Medi	must display in the facility and provide to residents and ssion, oral and written ow to apply for and use caid benefits, and how to previous payments covered by				
	and services to the	must provide a notice of rights resident prior to or upon ng the resident's stay.				
	and in writing in a la	inform the resident both orally anguage that the resident or her rights and all rules and				



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CENTER	RS FOR MEDICARE	& MEDICAID SERVICES				OMB NO	. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTION		E SURVEY MPLETED
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	PROVIDER OR SUPPLIER	REHAB		900	REET ADDRESS, CITY, STATE, ZIP CODE DICONDON BOULEVARD ORTSMOUTH, VA 23704		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETION DATE
F 156	responsibilities durin (ii) The facility must the State-developed obligations, if any. (iii) Receipt of such amendments to it, nowriting; (g)(17) The facility of the facility of the facility and when the facility of the reside (B) Those other iter facility offers and for charged, and the arrevices; and (ii) Inform each Medical the facility of the facil	ng resident conduct and ng the stay in the facility. also provide the resident with d notice of Medicaid rights and information, and any must be acknowledged in	F	156			
	services, including a	any charges for services not icare/ Medicaid or by the					

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CENTER	RS FOR MEDICARE	& MEDICAID SERVICES				OMB NO	D. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		ONSTRUCTION		ATE SURVEY DMPLETED
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NAME OF F	PROVIDER OR SUPPLIER		1	STREE	T ADDRESS, CITY, STATE, ZIP CODE		
PORTSN	OUTH HEALTH AND	REHAB			ONDON BOULEVARD TSMOUTH, VA 23704		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 156	Continued From pa		F	156			
	and services covered Medicaid State plan	in coverage are made to items ed by Medicare and/or by the n, the facility must provide of the change as soon as is e.	;				
	items and services facility must inform	are made to charges for other that the facility offers, the the resident in writing at least plementation of the change.					
	transferred and doe facility must refund representative, or e deposit or charges per diem rate, for the resided or reserved	s or is hospitalized or is as not return to the facility, the to the resident, resident state, as applicable, any already paid, less the facility's he days the resident actually or retained a bed in the of any minimum stay or quirements.					
	resident representa	t refund to the resident or tive any and all refunds due 30 days from the resident's om the facility.					
	behalf of an individu facility must not con these regulations. This REQUIREMEN by: Based on clinical re interview the facility	admission contract by or on all seeking admission to the affect with the requirements of all is not met as evidenced ecord review and staff staff failed to provide the to the independent reviewer					

authorized by Medicare upon issuance of a Notice of Medicare Non-Coverage for 3 residents



PRINTED: 07/24/2017

CENTE	RS FOR MEDICARE	& MEDICAID SERVICES					O. 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) D	ATE SURVEY OMPLETED
		495149	B. WING				C 97/13/2017
NAME OF I	PROVIDER OR SUPPLIER	-		STR	EET ADDRESS, CITY, STATE, ZIP COD		
PORTSM	OUTH HEALTH AND	REHAB			LONDON BOULEVARD RTSMOUTH, VA 23704		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 156	and 27. The facility staff fail name of the Quality (QIO) and toll-free or ask questions where Medicare Non-Coverand 27. The findings included 1. Resident #25 was Medicare part A, for The resident's diagrespiratory failure. A Non-Coverage (NO) that the effective das services would end signed by the resided (Center for Medicare 10123-NOMNC (apinclude the QIO name for an appeal or question of the resident's diagrintraventicular blockers.	le of 30, Residents #25, 26 led to provide in writing the provement Organization contact number to appeal and then issued a Notice of the least for Residents #25, 26 led: s admitted to the facility under the skilled services on 2/6/17. In the least formula was included chronic to a Notice of Medicare with MNC) informing the resident and least on 3/9/17 was issued and least on 3/7/17. The Form CMS re/Medicaid Services) proved 12/31//2011) did not the me or toll-free number to call	F '	156			
	resident that the eff current services wo issued and signed b The Form CMS 101 12/31//2011) did no	Non-Coverage informing the fective date coverage of old end on 3/14/17 was by the resident on 3/13/17. I23-NOMNC (approved to the QIO name or call for an appeal or questions.					

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3. Resident #27 was admitted to the facility under

Event ID: TD2W11

Facility ID: VA0035

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CENTER	RS FOR MEDICARE	& MEDICAID SERVICES				OMB N	<u>0. 0938-0391</u>
PORTSMOUTH HEALTH AND REHAB 900 LONDON BOULEVARD PORTSMOUTH, VA 23704 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORPERIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE				ATE SURVEY DMPLETED			
		495149	B. WING	i		0	C 7/13/2017
NAME OF F	PROVIDER OR SUPPLIER			7	STREET ADDRESS, CITY, STATE, ZIP CODE		
PORTSM	OUTH HEALTH AND	REHAB					
				L	PORTSMOUTH, VA 23704		
PRÉFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFI		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 156	Medicare part A, for The resident's diag tachycardia (a hear	r skilled services on 5/17/17. nosis included supraventicular t condition). A Notice of	F 1	156	5		
	that the effective da services would end signed by the reside 10123-NOMNC (ap include the QIO nar	ate coverage of current on 6/5/17 was issued and ent on 6/2/17. The Form CMS proved 12/31//2011) did not me or toll-free number to call					
	"How to Ask For an follows: * You must make you improvement Organ A QIO is the independed of the independed of the day before the above. * The QIO will notify as possible, general the effective date of Original Medicare. plan, the QIO general decision by the efferended of the collower of the collower QIO at: {	Immediate Appeal" read, as our request to your Quality nization (also known as QIO). Indent reviewer authorized by the decision to end these on immediate appeal should be					
	Set) Coordinator #1	pm, the MDS (Minimum Data was interviewed. She stated esponsible for issuing the					

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NOMNC notices since January 2017. She stated she filled the forms out, explains the appeal process and obtains the resident's signatures.

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Facility ID: VA0035

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CENTE	42 FOR MEDICARE	& MEDICAID SERVICES				<u> </u>
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 '		DNSTRUCTION	(X3) DATE SURVEY COMPLETED
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TO THE OT	NOVIDEN ON COLL FIEN				ONDON BOULEVARD	
PORTSN	IOUTH HEALTH AND	REHAB				
					TSMOUTH, VA 23704	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROFILIENCY)	D BE COMPLETION
F 156	contact the QIO on giving a copy of the the failure to includ was shared. The N	e writes the phone number to the form. The resident is then form. The above findings of e required contact information MDS Coordinator was not able was not added on the form	F 1	56		
	Administrator in he	tion was shared with the roffice on 7/13/17 prior to exit. nation was provided. FACILITY MANAGEMENT OF S	F 1		59	
	personal funds with authorization of a real fiduciary of the resafeguard, manage funds of the resider specified in this section (f)(10)(ii) Deposit of (A) In general: Excellibrial Excelli			 2. 3. 	No opportunity to correct preincidents with residents involved personal funds availability. Residents with personal funds potential to be affected. Resident funds will be available week from 9:00 a.m. To 5:00 Signage will be posted on the office door and in the recept make residents aware of the Random resident interviews completed weekly x 12 week practice is in place. Results of the audit will be of the monthly QAPI meetings issues identified will be additional personal funds.	ds have the able 7 days a 0 p.m. be business ionist area to availability. will be ks to ensure discussed in and any
	(B) Residents whos	e care is funded by Medicaid:			immediately	8/12/17

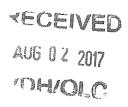
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8/13/17



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

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F 159 Continued From page 9 The facility must deposit the residents' personal funds in excess of \$50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain personal funds that do not exceed \$50 in a noninterest bearing account, interest-bearing account, or petty cash fund. (f)(10)(iii) Accounting and records. (A) The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf. (B) The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident. (C)The individual financial record must be available to the resident that receives Medicaid benefits- (A) When the amount in the resident's account reaches \$200 less than the \$SI resource limit for one person, specified in section 1611(a)(3)(B) of the Act; and	CENTER	RS FOR MEDICARE	& MEDICAID SERVICES				OMB I	NO. 0938-0391
NAME OF PROVIDER OR SUPPLIER PORTSMOUTH HEALTH AND REHAB STREET ADDRESS, CITY, STATE, ZIP CODE 90 LONDON BOULEVARD PORTSMOUTH, VA 23704 PREFIX SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAGS PROVIDERS PLAN OF CORRECTION CRACH CORRECTION SHOULD BE COMPARED IN TAGS PROVIDERS PLAN OF CORRECTION CRACH CORRECTION SHOULD BE COMPARED IN TAGS CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F159 Continued From page 9 F159 The facility must deposit the residents' personal funds in excess of \$50 in an interest bearing account, or accounts) that is separate from any of the facility must deposit the resident's share.) The facility must maintain personal funds that do not exceed \$50 in a noninterest bearing account, interest-bearing account, or petty cash fund. (f)(10)(iii) Accounting and records, (A) The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounts, interest-bearing account, principles, of each resident's personal funds entrusted to the facility on the resident's behalf. (B) The system must preclude any commingling of resident funds with facility under or with the funds of any person other than another resident. (C) The individual financial record must be available to the resident through quarterly statements and upon request. (f)(10)(iv) Notice of certain balances. The facility must notify each resident that receives Medicaid benefits- (A) When the amount in the resident's account reaches \$200 less than the SSI resource limit for one person, specified in section 1611(a)(3)(B) of the Act, and				1 ' '		CONSTRUCTION		
PORTSMOUTH HEALTH AND REHAB (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REQUIATORY OR LSC IDENTIFYING INFORMATION) FINETIX REGULATORY OR LSC IDENTIFYING INFORMATION) F 159 Continued From page 9 The facility must deposit the residents' personal funds in excess of \$50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, there must be a separate accounting for each resident's share.) The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds in excess of \$50 in a noninterest bearing account, interest-bearing account, resident's share.) The facility must establish and maintain a system that assures a full and complete and separate accounting principles, of each resident's personal funds with facility funds or with the funds of any person other than another resident. (C)The individual financial record must be available to the resident through quarterly statements and upon request. (f)(10)(iv) Notice of certain balances. The facility must notify each resident that receives Medicaid benefits. (A) When the amount in the resident's account reaches \$200 less than the SSI resource limit for one person, specified in section 1611(a)(3)(B) of the Act; and			495149	B. WING				
DORTSMOUTH HEALTH AND REHAB DORTSMOUTH, VA 23704	NAME OF F	PROVIDER OR SUPPLIER			STR	EET ADDRESS, CITY, STATE, ZIP CODE		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG (PACH CORRECTIVE ACTION \$40LD BE (CROSS-REFERENCE) TO THE APPROPRIATE DEFICIENCY) F 159 Continued From page 9 The facility must deposit the residents' personal funds in excess of \$50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, there must be a separate accounting for each resident's share.) The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's spersonal funds that credits all interest bearing account, interest-bearing account, or petty cash fund. (f)(10)(iii) Accounting and records. (A) The facility must establish and maintain a system that assures a full and complete and separate accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf. (B) The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident. (C)The individual financial record must be available to the resident through quarterly statements and upon request. (f)(10)(iv) Notice of certain balances. The facility must notify each resident that receives Medicaid benefits- (A) When the amount in the resident's account reaches \$200 less than the SSI resource limit for one person, specified in section 1611(a)(3)(B) of the Act, and	DODTOL		DELLAD		900	LONDON BOULEVARD		
FREERY TAG REGULATORY OR LSC IDENTIFYING INFORMATION) F 159 Continued From page 9 The facility must deposit the residents' personal funds in excess of \$50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain personal funds that do not exceed \$50 in a noninterest bearing account, interest-bearing account, or petty cash fund. (f)(10)(iii) Accounting and records. (A) The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident funds with facility funds or with the funds of any person other than another resident. (C) The individual financial record must be available to the resident through quarterly statements and upon request. (f)(10)(iv) Notice of certain balances. The facility must notify each resident that receives Medicaid benefits- (A) When the amount in the resident's account reaches \$200 less than the SSI resource limit for one person, specified in section 1611(a)(3)(B) of the Act; and	PURISIVI	OUTH HEALTH AND	KERAB		POI	RTSMOUTH, VA 23704		
The facility must deposit the residents' personal funds in excess of \$50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain personal funds that do not exceed \$50 in a noninterest bearing account, interest-bearing account, or petty cash fund. (f)(10)(iii) Accounting and records. (A) The facility must establish and maintain a system that assures a full and complete and separate accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf. (B) The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident. (C)The individual financial record must be available to the resident through quarterly statements and upon request. (f)(10)(iv) Notice of certain balances. The facility must notify each resident three solones that reaches \$200 less than the SSI resource limit for one person, specified in section 1611(a)(3)(B) of the Act; and	PRÉFIX	(EACH DEFICIENCY	/ MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP	OULD BE	COMPLETION
(B) That, if the amount in the account, in addition to the value of the resident's other nonexempt	F 159	The facility must defunds in excess of account (or account the facility's operating all interest earned continued account. (In pooled separate accounting The facility must manot exceed \$50 in a interest-bearing accounting accepted accounting acce	sposit the residents' personal \$50 in an interest bearing ts) that is separate from any of accounts, and that credits on resident's funds to that accounts, there must be a g for each resident's share.) aintain personal funds that do a noninterest bearing account, count, or petty cash fund. In g and records. It establish and maintain a sa full and complete and g, according to generally g principles, of each resident's susted to the facility on the st preclude any commingling the facility funds or with the nother than another resident. In ancial record must be dent through quarterly on request. In certain balances. The facility sident that receives Medicaid ant in the resident's account than the SSI resource limit for each in section 1611(a)(3)(B) of unt in the account, in addition		59			

resources, reaches the SSI resource limit for one

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER OF SUPPLIER PORTSMOUTH HEALTH AND REHAB (X2) DEFICIENCIES AND PLAN OF CORRECTION NAME OF PROVIDER OR SUPPLIER PORTSMOUTH HEALTH AND REHAB (X3) DEFICIENCIES ARGULATORY OR LISC IDENTIFYING INFORMATION) FREERIX TAG (X4) DEFICIENCY TAG (X5) DEFICIENCY STREET ADDRESS, CITY, STATE, ZIP CODE 900 LONDON BOULEVARD PORTSMOUTH, VA 23704 FREERIX TAG (X6) DEFICIENCY STREET ADDRESS, CITY, STATE, ZIP CODE 900 LONDON BOULEVARD PORTSMOUTH, VA 23704 FREERIX TAG (X6) DEFICIENCY STREET ADDRESS, CITY, STATE, ZIP CODE 900 LONDON BOULEVARD PORTSMOUTH, VA 23704 FREERIX TAG FREERIX TAG FREERIX TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 159 F 1			THE HOW IN OLIVIOLO					MAPPROVED
AND PLAN OF CORRECTION DENTIFICATION NUMBER A BUILDING B. WINC STREET ADDRESS, CITY, STATE, ZIP CODE O7/13/2017	CENTER	RS FOR MEDICARE	& MEDICAID SERVICES	.,			OMB NO	<u>0. 0938-0391</u>
NAME OF PROVIDER OR SUPPLIER PORTSMOUTH HEALTH AND REHAB XAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 900 LONDON BOULEVARD PORTSMOUTH, VA 23704 XAME OF PROVIDER OR SUPPLIER SOULDNOON BOULEVARD PORTSMOUTH, VA 23704 XAME OF PROVIDER OR SUMMARY STATEMENT OF DEFICIENCIES FREE PROCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PROVIDERS PLAN OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY				i				MPLETED
PORTSMOUTH HEALTH AND REHAB 200 LONDON BOULEVARD PORTSMOUTH, VA 23704			495149	B. WING			0.	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MIST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 159 Continued From page 10 person, the resident may lose eligibility for Medicaid or SSI. This REQUIREMENT is not met as evidenced by: Based on observation, resident group interview, staff interview, and facility document review, the facility staff failed to ensure residents had access to their personal funds 7 days a week. The findings included: On 7/11/17 at 3:30 pm, a group interview was conducted with 13 residents in attendance. During the group interview, the residents were asked if they had access to their personal funds. Residents with personal funds counts stated that they have access to their personal funds. Residents stated that they were available 5 days a week, Monday through Friday, but closed on weekends. Another resident stated that they were available 5 days a week, Monday through Friday, but closed on weekends. Another resident stated that they men available 5 days a week, Monday through Friday, but closed on weekends. Another resident stated that they men available 5 days a week, Monday through Friday, but closed on weekends. Another resident stated that they men available 5 days a week, Monday through Friday, but closed on weekends. Another resident stated that they men available 5 days a week, Monday through Friday, but closed on weekends. Another resident stated that they men available the money on weekends, they have to wait until Monday. During observation of the main lobby area with the Administrator on 7/12/17 at 9:00 am, there was no information posted for resident "banking"	NAME OF I	PROVIDER OR SUPPLIER						
FREEIX REGULATORY OR LSC IDENTIFYING INFORMATION) F 159 Continued From page 10 person, the resident may lose eligibility for Medicaid or SSI. This REQUIREMENT is not met as evidenced by: Based on observation, resident group interview, staff interview, and facility document review, the facility staff failed to ensure residents had access to their personal funds 7 days a week. The findings included: On 7/11/17 at 3:30 pm, a group interview was conducted with 13 residents in attendance. During the group interview, the residents were asked if they had access to their personal funds. Residents with personal fund accounts stated that they have access to their finds. One resident stated that they were available 5 days a week, Monday through Friday, but closed on weekends. Another resident stated that they were able to access their personal funds between 10:00 am - 11:00 am and at 1:00 pm - 2:00 pm, Monday through Friday. He stated that if they need the money on weekends, they have to wait until Monday. During observation of the main lobby area with the Administrator on 7/12/17 at 9:00 am, there was no information posted for resident "banking"	PORTSN	OUTH HEALTH AND	REHAB					
person, the resident may lose eligibility for Medicaid or SSI. This REQUIREMENT is not met as evidenced by: Based on observation, resident group interview, staff interview, and facility document review, the facility staff failed to ensure residents had access to their personal funds 7 days a week. The findings included: On 7/11/17 at 3:30 pm, a group interview was conducted with 13 residents in attendance. During the group interview, the residents were asked if they had access to their personal funds. Residents with personal fund accounts stated that they have access to their funds. One resident stated that they were available 5 days a week, Monday through Friday, but closed on weekends. Another resident stated that they were able to access their personal funds between 10:00 am - 11:00 am and at 1:00 pm - 2:00 pm, Monday through Friday. He stated that if they need the money on weekends, they have to wait until Monday. During observation of the main lobby area with the Administrator on 7/12/17 at 9:00 am, there was no information posted for resident "banking	PRÉFIX	(EACH DEFICIENC)	MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR	JLD BE	COMPLETION
hours". No signage was observed in other areas of the facility that were accessible to the residents. On 7/12/17 at 9:15 am, the Business Office Manager was interviewed and was asked about	F 159	person, the resident Medicaid or SSI. This REQUIREMENT by: Based on observation staff interview, and facility staff failed to to their personal fur. The findings include On 7/11/17 at 3:30 conducted with 13 r. During the group in asked if they had at Residents with personal fur. Another resident stated that they wer Monday through Frid Another resident state access their personal 1:00 am and at 1:00 through Friday. He money on weekend Monday. During observation the Administrator or was no information hours". No signage of the facility that we residents.	t may lose eligibility for NT is not met as evidenced cion, resident group interview, facility document review, the censure residents had access ands 7 days a week. ed: pm, a group interview was residents in attendance. terview, the residents were ceess to their personal funds. conal fund accounts stated that conal funds. One resident re available 5 days a week, day, but closed on weekends. attended that they were able to call funds between 10:00 am - colo pm - 2:00 pm, Monday stated that if they need the s, they have to wait until of the main lobby area with a 7/12/17 at 9:00 am, there posted for resident "banking was observed in other areas ere accessible to the am, the Business Office		159			

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hours" because "We make them available anytime". She was asked regarding resident

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		AND HUMAN SERVICES					APPROVED
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			C	<u>MB NO.</u>	<u>. 0938-0391</u>
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	СОМ	E SURVEY IPLETED
		495149	B. WING			1	C 13/2017
NAME OF F	PROVIDER OR SUPPLIER		<u> </u>	STR	EET ADDRESS, CITY, STATE, ZIP CODE	1 011	13/2017
					LONDON BOULEVARD		
PORTSM	OUTH HEALTH AND	REHAB		POI	RTSMOUTH, VA 23704		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	×	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 159	Continued From pa	ae 11	F 1	50			
1 100	•	funds on weekends and she	1 1	39			
		kends, the business office and					
		e closed for security reasons.					
		he business office is closed on					
		residents would access their estated, "Currently, they					
		e to call in, in an emergency					
		ed the money. I'm the only					
		cess to the cash box. The					
		n weekends would call theThis had never happened in					
		ger on duty has no key to the					
		ated that the facility had no					
	process/policy in pla residents' personal	ace for accessing the funds.					
	On 7/12/17 at 1:15	pm, observed a sign for					,
	"banking hours" pos	sted in the main hallway					
		another posted on the door to					
		ce. The notice read, "Resident nday-Friday, 10 AM - 11 AM, 1					
	PM - 2 PM".	nday-i riday, to Aivi - IT Aivi, T					
	On 7/13/17 at 9:00	am, an interview was					
		Administrator and she stated					
		s owned by the company, they					
		nours" on Saturdays until 12					
		at they will provide the same by. It was discussed that the					
		ands should be accessible to					
	the residents on an						
	On 7/12/17 at 10:20	am, the Business Office					
		a copy of the policy and					
		esident Trust Fund Policies".					
	The policy had no if	nformation that addressed					

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access to resident personal funds.

The Administrator and the DON were made

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<u> </u>	TO TOTAL TRANSPORT	C MILDIO, ND OLIVIOLO	·			1VID 140. 0000 000 1	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		ONSTRUCTION	(X3) DATE SURVEY COMPLETED	
						С	
		495149	B. WING			07/13/2017	
PORTSM	PROVIDER OR SUPPLIER OUTH HEALTH AND			900 L	ET ADDRESS, CITY, STATE, ZIP CODE ONDON BOULEVARD TSMOUTH, VA 23704		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETION	
F 167	was provided.	ings on 7/13/17 at pm. No further information RIGHT TO SURVEY	F 1	67			
55=C	(g)(10) The resident (i) Examine the resident of the facility condu	t has the right to- sults of the most recent survey cted by Federal or State plan of correction in effect with			The issue was corrected impon 7/12/17 during the surveyResidents and visitors have potential to be affected by the practice	y. the	
	and family member residents, the result the facility. (ii) Have reports wit certifications, and crespecting the facility years, and any plan respect to the facilit to review upon requiii) Post notice of the	eadily accessible to residents, s and legal representatives of its of the most recent survey of the respect to any surveys, omplaint investigations made the during the 3 preceding of correction in effect with y, available for any individual lest; and		3	of the facility to ensure ever aware of where the survey re located. An audit will be ad the morning round list to en- these signs remain in place.	yone is esults are lded to sure that ee API is morning	
	accessible to the put (iv) The facility shall	that are prominent and ublic. I not make available identifying omplainants or residents.			corrected miniediatory.	8/13/17	
	This REQUIREMEN by: Based on observat facility staff failed to	ions and staff interview, the display a posting to identify east three (3) year's survey					



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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495149	B. WING			C 07/13/2017
	PROVIDER OR SUPPLIEI			STREET ADDRESS, CITY, STATE, ZII 900 LONDON BOULEVARD PORTSMOUTH, VA 23704	P CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		ION SHOULD E HE APPROPRI	BE COMPLETION
F 167	Continued From presults.	page 13	F 1	167		
	The findings inclu	ded:				
	07/11/17 through to post a sign for the years of survey real. An interview was a Administrator on 0 a.m., who stated, in the front lobby of results, I have no The surveyor required.	al Observation of the facility on 07/13/17 the facility staff failed the location of the past three (3) sults. conducted with the 07/12/17 at approximately 10:35 "There were three (3) postings giving the location of the survey idea what happen to them." uested a policy for the posting of a Administrator replied, "I don't				
- s h k	have a policy for t because it's a CM	he posting of survey results is a requirement anything that is a there's no policy."				
F 241 SS=D	The above information was shared with the Administrator and Director of Nursing (DON) during a pre-exit meeting on 07/13/17 at 3:45 p.m. No additional information was provided. 483.10(a)(1) DIGNITY AND RESPECT OF INDIVIDUALITY			241		
	resident in a manupromotes mainter her quality of life r individuality. The f promote the rights This REQUIREME by: Based on observanterviews the facility	ust treat and care for each ner and in an environment that nance or enhancement of his or ecognizing each resident's facility must protect and sof the resident. ENT is not met as evidenced ation, resident and staff failed to promote care nance the dignity for 1 out of 30				

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CENTE	RS FOR MEDICARE	& MEDICAID SERVICES			OMB NO. 0938-039
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	FIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED
		495149	B. WING _		C 07/13/2017
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	
PORTSM	OUTH HEALTH AND	REHAR		900 LONDON BOULEVARD	
1 01(101)	100 III IILALIII AND	KEIIAB		PORTSMOUTH, VA 23704	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO ((EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE COMPLÉTION E APPROPRIATE DATE
F 241	Continued From pa	ge 14	F 24	41	
	·	#14) in the survey sample.		F241	
	The facility staff fail with a clothing prote	ed to provide Resident #14 ector during lunch.		1. Resident # 14 was grotector immediatel	-
	The findings include	ed:		2. Residents who dine i	•
	07/05/17. Diagnosi but not limited to *Greflux disease) and Resident #14 is a nourrently have a correctly for the sident #14 was a correctly have a correctly have a correctly have been upper chest who stated, "I would my clothes; I knew a light didn't want to mest they have protector eating."	ew admission and does not impleted MDS assessment. hission Data Collection Forming information under ication/Mood & Behavior: no cor long term memory loss. Troximately 12:25 p.m., during hain dining room during lunch, observed with a sheet covering ide eating her lunch. Inducted with Resident #14 drather have a protector over we were having spaghetti and is my clothes up, sometimes is to protect your clothes when		have a potential to be practice 3. Clothing protectors be placed in clear contains the 3 dining areas. So re-educated by the dinursing/ designee on clothing protectors are random audit will be week x 12 weeks of mealtimes and areas residents are given of protectors. 4. Audits will be review monthly QAPI meeting discrepancies will be immediately and reseas needed.	have been iners in each of taff have been arector of the use of and dignity. A completed 4 x various to ensure that lothing exed in the ing and any excorrected
	interview was condi Nurse Aide). The s	roximately 12:45 p.m., an ucted with CNA #4 (Certified urveyor asked, I noticed that using a sheet as a clothing			

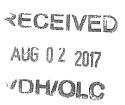
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protector throughout her meal, CNA stated, "There are usually two (2) CNAs in dining room during lunch time; I don't know what happened today but I couldn't leave the residents to go get

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			ONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495149	B. WING			C 07/42/0047	
	PROVIDER OR SUPPLIER			STRE	ET ADDRESS, CITY, STATE, ZIP CODE ONDON BOULEVARD TSMOUTH, VA 23704	07/13/2017	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLÉTION	
F 241	clothing protector b	ge 15 ecause someone could choke uld get into an altercation with	Fí	241			
	(Director of Nursing approximately 3:15 should be two (2) C times during lunch	onducted with the DON y) on 07/12/17 at p.m., who stated, "There NA's in the dining room at all time and a resident using a protector is unacceptable; this					
	finding during a brie approximately 3:45	tration was informed of the efing on 07/13/17 at p.m. The facility did not information about the findings.					
	into the esophagus	ow of contents of the stomach (Mosby's Dictionary of A Health Professions 7th					
	threatens necessar aspiration (Mosby's Nursing & Health P	an excess of body fat that y body functions such as Dictionary of Medicine, rofessions 7th Edition). RRLY ASSESSMENT AT IONTHS	F	276			
	assess a resident usinstrument specified by CMS not less from months. This REQUIREMENT by:	w Assessment. A facility must sing the quarterly review d by the State and approved equently than once every 3					
		ecord review and staff ty staff failed to ensure					

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		AND HUMAN SERVICES & MEDICAID SERVICES			FORM APPROVED OMB NO. 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED C
		495149	B. WING_	**************************************	07/13/2017
	PROVIDER OR SUPPLIER	REHAB		STREET ADDRESS, CITY, STATE, ZIF 900 LONDON BOULEVARD PORTSMOUTH, VA 23704	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENCY	ON SHOULD BE COMPLETION HE APPROPRIATE DATE
F 276	were completed no months for 1 of 30 months for 1 o	Data Set (MDS) assessments less than once every 3 residents (Resident #20) in the decident displayed and diabetes mellitus. Inimum Data Set (MDS) as submitted to the National of the Medicare and Medicaid a Significant Change in Status was the last assessment Resident per review of the BRA (Omnibus Budget Assessment Report. With the MDS Coordinator on the Massessment Report that identified it submitted to the National decided 1/23/17. She stated she is status and would have to	F 2'	F276 1. A quarterly assessm completed for reside ARD date of 7/19/1 2. Residents that have assessments due are practice. An audit v 7/28/17 to ensure the annual assessments 3. MDS staff re-educa Clinical Reimburser included the process completing the quartassessments. A mireport will be pulled ensure no resident he assessment. 4. The results of the massessment report with the monthly QAF	ent # 20 with an 7. quarterly e at risk for this was completed on nat quarterly and were completed. ted by the VP of ment. Education s for auditing and eterly ssing assessment d monthly to has a missing will be reviewed

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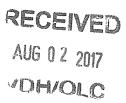
assessments. The RAI Manual indicated the following: "The Quarterly assessment is used to

tract the resident's status between

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Facility ID: VA0035

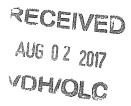
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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES.

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CENTER	RS FOR MEDICARE	: & MEDICAID SERVICES			<u> </u>	<u>MR NO. (</u>	<u>0938-0391</u>
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		ONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		495149	B. WING			07/1	; 3/2017
NAME OF I	PROVIDER OR SUPPLIER	<u> </u>	<u>'</u>	STRE	ET ADDRESS, CITY, STATE, ZIP CODE	, 0.7.	0,2011
					ONDON BOULEVARD		
PORTSN	IOUTH HEALTH AND	REHAB			TSMOUTH, VA 23704		
	CLUMMA DV. CT.	TEMPAT OF DEFICIENCIES					
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 276	Continued From pa	age 17	F 2	276			
F 278	comprehensive ass monitoring of critical onset of significant a minimum, three of comprehensive ass 12 month period, n every three months 483.20(g)-(j) ASSE	seessments and to ensure al indicators of the gradual changes in resident status. At quarterly assessments and one seessment are required in each ot less frequently than once s." SSMENT		278			
SS=D	ACCURACY/COOF	RDINATION/CERTIFIED			F278		
((g) Accuracy of Assessments. The assessment must accurately reflect the resident's status.(h) Coordination			1. 2.	Corrections to residents #16, #10 and #11 were made on 7/27/17 An audit was completed on the most current assessments for residents		t
	A registered nurse	must conduct or coordinate vith the appropriate lth professionals.			currently residing in the facil ensure the assessment accura reflected the status of the res	lity to ately	
	(i) Certification				This audit was completed 8/8		
		rse must sign and certify that completed.		3.	-	ated by	
	(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.(j) Penalty for Falsification(1) Under Medicare and Medicaid, an individual who willfully and knowingly-				Education included how to accurately fill out the MDS. will be completed by MDS s weekly x 12 weeks to verify	An audi staff 3 x	t
				А	MDS assessments accurately the current status of the resid	reflect	
	resident assessme	rial and false statement in a nt is subject to a civil money than \$1,000 for each		4.	discussed at the monthly QA meeting	.PI	8/13/17
		individual to certify a material t in a resident assessment is					



CENTER	SECONIEDICADE	9 MEDICAID SEDVICES					M APPROVED
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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		PLE CONSTRUCTION G		TE SURVEY MPLETED
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PORTSM	OUTH HEALTH AND	REHAR		!	900 LONDON BOULEVARD		
1 OICION	OOTH HEALTH AND	2 % Eron I V J T % Eron			PORTSMOUTH, VA 23704		
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F 278	Continued From pa	ge 18	F 2	278	8		
	subject to a civil mo \$5,000 for each ass	oney penalty or not more than sessment.					
	material and false some strains REQUIREMENT by: Based on resident clinical record review, the facility sassessments were 3 of 30 sampled resident #10, and for the section O0100J (Diagnostic Treatments, Proceeding to the section C under Conformental Status Health Condition (Page 13. The facility staff for Mental Status Health Condition (Page 14. The findings included the section B under (Health Condition (Page 14. The findings included the section B under (Health Condition (Page 14. The findings included the section B under (Health Condition (Page 14. The findings included the section B under (Health Condition (Page 14. The findings included the section B under (Health Condition (Page 14. The findings included the section B under (Health Condition B under (Health	interview, staff interview, w and facility document taff failed to ensure resident accurate and/or complete for sidents (Residents #16, Resident #11). failed to accurately code alysis (1)) under Special redures, and Programs for failed to accurately code gnitive Pattern (Brief Interview - BIMS) and section J under ain) for Resident #10. failed to accurately code gnitive Pattern (Brief Interview - BIMS) and section J under ain) for Resident #10. failed to accurately code earing, Speech and Vision) for red: failed to accurately code earing, Speech and Vision) for red: failed to accurately code earing, Speech and Vision) for red: failed to accurately code earing, Speech and Vision) for red:					
	Diagnoses for Resid						

The most recent MDS (Minimum Data Set) with an assessment reference date of 6/23/17, coded Resident #16 with a score 12 out of possible 15

DADTMENT OF HEALTH AND HUMAN CEDVICES

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		& MEDICAID SERVICES			0	FORM APPROVED MB NO. 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED
		495149	B. WING			C 07/13/2017
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(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		ACTION SHOULD TO THE APPROP	BE COMPLETION
F 278	indicating Resident in the skills needed On 7/13/17 at 9:50 interviewed and she dialysis treatment of Fridays at a dialysis site was located on On 7/13/17 at approfit #16's MDS (Minimus was reviewed. In Set Treatments, Procedinstruction to "Check treatments, proceding performed during the was documented as dialysis treatment. On 7/13/17 at 12:35 Coordinator #1 was inaccurate entry in the should be "Yes". It was was on dialysis treatment.	ew for Mental Status (BIMS), it #16 was moderately impaired for daily decision making. am, Resident #16 was e stated that she received in Mondays, Wednesdays and scenter. Her dialysis access her left upper arm. Eximately 10:15 am, Resident im Data Set) dated 6/23/17 ection O0100. Special dures, and Programs, with an ek all of the following ures, and programs that were ne last 14 days"; the response is "No" instead of "Yes" for the MDS. She stated, "It was probably an oversight; I italysis. I was probably rushing	F 2	278		
	On 7/13/17 at appro	oximately 1:00 pm, the MDS			•	

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Coordinator #1 presented a copy of a section in the Resident Assessment Manual titled, "Chapter 1: Resident Assessment Instrument (RAI)", dated 10/21/06. In section "1.5 MDS 3.0", it stated, "Goals: The goals of the MDS 3.0 revision are to introduce advances in assessment measures, increase the clinical relevance of items, improve the accuracy and validity of the tool...Providers, consumers, and other technical experts in nursing home are requested that MDS 3.0 revisions focus on improving the tool's utility,

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F 278	Continued From pa clarity, and accurac policy on MDS.	age 20 cy." The facility did not have a	F 2	78					
	aware of these find	and the DON were made ings on 7/13/17 at pm; no further information							
	Definition:								
	remove wastes or to adjust fluid and outilizing rates at whith through a semip (Source:	of two medical procedures to oxins from the blood and electrolyte imbalances by ich substances diffuse permeable membrane.							
	chronic kidney dise kidneys can no l needs. End-stage k end-stage renal	ey disease is the last stage of ase. This is when your longer support your body's cidney disease is also called disease (ESRD). (Source: .gov/ency/article/000500.htm)							
	facility on 03/22/16.	is originally admitted to the Diagnoses for Resident #10 ited to *Bipolar Disorder and tis (RA).							
	Minimum Data Set Reference date (AF C (Cognitive Pattern	t #10's comprehensive (MDS) with an Assessment RD) of 03/27/17 under section ns) asked the question, riew for Mental Status be							

Conducted" the MDS was coded yes; continued review of the MDS under section C was marked



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PORTSWIOUTH HEALTH AND RE			P(ORTSMOUTH, VA 23704	
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Conditions) asked the Assessment be Cond yes; continued review was also marked with was incomplete. An interview was cond coordinator #1 on 07/12:50 p.m., who state and section J under P completed; I guess I ji to complete those sec *Bipolar Disorder is a People who have it go changes. They go from active to very sad and inactive, and then back (https://medlineplus.go *Rheumatoid Arthritis (RA) is a form of arthres welling, stiffness and joints. It can affect any wrist and fingers (https://medlineplus.go 3. Resident #11 was a 08/15/13. Diagnoses but not limited to *Epil Resident #11's Minimal Assessment Reference.	g that section C was on section J under (Health e question, "Should Pain flucted" the MDS was coded of of the MDS under section J in dashes indicating section J ducted with MDS (13/17 at approximately ed, "Section C for Cognition Pain should have been just got distracted and forgot ections of the MDS." serious mental illness. The through unusual mood m very happy, "up," and d hopeless, "down," and ck again pov/ency/article/007365.htm). (RA). Rheumatoid arthritis	F 2	278		

impairment. In addition, the MDS coded Resident #11 requiring limited assistance of one with bed

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F 278	supervision of one eating. Resident #' of bowel and bladded Review of Resident with an ARD of 04/2 difficulty - speaker is speak distinctly but hearing aids or other Resident #11's comindicated a problem communication relative The goals the facility to be able to communication relative to be able to communication and Assist with hearing calm unhurried environmentation. On 07/12/17 at app p.m., Resident #11 hearing aids bilateration. On 07/13/17 at app Resident #11 was on hearing aids. On 07/13/17 at app interview was condustated, Resident #1 she then stated, "The stated, "The stated of the stated is a stated in the stated	and personal hygiene and with transfers, dressing and all is occasionally incontinent er. #11's comprehensive MDS 21/17 was coded for moderate has to increase volume and was coded 0 for wearing er hearing appliance used. prehensive care plan with the potential for impaired ated to (r/t) impaired hearing, by staff set for the resident was unicate basic needs. Some of cluded but not limited to: aids as needed and allow a dironment to encourage	F 2	78	DEFICIENCY)	
	the medication cart.	g aids are stored locked inside				



An interview was conducted with MDS Coordinator #2 on 07/13/17 at approximately

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	010000000	TELESIT OF PERIODICAL		* `			
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F 278	Continued From pa	ge 23	F 2	278			
	part, I should have	ated, "It was an oversite on my marked yes for hearing aids the use of hearing aids.					
	finding during a brie approximately 3:45	tration was informed of the efing on 07/13/17 at p.m. The facility did not information about the findings.					
	CMS's RAI Version 3.0 Manual (Chapter 1: Resident assessment Instrument (RAI)						
		of the RAI (1) the assessment the resident's status.					
	introduce advances increase the clinical the accuracy and varesident's voice by interview items. Protechnical experts in requested that MDS	the MDS 3.0 revision are to a in assessment measures, I relevance of items, improve alidity of the tool, increase the introducing more resident oviders, consumers, and other the nursing home care S 3.0 revision focus on clinical utility, clarity, and					
	characterized by rec seizures, sensory d behaviors, loss con	o of neurologic disorders current episodes of convulsive isturbances, abnormal sciousness, or all of these of Medicine, Nursing & 7th Edition).					
	of depression in wh regularly low (Mosb	er is a chronic (ongoing) type ich a person's moods are y's Dictionary of Medicine, rofessions 7th Edition).					

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F 279 483.20(d);483.21(b)(1) DEVELOP

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPP	PLIER		STREET ADDRESS, CITY, STATE, ZIP CODE	
PORTSMOUTH HEALTH	AND REHAB		900 LONDON BOULEVARD PORTSMOUTH, VA 23704	
PREFIX (EACH DEFIC	RY STATEMENT OF DEFICIENCIES CIENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETION

F 279 Continued From page 24 SS=D COMPREHENSIVE CARE PLANS

483.20

(d) Use. A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record and use the results of the assessments to develop, review and revise the resident's comprehensive care plan.

483.21

- (b) Comprehensive Care Plans
- (1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -
- (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and
- (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).
- (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR

F 279

F279

- 1. Care plans have been reviewed and corrected for residents #1, #4 and #6 to reflect the current status of the resident and also to reflect any CAA's that triggered from the MDS.
- 2. An audit was completed of residents in the facility to ensure their care plan accurately reflects their status and includes any triggered CAA areas from the MDS.
- 3. MDS and nursing staff were reeducated on care plans by DON/designee. Education included areas triggered by CAA and updating of care plans to reflect current status of resident. A random audit will be completed on 3 resident's 2x week x 12 weeks to ensure that care plans are being updated and accurately reflect the current status of the resident.
- 4. Results of the audit will be reviewed and discussed monthly in the QAPI meeting.

8/13/17

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				ξ	900 LONDON BOULEVARD	
PORTSM	OUTH HEALTH AND	REHAB 			PORTSMOUTH, VA 23704	
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F 279	findings of the PAS. rationale in the residuolity (iv)In consultation w	of a facility disagrees with the ARR, it must indicate its dent's medical record.	F 2	<u>?</u> 79	9	
	desired outcomes. (B) The resident's putter discharge. Fawhether the resident	poals for admission and preference and potential for acilities must document at's desire to return to the sessed and any referrals to				
	local contact agence entities, for this purpose. (C) Discharge plans plan, as appropriate.	ies and/or other appropriate pose. s in the comprehensive care e, in accordance with the				
	section.	rth in paragraph (c) of this				
	and facility docume failed to develop a G Resident-Centered Care Area Assessm (Minimum Data Set	rview, clinical record review nt review, the facility staff Comprehensive Plan of Care based on the tents triggered by the MDS of 3 of 30 sampled s #1, Resident #4 and				
	6 out	sident-Centered Care Plan for ssessments triggered by the				

2. The facility staff failed to revise the

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PORTSMOUTH HEALTH AND REHAB			İ	0 LONDON BOULEVARD		
					ORTSMOUTH, VA 23704	
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F 279	Continued From pa	ge 26	F 2	279		
	Comprehensive Ca Care	re Plan to show evidence for				
		s for all CAAs (Care Area ered by the MDS (Minimum sident #1.				
	3. The facility staff f Comprehensive Ca Care	ailed to revise the re Plan to show evidence for				
		s for all CAAs (Care Area ered by the MDS (Minimum sident #6.				
	The findings include	ed:				
	facility on 2/1/17 an on 2/21/17. Diagnos	originally admitted to the d was readmitted to the facility ses for Resident #4 included gh blood pressure and				
	an assessment refe Resident #4 with a son the Brief Intervie indicating Resident	arterly Minimum Data Set with brence date of 5/9/17, coded score of 9 out of possible 15 w for Mental Status (BIMS), #4 was moderately impaired for daily decision making.				
	Resident #4's clinica admission Minimum assessment referen Resident #4 with a son the Brief Intervie indicating Resident in the skills needed	eximately 11:00 am, the all records were reviewed. The a Data Set with an accedate of 2/9/17, coded score of 10 out of possible 15 w for Mental Status (BIMS), #4 was moderately impaired for daily decision making.				

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assistance with one person physical assist in dressing, toilet use, and hygiene; total

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NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
PORTSMO	OUTH HEALTH AND	REHAB		900 LONDON BOULEVARD PORTSMOUTH, VA 23704	
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F 279 Continued From page 27

dependence in eating and bathing with one person assist; always incontinent of bowel and bladder; usually understood with difficulty in communicating words or finishing thoughts; an impaired vision, able to see large print but not regular print in newspaper/book; and at risk of developing pressure ulcers.

The Care Area Assessment (CAA) Summary dated 2/14/17 indicated that 9 Care Area Assessments were triggered by the MDS (reference date of 2/19/17) and the decision was to proceed with developing care plans for all CAAs. In reviewing the Resident #4's Comprehensive Resident-Centered Plan of Care, it was documented that only 3 CAAs were addressed in the care plan: Falls, Feeding Tube, and Dehydration/Fluid Maintenance. The 6 CAAs that were not addressed in the plan of care were the following: Cognitive Loss/Dementia, Visual Function, Communications, ADL (Activities of Daily Living) Functional/Rehabilitation Potential, Urinary Incontinence, and Pressure Ulcer.

On 7/12/17 at 12:30 pm, MDS Coordinator #1 was interviewed regarding the missing care plans for Resident #4. She stated, "It probably was missed". She was asked who was responsible for completing the resident-centered plan of care and she stated, "It was me". She was asked regarding the facility process to ensure care plans are completed for the residents. She stated, "Usually, we look through them to make sure everybody's part is put in. We haven't done it as it's supposed to be done". She stated that if care plans were appropriately done, there would be no issues but "things have fallen through the cracks" and the "system is broken". She stated that action plans were in place in formalizing the process to make

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PORTSWOOTH HEALTH AND	REHAB		PORTSMOUTH, VA 23704		
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F 279 Continued From p	page 28	F 2	279		
	ive care plans were done				
correctly.	·				
conducted with the missing care plans had a process to despend assessments and on admission. She validated in the morevised daily as not the form titled, "More included areas to Hour Report" Issu Loss, Falls, New Fesychotropic Med	am, an interview was e Administrator regarding the s. She stated that the facility complete the resident the comprehensive care plan e stated that care plans were orning meeting and were eeded. She provided a copy of orning Meeting Agenda" and it document the residents' "24 es, New Skin Issues, Weight Restraints, and New ications. The tool is utilized to olan.				
copy of the facility Preparation" from Procedure textboo "A care plan direct from admission to plan is based on r been formulated a findingsA nursin for each patient, p admission."	D pm, the facility provided a procedure titled, "Care Plan the Lippincott's Nursing ok, 6th edition. It stated, in part, ts the patient's nursing care discharge. This written action nursing diagnoses that have after reviewing assessment g care plan should be written preferably within 24 hours of and the DON were made dings on 7/13/17 at				
	5 pm; no further information				

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2. For Resident #1, the facility staff failed to to revise the comprehensive Care Plan to show evidence for Care Plan Interventions for all CAA's

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DODTON		DELLAD		90	00 LONDON BOULEVARD		
PORTSIV	OUTH HEALTH AND	REHAB		P	ORTSMOUTH, VA 23704		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 279	Continued From pa	ge 29	F 2	279			
	(Care Assessment A (Minimum Data Set	Areas) triggered by the MDS).					
	3/21/17. Diagnoses are not limited to Not Malnutrition and Statulcer*. Resident #7 Set (MDS-an assess Assessment Refere Resident #1 with a Mental Status) of 1 cognition impairment Resident #1 had vis wear glasses. The #1 had unclear spell In addition the MDS requiring total depetor Transfers. Resi requiring total depetor Transfers. Resi requiring total depetor Transfers of Vis Resident #1's Curre include focus areas The Director of Nur 7/12/17 at approximated, "It is the Chato bring issues for OMDS staff will upda was asked if she sa	S scored Resident #1 as indence with 2 staff persons dent #1 was coded as indence with one staff person sing, Hygiene, and Bathing. #1's Admission MDS included ion and communication. ent 7/7/17 Care Plan did not of vision and communication. ses was interviewed on inately 1:15 p.m. The DON arge Nurse's responsibility first Care Plan updating and then the the Care Plan." The DON is included on Resident #1's ocus areas of Communication.					

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On 7/12/17 at approximately 1:35 p.m. the MDS Registered Nurse #2 was interviewed and asked

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CENTER	RS FOR MEDICARE	& MEDICAID SERVICES	·			<u> MB NO. 0938-03</u>	<u>91,</u>
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495149	B. WING			C 07/13/2017	
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PURISIV	OUTH HEALTH AND	KENAD		PC	DRTSMOUTH, VA 23704		
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F 279	Continued From pa	age 30	F 2	79			
	•	did not include the CAA	1 4	.10			
		nication and vision. The MDS					
	Registered Nurse #	#2 stated, "It was an oversight.					
	It should be on the	Care Plan."					
	The Facility Staff or	rovided a copied section from					
		RAI (Resident Assessment					
		l. Section 2.7 documented the					
		ompleting the MDS and CAA					
		prehensive assessment, the uate the information gained					
		sment processes in order to					
		causes, contributing factors,					
	and risk factors rela	ated to the problems.					
		DT (Interdisciplinary Team)					
		nformation gained to develop dresses those findings in the					
		lent's strengths, problems, and					
		n detail in Chapter 4 of this					
	manual).						
	The facility adminis	tration was informed of the					
		riefing on 7/13/17 at					
	0 0	p.m. The facility did not					
	present any further	information about the findings.					
		, the facility staff failed to to					
		ensive Care Plan to show					
		Plan Interventions for all CAA's					
	(Minimum Data Set	Areas) triggered by the MDS					
	Resident #6 was ac	dmitted to the facility on					
	8/19/15 with a read	mission on 9/14/16.					

Diagnoses for Resident #6 included but are not limited to Stage IV Sacral Pressure Ulcer* and Non-Alzheimer's Dementia*. Resident #6's Annual Minimum Data Set (MDS-an assessment

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		AND HUMAN SERVICES					RM APPROVED
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NAME OF F	PROVIDER OR SUPPLIER		<u>' </u>		STREET ADDRESS, CITY, STATE, ZIP CODE		7171072011
					900 LONDON BOULEVARD		
PORISM	OUTH HEALTH AND	KEHAB			PORTSMOUTH, VA 23704		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFII TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPROPRIES (EROCY)	ULD BE	(X5) COMPLETION DATE
F 279	8/24/16 coded Resi Interview for Mental moderate cognition In addition the MDS requiring Extensive person assistance f and Dressing. Resincontinent of Urine Bowel functions. Resident #6's Annu Assessment Areas) Communication. Recommunication. Recommunication and Communication and Communication and Communication and Communication. The Director of Nurror 1/12/17 at approximated, "It is the Chato bring issues for Communication. The Communication. The Communication. The Communication are plan for Communication. The Care Plan for Communication are plan for Communication. The Care Plan for Communication are plan for Communication. The Care Plan for Communication are plan for Communication. The Care Plan for Communication are plan for Communication. The Care Plan for Communication are plan for Communication. The Care Plan for Communication are plan for Communication. The Care Plan for Communication are plan for Communication. The Care Plan for Communication are plan for Communication. The Care Plan for Communication are plan for Communication. The Care Plan for Communication are plan for Communication. The Care Plan for Communication are plan for Communication. The Care Plan for Communication are plan for Communication. The Care Plan for Communication are plan for Communication are plan for Communication. The Care Plan for Communication are plan for Communication are plan for Communication. The Care Plan for Communication are plan for Communication are plan for Communication. The Care Plan for Communication are p	sessment Reference Date of dent #6 with a BIMS (Brief I Status) of 8 of 15 indicating a impairment. Secored Resident #6 as Assistance with two staff for Transfers, Bed Mobility, ident #6 was coded as always and frequently incontinent of all MDS CAA (Care triggered for Cognition and eview of Resident #6's did not show focus areas of munication. Ses was interviewed on attely 1:15 p.m. The DON arge Nurse's responsibility first Care Plan updating and then the Care Plan." The DON aw included on Resident #6's ocus areas of Cognition and the DON replied, "No." Eximately 1:35 p.m. the MDS 2 was interviewed and asked did not include the CAA ication and vision. The MDS 2 stated, "It was an oversight. Care Plan."	F 2	279			
	the October 2016 R	ovided a copied section from AI (Resident Assessment . Section 2.7 documented the					

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following: "After completing the MDS and CAA portions of the comprehensive assessment, the

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CENTER	42 FOR MEDICARE	& MEDICAID SERVICES				<u> </u>
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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					LONDON BOULEVARD	
PORTSM	OUTH HEALTH AND	REHAB				
				POF	RTSMOUTH, VA 23704	
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F 279	through both asses	uate the information gained sment processes in order to	F 2	!79		
	and risk factors rela Subsequently, the I must evaluate the ii a care plan that add context of the resid	rauses, contributing factors, ated to the problems. DT (Interdisciplinary Team) Information gained to develop dresses those findings in the ent's strengths, problems, and a detail in Chapter 4 of this				
	findings during a br approximately 3:45	tration was informed of the iefing on 7/13/17 at p.m. The facility did not information about the findings.				
	DEFINITIONS:					
	documented: forms	ementia: Medline Plus s of dementia other than e such as dementia caused by				
F 287 SS=E	Ulcer Advisory Pane Stage 4 Pressure In tissue loss Full-thick with exposed or directed tendon, ligament, co Slough and/or esch 483.20(f)(1)-(4) EN	CODING/TRANSMITTING	F 2	287		
	(1) Encoding Data. completes a resider	Within 7 days after a facility nt's assessment, a facility llowing information for each				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION ING	(X3) DATE SURVEY COMPLETED
				С
	495149	B. WING		07/13/2017
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
PORTSMOUTH HEALTH AND	DEUAR		900 LONDON BOULEVARD	
PORTSWOOTH HEALTH AND	KENAD		PORTSMOUTH, VA 23704	
PREFIX (EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		D BE COMPLETION

F 287 Continued From page 33 resident in the facility:

- (i) Admission assessment.
- (ii) Annual assessment updates.
- (iii) Significant change in status assessments.
- (iv) Quarterly review assessments.
- (v) A subset of items upon a resident's transfer, reentry, discharge, and death.
- (vi) Background (face-sheet) information, if there is no admission assessment.
- (2) Transmitting Data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State.
- (3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following:
- (i) Admission assessment.
- (ii) Annual assessment.
- (iii) Significant change in status assessment.
- (iv) Significant correction of prior full assessment.
- (v) Significant correction of prior quarterly assessment.
- (vi) Quarterly review.
- (vii) A subset of items upon a resident's transfer, reentry, discharge, and death.
- (viii) Background (face-sheet) information, for an initial transmission of MDS data on a resident that does not have an admission assessment.

F 287

F287

- 1. The state RAI coordinator was contacted during the survey and instruction was given on how to correct the discharge assessments and errors in transmittals. These items were corrected by 8/5/17
- 2. Residents that have assessments transmitted or are discharged are at risk for this practice.
- 3. The MDS coordinators were reeducated by the VP of clinical reimbursement. The education included transmittals, scheduling and discharge assessments.

 The audit report will be pulled monthly as part of the monthly QAPI meeting process. Any discrepancies will be corrected immediately.
- 4. Audit results will be reviewed in monthly QAPI meeting.

8/13/17

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PORTSN	OUTH HEALTH AND	REHAB	 - - - -		ONDON BOULEVARD TSMOUTH, VA 23704		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	<	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 287	Continued From pa	ge 34	F 2	87			
	in the format specific which has an altern the format specified CMS. This REQUIREMENT by: Based on clinical reinterview, the facility encoding and trans and Medicare (CMS (Resident #21, #22) 1. The facility staff fany Minimum Data 2/17/17 to the Natio for Medicare and M #21 who was a curr	failed to electronically transmit Set (MDS) assessments after onal Data Base, the Centers dedicaid (CMS) for Resident					
	any Minimum Data 1/2/17 to the Nation	Set (MDS) assessments after nal Data Base, the Centers for caid (CMS) for Resident #22					
	any Minimum Data 1/18/17 to the Natio	failed to electronically transmit Set (MDS) assessments after anal Data Base, the Centers edicaid (CMS) for Resident rent resident.					
	any Minimum Data 2/21/17 to the Natio for Medicare and M	failed to electronically transmit Set (MDS) assessments after anal Data Base, the Centers edicaid (CMS) for Resident discharged from the facility.					



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NAME OF I	PROVIDER OR SUPPLIER			STR	REET ADDRESS, CITY, STATE, ZIP CODE		
PORTSM	OUTH HEALTH AND	REHAB			LONDON BOULEVARD RTSMOUTH, VA 23704		
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F 287	Continued From pa		F	287			
	1. The facility staff fany Minimum Data 2/17/17 to the Natio for Medicare and M #21 who was a curr The Resident's last transmitted to CMS listed on the MDS 3 Budget Reconciliatidated 2/17/17. Resident #21 was a on 1/23/14 with diagonal transmitted to Dementia. During an interview 7/11/17 at 4:30 p.m attention the reside Missing OBRA Asset the last assessmen Data Base was date was not aware of the investigate with a resident #21 was a confirmed to say the Resident #21 was a confir	failed to electronically transmit Set (MDS) assessments after and Data Base, the Centers edicaid (CMS) for Resident rent resident. MDS submitted and was a Quarterly and currently 3.0 Missing OBRA (Omnibus on Act Assessment) Report admitted to the nursing facility gnoses that included with the MDS Coordinator on ., it was brought to her nt was listed on the 3.0 resident Report that identified the submitted to the National and 2/17/17. She stated she is status and would have to					
	The MDS Coordina (Resident Assessm guide to completing						

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Medicare and/or Medicaid-certified nursing homes must transmit required MDS data to

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DEPARI	MENT OF HEALTH	AND HUMAN SERVICES					FORM	APPROVED
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES				<u> </u>	MB NO.	. 0938-0391
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NAME OF F	PROVIDER OR SUPPLIER		<u>'</u>	S	TREET ADDRESS, CITY, STATE, ZIP COL	DE .		
				9(00 LONDON BOULEVARD			
PORTSM	IOUTH HEALTH AND	REHAB		Р	ORTSMOUTH, VA 23704			
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F 287	Continued From pa	ae 36	F 3	287				
	·	Quality Improvement and	1 2	_07				
		(QIES) Assessment						
	Submission and Pro	` '						
		ailed to electronically transmit						
	•	Set (MDS) assessments after						
		al Data Base, the Centers for caid (CMS) for Resident #22						
	who was a current r	• •						
	Willo Wao a carroller							
		MDS that was submitted and						
		was an Annual, and was						
		ne MDS 3.0 Missing OBRA						
	dated 1/2/17.	Reconciliation Act Assessment)						
	ualeu 1/2/17.							
		admitted to the nursing facility gnoses that included Diabetes.						
	During an interview	with the MDS Coordinator on						
		., it was brought to her						
		nt was listed on the 3.0						
		essment Report that identified						
		t submitted to the National						
		ed 1/2/17. She stated she was						
		atus and would have to						
	investigate with a re	лит ехритация.						
	On 7/13/17 at 4:00	p.m., The MDS Coordinator						
	returned to say the	last MDS completed for						
		quarterly assessment dated						
		a batch that did not get						
	transmitted to CMS	data base.						
	3. The facility staff f	ailed to electronically transmit						

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#23 who was a current resident.

any Minimum Data Set (MDS) assessments after 1/18/17 to the National Data Base, the Centers for Medicare and Medicaid (CMS) for Resident

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PORTSM	OUTH HEALTH AND	REHAB			D LONDON BOULEVARD DRTSMOUTH, VA 23704		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 287	Continued From pa	ge 37	F 2	:87			
	currently listed on the	MDS submitted and was an Annual, and was ne MDS 3.0 Missing OBRA Reconciliation Act Assessment)					
		admitted to the nursing facility gnoses that included Heart					
	7/11/17 at 4:30 p.m attention the reside Missing OBRA Assethe last assessmen Data Base was date	with the MDS Coordinator on ., it was brought to her nt was listed on the 3.0 essment Report that identified t submitted to the National ed 1/18/17. She stated she is status and would have to eturn explanation.					
	returned to say the Resident #23 was a	p.m., The MDS Coordinator last MDS completed for a quarterly assessment dated a batch that did not get data base.					
	any Minimum Data 2/23/17 to the Natio for Medicare and M	ailed to electronically transmit Set (MDS) assessments after anal Data Base, the Centers edicaid (CMS) for Resident discharged from the facility.					
	was admitted on 2/2	nical record, Resident #30 16/17 with heart disease and ess. She was discharged from on 2/27/17.					

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The resident's last transmitted Minimum Data Set (MDS) assessment was an Admission with an

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NAME OF F	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP (CODE			
				900 LONDON BOULEVARD				
PORTSM	OUTH HEALTH AND	REHAB		PORTSMOUTH, VA 23704				
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F 287	Continued From pa	nge 38		287				
1 201	•		Γ.	201				
		nce date of 2/23/17. This was vas submitted and transmitted						
		urrently on the MDS 3.0						
		nibus Budget Reconciliation						
	Act Assessment) R							
	During an interview	with the MDS Coordinator on						
		with the MDS Coordinator on , it was brought to her						
		nt was listed on the 3.0						
		essment Report that identified						
		it submitted to the National						
		ed 2/23/17. She stated she						
		nis status and would have to						
	investigate with a re	eturn explanation.						
	On 7/12/17 at 1:00	n m The MDS Coordinator						
		p.m., The MDS Coordinator the resident had been						
		e facility since 2/27/17 and						
		lete a discharge MDS and						
	transmit it to CMS.	ioto a dicerial go mbo ana						
		tor stated they used the						
		ent Instrument (RAI) as their						
	MDS Assessment p	oolicy.						
	The RAI Manual inc	dicated Discharge						
		a return that is not expected						
		when the resident is						
		e facility within 30 days.						
F 309	_	PROVIDE CARE/SERVICES	F;	309				
	FOR HIGHEST WE							
	483.24 Quality of lif	e						
		indamental principle that						
		and services provided to facility						
		sident must receive and the						
		e the necessary care and						
		maintain the highest						

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АВ					
TBE PRECEDED BY FULL		X	(EACH CORRECTIVE ACTION	N SHOULD BI	
ntal, and psychosocial th the resident's nent and plan of care. amental principle that and care provided to on the comprehensive at, the facility must ensure eatment and care in ional standards of sive person-centered ents' choices, including owing: that pain management is to require such services, and standards of practice, on-centered care plan, and preferences. must ensure that alysis receive such professional standards ensive person-centered ents' goals and anot met as evidenced ents' goals and anot met as evidenced resident interview, acility documentation with facility staff failed octor's) orders were	F	F3 1. 2.	MD orders were veri # 12 to ensure accura. An audit was comple to ensure residents the facility had accurate I being followed Licensed Nurses wer by DON/designee. The included how to trans notation of orders and orders. New orders we in morning meeting we team to ensure orders. An audit will be comp x 12 weeks to ensure accurate Results of audits will	eted by 8, at were in Physician re re-educate educate scribe or of following the review of the coupleted 2x orders ar albe review of the revie	/5/17 n orders cated tion ders, ng MD viewed clinical trate. tweek
	PROVIDER/SUPPLIER/CLIA DENTIFICATION NUMBER:	AB NT OF DEFICIENCIES T BE PRECEDED BY FULL ENTIFYING INFORMATION) Parent and plan of care. In the resident's ment and care provided to on the comprehensive at the facility must ensure eatment and care in sional standards of esive person-centered ents' choices, including owing: Ithat pain management is no require such services, on-centered care plan, and preferences. In that pain management is no require such services, on-centered care plan, and preferences. In that pain management is no require such services, on-centered care plan, and preferences. In that pain management is no require such services, on-centered care plan, and preferences. In that pain management is no require such services, on-centered care plan, and preferences. In that pain management is no require such services, on-centered care plan, and preferences. In that pain management is no require such services, on-centered care plan, and preferences. In that pain management is no require such services, on-centered care plan, and preferences. In that pain management is no require such services, on-centered care plan, and preferences. In that pain management is no require such services, on-centered care plan, and preferences. In that pain management is no require such services, on-centered care plan, and preferences. In that pain management is no require such services, on-centered care plan, and preferences. In that pain management is no require such services, on-centered care plan, and preferences.	PROVIDER/SUPPLIER/CLIA DENTIFICATION NUMBER: 495149 B. WING STREE 900 LG PORT NT OF DEFICIENCIES T BE PRECEDED BY FULL ENTIFYING INFORMATION) PREFIX TAG F 309 Intal, and psychosocial ifth the resident's ment and plan of care. Interpretation of the comprehensive int, the facility must ensure eatment and care in sional standards of sive person-centered ents' choices, including owing: Interpretation of the comprehensive interpretation of the comprehens	PROVIDER/SUPPLIER/ICLIA DENTIFICATION NUMBER: 495149 B. WING STREET ADDRESS, CITY, STATE, ZIP C 900 LONDON BOULEVARD PORTSMOUTH, VA 23704 NT OF DEFICIENCIES T BE PRECEDED BY FULL ENTIFYING INFORMATION) PREFIX CROSS-REFERENCED TO THE DEFICIENCY) F 309 Intal, and psychosocial ith the resident's nent and plan of care. F 309 Intal, and psychosocial ith the resident's nent and plan of care. F 309 Intal, and psychosocial ith the resident's nent and plan of care. Interpretation of care in the facility must ensure satment and care in sional standards of sive person-centered ents' choices, including owing: Intal pain management is no require such services, on-centered care plan, and preferences. Interpretation of the comprehensive in morning meeting we team to ensure orders we in morning meeting we team to ensure orders we in morning meeting we team to ensure orders and orders. New orders we in morning meeting we team to ensure orders and orders. New orders we in morning meeting we team to ensure orders and orders. New orders we in morning meeting we team to ensure orders and or	AB AB TOF DEFICIENCIES IT BE PRECEDED BY FULL INTERVING INFORMATION) TOF DEFICIENCIES IT BE PRECEDED BY FULL INTERVING INFORMATION) TOF DEFICIENCIES IT BE PRECEDED BY FULL INTERVING INFORMATION) TOF DEFICIENCIES IT BE PRECEDED BY FULL INTERVING INFORMATION) TOF DEFICIENCIES IT BE PRECEDED BY FULL INTERVING INFORMATION) TAG FROM DROWLEYARD PORTSMOUTH, VA 23704 TAG PROVIDER'S PLAN OF CORRECTION ACTION SHOULD BE PRECIDENCY) FROM DROWLEYARD PORTSMOUTH, VA 23704 FROM LONDON BOULEVARD PORTSMOUTH, VA 23704 TO PROVIDER'S PLAN OF CORRECTION ACTION SHOULD BE PROVIDER'S PLAN OF CORRECTION FROM THE APPROPRIATION OF THE APPROPRIATI

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The findings included:

sample.

Event ID: TD2W11

Facility ID: VA0035

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	TAND HOWAN OLIVIOLO			FORM APPROVED
CENTERS FOR MEDICAR	E & MEDICAID SERVICES			OMB NO. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
	495149	B. WING _		07/13/2017
NAME OF PROVIDER OR SUPPLIER	2		STREET ADDRESS, CITY, STATE, ZIP CO	DE
PORTSMOUTH HEALTH AND	O REHAB		900 LONDON BOULEVARD PORTSMOUTH, VA 23704	
PREFIX (EACH DEFICIENCE	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	SHOULD BE COMPLETION
F 309 Continued From p	age 40	F 30	9	
1/16/17. Diagnose but are not limited and open ulcers to Quarterly Minimur assessment proto Reference Date or with a BIMS (Brief 15 of 15 indicating). In addition the MD requiring extensive person assistance to ileting. Resident frequently inconting. Resident #12's cut he following 5/22/Altered skin integrovascular deficience Left lateral ankle left outer ankle left outer ankle left shin #1 left shin #2 left shin #3 right 2nd toe resol Interventions document to the product weekly Wound as Conduct weekly skin assessment center Policy.	ved 5/22/17 Imented included the following: lered seessment kin inspection to be completed per Living IR (Treatment Administration 017 documented the following			

7/6/17 MD order: Left anterior ankle: Cleanse

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

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CENTER	CENTERS FOR MEDICARE & MEDICAID SERVICES						O. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION		OATE SURVEY OMPLETED
		495149	B. WING				C)7/13/2017
	PROVIDER OR SUPPLIER	REHAB		900	EET ADDRESS, CITY, STATE, ZIP COD LONDON BOULEVARD	ÞE	
				POF	RTSMOUTH, VA 23704		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 309	wound bed, cover v 7/6/17 MD order: L saline, apply silvade dry dressing daily. 7/6/17 MD order: L normal saline, apply bed, cover with dry 7/6/17 MD order: L cleanse with normal thick to the wound be daily. Skin prep apply to r day for protection. Left transmetatarsat to air and monitor a Triad Hydrophillic V scrotum topically ev LPN (Licensed Pract doing wound care for approximately 12:00 Resident #12's dres wound care orders open ulcer on shin a Resident #12 had h with dressings. The LPN called Res and obtained phone Clean all leg wound santyl ointment, cov kling gauze. Resident #12 refuse	apply alginate dressing to with dry dressing daily. Left heel: Cleanse with normal ene to wound bed, cover with deft outer ankle: Cleanse with santyl nickel thick to wound dressing, daily. Left shin area #1, top area: all saline, apply santyl nickel bed, cover with dry dressing, dight second toe topically every all amputation site: leave open area at this time. Vound Dressing Paste apply to very shift for healing. Letical Nurse) #2 was observed or Resident #12 on 7/12/17 at 0 noon. LPN #2 removed asing and needed to clarify as she noted three areas of area and she observed that his entire lower leg covered sident 12's Vascular Surgeon	F	309			
	Review of Resident Administration Reco	#12's Treatment ord (TAR) for July 2017					

showed 16 omissions for completed wound care orders. Review of Resident #12's June 2017 TAR

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		AND HOWAN SERVICES						MAPPROVED
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES				0	<u>MB NC</u>	D. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		LE CONSTRUCTION			TE SURVEY MPLETED
		495149	B. WING				07	C 7/ 13/2017
NAME OF F	PROVIDER OR SUPPLIER		<u> </u>		STREET ADDRESS, CITY, STATE, Z	IP CODE		710/2011
				ç	900 LONDON BOULEVARD			
PORTSM	OUTH HEALTH AND	REHAB		F	PORTSMOUTH, VA 23704			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD THE APPROPI	BE	(X5) COMPLETION DATE
F 309	Continued From pa	ne 42	E 3	309	1			
, 000	·	ns for completed wound care.	, ,	,00				
	after 6/20/17. The the facility wound condiscontinued July 2 been the Resident's complete wound can be last wound as noted one wound of the two large ulcers heel. A Braden Scale ass Resident #12 as has Pressure Sore Risk	ot reveal any assessments Director of Nurses stated that are nurse position was 0, 2017, and that it would have is Nurse's responsibility to are as ordered by the Doctor. Ressment on 6/20/17 only in the shin. It did not address is noted at the left ankle and left dessessment of 1/17/17 scored aving "High Risk" for predicting						
	approximately 1:15 explanation as to w The DON added, N orders the doctor w stated following ME job description. Th wound can develop not following orders Resident #12 states	p.m.: "I couldn't find any thy treatments were not done." Jursing staff is to follow the rites for patients. The DON 0 orders is part of the Nurse's e DON also stated that a complications as a result of a for wound care.						

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Review of the Facility Policy titled, "Skin Assessment Weekly" with an effective date of 1/2017 documented the following: "A Licensed

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

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		ONSTRUCTION	(X3) DATE SURVEY COMPLETED
		405440	D WING			С
		495149	B. WING			07/13/2017
	PROVIDER OR SUPPLIER IOUTH HEALTH AND	REHAB		900 L	ET ADDRESS, CITY, STATE, ZIP CODE ONDON BOULEVARD TSMOUTH, VA 23704	
			·····			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETION
F 309	Continued From pa	ge 43	F:	309		
	Nurse will complete each resident week	e a total body assessment on ly and document the "Weekly Skin Integrity				
	procedures sixth ed following: "Docume preparing a comple and is a vital tool fo health care team m charting shows the that nurses provide and treatment and needs. Thorough, a	ce from Lippincott's Nursing dition documented the entation is the process of te record of a patient's care r communication among embers. Accurate, detailed extent and quality of the care, the outcomes of that care, education that the patient still accurate documentation ntial for miscommunication				
	findings during a br approximately 3:45	p.m. The facility did not information about the findings. TMENT/SVCS TO	F	314		
	(b) Skin Integrity -					
	(1) Pressure ulcers comprehensive ass facility must ensure	essment of a resident, the				
	professional standa pressure ulcers and ulcers unless the in	es care, consistent with ords of practice, to prevent didoes not develop pressure dividual's clinical condition hey were unavoidable; and				
	(ii) A resident with p	ressure ulcers receives				

		AND HUMAN SERVICES					FORM APPROVE
STATEMENT	S FOR MEDICARE OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '			NSTRUCTION	OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED
		495149	B. WING	·			C 07/13/2017
NAME OF I	PROVIDER OR SUPPLIER			8	STREET	ADDRESS, CITY, STATE, ZIP CODE	
DODTSM	OUTH HEALTH AND	DEHAR		9	900 LO	NDON BOULEVARD	
FORTON	100 III IILALIII AND	KENAD		F	PORTS	SMOUTH, VA 23704	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG			PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMPLÉTION
F 314	•	nt and services, consistent with		314	4	F314	
	healing, prevent inf	ards of practice, to promote ection and prevent new ulcers			1.	Licensed nurse #22 that p wound care on resident #1	
	from developing.	NT : 4 4					
		NT is not met as evidenced				educated on the profession	
	by: Based on observa:	tions, resident interview,				of wound care dressing ch	anges. They
		ew, facility documentation				were given a competency	return
		terview the facility staff failed				demonstration test on 8/3/	17.
		are was done to promote				Resident #1 is receiving w	ound care per
		vent infection of pressure	•			physicians order. Resider	•
		nts (Resident #1 and #6) of 30					
	Residents in the su	rvey sample.				weekly skin assessments a	ire being
	The findings include	ad:				completed per policy.	
	The intuings include	eu.			2.	Residents that require wo	und care are at
	1. Resident #1 was	s admitted to the facility on				risk for this deficient prac	tice.
		mission on 4/26/17 after			3.	Licensed nurses will be re	educated on
	•	wound infection and urinary				the professional standard	
		gnoses for Resident #1				•	
		t limited to Non-Alzheimer's				by AMT on 8/3/17 and 8/9	
		tion and Stage IV* Right Heel				Return demonstration con	1
		esident #1's Quarterly (MDS-an assessment				were completed for each l	icensed nurse
		ssessment Reference Date of				by Unit Managers and wil	l continue to
		ident #1 with a BIMS (Brief				be on-going as needed.	
	Interview for Menta	Status) of 1 out of 15				Wound dressing observat	ion will be
	indicating severe co	ognition impairment.				completed randomly 3 x v	
						_	
		S scored Resident #1 as				to ensure licensed nurses	•
		ndence with 2 staff persons				professional standards of	wound care.
		dent #1 was coded as ndence with one staff person				Re-education and training	provided as
		sing Hygiene and Rathing				needed.	-

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8/13/17



4. Results of wound observations will be

reviewed in the monthly QAPI meeting

Resident #1's physician orders documented the

7/5/17 MD order: Cleanse Right heel wound with

normal saline. Apply nickel thick santyl and

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CENTER	RS FOR MEDICARE	& MEDICAID SERVICES					O. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		LE CONSTRUCTION		ATE SURVEY OMPLETED
		495149	B. WING			0	C 7/13/2017
NAME OF F	PROVIDER OR SUPPLIER			s	TREET ADDRESS, CITY, STATE, ZIP CODI	=	
PORTSN	OUTH HEALTH AND	REHAB		į .	00 LONDON BOULEVARD PORTSMOUTH, VA 23704		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 314	Continued From pa	•	F:	314			
	alginate to wound be gauze and kerlix da	ped daily. Cover with dry aily and as needed.					
	(TAR) for June 201 documentation omi	tment Administration Record 7 included two wound care ssions and the TAR for July bund care documentation					
	observed performing approximately 3:20 infection control meremoving soiled global solutions.	Nurse (LPN) #22 was ng wound care on 7/12/17 at p.m. The LPN did not utilize easures of hand hygiene after oves and she did not sanitize or to placing a clean field.					
	focus area of: At risk for further sk Assistance required repositioning and in	in inspection					
	3/21/17 initial Risk	al record documented a for Pressure Ulcers to be 12 k for Pressure Ulcers.					
	from her initial adm ulcer was initially id	al record weekly assessments ission documented the heel entified at a Stage II and je III* on 4/24/17 when the					

resident required hospitalization. Upon

readmission 4/26/17, weekly assessments were documented from admission through 6/18/17.

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

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CENTER	CENTERS FOR MEDICARE & MEDICAID SERVICES					OMB N	D. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILE		CONSTRUCTION		ATE SURVEY OMPLETED
		495149	B. WING	i			C 7/13/2017
NAME OF I	PROVIDER OR SUPPLIER			STR	REET ADDRESS, CITY, STATE, ZIP CODE	1 0	713/2017
PORTSN	OUTH HEALTH AND	REHAB		1	LONDON BOULEVARD RTSMOUTH, VA 23704		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 314	Assessment Weekl 1/2017 documented Nurse will complete each resident week assessment on the Checks" form. The Facility Guidan procedures sixth ed	ge 46 Ity Policy titled, "Skin y" with an effective date of d the following: "A Licensed a total body assessment on ly and document the "Weekly Skin Integrity ce from Lippincott's Nursing lition documented the entation is the process of	F	314			
	preparing a comple and is a vital tool fo health care team m charting shows the that nurses provide and treatment and oneeds. Thorough, a	te record of a patient's care r communication among embers. Accurate, detailed extent and quality of the care, the outcomes of that care, education that the patient still accurate documentation ntial for miscommunication					
	evidence that the w omissions was com 7/12/17 at approxim find any explanation not done." The DO follow the orders the The DON stated fol the Nurse's job des that a wound can de	sing was asked to show ound care documentation pleted. The DON stated on nately 1:15 p.m.: "I couldn't as to why treatments were N added, Nursing staff is to e doctor writes for patients. lowing MD orders is part of cription. The DON also stated evelop complications as an gorders for wound care.					
	findings during a bri approximately 3:45	tration was informed of the efing on 7/13/17 at p.m. The facility did not information about the findings.					

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		AND HUMAN SERVICES				FORM APPR	OVED
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES				DMB NO. 0938	-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′		DNSTRUCTION	(X3) DATE SURV COMPLETED	
		495149	B. WING			07/13/20	17
NAME OF F	PROVIDER OR SUPPLIER	L	<u> </u>	STRE	ET ADDRESS, CITY, STATE, ZIP CODE	1 01/10/20	
					ONDON BOULEVARD		
PORTSM	OUTH HEALTH AND	REHAB			TSMOUTH, VA 23704		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION OF T	DBE COMPI	K5) LETION ATE
F 314	Continued From pa	ge 47	F 3	14			
	8/19/15 with a read Diagnoses for Resilimited to Stage IV Pressure required in bed mot Score 18 or less that of Foley catheter for 9/14/16 readmitted	dent #6 included but are not Sacral Pressure Ulcer* and ementia*. Resident #6's ata Set (MDS-an assessment seessment Reference Date of ident #6 with a BIMS (Brief I Status) of 8 out of 15 ate cognition impairment. Secored Resident #6 as Assistance with two staff for Transfers, Bed Mobility, ident #6 was coded as always and frequently incontinent of Plan documented a focus Plan documented a focus ulcer due to Assistance collity, wound assessment an, bowel incontinence. Use r wound healing auterization performed by lange ent ent ent nt					
	Conduct weekly ski Foley cath (cathete Treatments as orde	r) as needed					

Weekly wound assessment

7/19/17 Braden Scale scored Resident #6 as

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		MEDICAID SERVICES					I APPROVED
	S FOR MEDICARE OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA		TIDLE	CONSTRUCTION		. 0938-0391 E SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:	1			COV	MPLETED
		495149	B. WING			1	C / 13/2017
NAME OF F	PROVIDER OR SUPPLIER		<u> </u>	STF	REET ADDRESS, CITY, STATE, ZIP CODE	1 077	13/2017
PORTSM	OUTH HEALTH AND	REHAR		900	LONDON BOULEVARD		
FORTON				PO	RTSMOUTH, VA 23704		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 314	Continued From pa	ge 48	F3	314			
	High Risk for devel	oping Pressure Ulcers.					
	included: Clean wo collagen to wound be	sician order for wound care bund with normal saline, apply bed, apply skin prep to skin und apply clean dressing and					
	sacral wound are Lo	Physician measurements of ength by width by depth: 1 by ers; surface area .40 ate sero sanguinous exudate ion tissue.					
	care omissions; 8 c	2017 Treatment ord included 3 sacral wound atheter care omissions, and ication omissions to buttock					
	showing documents measurements. The	sessment form stopped ation after the 6/28/17 is same form documented on 3/20/17, 4/3/17, 4/10/17, 7.					
	Assessment Weekl 1/2017 documented Nurse will complete each resident week	ty Policy titled, "Skin y" with an effective date of d the following: "A Licensed a total body assessment on ly and document the "Weekly Skin Integrity					
	procedures sixth ed	ce from Lippincott's Nursing ition documented the entation is the process of					

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preparing a complete record of a patient's care and is a vital tool for communication among

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Facility ID: VA0035

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CENTERS FOR MEDICARE & MEDICAID SERVICES				OMB NO. 0938-039					
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3)	DATE SURVEY COMPLETED		
		495149	B. WING	i			C 07/13/2017		
NAME OF F	PROVIDER OR SUPPLIER		-	STF	REET ADDRESS, CITY, STATE, ZIP CO	DE			
PORTSM	OUTH HEALTH AND	REHAB		1	RTSMOUTH, VA 23704				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION E DATE		
F 314	charting shows the that nurses provide and treatment and needs. Thorough, decreases the pote and errors. The Director of Nur evidence that the modoumentation omi DON stated on 7/12 p.m.: "I couldn't finit reatments were not Nursing staff is to five writes for patients. orders is part of the DON also stated the complications as a for wound care. The facility administ findings during a brapproximately 3:45 present any further DEFINITIONS: Stage II Pressure Leulicer Advisory Panel Pressure Injury: P	embers. Accurate, detailed extent and quality of the care, the outcomes of that care, education that the patient still accurate documentation ntial for miscommunication sing was asked to show nultiple wound care ssions were completed. The 2/17 at approximately 1:15 d any explanation as to why the done." The DON added, collow the orders the doctor. The DON stated following MD and the Nurse's job description. The at a wound can develop result of not following orders tration was informed of the iefing on 7/13/17 at p.m. The facility did not information about the findings. Ulcer: The National Pressure el: documented: Stage 2 rtial-thickness skin loss with	F :	314					
	with exposed dermi	artial-thickness loss of skin is. The wound bed is viable, and may also present as an							

intact or ruptured serum-filled blister. Adipose (fat) is not visible and deeper tissues are not visible. Granulation tissue, slough and eschar are

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		AND HOWAN SERVICES				FORM API	
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			(<u> MB NO. 09</u>	<u>38-0391</u>
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION	(X3) DATE SU COMPLE	
		495149	B. WING	i		07/13/	2017
NAME OF F	PROVIDER OR SUPPLIER			,	STREET ADDRESS, CITY, STATE, ZIP CODE		
DODTSM	OUTH HEALTH AND	DEHAR		ć	900 LONDON BOULEVARD		
FORTSIVI	OO IN NEALIN AND	KLIIAD		F	PORTSMOUTH, VA 23704		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE CC	(X5) DMPLETION DATE
F 314	Continued From pa	ge 50	F 3	314	4		
		injuries commonly result from					
		te and shear in the skin over					
		r in the heel. This stage					
		to describe moisture mage (MASD) including					
		iated dermatitis (IAD),					
	intertriginous derma	atitis (ITD), medical adhesive					
	, , ,	MARSI), or traumatic wounds					
	(skin tears, burns, a	abrasions).					
	Ulcer Advisory Pane Full-thickness loss is visible in the ulce epibole (rolled wour Slough and/or esch of tissue damage va areas of significant wounds. Undermin Fascia, muscle, ten and/or bone are not	of skin, in which adipose (fat) r and granulation tissue and and edges) are often present. ar may be visible. The depth aries by anatomical location; adiposity can develop deep ing and tunneling may occur. Idon, ligament, cartilage t exposed. If slough or eschart of tissue loss this is an					
F 315 SS=D	Ulcer Advisory Pane Full-thickness skin a or directly palpable ligament, cartilage of and/or eschar may edges), underminin Depth varies by and eschar obscures the an Unstageable Pre	and tissue loss with exposed fascia, muscle, tendon, or bone in the ulcer. Slough be visible. Epibole (rolled g and/or tunneling often occur. atomical location. If slough or e extent of tissue loss this is essure Injury. O CATHETER, PREVENT UTI,	FS	315	5		

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(e) Incontinence.

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Facility ID: VA0035

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		AND HUMAN SERVICES & MEDICAID SERVICES				PRINTED: 07/24/2017 FORM APPROVED OMB NO. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	INTIMPED: '		NSTRUCTION	(X3) DATE SURVEY COMPLETED
		495149				C 07/13/2017
NAME OF PROVIDER OR SUPPLIER					ET ADDRESS, CITY, STATE, ZIP CODE	
PORTSMOUTH HEALTH AND REHAB					ONDON BOULEVARD ISMOUTH, VA 23704	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETION
F 315	continent of bladde	t ensure that resident who is rand bowel on admission	F;	B15 F3		
receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain.			1.	LPN nurse #12 was an ager and will not return to the fac- until agency provides proof	cility of	
	(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that-				training and competencies f care. C.N.A #1 was re-educ Foley catheter care and retu	ated on

- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary;
- (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary and
- (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible.
- (3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible.

This REQUIREMENT is not met as evidenced

Based on observation, staff interview, clinical record review and facility document review the facility staff failed to provide the appropriate care

- demonstration competency on 8/4/17.
- 2. Residents with Foley catheters are at risk for this practice.
- 3. Nursing staff were re-educated on proper Foley care by DON/designee. Return demonstration were completed for current nursing staff by the Unit Managers and will continue to be on-going as needed. A random observation of Foley care will be completed 2 x week x 12 weeks to ensure that appropriate Foley care is provided.
- 4. The results of the audit will be discussed and reviewed in the monthly QAPI meeting.

8/13/17

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PORTSMOUTH HEALTH AND REHAB				ľ	LONDON BOULEVARD RTSMOUTH, VA 23704		
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F 315	of a Foley catheter survey sample, Res The facility staff fail catheter tubing was properly and failed infection control pra	vent complications for the use for 1 of 30 residents in the sident #7. ed to ensure the Foley anchored and secured to implement appropriate actices during the change of eg bag for Resident #7.	F	315			
	The resident's current limited to Alzhei ulcer (full thickness may be visible but be exposed). The current MDS (Notes the current MDS)	dmitted to the facility on 8/1/14. ent diagnoses included, but mer's and a stage 3 pressure tissue loss, subcutaneous fat cone, tendon, or muscle is not dinimum Data Set) a quarterly treference date of 4/17/17					
	coded the resident possible 15 on the I Status (BIMS), indicessory impaired coded as having on A review of the compared plan dated 6/1 had alteration in elimedue to a indwelling promote wound hear resident would not be the use of the indwe infection, obstruction listed to achieve/ manchor catheter, av	as scoring a 00 out of a Brief Interview for Mental cating the resident had ognition. The resident was the stage 3 pressure ulcer. Aprehensive person-centered 5/17 identified the resident mination of bowel and bladder urinary catheter inserted to aling. One goal listed was the have any complications from celling catheter such as pain, in. Three of the interventions aintain the goal included; oid excessive tugging on the sefer and delivery of care and					

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change catheter bag every 2 weeks and as

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TWANE OF T	TOVIBER OR GOLF ELER				ONDON BOULEVARD		
PORTSN	OUTH HEALTH AND	REHAB			TSMOUTH, VA 23704		
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F 315	Continued From pa	ige 53	F 3	15			
	·	catheter care every shift and	, ,	,10			
	as needed.	catheter care every shift and					
	range 5/1/17 through dated 6/15/17. The catheter (1), 16 Fre	er Summary Report order date gh 7/31/17 included an order e order was for a Foley ench, 10 cc (cubic centimeter) aling of stage 3 ulcer of the					
	catheter care with a Practical Nurse #12 (Certified Nurse Aid resident was transfethe bed by CNA#1. removed to evident The leg bag was obthe resident's right one of two straps, the knot. Upon untying under the strap was indentation encircling blanchable. The Fobunched up around adhered to the residenter from a basin placed nurse washed her hashe then cleaned a 3) and the Foley tut gloves hands into the removed a new leg disconnected the legal content of the removed and the straps washed the straps washed her hashe then cleaned a content of the removed and the legal connected the legal content of the straps washed her hashe then cleaned a content of the straps washed her hashe then cleaned a content of the straps washed her hashe then cleaned a content of the straps washed her hashe then cleaned a content of the straps washed her hashe the straps washed her h	ar am, an observation of Foley an agency nurse (Licensed 2) accompanied by CNA #1 de) was conducted. The erred from the wheelchair to The resident's pants were be a Foley catheter leg bag. Deserved secured tightly around leg. The leg bag was missing the one strap was tied with a part to the knot the resident's skin is noted to be dark red with an ang the leg. The area was obley catheter anchor was at the catheter tubing and not dent's skin. The nurse care by using soap and water don the bedside table. The mands and then put on gloves, round the urethral meatus (2, bing several times, dipping her he water basin. She then bag from the plastic package, ag bag from the Foley catheter cted the clean leg bag using					

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bunched up anchor from the tubing. The nurse then stated she would obtain an anchor. She then removed the gloves, washed her hands and

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CENTERS FOR MEDICARE	& MEDICAID SERVICES			<u>OMB NO. 0938-0391</u>			
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION DING	(X3) DATE SURVEY COMPLETED			
	495149	B. WING		C 07/13/2017			
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE				
PORTSMOUTH HEALTH AND REHAB			900 LONDON BOULEVARD PORTSMOUTH, VA 23704				
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F 315 Continued From pa	ge 54	F 3	315				

F 315 Continued From page 54 left the room.

After the Foley catheter care observation the nurse was interviewed at 2:36 pm. The observation of using the same gloves for both cleaning the meatus and Foley catheter and then changing out the old leg beg with the new leg bag was discussed. She stated she should have removed the gloves, and washed her hands before changing the leg bag to prevent potential cross contamination.

The above observation was shared with the Administrator and the Director of Nursing during a pre-exit meeting conducted on 7/13/17 at 3:45 pm.

The facility utilized Lippincott's Nursing Procedures Sixth Edition for standards of care. A copy of the section titled "Indwelling urinary catheter care and removal" pages 374-375 was provided for review and read, in part: Clean the outside of the catheter and the tissue around the meatus using soap and water...Remove and discard your gloves and perform hand hygiene. Reapply the leg band, and reattach the catheter to the leg band.

Potter and Perry Fundamentals of Nursing 7th Edition chapter 45 Urinary Elimination skill 45-2 page 1160 read, in part: 31. Anchor catheter: Secure catheter tubing to inner thigh with strip of nonallergenic tape (or multipurpose tube holders with a Velcro strap). Allow for slack so movement of this does not create tension on catheter. Rationale-Anchoring catheter to inner thigh reduces pressure on urethra, thus reducing possibility of tissue injury.

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	OUTH HEALTH AND	REHAB		900 L	ONDON BOULEVARD TSMOUTH, VA 23704		
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F 315	Continued From pa	ge 55	F3	315			
	balloon attachment is inserted, the ballo catheter is prevente until the balloon is e	urinary tract catheter with a at one end. After the catheter con is inflated. Thus the ed from leaving the bladder emptied. (Source-Taber's Dictionary Edition 20).					
F 323 SS=D	extending from the (Source-Taber's Cy Edition 20). 3. Urethra Meatus-Iurethra. (Source-Ta Dictionary Edition 2	1)-(3) FREE OF ACCIDENT	F3	323			
	(d) Accidents. The facility must en	sure that -					
	` '	vironment remains as free rds as is possible; and					
	` '	eceives adequate supervision ices to prevent accidents.					
	appropriate alternat bed rail. If a bed or must ensure correct	e facility must attempt to use tives prior to installing a side or side rail is used, the facility t installation, use, and a rails, including but not limited ments.					
	(1) Assess the residence from bed rails prior	dent for risk of entrapment to installation.					
	(2) Review the risks	and benefits of bed rails with					



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NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
PORTSMOUTH HEALTH AND REHAB			900 LONDON BOULEVARD PORTSMOUTH, VA 23704	
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F 323 Continued From page 56

the resident or resident representative and obtain informed consent prior to installation.

(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by:

Based on observation, facility documentation review, staff interviews and clinical record review the facility staff failed to implement interventions to reduce a potential accident hazard for 1 Resident (Resident #1) of 30 residents in the survey sample.

The findings included:

Resident #1 was admitted to the facility on 3/21/17. Diagnoses for Resident #1 included but are not limited to Non-Alzheimer's Dementia, Malnutrition and Stage IV Right Heel Pressure Ulcer. Resident #1's Minimum Data Set Quarterly assessment (MDS-an assessment protocol) with an Assessment Reference Date of 6/26/17 coded Resident #1 with a BIMS (Brief Interview for Mental Status) of 1 of 15 indicating severe cognition impairment.

In addition the MDS scored Resident #1 as requiring total dependence with 2 staff persons for Transfers. Resident #1 was coded as requiring total dependence with one staff person assistance for Dressing, Hygiene, and Bathing.

During an observation of wound care for Resident #1 on 7/12/17 at approximately 3:20 p.m., LPN #22 removed the soiled dressing using pointed tip scissors from her pocket that she did not sanitize. After completion of the wound care, the LPN was asked what type tipped scissors she should have

F 323

F323

- 1. LPN #22 that utilized the scissors was re-educated on 8/3/17 on proper wound care including type of scissors to utilize.
- 2. An audit was completed to ensure that nursing staff were not utilizing the wrong type of scissors for resident care, and that every nurse had appropriate scissors needed for patient care needs.
- 3. Nursing staff were re-educated by the DON/designee on safe practice standards for residents. An audit will be completed 2x week x 12 weeks by unit managers to ensure resident care is conducted in a safe manner.
- 4. Results of the audit will be discussed daily in the morning meeting and in the monthly QAPI meeting

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				900 LONDON BOU		
PORTSM	OUTH HEALTH AND	REHAB		PORTSMOUTH,		
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F 323	won't risk cutting the The Director of Nur	d: "bandage scissors so I	F3	23		
	pointed tip scissors pointed tip scissors	. The DON stated: "No, can possibly cut the Resident of scissors should be				
	findings during a br approximately 3:45 present any further	p.m. The facility did not information about the findings. OF MEDICATION ERROR	F 3	32		
	(f) Medication Error that its-	s. The facility must ensure				
	greater;	rates are not 5 percent or				
	by: Based on observat and staff interview t its medication error A medication admir was conducted to ir medication errors re	ions, clinical record reviews he facility failed to ensure that rates were not 5% or greater. istration observation pass include 27 opportunities, with 2 esulting in a 7.40% error rate, s, Residents #18 and #19.				
	appetite stimulant) t	to shake the drug Megace (an that was in a liquid suspension 18 prior to administration.				

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2. The nurse failed to administer a 20 mEq

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STATEMENT	RS FOR MEDICARE OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION	O	MB NO. 0938-0391 (X3) DATE SURVEY COMPLETED
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PORTSM	OUTH HEALTH AND	REHAB		900 LONDON BOUL		v
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH COF	ER'S PLAN OF CORRECTION RRECTIVE ACTION SHOULD ERENCED TO THE APPROP DEFICIENCY)	BE COMPLETION
The findings in 1. Resident #18 3/9/17 with diag vascular demendent The current ME with an assess coded the resist possible 15 on status indicating severely impair A physician teles Megace oral su (milliliter) BID (milliliter)		tablet before dinner as nt #19. ed: s admitted to the facility on is to include, but not limited to Minimum Data Set) a quarterly treference date of 6/16/17 as scoring a 00 out of a brief interview for mental eresident cognition was ne order dated 5/23/17 read: nsion 40 milligrams (mg)/mle a day) r/t (related to) Under this order was a	F 33	F332 1. LPN #1 suspensi suspensi unavaila #18 and physicia 2. Resident risk for t 3. License on the 8 administ random administ	 LPN #1 that did not shake the suspension was re-educated on liquid suspensions and correct process for unavailable medications. Residents #18 and #19 receive medications per physicians order. Residents that reside in facility are at risk for this practice 	
	clarified order change reading, "Megace oral suspension 400 mg BID r/t decrease appetite". A medication pass administration observation for Resident #18 was conducted with Licensed Practical Nurse #1 on 7/11/17 at 4:09 pm. The nurse obtained the Megace suspension from inside the medication cart. The label was incorrect and read Megace take 1 ml (40 mg) by			have err immedia 4. Results discusse	Nurses who are not ors will be re-educantely. of the audit will be and reviewed in the QAPI meeting.	ited

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mouth twice a day. The pharmacy label was not changed when the order was clarified. A

pharmacy auxiliary label read, "Shake well before each use". The nurse poured 10 ml of Megace (400 mg) inside a medication cup without shaking the suspension first. The nurse administered the medication. After the medication pass the nurse was questioned about the failure to read the instructions for shaking the suspension prior to pouring the Megace. She stated she normally

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(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 332	stated the rationale was to ensure "you acknowledged the pinaccurate and state pharmacy. The above observation with the Administrated during a pre-exit med 3:45 pm. Suspension drugs-provide important dose or on the med to remind nurses at techniques that shop preparation of a dose a multi-dose suspension is (are throughout the vehicus (Source Agency for Quality (AHRQ) U.S. Human Services). 2. The nurse failed (milieu) potassium to ordered for Resident #19 was a service was to ensure the suspension of the sus	but did not this time. She for shaking the suspension get a good mixture". She also charmacy label dose was ed she would call the tion and findings was shared for and the Director of Nursing setting conducted on 7/13/17 at charmacy departments often rug use information on each lication administration record rout special administration sold be employed in the se. Failure to vigorously shake astion administration error. It is that the active ingredient(s) in the properly dispersed cle before administration. Healthcare Research and S. Department of Health & to administer a 20 mEq tablet before dinner as	F	332			
	to hypo-osmolality('sodium).	1) and hyponatremia (low					

The current MDS (Minimum Data Set) a a quarterly with an assessment reference date of

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		& MEDICAID SERVICES	<u> </u>				0	T	<u>). 0938-0391</u>
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		DELLAD		ξ	900 L	ONDON BOULEVARD			
PORTSM	OUTH HEALTH AND	KEHAB		P	PORT	rsmouth, va 23704			
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F 332	Continued From pa	ae 60	F 3	332	· >				
1 002	<u> </u>	esident as scoring a 9 out of a	1 3	,02	-				
	possible 15 on the I Status, indicating the	Brief Interview for Mental ne resident had moderately							
	impaired daily decis	sion making skills.							
	The physician order	dated 5/19/17 instructed the							
		Potassium Chloride Crystals							
		vith meals related to d hyponatremia. The							
		neduled to be administered at							
	8 am, 12 pm and 6	pm every day.							
	Resident #19 was of Practical Nurse #1 of 5:00 pm. The Pota available in the med The nurse stated di between 5:30 pm-6 call the pharmacy for the properties of the pharmacy for	administration observation for conducted with Licensed on 7/11/17 at approximately ssium Chloride was not dication cart for administration. nner arrives on the unit :00 pm. She stated she would or a refill. The nurse stated ld be sent on the night run							
	on 7/12/17 evidence	lication Administration Record ed the resident was not 00 pm dose of Potassium							
	with the Administrat	tion and findings was shared or and the Director of Nursing eeting conducted on 7/13/17 at							
	the body fluids; bod	a decrease in the osmolality of y fluid volume increases and ally decrease. Symptoms are							

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those of hyponatremia such as cerebral edema with disorientation, focal neurological deficits, and seizures. (Source-National Health Institute-NIH).

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		ONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495149	B. WING			C 07/13/2017
	PROVIDER OR SUPPLIER	REHAB		900	EET ADDRESS, CITY, STATE, ZIP CODE LONDON BOULEVARD RTSMOUTH, VA 23704	
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	483.45(f)(2) RESID SIGNIFICANT MED		F 3	333 F	333	
	483.45(f) Medicatio	n Errors.			1. Resident #24 receives m	edications
	medication errors. This REQUIREMENT by: Based on staff inter and facility docume failed to ensure 1 of (Resident #24) was error. The facility staff faile #24's medications as by the physician.	rfree of any significant NT is not met as evidenced rview, clinical record review nt review, the facility staff f 30 sampled residents free of significant medication ed to administer Resident according to the times ordered			per physicians order. LP re-educated on medication administration and evaluadditional training for meadministration. 2. An audit was completed that residents that current the facility have their meavailable. 3. Licensed nursing staff weducated by the DON/de regarding obtaining orders ensuring medications are	nated for edication to ensure tly reside in dications vere resignee rs and
	4/8/15 and was read	ed: Idmitted to the facility on Idmitted on 2/2/16. Diagnoses Iduded but not limited to, high	: ,		An audit will be completed at 12 weeks on random recensure medications are a timely.	ed 2x week esidents to

blood pressure and diabetes mellitus (1).

The most recent Minimum Data Set with an assessment reference date of 5/31/17, assessed Resident #24 with a score of 14 out of possible 15 on the Brief Interview for Mental Status (BIMS), indicating Resident #24's cognitive abilities for daily decision making are intact.

On 7/13/17, Resident #24's clinical record review was conducted. The Physician Order Review Report documented the following orders:

a. Humalog Solution 100 unit/ml (milliliter). Inject

- timely.
- 4. Results of the audit will be reviewed and discussed at the monthly QAPI meeting.

8/13/17

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

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CENTE	RS FOR MEDICARE	& MEDICAID SERVICES		O	MB NO. 0938-0391		
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		495149	B. WING			C 07/13/2017	
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY,	STATE, ZIP CODE	0.7.10,2011	
PORTSM	OUTH HEALTH AND	REHAB		900 LONDON BOULEVA PORTSMOUTH, VA 2			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD NCED TO THE APPROPE DEFICIENCY)	BE COMPLETION	
F 333	b. Metformin HCI Ta Give 500 mg by mo Type 2 Diabetes Me c. Humalog Sliding 2 units; 251 - 300 4 351-400 8 units; 40 and at bedtime rela Mellitus. Order date A review of Resider Administration Reco delayed administrat diabetes such as, H Metformin HCI Tabl Resident #24's Med Report documented On 7/13/17, Humalo subcutaneously with administered at 8:00 that it was administ	usly (4) with meals related to ellitus. Order date - 5/24/17. ablet 500 mg. (milligrams) buth two times a day related to ellitus. Order date - 5/24/17 Scale 0-200 0 unit; 201 - 250 units; 301-350 6 units; 1-450 10 units before meals ted to Type 2 Diabetes - 4/29/16 at #24's Medication ord on 7/13/17, indicated ion of medications for lumalog Solution (2) and ets (3).	F3	33			
	was scheduled to be The report indicated 13:09 (1:09 pm), 4 li was supposed to be On 7/13/17, Humald	nin HCL 500 mg by mouth e administered at 9:00 am. I that it was administered at nours and 9 minutes after it					

meals. The report indicated that it was

administered at 13:18 (1:18 pm), 1 hour and 48



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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILE	TIPLE CONSTRUCTION JING	(X3) DATE SURVEY COMPLETED		
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NAME OF BROWERS OF CHERTIES	OTDEET ADDRESS OF STATE TO CODE	01/13/2017				
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
DODTORACHTU HEALTH AND	DELLAD		900 LONDON BOULEVARD			
PORTSMOUTH HEALTH AND	REHAB		PORTSMOUTH, VA 23704			
(X4) ID SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	ON (X5)		
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F 222 Continued France	62		200			
F 333 Continued From pa	ide os	F :	333			

minutes after it was supposed to be administered. The blood sugar level was 123.

The Comprehensive Resident Centered Plan of Care for Resident #24 stated, "Focus: Alteration in Blood Glucose (blood sugar) due to: Insulin Dependent Diabetes Mellitus; Goal: Patient will experience minimal signs and symptoms associated with hyperglycemia (high blood sugar)/hypoglycemia (low blood sugar) through next review. Date initiated - 5/21/15; Interventions: Administer medications as ordered."

On 7/13/17, the facility policy titled "Preventing Medication Errors ABC's Quick Reference" (not dated) stated, in part, "Key Points in Medication Pass: ...Medications must be passed within one hour of scheduled time".

On 7/13/17 at approximately 3:45 pm, the Administrator and Director of Nursing (DON) were made aware of the findings and were asked what had caused the delay in the administration of Humalog and Metformin HCl on Resident #24. They stated that LPN (Licensed Practical Nurse) #3 was a new nurse who started in June 2017. The Administrator stated that the new nurses went through 4 weeks of orientation; the first week was classroom orientation, the second week was with their mentor, the third week was performing a few assigned tasks and the fourth week was performing more assigned duties. The DON stated that LPN #3 was in orientation for a month and had recently "took a medication cart". The DON was asked what could be the possible outcome if the administration of the medications, like Humalog and Metformin, were delayed. She stated that a resident could have a complication

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F 333	on the resident's block The DON provided Competency Review date of 7/13/17. For Competency, LPN; "Experienced" (0 - I Experience; 2 - Exp No further informati Definition: (1) Diabetes Mellitut blood glucose, or block high. (Source: N Medicine: Medline (2) Humalog Solution a fast-acting insulin about 15 minutes about 1 hour, and k hours. Insulin is a lowering levels of glock (Source: https://www.drugs.com (3) Metformin HCl T alone or with other insulin, to treat ty which the body doe and, therefore, casugar in the blood). (Source)	igh blood sugar) depending bod sugar level at the time. a copy of LPN #3's Core w Checklist with a completion Medication Administration 3 was coded "2" as No experience; 1 - Minimal perienced; 3 - Does not Apply). on was provided. s - is a disease in which your ood sugar, levels are too IH U.S. National Library of Plus) on - Humalog (insulin lispro) is that starts to work after injection, peaks in eeps working for 2 to 4 a hormone that works by ucose (sugar) in the blood.	F	3333				

(4) Subcutaneously - being, living, used, or made

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
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F 425	aneous%20ly) 483.45(a)(b)(1) PH ACCURATE PROC (a) Procedures. A pharmaceutical set that assure the acc dispensing, and ad biologicals) to mee (b) Service Consult employ or obtain th pharmacist who (1) Provides consult provision of pharm This REQUIREME by: Based on observate record review the findings were at 1 of 30 residents in #19. The facility staff fat Chloride 20 mEq (refor administration at The findings included Resident #19 was at 5/25/16 with diagnot to hypo-osmolality(sodium).	ARMACEUTICAL SVC - CEDURES, RPH facility must provide rvices (including procedures curate acquiring, receiving, ministering of all drugs and to the needs of each resident. Itation. The facility must be services of a licensed. Itation on all aspects of the acy services in the facility; NT is not met as evidenced. Itation, staff interview and clinical acility staff failed to ensure acquired to meet the needs of a the survey sample, Resident. Itation on all aspects of the acy services in the facility; NT is not met as evidenced. Itation on all aspects of the acy services in the facility; NT is not met as evidenced. Itation on all aspects of the acy services in the facility; NT is not met as evidenced.	F 429		der. ted on ility of facility t practice. ducated on audit on will be designee ses who ll be re-	

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PORTSM	OUTH HEALTH AND	REHAB			RTSMOUTH, VA 23704	
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F 425	4/11/17 coded the repossible 15 on the Restatus, indicating the impaired daily decise. The physician order staff to administer Fe 20 mEq by mouth whypo-osmolality and medication was schewed am, 12 pm and 6. A medication pass a Resident #19 was of Practical Nurse #1 of 5:00 pm. The Potatavailable in the medication wou after 11:00 pm. A review of the Medion 7/12/17 evidence administered the 6:00 Chloride on 7/11/17. The above observativith the Administrat during a pre-exit medication and side of the medication and side of the Medion 7/11/17.	esident as scoring a 9 out of a Brief Interview for Mental are resident had moderately sion making skills. If dated 5/19/17 instructed the Potassium Chloride Crystals with meals related to disconsistered at a pm every day. Indication cart for administration and findings was shared for and the Director of Nursing setting conducted on 7/13/17 at a procession of the resident of the number of	F	425		
		a decrease in the osmolality of y fluid volume increases and				

solute volumes usually decrease. Symptoms are those of hyponatremia such as cerebral edema with disorientation, focal neurological deficits, and

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
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		495149	B. WING		07/13/2017	
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
				900 LONDON BOULEVARD		
PORTSIV	OUTH HEALTH AND	REHAB		PORTSMOUTH, VA 23704		
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F 425	Continued From pa	~	F4	125		
F 431 SS=D	483.45(b)(2)(3)(g)(l	National Health Institute-NIH). n) DRUG RECORDS, LUGS & BIOLOGICALS	F	F431		
	The facility must provide routine and emergency drugs and biologicals to its residents, or obtain			1. The medication that was o		

The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g) 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) Procedures. 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.
- (b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who--
- (2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and
- (3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.
- (g) Labeling of Drugs and Biologicals.
 Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.

- 1. The medication that was observed to be on the medication cart was removed and stored properly at the time of the survey. LPN #4 was reeducated on proper storage of medications and LPN #1 was reeducated on administration of an oral suspension medication.
- 2. The licensed nursing staff were reeducated by the DON/designee regarding the appropriate storage of medications. An audit was conducted on 8/5/17 to ensure that medications were stored appropriately on each nursing unit.
- 3. A random audit will be conducted 3x week x 12 weeks to check nursing units for appropriate storage of medications.
- 4. Results of the audit will be reviewed in the monthly QAPI meeting.

8/13/17

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CENTERS FOR MEDICARE & MEDICAID SERVICES				OMB NO. 0938-0391					
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DUBLEW	OUTH HEALTH AND	REHAR		90	0 LONDON BOULEVARD				
r Oit i Oiv	100 III IILALIII AND	NEI IAU		PC	ORTSMOUTH, VA 23704				
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F 431	(h) Storage of Drug (1) In accordance with facility must sto locked compartmer controls, and perminave access to the (2) The facility must permanently affixed controlled drugs list Comprehensive Drug Control Act of 1976 abuse, except when package drug distriquantity stored is mistage and permanently affixed facility, the facility facility facility in a secured medication label of accurate for 1 out of 2 units, Unit 2. The facility staff	s and Biologicals. with State and Federal laws, re all drugs and biologicals in ints under proper temperature it only authorized personnel to keys. It provide separately locked, It compartments for storage of ited in Schedule II of the ing Abuse Prevention and ind other drugs subject to in the facility uses single unit bution systems in which the inimal and a missing dose can into its not met as evidenced industrial observations of the nursing ited to ensure medications invariately PPD-Aplisol was incation and to ensure a in a resident's drug was if 30 residents (Resident #18) ited. Italied to ensure medication ited Protein Derivative) ited or ensure that the increase of the nursing ited in a secured location, on it 2. Italied to ensure that the increase of the nursing ited in a secured location, on it 2. Italied to ensure that the item of the nursing ited in a secured location, on it 2.		431					
	The findings include	ed:							

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

1. On 7/13/17 at approximately 9:30 a.m., during

Event ID: TD2W11

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		AND HUMAN SERVICES						APPROVED
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES				<u> </u>	<u>MB NO</u>	<u>. 0938-0391</u>
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DODTEN	OUTH HEALTH AND	DELIAR		9	00 LONDON BOULEVARD			
PORTSIV	OOTH HEALIN AND	KLIAD		Р	ORTSMOUTH, VA 23704			
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F 431	director, an open m tuberculosis testing on top of the treatm An interview was co	ulti-dose vial of PPD (for) solution was observed sitting ent cart on Unit 1 unattended.	F 4	131				
	approximately 9:35 getting to work but the have been locked urefrigerator; not sitting	ng on top of the treatment."						
	stated, I may have I the treatment cart; I tracked. The surve open vial of PPD so replied, "Either on the medication refrigera	virector paged LPN #4 who et the PPD solution on top of I'm new and I just got side yor asked, "Where should the plution have been stored, she he treatment cart or in the ator; it was a mistake leaving op of the treatment cart						
	Nursing (DON) on 0 p.m., who stated, "T should have been to	onducted with the Director of 07/13/17 at approximately 1:53 he open vial of PPD solution ocked in the medication cart or frigerator but not sitting on top nattended."						
	from the DON on 0 p.m. On the same surveyor a policy, tit	of medications was requested 7/13/17 at approximately 2:05 day the DON handed the tled "ADU Policies and lid not contain any information ge of medications.						

The above information was shared with the Administrator and DON during a pre-exit meeting

on 07/13/17 at 3:45 p.m. No additional

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NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE						
DODTEM	OUTH HEALTH AND	DELIAD		900 LONDON BOULEVARD						
PURISIV	OOTH HEALTH AND	KENAD		PORTSMOUTH, VA 23704						
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F 431	Continued From pa	ge 70	F	431						

information was provided.

2. The facility staff failed to ensure that the

Resident #18 was admitted to the facility on 3/9/17 with diagnosis to include, but not limited to vascular dementia.

medication label in response to an order change was accurate for Resident #18's Megace (an

appetite stimulant) suspension.

The current MDS (Minimum Data Set) a quarterly with an assessment reference date of 6/16/17 coded the resident as scoring a 00 out of a possible 15 on the brief interview for mental status indicating the resident cognition was severely impaired.

A physician telephone order dated 5/23/17 read: Megace oral suspension 40 milligrams (mg)/ml (milliliter) BID (twice a day) r/t (related to) decrease appetite. Under this order was a clarified order change reading, "Megace oral suspension 400 mg BID r/t decrease appetite".

A medication pass administration observation for Resident #18 was conducted with Licensed Practical Nurse #1 on 7/11/17 at 4:09 pm. The nurse obtained the Megace suspension from inside the medication cart. The label was incorrect and read Megace take 1 ml (40 mg) by mouth twice a day. The pharmacy label was not changed when the order was clarified. A pharmacy auxiliary label read, "Shake well before each use". The nurse poured 10 ml of Megace (400 mg) inside a medication cup without shaking the suspension first. The nurse administered the medication. After the medication pass the nurse was questioned about the failure to read the

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CENTER	CENTERS FOR MEDICARE & MEDICAID SERVICES				S OMB NO. 0938-039					
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F 431	instructions for shall pouring the Megace reads all the labels stated the rationale was to ensure "you acknowledged the pinaccurate and state pharmacy. The electronic Med included the correct	king the suspension prior to e. She stated she normally but did not this time. She for shaking the suspension get a good mixture". She also charmacy label dose was ed she would call the ication Administration Record ted dose of 400 mg twice a	F4	131						
	included the corrected dose of 400 mg twice a day. The pharmacy label for the dose amount to be given in milliliter equivalents on the multi-dose bottle of Megace was incorrect. The above observation and findings was shared with the Administrator and the Director of Nursing during a pre-exit meeting conducted on 7/13/17 at 3:45 pm.									
	Receiving From Ph. Section 3.10 revises. Policy-Medications facility requirements. Only the dispensing pharmacist can morpharmacist can mo	elled "Medication Ordering and armacy Medication Labels" s 05/12 read, in part: are labeled in accordance with a and state and federal laws. It is pharmacy/registered dify, change, or attach in prescription medication label cation a. Injectable's and it ml, and the amount to be led equivalents on the label.		141						
	(a) Infection preven	tion and control program.								

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NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
PORTSMOUTH HEALTH AND REHAB			900 LONDON BOULEVARD PORTSMOUTH, VA 23704	
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F 441 Continued From page 72

The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:

- (1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2);
- (2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
- (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
- (ii) When and to whom possible incidents of communicable disease or infections should be reported;
- (iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
- (iv) When and how isolation should be used for a resident; including but not limited to:
- (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
- (B) A requirement that the isolation should be the least restrictive possible for the resident under the

F 441

F441

- 1. No opportunity to correct missing infection control log for October-December 2016. LPN #2 and #22 were re-educated on Infection control practices. LPN #9, #10 and #11 were re-educated on infection control practices and wound dressing label codes. Linen on the shower room floor was removed during survey, Medication carts and pill crushers were cleaned immediately.
- 2. An audit was completed on 7/31/17 to ensure that the infection control monitoring process is current and up to date. An audit was completed on 7/31/17 to ensure that wound dressing treatments were intact and unopened per package coding.

8/13/17

		AND HUMAN SERVICES & MEDICAID SERVICES				APPROVED . 0938-0391	
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		495149	B. WING		<u> </u>	i	C / 13/2017
NAME OF I	PROVIDER OR SUPPLIER			STRI	EET ADDRESS, CITY, STATE, ZIP CO		
PORTSN	OUTH HEALTH AND	REHAB		I	LONDON BOULEVARD RTSMOUTH, VA 23704		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 441	must prohibit emplodisease or infected contact with resider contact will transmit (vi) The hand hygie by staff involved in (4) A system for redunder the facility's lactions taken by the (e) Linens. Person	ces under which the facility byees with a communicable skin lesions from direct at the disease; and the procedures to be followed direct resident contact.	F	441	3. Facility staff were rethe DON/designee to infection control practices and wou An audit will be come x 12 weeks to ensure control practices are This will include ger practices, medication crushers and wound observations. Discreptorected immediate. 4. Audits will be reviewed.	o include ctices that e, standard and care. apleted 3x we e infection being followneral care a carts and picare. pancies will ly. wed in the	eek ved. ll
	(f) Annual review. annual review of its program, as necess This REQUIREMEN by: Based on observat record review and f facility staff failed to healthcare-associat and failed to mainta prevention and con infections for 2 of 30 (Residents #1, #12 appropriate hand hy ensure medical equ	ion, staff interview, clinical acility document review, the			monthly QAPI meeti	ings.	8/13/17

storage space.

failed to place soiled items in the appropriate

1. The facility staff failed to ensure surveillance

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

PRINTED: 07/24/2017 FORM APPROVED OMB NO. 0938-0391

CENTER	<u>RS FOR MEDICARE</u>	& MEDICAID SERVICES	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		(<u>)MB NO</u>	<u>. 0938-0391</u>
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		E CONSTRUCTION		TE SURVEY MPLETED
		495149	B. WING			į.	C / 13/2017
NAME OF F	PROVIDER OR SUPPLIER		'	ST	FREET ADDRESS, CITY, STATE, ZIP CODE		
				90	00 LONDON BOULEVARD		
PORTSN	IOUTH HEALTH AND	REHAB			ORTSMOUTH, VA 23704		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 441	Continued From pa	ae 74	F 4	141			
	•	-		r-y 1			
		ciated infections were ber 2016, November 2016 and					
	control measures w	ailed to ensure infection vere followed to prevent the on of infection for Resident					
	control measures w	ailed to ensure infection vere followed to prevent the on of infection for Resident					
		ailed to implement appropriate ique during a medication pass ted on 7/11/17.					
	medical equipment	ailed to ensure resident and medical supplies were zed in a manner to prevent ss-contamination.					
	bag of soiled towels	ailed to put soiled linens and a in the designated area on 1 out of 2 units (Unit 2).					
	The findings include	ed:					
	for healthcare-asso	ailed to ensure surveillance ciated infections were ber 2016, November 2016 and					
	the HAI surveillance through July 2017 v	oximately 1:00 pm, a review of e records from July 2016 vas conducted. The 2016 fection surveillance reports					

from 7/1/16 through 9/30/16 only. Surveillance

PRINTED: 07/24/2017

		AND HOMAN SERVICES					APPROVED
CENTE	RS FOR MEDICARE	& MEDICAID SERVICES			0	<u>MB </u>	<u>. 0938-0391</u>
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		E CONSTRUCTION	COM	E SURVEY MPLETED
		495149	B. WING			1	C /13/2017
NAME OF	PROVIDER OR SUPPLIER			S ⁻	TREET ADDRESS, CITY, STATE, ZIP CODE		
DODTSI	OUTH HEALTH AND	PEHAR		90	00 LONDON BOULEVARD		
FORTSI	MOOTH HEALTH AND	KLIIAD		P	ORTSMOUTH, VA 23704		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 441	Continued From pa	ge 75	F4	441			
		ng for the months of October 016 and December 2016.					
	Director of Nursing she was informed of surveillance reports did not have these but were unable to On 7/13/17 at 3:10 interviewed and she access to the old far December 2016 du ownership. The Adricurrent process for facility and provided procedures that add. The facility policy a Control Surveillance 02/2017, stated, "P Committee is response."	pm, an interview with the (DON) was conducted and of the missing infection s. She stated that the facility records; they had searched locate them. pm, the Administrator was a stated that the facility had no acility records through a to change of facility ministrator described the infection surveillance at the discopies of policies and dressed the following: Indicate the procedure titled, "Infection and procedure titled, "In					
	Indicator data are of reported to the Infe the Performance In The policy and produced Surveillance Report Stated, "Specific Recontrol and Surveill by the ICC (Infection ICC reports its activities).	Indicators are chosen. collected, analyzed, and ction Control Committee and approvement Committee". cedure titled, "Infection Control ting", effective 02/2017, ecommendations for Infection lance activities are identified in Control Committee). The vities to the Quality Assurance over the committee of the committee of the committee.					

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The policy and procedure titled, "Infection Control Reports" stated, "The facility will monitor and

Event ID: TD2W11

Facility ID: VA0035

If continuation sheet Page 76 of 99



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

PRINTED: 07/24/2017 FORM APPROVED OMB NO. 0938-0391

CENTER	ENTERS FOR MEDICARE & MEDICAID SERVICE					OMB N	O. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION		OATE SURVEY OMPLETED
		495149	B. WING	;			C 07/13/2017
NAME OF F	PROVIDER OR SUPPLIER	<u> </u>		STR	EET ADDRESS, CITY, STATE, ZIP CODE		
PORTSM	OUTH HEALTH AND	REHAB			LONDON BOULEVARD RTSMOUTH, VA 23704		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 441	Continued From painvestigate the cause Continuous surveilla. Any infection will be Report Form. The policy and proceed Resident Worksheet 02/17 and explained surveillance activities stated, "The Infection Worksheet will be useful collection tool for reinfections. The Infections. The Infection Control Surveillance Infections of the forms Form", "Epidemiolo Control Surveillance Infections" were proceed by the stated that the completed by the stated that the completed form to the Infection Control Surveillance Infection Control Surveillance Infections" were proceed by the stated that the completed form to the Infection Control Surveillance Infec	ige 76 se and spread of infection. ance will be provided by staff. a reported using the Infection cedure titled "Infection Control et" with an effective date of d the process of infection es in the facility. The policy on Control Resident used as a surveillance data according information related to ction Control Nurse will utilize tool to gather information for ion and analysis as directed by	F	441			
	Administrator and the	were discussed again with the he DON on 7/13/17 at pm; no further information					

2. Resident #1 was admitted to the facility on 3/21/17. Diagnoses for Resident #1 included but

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		AND HOWAR OFFICE					MAPPROVED
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES	1			<u>OMB NO</u>	<u>). 0938-0391</u>
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		E CONSTRUCTION		TE SURVEY MPLETED
		495149	B. WING	i		07	C 7/ 13/2017
NAME OF F	PROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
PORTSM	OUTH HEALTH AND	REHAR		90	00 LONDON BOULEVARD		
FORTSIVI	OOTH HEALTH AND	ILLIAD		P	ORTSMOUTH, VA 23704		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 441	Continued From pa	-	F	441			
	Malnutrition and Staulcer. Resident #1 assessment protocon Reference Date of with a BIMS (Brief I 1 out of 15 indicating impairment. In addition the MDS requiring total deperor Transfers. Resident requiring total deperor assistance for Dresident Policy and State of the State	S scored Resident #1 as ndence with 2 staff persons dent #1 was coded as ndence with one staff person sing, Hygiene, and Bathing. bserved on 7/12/17 at p.m. The LPN initially took ocket and used them to essing. The nurse did not sprior to use nor did she use. The scissors were not ssors but pointed tip scissors. Clean barrier on a soiled and seded to perform wound care. Viously washed her hands, on the clean barrier and dressing. The nurse then a and did not wash her hands d applying a clean dressing rders. The Nurse did not not sedes after care.					
		nd procedure titled, "Hand es" with an effective date					

All personnel will wash hands before beginning the treatment/care of a resident and upon completion of such tasks, to prevent the spread

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		AND HOWAN SERVICES				0		APPROVED
		& MEDICAID SERVICES					1) <u>. 0938-0391</u>
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		LE CONSTRUCTION			TE SURVEY MPLETED
		495149	B. WING			-	07	C / /13/2017
NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STAT	E, ZIP CODE		
PORTSM	OUTH HEALTH AND	REHAB			900 LONDON BOULEVARD PORTSMOUTH, VA 2370	4		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN (EACH CORRECTIVE CROSS-REFERENCED DEFIC	ACTION SHOULD	BE	(X5) COMPLETION DATE
F 441	removal of gloves of barrier equipment.	tions. Wash hands after or other personal protective	F 4	∤41				
	Precautions" with a documented the fol Wash hands after gresident contacts, a to avoid transfer of residents or enviror Wash hands between the resident when contacts.	loves are removed between and when otherwise indicated micro-organisms to other						
	Resource Sheet" (ufollowing: Standard Precaution fluids, secretions, ewhether or not they and mucous member Environmental Con	tled, "Standard Precautions indated) documented the insapply to all blood, all body xcretions except sweat are visibly bloody, non-intact ranes of all residents trol: follow procedures for ng and disinfecting of resident vironment.						
	4:00 p.m., if the soi	ed on 7/12/17 at approximately led over-bed table should d prior to the placement of a DON stated, "Yes."						
	findings during a br approximately 3:45	tration was informed of the iefing on 7/13/17 at p.m. The facility did not information about the findings.						



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	AND HOMAN SERVICES			FORM APPROVED
CENTERS FOR MEDICARE	& MEDICAID SERVICES			OMB NO. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TIPLE CONSTRUCTION ING	(X3) DATE SURVEY COMPLETED
	495149	B. WING		07/13/2017
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
PORTSMOUTH HEALTH AND	DEHAR		900 LONDON BOULEVARD	
1 OKTOWOO III IILALIII AND	TETIAD		PORTSMOUTH, VA 23704	
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORREC X (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETION
1/16/17. Diagnoses but are not limited to and open ulcers to Quarterly Minimum assessment protocon Reference Date of with a BIMS (Brief In 15 of 15 indicating In addition the MDS requiring extensive person assistance for toileting. Resident frequently incontines. Resident #12's currently incontines. Resident #12's currently frequently incontines. Resident #12's TAFE but are not provided with the provided	s admitted to the facility on s for Resident #12 included to Peripheral Vascular Disease Left leg. Resident #12's Data Set (MDS-an ol) with an Assessment 5/26/17 coded Resident #12 interview for Mental Status) of no cognition impairment. Secored Resident #12 as assistance with two staff for transfers, bed mobility and #12 was coded as being ent of bowel functions. The compart of	F 4	.41	

7/6/17 MD order: Left anterior ankle: Cleanse with normal saline, apply alginate dressing to



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		AND HUMAN SERVICES					RM APPROVED
CENTER	<u>RS FOR MEDICARE</u>	& MEDICAID SERVICES				<u>OMB N</u>	<u>O. 0938-0391</u>
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		E CONSTRUCTION		ATE SURVEY OMPLETED
		495149	B. WING			0	C 7/ 13/2017
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
DODTEM	OUTH HEALTH AND	DELIAD		90	00 LONDON BOULEVARD		
PURISIV	OUTH REALTH AND	REHAD		Р	ORTSMOUTH, VA 23704		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETION DATE
F 441	7/6/17 MD order: L saline, apply silvade dry dressing daily. 7/6/17 MD order: L normal saline, apply bed, cover with dry 7/6/17 MD order: L cleanse with normal thick to the wound be daily. Skin prep apply to r day for protection. Left transmetatarsat to air and monitor a Triad Hydrophillic V scrotum topically except the serious doing wound care frapproximately 12:00 Resident #12's dres wound care orders open ulcer on shin Resident #12's dres wound care orders open ulcer on shin Resident #12 had h with dressing. The LPN called Resand obtained phone Clean all leg wound santyl ointment, covaling gauze. Resident #12 refuse assessed as he sta After clarification of Resident, the LPN page 12.00 Resident, the LPN page 13.00 Resident, the LPN page 14.00 Resident, the LPN page 15.00 Resident #12 refuse 15.00 Resident, the LPN page 15.00 Resident, the LPN page 15.00 Resident #12 refuse 15.00 Resident, the LPN page 15.00 Resident, the LPN page 15.00 Resident #12 refuse 15.00 Resident, the LPN page 15.00 Resident #12 refuse 15.00 Resident, the LPN page 15.00 Resident #12 refuse 15.00 Resident, the LPN page 15.00 Resident #12 refuse 15.00 Resident, the LPN page 15.00 Resident #12 refuse 15.00 Resident, the LPN page 15.00 Resident #12 refuse 15.00 Resident, the LPN page 15.00 Resident #12 refuse 15.00	with dry dressing daily. eft heel: Cleanse with normal ene to wound bed, cover with eft outer ankle: Cleanse with y santyl nickel thick to wound dressing, daily. eft shin area #1, top area: Il saline, apply santyl nickel bed, cover with dry dressing, eight second toe topically every Il amputation site: leave open area at this time. Vound Dressing Paste apply to very shift for healing. ctical Nurse) #2 was observed or Resident #12 on 7/12/17 at 0 noon. LPN #2 removed asing and needed to clarify as she noted three areas of area and she observed that ais entire lower leg covered esident 12's Vascular Surgeon es orders as followed: Is with normal saline, apply ever with dry dressing, wrap in ed to have his scrotum ted that area was healed. Physician orders for the colaced a clean barrier onto a	F 4	141			
	soiled over bed tabl	le without sanitizing the table seeded with wound care as					

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

ordered and when completed, she did not sanitize

the over bed table after removing all of the

Event ID: TD2W11

Facility ID: VA0035

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		AND HUMAN SERVICES & MEDICAID SERVICES			FORM APPROVED MB NO. 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION JUNE	(X3) DATE SURVEY COMPLETED
		495149	B. WING		C 07/13/2017
	PROVIDER OR SUPPLIER	REHAB		STREET ADDRESS, CITY, STATE, ZIP CODE 900 LONDON BOULEVARD PORTSMOUTH, VA 23704	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		BE COMPLETION
F 441	Continued From pa	ge 81	F	441	
	showed 16 docume completed wound of Resident #12's Jun	t #12's Treatment ord (TAR) for July 2017 entation omissions for care orders. Review of e 2017 TAR showed 69 te completed wound care.			
	after 6/20/17. The the facility wound constituted July 2 been the Resident's	t #12's weekly skin of reveal any assessments Director of Nurses stated that are nurse position was 0, 2017, and that it would have is Nurse's responsibility to are as ordered by the Doctor.			

A Braden Scale assessment of 1/17/17 scored Resident #12 as having "High Risk" for predicting Pressure Sore Risk".

The last wound assessment of 6/20/17 only noted one wound on the shin. It did not address the large two ulcers noted at the left ankle and left

The Director of Nursing was asked to show evidence that the 85 wound care documentation omissions were completed. The DON stated on 7/12/17 at approximately 1:15 p.m.: "I couldn't find any explanation as to why treatments were not done." The DON added, Nursing staff is to follow the orders the doctor writes for patients. The DON stated following MD orders is part of the Nurse's job description. The DON also stated that a wound can develop complications as a result of not following orders for wound care.

Resident #12 stated on 7/12/17 at approximately 1:45 p.m.: "Staff often don't do wound care. It

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heel.

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	RS FOR MEDICARE	& MEDICAID SERVICES					0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE	
		495149	B. WING	i		07/1	; 3/2017
NAME OF F	PROVIDER OR SUPPLIER			STR	EET ADDRESS, CITY, STATE, ZIP CODE		
PORTSM	OUTH HEALTH AND	REHAB		1	LONDON BOULEVARD RTSMOUTH, VA 23704		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 441	Continued From pa	-	F	441			
	has gotten a little b	etter recently.					
	Precautions" with a documented the fol Wash hands after gresident contacts, a to avoid transfer of residents or environ Wash hands between the resident when or the state of t	gloves are removed between and when otherwise indicated micro-organisms to other					
	Resource Sheet" (ufollowing: Standard Precaution fluids, secretions, ewhether or not they and mucous members and mucous members are second for the second fluids.	itled, "Standard Precautions undated) documented the ons apply to all blood, all body excretions except sweat or are visibly bloody, non-intact oranes of all residents atrol: follow procedures for ing and disinfecting of resident navironment.					
	findings during a brapproximately 3:45	stration was informed of the riefing on 7/13/17 at p.m. The facility did not information about the findings.					
		failed to implement appropriate nique during a medication pass oted on 7/11/17.					
		administration observation n Licensed Practical Nurse #1					

on 7/11/17 on unit 2 from 4:00 pm to

approximately 5:00 pm. During this time the

		& MEDICAID SERVICES			FORM APPROVED OMB NO. 0938-0391
STATEMEN	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED
		495149	B. WING		C 07/13/2017
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
PORTSN	OUTH HEALTH AND	REHAB		900 LONDON BOULEVARD PORTSMOUTH, VA 23704	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUND CROSS-REFERENCED TO THE APPRODEFICIENCY)	JLD BE COMPLETION
F 441	administration of dr hands on six (6) sel of those hand wash washed her hands it seconds; i.e., five (5 seconds, ten (10) s. For five (5) of the si the nurse turned off her bare hands and dry her hands. After the medication was shared with the long should you rub hand washing, she The above observa with the Administrate during a pre-exit medication as:45 pm. Per the Administrate standards are obtain	ge 83 d before prepping and after ugs to have washed her parate occasions. For four (4) ing occasions the nurse for a count of less than fifteen 5) seconds, eleven (11) econds and ten (10)seconds. x (6) hand washing occasions f the water faucet handles with I then grabbed paper towels to n pass observation the above e nurse. She was asked how o your hands with soap during stated, "15 seconds". tions and findings was shared for and the Director of Nursing eeting conducted on 7/13/17 at or the facility's nursing ned from Lippincott's Nursing dition. Under Hand Hygiene	F 4		

faucet, adjust the water temperature until it's comfortably warm. 2. Work up a generous lather by scrubbing

technique. To minimize the spread of infection, follow these basic hand-washing instructions. 1. With your hands angled downward under the

- vigorously for 15 seconds...
- 3. Rinse your hands completely to wash away suds and microorganisms. Pat dry with a paper towel. To prevent recontamination your hands on the faucet handles, cover each one with a dry paper towel when turning off the water.

Facility ID: VA0035

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CENTE	CENTERS FOR MEDICARE & MEDICAID SERVICES			OMB NO. 0938-0391						
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3)	DATE SURVEY COMPLETED			
		495149	B. WING	i			C 07/13/2017			
	PROVIDER OR SUPPLIER	REHAB		900 (EET ADDRESS, CITY, STATE, ZIP CODE LONDON BOULEVARD RTSMOUTH, VA 23704					
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION E DATE			
F 441	with the Administrat	ge 84 tion and findings was shared tor and the Director of Nursing seting conducted on 7/13/17 at		441						
	medical equipment maintained and utili the potential for cro									
		e facility's medication carts and s conducted on 7/13/17 from 11:25 a.m.								
	(a total of 4) were for loose medication procontaining the multing in need of cleaning drawers containing observed with stick the drawers from specific the unit 1 odd cart at	nedication administration carts bund to have multiple various lls inside the drawers dose blister packs and were achoe better packs and were bulk liquid medications were y substances on the bottom of billage. The pill crushers on and unit 2 back hall cart had a the back that were in need of								
	contained multiple of dressings that were as single use items used dressings incl matrix wound dress DermaGinate/Ag (s package of Mesalt is sodium chloride dre x 4 xeroform petrol	s on both unit 1 and unit 2 opened and partially used designated on the package These opened and partially uded Promgram 4.34 inch sing, 4 packages of ilver) 4 x 5 packages, one 2 x 100 cm (centimeter) essing, 3 packages of Curad 4 lutum dressings, and one extra 4 x 8. The tops of both								

treatment carts were in need of cleaning. The



		AND HUMAN SERVICES					M APPROVED
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES				<u>OMB N</u>	O. 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		LE CONSTRUCTION		ATE SURVEY DMPLETED
		495149	B. WING			1 0	C 7/13/2017
NAME OF F	PROVIDER OR SUPPLIER	L	' 	٤	STREET ADDRESS, CITY, STATE, ZIP CODE		771072011
				ć	900 LONDON BOULEVARD		
PORTSM	OUTH HEALTH AND	KEHAB		F	PORTSMOUTH, VA 23704		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 441	Continued From pa	nge 85	F 4	1/11			
	·	carts needed to be cleaned	1 7	r 1			
	also.						
	contained the university usage. Three nurses separately and ask symbol meant. Lice #9) stated, "I'd have nurse checked the know". She was as ensuring the medic cleaned she stated the cart". LPN #10 response	e use dressings packages ersal symbol for one time es were shown the symbol ed if they knew what this ensed practical nurse (LPN e to check the box". The box and then stated, "I don't sked who is responsible for ation and treatment carts are, "Every nurse should clean to the universal one time use					
		ure, is it use only once?" She g) are supposed to clean it t) every shift".					
	LPN #11's response symbol was, "I'm no	e to the universal on time use ot sure".					
	with the Administrat	tions and findings was shared tor and the Director of Nursing eeting conducted on 7/13/17 at					
	9:40 a.m., located i was a dirty towel ar maintenance direct housekeeping to re floor; housekeeping items off the shower	Observation on 07/13/17 at n the shower room on Unit 2 nd wash cloth. The or immediately called move the soiled items off the garrived and removed soiled er room floor, placed them in a nd stated, "I'm putting these utility room."					

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

On 07/13/17 at 9:52 a.m., located on the floor in

Event ID: TD2W11

Facility ID: VA0035

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

PRINTED: 07/24/2017 FORM APPROVED OMB NO. 0938-0391

CENTE	19 LOV MEDICAVE	A MEDICAID SERVICES	,			OIVID NO. U	<u> </u>		
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		NSTRUCTION	COMPL	(X3) DATE SURVEY COMPLETED		
		495149	B. WING			07/1;	3/2017		
NAME OF F	PROVIDER OR SUPPLIER			STREE	ET ADDRESS, CITY, STATE, ZIP COD				
PORTSN	OUTH HEALTH AND	REHAB			ONDON BOULEVARD FSMOUTH, VA 23704				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE		
F 441	soiled towels. The linursing who remove from the floor and so put in the soiled utility.	ye on Unit 2 was a bag of Maintenance Director called ed the bag of soiled towels stated, "This should have been ity room, not on the floor."	F 4	41					
	Linen Handling" (Effective Procedure: Facilities 1) All soiled linen medirectly into mobile location where it is 483.90(i)(5) SAFE/FUNCTIONAE ENVIRON (i) Other Environmed The facility must prosanitary, and comforms anitary, and comforms anitary, and comforms anitary, staff and (5) Establish policies applicable Federal, regulations, regardiand smoking safety non-smoking resided This REQUIREMENT by: Based on observations and soil processes the same processes the sa	s without Laundry Chutes pust be bagged or placed soiled linen barrels/carts at the generated. AL/SANITARY/COMFORTABL ental Conditions ovide a safe, functional, ortable environment for the public. es, in accordance with State, and local laws and ng smoking, smoking areas, or that also take into account ents. NT is not met as evidenced sion and staff interviews, the ormaintain a safe, clean, nitary environment.	F 4	2.3.	F465 A contractor has been sand paint the Facial boat activities room and for #1,#3,#7,#9,#15,#17 and repair the wooden casing conditioning unit. The cand drain were cleaned during the survey on 7/Environmental rounds were completed on facility place. Rounds are made 5x were completed. Rounds are made 5x were department managers to repairs or maintenance in the completed. Any idea discussed in morning managers for rounds up will be discussed.	ards under the exterior of road #19. Also to a garound the outside mop a immediately 13/17. Were mysical plant of pairs needed duled to be seek by a identify any items that need tified areas a getting and assed.	oms o air area on		
	During General Ob	servation of the facility on m., with the Maintenance		т,	monthly QAPI and any items will be addressed.	outstanding	n 8/13/17		

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

Event ID: TD2W11

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

PRINTED: 07/24/2017 FORM APPROVED OMB NO. 0938-0391

CENTERS FOR MEDICARE & MEDICAID SERVICES ON							
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION ING	(X3) DATE SURVEY COMPLETED			
	495149	B WING		C			
	493149			07/13/2017			
NAME OF PROVIDER OR SUPPLIE	:R		STREET ADDRESS, CITY, STATE, ZIP CODE				
PORTSMOUTH HEALTH AND REHAB			900 LONDON BOULEVARD PORTSMOUTH, VA 23704				
(X4) ID	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL	ID PREF		HOULD BE COMPLETION			
TAG REGULATORY OF	R LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE AP DEFICIENCY)	PROPRIATE DATE			
F 465 Continued From	page 87	F	465				

Director, the facility staff failed to maintain a safe, clean, comfortable and sanitary environment.

During observation of the exterior surrounding of the building, in the back of the building a wooden facial board located directly under the windows was observed with chipped paint and a hole was observed in the wooden siding measuring 2 inches x 8 inches.

The outside screen to the window next to the activities room was torn. Outside the activities room and the back hall of the activities room, the wooden casing around the air-conditioning unit was observed with chipped paint and rotten boards. The Maintenance Director stated the chipped paint and rotten boards were probably the result of water damage or just from being old.

On the right side of the building facing London Boulevard, the facial boards under the following rooms was observed with chipped and rotten boards; Rooms 1, 3, 7, 9 15, 17 19 and the Administrators office.

On the side of the building was a mop area with a drain. The drain was observed with debris and a tan colored stringy substance. The Maintenance Director stated that housekeeping uses this area to empty their mop buckets. He stated he would call housekeeping to clean the drain out right away.

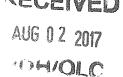
The Administrator and DON (Director of Nursing) were informed of the findings during a briefing on 07/13/17 at approximately 3:45 p.m. The facility did not present any further information about the findings.

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Event ID: TD2W11

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

PRINTED: 07/24/2017 FORM APPROVED OMB NO. 0938-0391

CENTER	<u>RS FOR MEDICARE</u>	& MEDICAID SERVICES			(<u> </u>
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			ONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495149	B. WING			C 07/13/2017
NAME OF F	PROVIDER OR SUPPLIER		<u> </u>	STRE	EET ADDRESS, CITY, STATE, ZIP CODE	1 01/13/2011
TO THE CT I	THO VIDENCE OF COLUMN				LONDON BOULEVARD	
PORTSN	IOUTH HEALTH AND	REHAB			RTSMOUTH, VA 23704	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION OF T	DBE COMPLETION
	Continued From pa		F 5			
F 514 SS=E	483.70(i)(1)(5) RES RECORDS-COMP LE	LETE/ACCURATE/ACCESSIB	F 5		514	
	standards and prac	vith accepted professional ctices, the facility must ecords on each resident that			1. There is no opportunity to missing documentation for #1, #3 and #6. Resident #1 #6 currently have treatmen and completed per physicial	Resident 1, #3 and its signed ans order.
	(i) Complete;	ar and a de		2	 Residents that previously the facility are at risk for the 	
	(ii) Accurately docu	mented;			practice	
	(iii) Readily accessi	ble; and		3	Nursing staff have been re by the DON/ Designee rega	
	(iv) Systematically	organized			professional standards of	
	(5) The medical red				documentation in the medical The nursing staff were also	re-
		ation to identify the resident;			educated on the clinical das and how to check for alerts	
	,	resident's assessments;			indicating missing docume	ntation.
	(iii) The compreher provided;	nsive plan of care and services			An audit will be completed x 12 weeks to ensure that	
	and resident review determinations con	ducted by the State;			documentation is completed Unit Managers will also me documentation in Point Cli- daily by accessing "clinical	onitor ck Care
	professional's prog	se's, and other licensed ress notes; and		4	dashboard".	
	(vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by:			4	 Results of the audit will be in the monthly QAPI meeti discrepancies will be addre- re-education provided imm 	ng. Any ssed and

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Based on staff interview, clinical record review

Event ID: TD2W11

Facility ID: VA0035

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

PRINTED: 07/24/2017 FORM APPROVED OMB NO. 0938-0391

CENTERS FOR MEDICARE & MEDICAID SERVICES				OMB NO. 0938-					
STATEMENT OF AND PLAN OF C		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		E CONSTRUCTION		TE SURVEY		
		495149	B. WING			07	C 7/ 13/2017		
NAME OF PRO	VIDER OR SUPPLIER			Sī	FREET ADDRESS, CITY, STATE, ZIP CODE				
PORTSMOU	ITH HEALTH AND	REHAB			00 LONDON BOULEVARD ORTSMOUTH, VA 23704				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREG (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE		
F 514 C	ontinued From pa	ge 89	F (514					
fa m	iled to maintain a edical record for 3	nt review, the facility staff complete and accurate 3 of 30 residents in the survey 3, Resident #1, Resident #6.							
TI	The findings included:								
8/ Di	28/15 with a read agnoses for Resi	admitted to the facility on mission date of 12/14/16. dent #3 included but not egia (1) and pressure ulcer (2).							
as Ro or in de at	sessment referer esident #3 with a n the Brief Intervie dicating an intact ecision making. R	inimum Data Set with an ince date of 4/12/17, coded score of 13 out of possible 15 w for Mental Status (BIMS), cognitive abilities for daily esident #3 was assessed as ulcer with a history of							
Ro (T we tre in	esident #3's Treat AR) for May 2017 ere missing nursir eatments ordered	the clinical record review, ment Administration Records 7, June 2017, and July 2017 ng documentation for . The nurses' initials that were provided were missing lers:							
or do	ne time a day for o ocumentation on 5	5/21/17 at 0900; 6/13/17 at			R	ECEIN	/ED		
08	900; 7/6/17 at 090	0.							
SI	dn Prep Wipes M	iscellaneous, apply to left				NG 02 2	2017		

buttocks topically every shift for prevention -

missed documentation on 5/21/17 on day shift; 6/9/17 on evening shift; 6/13/17 on day shift; 6/16/17 on evening shift; 6/20/17 on evening shift;

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		AND HUMAN SERVICES					APPROVED
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES				<u> МВ NC</u>	0. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495149	B. WING			07	C / 13/2017
NAME OF F	PROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
DODIEM	OUTH HEALTH AND	PEHAR		90	0 LONDON BOULEVARD		
r Olvi Siv	OO III IILALIII AND	ILLIAD		PC	DRTSMOUTH, VA 23704		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 514	6/29/17 on evening evening shift; 7/1/17 on day shift.	shift; 6/26/17 on evening shift; and night shift; 6/30/17 on 7 on evening shift; and 7/6/17	F 5	14			
	Dressings); apply to shift for prevention. buttock - missed do day shift; 6/9/17 on shift; 6/14/17 on day shift; 6/20/17 on eve shift; 6/26/17 on eve and night shift; 6/30	and Dress Paste (Wound oright buttock topically every Apply thin layer to right ocumentation on 5/21/17 on evening shift; 6/13/17 on day y shift; 6/16/17 on evening ening shift; 6/23/17 on evening ening shift; 6/29/17 on evening will on evening shift; 7/1/17 on evening shift; 7/1/17 on day shift.					
	conducted with the was asked regarding on the TARs. She streatment was not a document the reason would notify the phy	pm, an interview was Director of Nursing (DON) and g the missing documentation tated that usually, when lone, the nurse had to on why it was not done and rsician. The DON was asked ons for missing documentation 7, 6/17 and 7/17.					
	did not find the reas documentation on the	pm, the DON stated that she cons for missed he TARs. She stated, "It is move forward and do better".					
	Nurse (LPN) #3 was what it meant when documented on the not able to get it don	am, Licensed Practical sinterviewed and was asked treatment orders were not TAR. She stated, "It means not The nurse should let the mplete the task." She stated					

that nurses are expected to make sure

treatments were done and documented; nurses

		AND HUMAN SERVICES				FORM APPROVED
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES	·		0	<u>MB NO. 0938-0391</u>
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495149	B. WING			C 07/13/2017
NAME OF F	PROVIDER OR SUPPLIER		<u>' </u>	STR	EET ADDRESS, CITY, STATE, ZIP CODE	
		DELLAD		900	LONDON BOULEVARD	
PORTSIVI	OUTH HEALTH AND	KEHAB		PO	RTSMOUTH, VA 23704	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	×	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLÉTION
F 514	Continued From pa	ae 91	F 5	.14		
	=	ocumentation on the computer	1 0	17		
		the end of the shift.				
	On 7/12/17, a copy	of the facility policy on				
		provided as requested. The				
		ed from the Lippincott's sing Procedures", 6th edition.				
		n" procedure read, in part,				
	"Documentation is t	the process of preparing a				
	•	a patient's and is a vital tool				
		among health care team e, detailed charting shows the				
		f the care that nurses provide,				
		at care, and treatment and				
		patient still needs. Thorough,				
	accurate document for miscommunicati	ation decreases the potential ion and errors."				
	The findings were r	eviewed with the Administrator				
		13/17 at approximately 3:45				
		mation was provided.				
	Definition:					
	_ 3					
		artial or complete paralysis of				
		egs that is usually due to the spinal cord in the region of				
	the neck. (Source:	the spinar cord in the region of				
		bster.com/medlineplus/quadri				
	plegia)	•				
		- also known as bedsore - an				
		deprived of adequate blood				
		d pressure. (Source: bster.com/medlineplus/bedsor				
	poowo					

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DEFANI	MENT OF HEALTH	AND HOMAN SERVICES				FORM	IAPPROVED
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			0	MB NO	. 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		CONSTRUCTION	COV	E SURVEY MPLETED
		495149	B. WING			1	C / 13/2017
NAME OF F	PROVIDER OR SUPPLIER		<u> </u>	STR	EET ADDRESS, CITY, STATE, ZIP CODE	1 077	13/2017
DODTON	OUTH HEALTH AND	DELIAD		900	LONDON BOULEVARD		
PORTSIVI	OUTH HEALTH AND	RENAD		POF	RTSMOUTH, VA 23704		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 514	Continued From pa	ge 92	F (514			
	3/21/17 with a readinospitalization for a tract infection. Diagincluded but are no Dementia, Malnutrit Pressure Ulcer. Reminimum Data Set protocol) with an As 6/26/17 coded Resinterview for Mental indicating severe collination the MDS	s admitted to the facility on mission on 4/26/17 after wound infection and urinary gnoses for Resident #1 t limited to Non-Alzheimer's cion and Stage IV* Right Heel esident #1's Quarterly (MDS-an assessment sessment Reference Date of dent #1 with a BIMS (Brief I Status) of 1 out of 15 ognition impairment.					
	requiring total depe	dent #1 was coded as ndence with one staff person sing, Hygiene, and Bathing.					
	following: 7/5/17 MD order: C normal saline. App	cian orders documented the Cleanse Right heel wound with ly nickel thick santyl and ed daily. Cover with dry ily and as needed.					
	(TAR) for June 2013 documentation omis	ment Administration Record 7 included two wound care ssions and the TAR for July und care documentation					
	Resident #1's 4/26/	17 Care Plan documented a					

At risk for further skin breakdown due to: Assistance required in bed mobility and

focus area of:

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CENTER	CENTERS FOR MEDICARE & MEDICAID SERVICES				OMB NO. 0938-03					
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE SURVEY COMPLETED				
		495149	B. WING			C 07/13/2017				
NAME OF F	PROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE					
PORTSM	OUTH HEALTH AND	REHAB		l	0 LONDON BOULEVARD DRTSMOUTH, VA 23704					
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE COMPLETION				
F 514	bladder. 4/26/17 S Interventions include Conduct weekly ski Float heels Treatments as order Resident #1's clinic 3/21/17 initial Risk indicating High Risk Resident #1's clinic from her initial admulcer was initially id worsened to a Stagresident required hereadmission 4/26/1 documented from a Review of the Facill Assessment Weekl 1/2017 documented Nurse will complete each resident week assessment on the Checks" form. The Facility Guidan procedures sixth each following: "Docume preparing a comple and is a vital tool fo	accontinence of bowel and tage III* to right outer heel led: In inspection ared all record documented a for Pressure Ulcers to be 12 or for Pressure Ulcers. all record weekly assessments ission documented the heel entified at a Stage II and let III* on 4/24/17 when the ospitalization. Upon 17, weekly assessments were admission through 6/18/17. All Policy titled, "Skin y" with an effective date of the following: "A Licensed a total body assessment on ally and document the "Weekly Skin Integrity ce from Lippincott's Nursing dition documented the entation is the process of te record of a patient's care recommunication among	F	514		EIVED				
	charting shows the that nurses provide	embers. Accurate, detailed extent and quality of the care, the outcomes of that care, adjusting that the patient ctill				02 ₂₀₁₇ -1/OLC				

and errors."

and treatment and education that the patient still needs. Thorough, accurate documentation decreases the potential for miscommunication

		AND HUMAN SERVICES					IAPPROVED
CENTER	S FOR MEDICARE	& MEDICAID SERVICES			C	<u>MB NO</u>	<u>. 0938-0391</u>
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	COV	E SURVEY MPLETED
		495149	B. WING	3		1	C / 13/2017
NAME OF PR	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
DODTON	NITHILLEALTHAND	DELIAR		90	00 LONDON BOULEVARD		
PURISINIC	OUTH HEALTH AND	KEHAB		P	ORTSMOUTH, VA 23704		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 514	Continued From pa	ge 94	F 5	514			
	evidence that the womissions was com 7/12/17 at approximation any explanation of done." The DO follow the orders the The DON stated follow the Nurse's job designation of not following that a wound can detesult of not following findings during a briapproximately 3:45 present any further	sing was asked to show ound care documentation pleted. The DON stated on nately 1:15 p.m.: "I couldn't as to why treatments were N added, Nursing staff is to e doctor writes for patients. lowing MD orders is part of cription. The DON also stated evelop complications as an gorders for wound care. Itration was informed of the defing on 7/13/17 at p.m. The facility did not information about the findings.					
 	8/19/15 with a reading process for Reside it is stage IV	s admitted to the facility on mission on 9/14/16. dent #6 included but are not Sacral Pressure Ulcer* and ementia*. Resident #6's ata Set (MDS-an assessment sessment Reference Date of dent #6 with a BIMS (Brief Status) of 8 out of 15 te cognition impairment.					
! :	requiring Extensive person assistance f and Dressing. Resi	Assistance with two staff or Transfers, Bed Mobility, ident #6 was coded as always and frequently incontinent of					

Bowel functions.

Resident #6's Care Plan documented a focus

		AND HUMAN SERVICES					RM APPROVED
CENTE	RS FOR MEDICARE	& MEDICAID SERVICES				<u>OMB N</u>	<u>IO. 0938-0391</u>
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				OATE SURVEY OMPLETED
		495149	B. WING			· ·	C)7/13/2017
NAME OF	PROVIDER OR SUPPLIER		<u>'</u>	STI	REET ADDRESS, CITY, STATE, ZIP COD		
PORTSN	OUTH HEALTH AND	REHAB) LONDON BOULEVARD PRTSMOUTH, VA 23704		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	/ MUST BE PRECEDED BY FULL	ID PREFI TAG		PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SI- CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 514	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 314 Continued From page 95 area of: Stage IV* Pressure ulcer due to Assistance required in bed mobility, wound assessment Score 18 or less than, bowel incontinence. Use of Foley catheter for wound healing 9/14/16 readmitted 9/21/16 chemical cauterization performed by wound specialist 2/6/17 treatment change 4/17/17 new treatment 4/24/17 new treatment Interventions included: Conduct weekly skin inspection Foley cath (catheter) as needed Treatments as ordered Weekly wound assessment 7/19/17 Braden Scale scored Resident #6 as High Risk for developing Pressure Ulcers. Current 7/5/17 Physician order for wound care included: Clean wound with normal saline, apply collagen to wound bed, apply skin prep to skin surrounding the wound apply clean dressing and secure. 7/5/17 Wound Care Physician measurements of sacral wound are Length by width by depth: 1 by 0.4 by 0.3 centimeters; surface area .40 centimeters, moderate sero sanguinous exudate with 100% granulation tissue.		F 5	i14	CEIVE 3 0 2 201		
	Review of the June 2017 Treatment Administration Record included 3 sacral wound care omissions; 8 catheter care omissions, and					HOL(•

area excoriations.

16 Triad Paste application omissions to buttock

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DELAKTIVICINI OF TICALITY	AND HOWAN SERVICES			F	ORM APPROVED
CENTERS FOR MEDICARE	& MEDICAID SERVICES			OME	NO. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3	3) DATE SURVEY COMPLETED
	495149	B. WING			C 07/13/2017
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE,	ZIP CODE	
PORTSMOUTH HEALTH AND	REHAB		900 LONDON BOULEVARD PORTSMOUTH, VA 23704		
PREFIX (EACH DEFICIENCY	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG		CTION SHOULD BE THE APPROPRIAT	
F 514 Continued From pa	nge 96	F 5	514		
The weekly skin as showing document measurements. Th	sessment form stopped ation after the 6/28/17 nis same form documented on 3/20/17, 4/3/17, 4/10/17,				
Assessment Week 1/2017 documented Nurse will complete each resident week	ity Policy titled, "Skin ly" with an effective date of d the following: "A Licensed e a total body assessment on tly and document the "Weekly Skin Integrity				
procedures sixth ed following: "Docume preparing a comple and is a vital tool fo health care team m charting shows the that nurses provide and treatment and needs. Thorough,	ice from Lippincott's Nursing dition documented the entation is the process of the record of a patient's care in communication among tembers. Accurate, detailed extent and quality of the care in the outcomes of that care, education that the patient still accurate documentation intial for miscommunication				
evidence that the m documentation omi DON stated on 7/12 p.m.: "I couldn't find treatments were no Nursing staff is to fo	sing was asked to show nultiple wound care ssions were completed. The 2/17 at approximately 1:15 d any explanation as to why t done." The DON added, bllow the orders the doctor				

orders is part of the Nurse's job description. The DON also stated that a wound can develop complications as a result of not following orders

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

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CENTE	MB NO. 0938-0391					
1	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495149	B. WING		C 07/13/2017	
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
PORTSMOUTH HEALTH AND REHAB				900 LONDON BOULEVARD PORTSMOUTH, VA 23704		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	• • • • • • • • • • • • • • • • • • • •	DBE COMPLETION	
F 514	for wound care. The facility adminis findings during a br approximately 3:45	rge 97 tration was informed of the iefing on 7/13/17 at p.m. The facility did not information about the findings.	F 5	514		

DEFINITIONS:

Stage II Pressure Ulcer: The National Pressure Ulcer Advisory Panel: documented: Stage 2 Pressure Injury: Partial-thickness skin loss with exposed dermis. Partial-thickness loss of skin with exposed dermis. The wound bed is viable, pink or red, moist, and may also present as an intact or ruptured serum-filled blister. Adipose (fat) is not visible and deeper tissues are not visible. Granulation tissue, slough and eschar are not present. These injuries commonly result from adverse microclimate and shear in the skin over the pelvis and shear in the heel. This stage should not be used to describe moisture associated skin damage (MASD) including incontinence associated dermatitis (IAD), intertriginous dermatitis (ITD), medical adhesive related skin injury (MARSI), or traumatic wounds (skin tears, burns, abrasions).

Stage III Pressure Ulcer: The National Pressure Ulcer Advisory Panel: documented: Full-thickness loss of skin, in which adipose (fat) is visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present. Slough and/or eschar may be visible. The depth of tissue damage varies by anatomical location; areas of significant adiposity can develop deep wounds. Undermining and tunneling may occur. Fascia, muscle, tendon, ligament, cartilage

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CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-						
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	LAN OF CORRECTION IN IMPER		TIPLE CONSTRUCTION ING	(X3) DATE SURVEY COMPLETED		
				С		
	495149	B. WING		07/13/2017		
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
PORTSMOUTH HEALTH AND REHAB			900 LONDON BOULEVARD PORTSMOUTH, VA 23704			
PREFIX (EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREF TAG	PROVIDER'S PLAN OF CORRECTION (X5) (EACH CORRECTIVE ACTION SHOULD BE COMPLETION CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY)			
F 514 Continued From page 98			514			

and/or bone are not exposed. If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Injury.

Stage IV Pressure I lear: The National Pressure.

Stage IV Pressure Ulcer: The National Pressure Ulcer Advisory Panel: documented: Full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer. Slough and/or eschar may be visible. Epibole (rolled edges), undermining and/or tunneling often occur. Depth varies by anatomical location. If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Injury.

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