State of Virginia STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING VA0415 06/29/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1948 LANDSTOWN CENTRE WAY PRINCESS ANNE HEALTH & REHABILITATION VIRGINIA BEACH, VA 23456 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) F 000 Initial Comments F 000 An unannounced biennial State licensure survey was conducted on 6/27/17 through 6/29/17. 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 108 at the time of the survey. The survey sample consisted of 25 residents, 19 current Resident reviews (Resident #1 through 19) and 6 closed record reviews (Resident # 20 through 25). F 001 Non Compliance F 001 Please cross reference F-tag 425. The facility was out of compliance with the following state licensure requirements: 12VAC 5-371-150. Refer to F167 and F168 This RULE: is not met as evidenced by: The facility staff failed to have medications 12VAC 5-371-220. Refer to F309 available for one resident (Resident #20) in the and F328 survey sample. 12VAC 5-371-360. Reference F514 Findings: Resident #20 was not provided medications in accordance to 12 VAC 5-371-300 12VAC 5-371-220. Refer to F157 A. and F309 Cross reference to F-tag 425. 12VAC 371-250. Reference F280 12 VAC 5-371-150. Resident Rights (A, C), Refer 12VAC 5-371-210. Reference F496 to F167 and F168 12 VAC 5-371-220 (B) Nursing Services Reference F-309 and F-328 12 VAC 5-371-360 (E) Clinical Records Reference F-514

ABORATORY DIRECTOR'S OR PROVIDER SUPPLIER REPRESENTATIVE'S SIGNATURE

12 VAC 5-371-220 B and H. Nursing Services.

Administrator

7/12/17

State of	Virginia				
	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		VA0415	B. WING		06/29/2017
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE	
		1948 LA	NDSTOWN CE		
PRINCE	SS ANNE HEALTH & I	VIRGINI	A BEACH, VA	23456	
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F 001	Continued From pa	ige 1	F 001		
	12 VAC 5-371-250	gs F-157 and F-309 F. Resident Assessment and ss reference Tag F-280			
	12 VAC 5-371-210 Please Cross - Ref	(F.2). Nurse Staffing. erence to F496 (i)			
	review, the facility s requirements of the Regulations Govern	rview and facility document staff failed to meet the e Virginia Board of Nursing hing Certified Nurse Aides as a CNA in the state of			
	by endorsement for certification to the \	bmit the required application r an out of state nurse aide /irginia Board of Nursing to in the state of Virginia.			
	employee records of CNA #1's nurse aid the state of Georgia Registry verification Human Resources CNA #1's original cand the expiration on Virginia nurse aid	oximately 10:00 am, the were reviewed and found that ie certification was issued in a. The Georgia Nurse Aide in record provided by the facilit (HR) Manager stated that ertification date was 6/18/04 date was 6/18/18. There was ide registry verification record #1 was hired on 10/19/16.	y		
	conducted with the was an oversight or entering the data in to enter the correct required certificatio the system. This harecognize CNA #1's	pm, an interview was HR Manager and stated that in the former HR Manager to the HR system. She failed information on CNA #1's in due date of 120 days into ad caused the system to not is nurse aide certification due intly, was not flagged to be	it		

State of	Virginia				
	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		VA0415	B. WING		06/29/2017
NAME OF	PROVIDER OR SUPPLIER	STREET AI	DORESS, CITY, S	TATE, ZIP CODE	
PRINCES	S ANNE HEALTH & F	REHABILITATION	NDSTOWN CE A BEACH, VA		The said
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	DBE COMPLETE
F 001	Continued From pa	ge 2	F 001		
	updated. She stated and according to Company to the period of the period	d that she interviewed CNA #1 NA #1, she had tried to apply her Georgia certification but otain her Virginia certification.  1 was contacted twice via s no answer each time. The act CNA #1 was on 6/29/17 at			
	(DON) was interview	pm, the Director of Nursing wed and was asked about the			
	CNA's certification of stated that HR usual certification status and Department. In regastatus, she stated the	now the facility ensured a was current and valid. She ally checked the nurse aide and then notified the Nursing ards to CNA #1's certification hat she was just informed "an ed that CNA #1 was taken off diately.			
	Administrator, DON	oximately 3:45 pm, the I and Corporate Nurse were above findings and no further ovided.			

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CENTE	KS FOR MEDICARE	& MEDICAID SERVICES		C	DMB NO. 0938-0391
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL' A. BUILDI	TIPLE CONSTRUCTION ING	(X3) DATE SURVEY COMPLETED
		495418	B. WING		06/20/2047
	PROVIDER OR SUPPLIER	REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1948 LANDSTOWN CENTRE WAY VIRGINIA BEACH, VA 23456	06/29/2017
(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 SHOULD  CROSS-REFERENCED TO THE APPROP	D BE COMPLETION
F 000	INITIAL COMMENT		FO	00	
	survey was conduct 6/29/17. Two compl Corrections are req following 42 CFR Pacare requirements. survey/report will for				
	108 at the time of the consisted of 25 resireviews (Resident #		F 1	57 The physician/designee and	8/9/11
	consult with the resi	mediately inform the resident; dent's physician; and notify, or her authority, the resident		resident representative of Resident #9 were notified of the discontinuation of the CPAP therapy.  Current residents will be reviewed	
(A) An accident involving results in injury and has physician intervention;		has the potential for requiring		to identify those refusing physician ordered therapy and to ensure that there is documentation that the physician/designee and	
	mental, or psychoso deterioration in health	inge in the resident's physical, ocial status (that is, a th, mental, or psychosocial hreatening conditions or s);		resident representative have been notified of the refusal.	
	a need to discontinu	reatment significantly (that is, the an existing form of exerse consequences, or to form of treatment); or			

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

Admini Strator

11217

Any deficiency statement enting 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.

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		THE OLIVIOLO			OMP 140: 0320-038
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED
		495418	B. WING		06/29/2017
NAME OF PE	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
PRINCES	S ANNE HEALTH &	REHABILITATION CENTER		1948 LANDSTOWN CENTRE WAY VIRGINIA BEACH, VA 23456	11
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETION
F 157	Continued From pa	ige 1	F 15	7	

- (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii).
- (ii) When making notification under paragraph (g) (14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician.
- (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is-
- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or
- (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section.
- (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). This REQUIREMENT is not met as evidenced by:

Based on observations, resident interview, staff interviews, review of the facility's policy and clinical record review the facility staff failed to notify the physician and/or designee and the resident's representative of a change in physical, mental, or psychosocial status for 1 of 25 residents in the survey sample, Resident #9.

The facility staff failed to notify the physician and/or designee and the resident's representative that Resident #9 was not receiving the physician ordered Continuous positive airway pressure

Nurses will be educated on documenting refusals of physician ordered therapy to include notification of the physician/designee and resident representative.

A random audit of residents will be completed on a weekly basis to identify residents refusing physician ordered therapy and documentation of physician/designee and resident representative notification of the refusal. Results of the audits will be referred to the Quality Assurance Committee for review and recommendation.

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CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			OWR M	<u> J. 0938-0391</u>
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI	TIPLE CONSTRUCTION ING		ATE SURVEY OMPLETED
		495418	B. WING		0	6/29/2017
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
PRINCES	SS ANNE HEALTH &	REHABILITATION CENTER		1948 LANDSTOWN CENTRE WAY VIRGINIA BEACH, VA 23456		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPROPRIEM (PROSS-REFERENCE)	ULD BE	(X5) COMPLETION DATE
F 157	Continued From pa (CPAP) therapy.	age 2	F 1	57		П
	The findings includ	ed:				
	7/8/15 and readmit hospital visit for altrahortness of breath included; chronic or and obstructive sleep Resident #9's quarassessment with a (ARD) of 6/6/17 conthe Brief Interview scoring 12 out of a Resident #9's cogmaking were model.	terly Minimum Data Set (MDS) in assessment reference date ded the resident as completing for Mental Status (BIMS) and possible 15. This indicated litive abilities for daily decision trately impaired.				
	coded the resident mood and having li week and exhibiting was coded as set-to with eating, limited extensive assistant hygiene, dressing a	by MDS assessment also as exhibiting a depressed ttle energy two to six days per g no behaviors. The resident up assistance of one person assistance with locomotion, ce of one with personal and toilet use, extensive with bed mobility and transfers ne with bathing.				
	interview was cond room. The resident	oximately 12:30 p.m., an ucted with Resident #9 in his was still in bed and had just zer treatment for an episode of				

shortness of breath and congestion. This

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CENTER	CENTERS FOR MEDICARE & MEDICAID SERVICES				OMB NO. 0938-0391						
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI		NSTRUCTION		TE SURVEY MPLETED				
		495418	B. WING			06	5/29/2017				
	NAME OF PROVIDER OR SUPPLIER PRINCESS ANNE HEALTH & REHABILITATION CENTER			1948 [	T ADDRESS, CITY, STATE, ZIP CODE LANDSTOWN CENTRE WAY INIA BEACH, VA 23456		00/29/2017				
(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 157	bedside dresser a r machine. The CPAl dust and both were dust and debris. The if he had received (Resident #9 stated in many months be beneficial. Residen not discussed with but the nursing staf receive CPAP there the CPAP equipme	on the floor next to the nebulizer machine and a CPAP P machine was covered with uncovered/unprotected from the surveyor asked Resident #9 CPAP therapy last night and he had not had CPAP therapy cause he decided it was not the stated the decision was his physician and or designee if was aware he decided not to apply and they knew not to apply that bedtime.	F 1	57							
	order summary rev date of 8/30/16 whi sleep at bedtime for Review of Resident record for six monti 1/1/17 through 1/31 CPAP therapy 4 nights.	t #9's, 6/1/2017 physician's ealed an order with a start ch read: "CPAP every hour of r Sleep apnea."  t #9's treatment administration hs revealed the following; /17; Resident #9 refused ights and accepted CPAP									
	CPAP therapy 26 n therapy 2 nights.  3/1/17 through 3/31	ights and accepted CPAP /17; Resident #9 refused ights and there was no									
	CPAP therapy 21 n	0/17; Resident #9 refused ights, accepted CPAP therapy was no documentation									

Facility ID: VA0415

available for 4 nights.

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		495418	B. WING		06	5/29/2017	
NAME OF I	PROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CO			
PRINCES	SS ANNE HEALTH & I	REHABILITATION CENTER		1948 LANDSTOWN CENTRE WAY VIRGINIA BEACH, VA 23456			
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F 157	Continued From pa	one 4	F 1	57			
		/17; Resident #9 didn't refuse	1- 1	37			
	CPAP therapy any	nights, accepted CPAP					
	therapy 25 nights a						
	documentation ava	liable for 3 hights.					
	6/1/17 through 6/28	3/17; Resident #9 refused					
		hts, accepted CPAP therapy					
		ras documented 1 night and mentation available for 4					
	nights.	Homewort available for 4					
	An interview was co	onducted with Registered					
		6/29/17 at approximately 1:35					
		she recognized on 6/28/17 at					
		0 p.m., that Resident #9 was eriencing shortness of breath;					
		ratory medication Albuterol					
	Sulfate was admini	stered to the resident to					
		ns. RN #1 stated the resident ne saw him the first time for					
		I not remove the CPAP					
	equipment which w	as applied the night before.					
		d she works with the resident nd she has never known the					
		e CPAP equipment. She					
	stated the resident	was non-compliant with use of					
		had not educated the resident					
	on the benefits of u	se.					
		so conducted with the treating					
	Nurse Practitioner (						
		p.m. The NP stated she is in I she knows Resident #9 very					
	well. She stated, Re	esident #9 fluctuates with					
		ntire program and some days					
		like being bothered. The NP has sleep apnea; therefore,					

CPAP therapy was ordered. She further stated

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CENTE	RS FOR MEDICARE	& MEDICAID SERVICES	OMB NO. 0938-0391				
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F 157	feel tired, not be condecreased cognitive of her visits with Resymptoms related to the NP also stated visited the resident diagnosis of sleep a saturation and facility resident was rejective stated she had not resident's oxygen seducate the resident compliance with CF stated the facility stresident was rejective The Corporate Nursprovide any documer record which stated the resident's reprephysician's designe CPAP therapy and clinical record statir on the benefits of Consequences of consequences of consequences of the symptoms of the state of the consequences of conseq	nerapy the resident is likely to mpletely alert and have a abilities. The NP stated most sident #9 are for managing to heart failure.  she couldn't say she had recently related to the apnea or low oxygen ity staff had not notified her the ng CPAP therapy. The NP personally obtained the aturation or had any reason to not the importance of PAP therapy. The NP also aff had not informed her the ng the CPAP therapy.  se Consultant was asked to entation from the clinical at the facility staff had notified sentative and physician or the of the residents rejection of any documentation from the ng Resident #9 was educated in the potential ontinuous rejection of care, se Consultant stated no		157			
		titled "Refusal of ent Care" with an effective ad: "A licensed purse is to					

document and notify the physician and responsible party when a resident refuses

1		& MEDICAID SERVICES			0	MB NO. 0938-0391
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MUI A. BUILD	TIPLE CONSTRUCTION	and the	(X3) DATE SURVEY COMPLETED
		495418	B. WING			00/20/2047
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	TATE, ZIP CODE	06/29/2017
PRINCE	SS ANNE HEALTH &	REHABILITATION CENTER		1948 LANDSTOWN CENT VIRGINIA BEACH, VA	RE WAY	
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F 157	Continued From pa	age 6	F 1	57		
	medication(s) and onumber 2; three da medication(s)/treatmotification of the p The physician will recurrent drug/treatm whether discharge Procedure number result in a review and Documentation will record if patient and unable or unwilling conference. Procedures ponsible party to regarding the potential of the p	or treatment. Procedure ys of patient's refusals of ment/care requires the hysician and responsible party. eview and determine if the ent plan is appropriate and planning may be initiated.  3; three days of refusals will not revision of care plan. be placed in the medical d/or Responsible party is to attend the care plan fure number 4; Patient and/or eaching will include specifics		51		
	Administrator, Direct Nurse Consultant o 3:00 p.m. No addition	were shared with the stor of Nursing, and Corporate n 6/29/17 at approximately onal information was provided. RIGHT TO SURVEY LY ACCESSIBLE	F 1	67		
	of the facility conduc	uits of the most recent survey cted by Federal or State plan of correction in effect with		Facility staff changed to of the posting of the management of the	nost recent minent and ented by	8 9 17
	and family members	nust eadily accessible to residents, s and legal representatives of s of the most recent survey of		The location of the pos most recent survey res discussed with resident next Resident Council N	ults will be ts at the	

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULT A. BUILDI	IPLE CONSTRUCTION	0.0746	3) DATE SURVEY COMPLETED
		495418	B, WING_			06/29/2017
	ROVIDER OR SUPPLIER  S ANNE HEALTH & I	REHABILITATION CENTER		STREET ADDRESS, CITY, STATE 1948 LANDSTOWN CENTRE VIRGINIA BEACH, VA 234	WAY	
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#### F 167 Continued From page 7

- (ii) Have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding years, and any plan of correction in effect with respect to the facility, available for any individual to review upon request; and
- (iii) Post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public.
- (iv) The facility shall not make available identifying information about complainants or residents. This REQUIREMENT is not met as evidenced by:

Based on general observations, group interview, staff and resident interview, the facility staff failed to ensure the posting of the availability of the survey results was in a prominent and accessible place frequented by residents with large enough print enabling easy reading.

#### The findings include:

On 6/28/17 at 1:30 p.m., during the group interview with 6 residents that represented the facility, they were unable to identify the location in the building where the survey results were located for review. Each resident was taken to the lobby and they could not find the signage that directed them to where the survey results were located. This writer took each resident to the small print framed sign that indicated where the survey results were located and none of the residents were able to read the information in the framed sign. All of the residents stated they very rarely frequented the main lobby and spent most of their time on the unit's activities unit and day

#### F 167

The Activity Department will be educated on reviewing the location of the most recent survey results with newly admitted residents.

The Administrator will monitor the posting of the most recent survey results on a random weekly basis to ensure that the posting is in a prominent and accessible place frequented by residents and that the posting is easily readable. Results of the monitoring will be referred to the Quality Assurance Committee for review and recommendation.

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		495418	B. WING		06/29/2017
	PROVIDER OR SUPPLIER SS ANNE HEALTH &	REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1948 LANDSTOWN CENTRE WAY VIRGINIA BEACH, VA 23456	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETION
F 167	rooms. There was resident frequented of their time, regard they were located. never read any of the Review of the previous Meeting midiscussions about the and Certification recorded in the Administrator, Direct Corporate Nurse. The Rights information that the right to be padmission, a survey findings and outcome requirements."	no information in these of areas, where they spent most ding survey results or where The residents stated they had the survey results.  The residents stated they had the survey results.  The resident stated they had the survey results.  The resident state survey sults.  The location of the State survey sults.  The promation was shared with the corn of Nursing (DON) and the shey presented the Resident that indicated "The resident provided, at the time of y summary of the most recent nes concerning Federal			
F 168 SS=C	(g)(10) The resident (ii) Receive information advocates, are to contact these age (k) Contact with Ext. A facility must not publication discourage a resident federal, state, or localimited to, federal are federal or state hear	ADVOCATE AGENCIES  It has the right to- ution from agencies acting as and be afforded the opportunity encies.	F 16	The signs listing State Agency and Advocate telephone numbers and addresses have been moved to be easily accessible and readable if in a wheelchair.  The location of the State Agency and Advocate telephone numbers and addresses will be reviewed with residents at the next Resident Council Meeting.	0/9/11

Long-Term Care Ombudsman and any

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	TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION (X1) PROVIDER IDENTIFICA		(X2) MULTIPLE CONSTRUCTION A. BUILDING		0	(3) DATE SURVEY COMPLETED
		495418	B. WING_			06/29/2017
NAME OF PROVIDER OR SUPPLIER PRINCESS ANNE HEALTH & REHABILITATION CENTER				STREET ADDRESS, CITY, STA 1948 LANDSTOWN CENTRI VIRGINIA BEACH, VA 23	E WAY	
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#### F 168 Continued From page 9

representative of the agency responsible for the protection and advocacy system for individuals with mental disorder (established under the Protection and Advocacy for Mentally III Individuals Act of 2000 (42 U.S.C. 10801 et seq.), regarding any matter, whether or not subject to arbitration or any other type of judicial or regulatory action.

This REQUIREMENT is not met as evidenced by:

Based on general observations, group interview, staff and resident interview, the facility staff failed to ensure information regarding State agencies and other advocates were conspicuously located, as well as positioned on the wall to enable residents in wheelchairs to read the information.

#### The findings include:

On 6/28/17 at 1:30 p.m., during the group interview with 6 residents that represented the facility, they were unable to identify the location in the building where the State Agencies and Advocates telephone numbers and addresses could be accessed; and then be afforded the opportunity to contact these agencies.

Each of these residents were taken to the location where the aforementioned information was posted and stated it was their first awareness of this posting. Five out of the six residents were in wheelchairs and stated they were unable to read the postings because they were too high up on the wall.

Review of the previous 6 months Resident Council Meeting minutes did not reveal any discussions about location of the postings of State, Federal and local advocacy addresses and

#### F 168

The Activity Department will be educated on reviewing the location of State Agency and Advocate telephone numbers and addresses with newly admitted residents.

The Administrator will complete a random weekly interview with residents to ensure that the resident is aware of the location of State Agency and Advocate telephone numbers and addresses and that the information is easily readable. Results of the interviews will be referred to the Quality Assurance Committee for review and recommendation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING	E CONSTRUCTION		3) DATE SURVEY COMPLETED			
		495418	B WING			06/29/2017		
	SUMMARY STA	REHABILITATION CENTER  TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	STREET ADDRESS, CITY, STATE, ZIP CODE  1948 LANDSTOWN CENTRE WAY  VIRGINIA BEACH, VA 23456  ID PROVIDER'S PLAN OF CORRECTION (X5)  PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETION TAG CROSS-REFERENCED TO THE APPROPRIATE DATE					
F 280	aforementioned info Administrator, Direct Corporate Nurse. 483.10(c)(2)(i-ii,iv,v PARTICIPATE PLA! 483.10 (c)(2) The right to pand implementation plan of care, including the right to be including the right to be included in the particular meetings are revisions to the personal content of the particular meetings are revisions to the personal content of the particular meetings and amount, frequency, other factors related plan of care.  (iv) The right to receive included in the plan (v) The right to see fright to sign after sign of care.	eximately 3:30 p.m., the cormation was shared with the cor of Nursing (DON) and the cor of Nursing (DON) and the cor of Nursing (DON) and the core of Nursing (DON) and the core of Nursing (DON) and the core of Nursing Care of Nursing the core of	F 168	Resident #9's person-cent of care has been revised this current strengths and well as personal and culture preferences.  Current residents were reto ensure that rejection of physician ordered treatmed included in the resident's care.  The interdisciplinary team charge nurses will be educed developing and revising a resident's plan of care to in rejection of physician ordereatments.  The Director of Nursing/As Director of Nursing will contained making and the plans of care to ensure that plan of care addresses the resident's strengths, needs	tered plan to address needs as ural viewed f ent is plan of and cated on nclude ered sistant mplete a sident et the	8/9/17		
	right to participate in	his or her treatment and ident in this right. The		personal and cultural preference Results of the audits will be referred to the Quality Associated Committee for review and recommendation.	9			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILD	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED
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F 280	(ii) Include an assess strengths and need (iii) Incorporate the cultural preferences 483.21 (b) Comprehensive (2) A comprehensive (i) Developed within the comprehensive (ii) Prepared by an includes but is not I (A) The attending p (B) A registered nurresident.	usion of the resident and/or tive.  ssment of the resident's s.  resident's personal and s in developing goals of care.  Care Plans re care plan must be- a 7 days after completion of assessment.  interdisciplinary team, that imited to	F	280		
	(D) A member of fo (E) To the extent pr the resident and the An explanation mus medical record if the and their resident re	od and nutrition services staff.  acticable, the participation of e resident's representative(s). It is included in a resident's e participation of the resident epresentative is determined the development of the included.				

CENTER	RS FOR MEDICARE	: & MEDICAID SERVICES				<u> NUBIN</u>	<u>0. 0938-0391</u>
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		ONSTRUCTION		ATE SURVEY DMPLETED
		495418	B. WING			0	6/29/2017
NAME OF F	PROVIDER OR SUPPLIER			STRE	ET ADDRESS, CITY, STATE, ZIP CODE		
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F 280	Continued From pa	age 12	F 2	80			
. 550	(F) Other appropria	ate staff or professionals in mined by the resident's needs	1				
	team after each as	revised by the interdisciplinary sessment, including both the					
	comprehensive and assessments. This REQUIREME	NT is not met as evidenced					
		tions, resident interview, staff					
	clinical record revise t	of the facility's policy and by the facility staff failed to he person-centered plan of it's status changed.					
	Resident #9's persinclude rejection of	led to review and revise on-centered plan of care to the physician ordered airway pressure (CPAP)					
	The findings includ	ed:					
	7/8/15 and readmit hospital visit for all shortness of breath	riginally admitted to the facility ted 8/29/16 after an acute ered mental status and n. The current diagnoses bstructive pulmonary disease ep apnea.					
	assessment with a (ARD) of 6/6/17 co	terly Minimum Data Set (MDS) n assessment reference date ded the resident as completing for Mental Status (BIMS) and					

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CENTER	KS FUR MEDICAR	E & MEDICAID SERVICES			OMB NO. 0938-0391
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F 280	Resident #9's cog making were mod The 6/6/17 quarte coded the residen mood and having week and exhibiting was coded as setwith eating, limited extensive assistant hygiene, dressing assistance of two and total care of CObservations/date On 6/28/17 at apprinterview was con room. The resider completed a nebus shortness of breat surveyor observed bedside dresser as	a possible 15. This indicated nitive abilities for daily decision iterately impaired.  If MDS assessment also at as exhibiting a depressed little energy two to six days pering no behaviors. The resident up assistance of one person disassistance with locomotion, and toilet use, extensive with bed mobility and transfers one with bathing.  If was still in bed and had just lizer treatment for an episode of the and congestion. This is don the floor next to the nebulizer machine and a CPAP	F 28		
	dust and both wer dust and debris. T if he had received Resident #9 states in many months b beneficial. Reside not discussed with but the nursing sta	AP machine was covered with a uncovered/unprotected from the surveyor asked Resident #9 CPAP therapy last night and the had not had CPAP therapy ecause he decided it was not not #9 stated the decision was a his physician and or designee aff was aware he decided not to rapy and they knew not to apply ent at bedtime.			

Review of Resident #9's, 6/1/2017 physician's order summary revealed an order with a start

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E 280	Continued From pa	000 14	E (	100			
1 200	,	ich read; CPAP every hour of	F 2	280			
	record for six mon 1/1/17 through 1/3	nt #9's treatment administration ths revealed the following; 1/17; Resident #9 refused nights and accepted CPAP					
		8/17; Resident #9 refused nights and accepted CPAP					
		1/17; Resident #9 refused nights and there was no nilable for 3/29/17.					
	CPAP therapy 21 r	0/17; Resident #9 refused nights, accepted CPAP therapy was no documentation nts.					
	CPAP therapy 4 nights, "other" v	8/17; Resident #9 refused ghts, accepted CPAP therapy was documented 1 night and mentation available for 4					
	Nurse (RN) #1, on	conducted with Registered 6/29/17 at approximately 1:35 she recognized on 6/28/17 at					

approximately 12:00 p.m., that Resident #9 was congested and experiencing shortness of breath

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F 280	Sulfate was admir relieve the sympto was in bed when s the day and she d equipment which a RN #1 further stat every other week resident to utilize to stated the resident	piratory medication Albuterol histered to the resident to thes. RN #1 stated the resident she saw him the first time for id not remove the CPAP was applied the night before, ed she works with the resident and she has never known the the CPAP equipment. She that not educated the resident	F 2	280				
	Nurse Practitioner approximately 1:4 the facility daily ar well. She stated R compliance of his he just doesn't fee stated the residen CPAP therapy was without the CPAP feel tired, not be codecreased cognition.	also conducted with the treating (NP) on 6/29/17 at 5 p.m. The NP stated she is in ad she knows Resident #9 very resident #9 fluctuates with entire program and some days of like being bothered. The NP thas sleep apnea therefore, is ordered. She further stated therapy the resident is likely to ompletely alert and have be abilities. The NP stated most desident #9 are for managing to heart failure.						
	visited the resident diagnosis of sleep saturation and fact resident was reject stated she had no resident's oxygen	d she couldn't say she had at recently related to the apnea or low oxygen ality staff had not notified her the tring CPAP therapy. The NP t personally obtained the saturation or had any reason to ent on the importance of						

compliance with CPAP therapy.

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		RE & MEDICAID SERVICES	OMB NO: 0938-039						
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	PROVIDER OR SUPPLIED SS ANNE HEALTH 8	R REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP COO 1948 LANDSTOWN CENTRE WAY VIRGINIA BEACH, VA 23456	06/29/2017 E				
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F 280	Continued From p	page 16	F 28	0					
	provide any documers on-centered prejected CPAP the benefits of CPAP to consequences of therapy. The Corp the person-center plan of care specifically a comment in	urse Consultant was asked to mentation from the plan of care stating Resident #9 erapy and was educated on the therapy and the potential continuous rejection of CPAP porate Nurse Consultant stated ed plan of care did not have a fic to rejection of CPAP therapy, in the problem list stating "refusal goal or interventions related to							
	effective date of 02 care plan will be up ongoing basis as cand reviewed quarassessment."  The above findings Administrator, Dire Nurse Consultant of	y titled "Care Planning" with an 2/01/15 read: "A computerized pdated by each discipline on an changes in the patient occurs, rterly with the quarterly swere shared with the ector of Nursing, and Corporate on 6/29/17 at approximately							
F 309	3:00 p.m. No addit	tional information was provided.  I) PROVIDE CARE/SERVICES	F 309	9					
	applies to all care a	ife fundamental principle that and services provided to facility		Resident #5 is utilizing the TED hose as ordered by the physician The CPAP therapy has been discontinued for Resident #0	8/9/17				

facility must provide the necessary care and services to attain or maintain the highest

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		REHABILITATION CENTER		STREET ADDRESS, CITY, ST 1948 LANDSTOWN CENT VIRGINIA BEACH, VA	RE WAY	06/29/2017
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F 309	Continued From pa	an 17				
1 000		ge 17 f, mental, and psychosocial	F 30	9		
	well-being, consiste	ent with the resident's	(	Current residents with or	ders for	
	comprehensive ass	essment and plan of care.		ED hose were reviewed		
	400.05.0 ()			hat the TED hose are in (		
	483.25 Quality of ca	are fundamental principle that	C	ordered. Current residen	ts with	
	applies to all treatm	ent and care provided to	0	orders for CPAP were rev	iewed to	
	facility residents. Ba	sed on the comprehensive	е	nsure that the CPAP is in	use as	
	assessment of a res	sident, the facility must ensure	0	rdered or that there is		
	that residents received	ve treatment and care in	d	ocumentation of		
	practice, the compre	ofessional standards of ehensive person-centered		hysician/designee and re		
	care plan, and the re	esidents' choices, including		epresentative notificatio		
	but not limited to the	e following:	re	efusals to comply with th	e order.	
	(k) Pain Manageme	nt.	N	urses will be educated o	n	
	The facility must ens	sure that pain management is		ollowing physician/design		
	provided to resident	s who require such services.		rders, documentation of		
	the comprehensive	essional standards of practice, person-centered care plan,	a	dministration of		
	and the residents' or	person-centered care pran, oals and preferences.		hysician/designee orders		
			de	ocumentation of refusals	of	
	(I) Dialysis. The faci	ility must ensure that		nysician/designee orders	, and	
	residents who requir	e dialysis receive such with professional standards		ocumentation of		
	of practice, the com-	prehensive person-centered		nysician/designee notific		
	care plan, and the re	esidents' goals and	ге	sident refusals of orders	. =	
	preferences.			1.47		
		T is not met as evidenced				
	by: Based on observation	ons, resident interviews, staff				
	interviews, clinical re	ecord review and facility				
	document review the	facility staff failed to ensure				
	2 of 25 residents in t	he survey sample received				

#9.

the treatment and care in accordance to the person-centered care plan to maintain their highest practicable well-being, Residents #5 and

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	<u> </u>	- WINDOWN OCKANOCO			, Oiv	10 NO. 0936-039 I
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (DENTIFICATION NUMBER:		(X2) MULT A. BUILDI	FIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
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}	ROVIDER OR SUPPLIER S ANNE HEALTH &	REHABILITATION CENTER		STREET ADDRESS, CITY, S 1948 LANDSTOWN CEN' VIRGINIA BEACH, VA	TRE WAY	
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		13.				

#### F 309 Continued From page 18

- 1. The facility staff failed to follow the physician's plan of care for the use of thromboembolic disease stockings (TED-compression stockings) for the management of bilateral lower extremity edema (1) for Resident #5.
- 2. The facility staff failed to provide physician ordered Continuous positive airway pressure (CPAP) therapy to Resident #9.

The findings included:

 Resident #5 was admitted to the facility on 5/11/17 with diagnoses to include history of congestive heart failure, deep vein thrombosis (DVT-blood clots) of lower extremity with IVC (inferior vena cava) filter placement and diabetes.

The admission MDS (Minimum Data Set) with an assessment reference date of 5/18/17 coded the resident as scoring a 15 out of a possible 15 on the Brief Interview for Mental Status indicating the resident's cognition was intact.

The Physician Order Summary Report included an order dated 5/31/17 that read, "TED (compression stockings) to be apply to bilateral lower extremity. If not able to tolerate they may use Ace wraps from toes to knees one time a day for edema and remove per schedule". The start date was 6/1/17.

On 6/2/17 the resident was examined by the Nurse Practitioner (NP #1) for the swelling of bilateral (both) lower extremities and continued weight gain. The physical exam evidenced the resident's lower extremities had significant edema to both lower legs with the left being greater than the right. The NP documented, "...the patient

F 309

The Director of Nursing/Assistant
Director of Nursing will complete a
random weekly audit of residents
with orders for TED hose or with
orders for CPAP therapy to ensure
that the orders are followed or
that the physician/designee has
been notified of refusals to comply
with the order. Issues noted
during the audits will be referred
to the Quality Assurance
Committee for review and
recommendation.



CENTERS FOR MEDICARE & MEDICAID SERVICES				OMB NO. 0938-0391		
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	-35	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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F 309	stockings". Impincluded: 1. Bilate Venous PVL bilate (Peripheral vascul presence of blood patient has throm daily as ordered. (milligrams) P.O. restriction of 1200 continue daily well the PVL studies in normal without evenomenal without evenomenal without evenomenal management of the NP document compression and P Bilateral lower extended to the will increase I b.i.d (twice a day)	ression and Plan Of Care ression and Plan Of Care real lower extremity edema. For all lower extremities are lab-studies to show for a clots). Please make sure the boembolic disease stockings on Change Lasix to 40 mg (by mouth) dailycontinue fluid of ml (milliliters) per 24 hours, ights parameters.  The sults dated 6/3/17 were ridence of DVT-blood clots.  The defended of the isonature of the isonature of the isonature of the isonature of identification. The lan Of Care included: 1.  The isonature daily weights. Lasix to 40 mg P.O. (by mouth).  5. Bilateral lower extremity thromboembolic disease	F 3	09		
	#1. The NP docur weighing him daily compression stod does not have any Extremities:Ho note to bilateral lo and Plan Of Care edema. Continue sure the patients'	sident was re-examined by NP mented, "He states they are y, however, he is not wearing his kings today as he states he y at all." "Physical Examination: e does have mild pitting edema wer extremities." Impression: 1. Bilateral lower extremity daily weights. Please make TED stockings are applied daily speak with his day nurse, (name				

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CENTERS FOR MEDICARE		E & MEDICAID SERVICES			OMB NO	OMB NO. 0938-0391	
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	PROVIDER OR SUPPLIER	REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 1948 LANDSTOWN CENTRE WAY VIRGINIA BEACH, VA 23456		120/2011	
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F 309	the patient has cor again. 2. Acute kid 20 mg P.O. twice of A physician order of	regard to this and to ensure mpression stockings on daily lney injury. Decrease Lasix to	F3	09			
	daily as ordered.  On 6/27/17 at 4:30 observed sitting in resident was wear with edema to both right. The resident hose. He stated, 'the NP had also query on 6/28/17 at 10:3 wheelchair awaitin TED hose on. At	p.m., the resident was his room in a wheelchair. The ing blue socks, and presented heles, the left greater than the t was asked about the TED I never got those. He stated uestioned him about them.  30 a.m., sitting up in the g for therapy. He did not have 1:00 p.m., the resident was om, in the bed. The resident					
	the month of June entry for the daily a at 9 am and the re evening at 9 pm. Inursing staff had in were applied, to in On 6/28/17 at 3:50	ent Administration Record) for 2017 was reviewed. It had an application of the TED hose on moval of the TED hose every From 6/1/17 the day shift nitialed daily that the TED hose clude RN #2 initials.  2 p.m., RN #2 was interviewed. We does she ensure the TED					
	hose are on Resid goes into the room asked if the reside	ent #9. She stated when she is she checks for them. When in that on TED hose today she I went in there they were on."					

RN #2 had initialed on the TAR for today that the TED hose were on, when in fact they were not.

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CENTERS FOR MEDICARE & MEDICAID SERVICES			OMB NO. 0938-				
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	(2) MULTIPLE CONSTRUCTION  BUILDING		TE SURVEY	
		<u></u>	D. 11110			5/29/2017	
	PROVIDER OR SUPPLIER S ANNE HEALTH &	REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 1948 LANDSTOWN CENTRE WAY VIRGINIA BEACH, VA 23456	DE		
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F 309	resident about the resident's room, the TED hose. RN #2 and the Resident state then checked a room to ensure the there were no TEE surveyor then left the was asked if TED building, she state the medical supply supply room on a containing multiple various sizes. RN and a disposable proper size. The Froom.  On 6/28/17 the about the Director of Nur. Nursing and the CO on 6/29/17 at 2:15 She was asked about and stated, "When have any increase started having increase started having increase of RN #2) at the TEO of RN #2) at the residence of RN #2 at the resid	to go and check with the TED hose. RN #2 went to the resident was not wearing any inquired about the TED hose stated, "I never got them". RN III drawers in the resident's ey were not stored somewhere, to hose found. The RN and this the resident's room. RN #2 hose were available in the d, "Yes". RN #2 then went into a room. Stored inside the shelf with a plastic bin the testing of TED hose stockings of the paper measuring tape to ent's calf and leg to ensure for the then went to the resident's cove findings was shared with using, the Assistant Director of	F 3	309			
	on if I wrote an ord nurse".  The facility staff fa	iled to follow the Physician's e application of TED stockings					

Facility ID: VA0415

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CENTE	<u>RS FOR MEDICAP</u>	RE & MEDICAID SERVICES			OMB NO. (	<u> </u>	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MUL A. BUILD	TIPLE CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
		495418	B. WING		06/2	9/2017	
	PROVIDER OR SUPPLIE	R REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, Z 1948 LANDSTOWN CENTRE WA VIRGINIA BEACH, VA 23456	IP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI) TAG		TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 309	which the body tis amount of tissue	page 22 cal or generalized condition in successive fluid. (Source Taber's cal Dictionary Edition 20).	F 3	309			
	facility 7/8/15 and acute hospital vis shortness of brea	as originally admitted to the readmitted 8/29/16 after an it for altered mental status and th. The current diagnoses obstructive pulmonary disease leep apnea (1).					
	assessment with (ARD) of 6/6/17 of the Brief Interview scoring 12 out of	arterly Minimum Data Set (MDS) an assessment reference date oded the resident as completing of for Mental Status (BIMS) and a possible 15. This indicated onlive abilities for daily decision derately impaired.					
	coded the resider mood and having week and exhibiti was coded as set with eating, limite extensive assista hygiene, dressing	erly MDS assessment also at as exhibiting a depressed little energy two to six days per ng no behaviors. The resident -up assistance of one person d assistance with locomotion, nce of one with personal and toilet use, extensive with bed mobility and transfers one with bathing.					
	interview was con room. The reside	proximately 12:30 p.m., an aducted with Resident #9 in his nt was still in bed and had just alizer treatment for an episode of					

shortness of breath and congestion. This

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CENTERS FOR MEDICARE & MEDICAID SERVICES					OMB NO. 0938-0391		
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER.	(X2) MULT A. BUILDI		CONSTRUCTION		TE SURVEY MPLETED
		495418	B. WING			06	/29/2017
	PROVIDER OR SUPPLIER	REHABILITATION CENTER		194	EET ADDRESS, CITY, STATE, ZIP CODE 8 LANDSTOWN CENTRE WAY GINIA BEACH, VA 23456		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	ĸ	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	DBE	(X5) COMPLETION DATE
F 309	surveyor observed of bedside dresser and machine (2). The Cowith dust and both of from dust and debrick Resident #9 if he have night and Resident CPAP therapy in madecided it was not be the decision was not and or designee but he decided not to reside the decided not to reside the decided in the decided in the decided not to reside the decided not to res	ge 23 on the floor next to the nebulizer machine and a CPAP PAP machine was covered were uncovered/unprotected is. The surveyor asked ad received CPAP therapy last #9 stated he had not had any months because he beneficial. Resident #9 stated of discussed with his physician t the nursing staff was aware eceive CPAP therapy and they he CPAP equipment at	F 3	09			
	order summary reve	#9's 6/1/2017 physician's ealed an order with a start lich read; CPAP every hour of r Sleep apnea.					
	care plan for sleep	#9's care plan revealed no apnea or ection of CPAP therapy.					
	record for six month 1/1/17 through 1/31	#9's treatment administration ns revealed the following; /17; Resident #9 refused ights and accepted CPAP					
		/17; Resident #9 refused ights and accepted CPAP		â			-

3/1/17 through 3/31/17; Resident #9 refused CPAP therapy 30 nights and there was no

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CENTER	RS FOR MEDICARE	& MEDICAID SERVICES		C	MB NO. 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495418	B. WING		06/29/2017
	PROVIDER OR SUPPLIER	REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1948 LANDSTOWN CENTRE WAY VIRGINIA BEACH, VA 23456	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		D BE COMPLETION
F 309	documentation ava  4/1/17 through 4/30 CPAP therapy 21 ni 5 nights and there is available for 4 night  5/1/17 through 5/31 CPAP therapy any is therapy 25 nights a documentation ava  6/1/17 through 6/28 CPAP therapy 4 nig 21 nights, "other" withere was no documentation available.  An interview was converse (RN) #1, on ep.m. RN #1 stated approximately 12:06	ollable for 3/29/17. O/17; Resident #9 refused lights, accepted CPAP therapy was no documentation ts.  1/17; Resident #9 didn't refuse nights, accepted CPAP and there was no	F3	309	
	therefore, the respin Sulfate was administrative the sympton was in bed when shaded the day and she did equipment which wRN #1 further state every other week a resident to utilize the stated the resident	ratory medication Albuterol stered to the resident to ms. RN #1 stated the resident he saw him the first time for d not remove the CPAP vas applied the night before. It is she works with the resident and she has never known the ne CPAP equipment. She was non-compliant with use of had not educated the resident			

An interview was also conducted with the treating

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CENTE	RS FOR MEDICARE	& MEDICAID SERVICES		<u> </u>	OMB NC	<u>). 0938-0</u> 391
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL' A. BUILDI	TIPLE CONSTRUCTION NG		TE SURVEY MPLETED
		495418	B. WING	75	06	5/29/2017
	PROVIDER OR SUPPLIER  SS ANNE HEALTH & I	REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1948 LANDSTOWN CENTRE WAY VIRGINIA BEACH, VA 23456		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL  SC (DENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 309	the facility daily and well. She stated Recompliance of his e he just doesn't feel stated the resident CPAP therapy was without the CPAP the feel tired, not be confered to decreased cognitive of her visits with Resymptoms related to the NP also stated visited the resident diagnosis of sleep a saturation and facility resident was rejectively stated she had not resident's oxygen seducate the resident compliance with CP The Corporate Nurse provide any documer record which stated the resident's reprephysician's designe CPAP therapy and clinical record statir on the benefits of Consequences of consequences of consequences of the stated the resident's reprephysician's designe CPAP therapy and clinical record statir on the benefits of Consequences of consequences of consequences of the stated the resident's reprephysician's designe CPAP therapy and clinical record statir on the benefits of Consequences of consequences of consequences of the stated the resident's reprephysician's designer CPAP therapy and clinical record statir on the benefits of Consequences of consequences of consequences of consequences of the stated the resident the re	(NP) on 6/29/17 at p.m. The NP stated she is in a she knows Resident #9 very sident #9 fluctuates with antire program and some days like being bothered. The NP has sleep apnea therefore; ordered. She further stated herapy the resident is likely to impletely alert and have a abilities. The NP stated most esident #9 are for managing to heart failure.  she couldn't say she had recently related to the apnea or low oxygen ity staff had not notified her the ng CPAP therapy. The NP personally obtained the aturation or had any reason to not on the importance of PAP therapy.  see Consultant was asked to entation from the clinical and the facility staff had notified sentative and physician or the of the residents rejection of any documentation from the ng Resident #9 was educated continuous rejection of care. See Consultant stated no	F3	09		

The facility's policy titled "Respiratory/Oxygen

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CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			OME	<u>3 NO. 0938-0391</u>
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION IG	(X	3) DATE SURVEY COMPLETED
		495418	B. WING			06/29/2017
NAME OF F	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, S	STATE, ZIP CODE	
				1948 LANDSTOWN CEN	TRE WAY	
PRINCES	S ANNE HEALTH & I	REHABILITATION CENTER		VIRGINIA BEACH, VA	23456	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECT CROSS-REFERENCE	PLAN OF CORRECTION TIVE ACTION SHOULD BE DED TO THE APPROPRIA FICIENCY)	
E 300	Continued From pa	26	Г 24	10		
F 308			F 30	19		
		effective date of 08/04/15 ses will administer and				
		y equipment, oxygen				
		oxygen equipment per				
	physician's order ar	nd in accordance with				
	standards of practic	ce."				
	The facility's policy	titled "Refusal of				
		ent Care" with an effective				-
		ad: "A licensed nurse is to				
		fy the physician and				
		hen a resident refuses				
		or treatment. Procedure				
		ys of patient's refusals of ment/care requires the				
		hysician and responsible party.				
		eview and determine if the				
		ent plan is appropriate and				
		planning may be initiated.				
		3: three days of refusals will				
		nd revision of care plan. be placed in the medical				
		d/or Responsible party is				
		to attend the care plan				
		dure number 4; Patient and/or				
		eaching will include specifics				
	regarding the poten					
	consequences/outo	come of continued refusals."				
	The above findings	were shared with the				
		ctor of Nursing, and Corporate				
		n 6/29/17 at approximately				
	3:00 p.m. No addition	onal information was provided,				
	(1) Sloop carea is:	a common disorder in which				
	you have one or mo	a common disorder in which ore pauses in breathing or				

shallow breaths while you sleep.

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILD	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		495418	B. WING			06/29/2017	
	PROVIDER OR SUPPLIER	REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIF 1948 LANDSTOWN CENTRE WAY VIRGINIA BEACH, VA 23456			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREF TAG		ON SHOULD I IE APPROPR	BE COMPLETION	
F 328 SS=E	(2) Continuous positherapy is a treatment to keep your breath used to treat sleep-including sleep apro (https://www.nhlbi.nics/cpap/)  For the treatment to CPAP machine ever while traveling, and using your CPAP mrequires patience. Now your pressure setting work with your sleep comfortable mask to the humidifier chama a different CPAP mauto-adjusting presentice immediate in CPAP treatment, sureduction or eliminal daytime sleepiness long-term benefits to helping to prevent colowering your risk for memory and other of (https://www.nhlbi.nics/sleepapnea) 483.25(b)(2)(f)(g)(5) FOR SPECIAL NEED	itive airway pressure (CPAP) ent that uses mild air pressure ing airways open CPAP is related breathing disorders ea with gov/health/health-topics/top of work, you should use your rry time you sleep at home, during naps. Getting used to achine can take time and four doctor may need to adjust the group of you. You may have to p doctor to find the most hat works best for you, to try other in your machine, or to use achine that allows multiple or sure settings. Some patients after starting uch as better sleep quality, ation of snoring, and less at control high blood pressure, or stroke, and improving cognitive function.  (h)(i)(i)(j) TREATMENT/CARE		328			
		nd care to maintain mobility					

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					CIVII	D 140. 0930-039
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	TIPLE CONSTRUCTION NG	(X	(3) DATE SURVEY COMPLETED
		495418	B. WING			06/29/2017
	S ANNE HEALTH &	REHABILITATION CENTER		STREET ADDRESS, CITY, S 1948 LANDSTOWN CEN VIRGINIA BEACH, VA	TRE WAY	#
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECT CROSS-REFERENCE	PLAN OF CORRECTION TIVE ACTION SHOULD BE CED TO THE APPROPRIA FICIENCY)	(X5) COMPLETION TE DATE
F 328	Continued From pa	age 28	F 0/	20		

- (i) Provide foot care and treatment, in accordance with professional standards of practice, including to prevent complications from the resident's medical condition(s) and
- (ii) If necessary, assist the resident in making appointments with a qualified person, and arranging for transportation to and from such appointments
- (f) Colostomy, ureterostomy, or ileostomy care. The facility must ensure that residents who require colostomy, ureterostomy, or ileostomy services, receive such care consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences.
- (g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to ... prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers.
- (h) Parenteral Fluids. Parenteral fluids must be administered consistent with professional standards of practice and in accordance with physician orders, the comprehensive person-centered care plan, and the resident's goals and preferences.
- (i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care. including tracheostomy care and tracheal suctioning, is provided such care, consistent with

F 328

Resident #5 has been seen by the Podiatrist as ordered.

8/9/17

Residents with orders for a podiatry consult were reviewed to ensure that the consult has been completed.

Nurses will be educated on completion of consult orders in a timely manner.

The DON/ADON will complete a random weekly audit of consults to ensure that the consult has been completed as ordered. Issues noted will be referred to the Quality Assurance Committee for review and recommendation.

CENTER	<u>RS FOR MEDICARE</u>	& MEDICAID SERVICES			OMB NO	<u>). 0938-0391</u>
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI	TIPLE CONSTRUCTION NG		TE SURVEY MPLETED
		495418	B. WING		06	5/29/2017
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD		
PRINCES	SS ANNE HEALTH &	REHABILITATION CENTER		1948 LANDSTOWN CENTRE WAY VIRGINIA BEACH, VA 23456		
(X4) !D PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 328	Continued From pa	nge 29	F3	28		-71
. 020	professional standa comprehensive per	ards of practice, the son-centered care plan, the d preferences, and 483.65 of	7 3	20		
	resident who has a and assistance, co standards of practic person-centered cand preferences, to prosthetic device. This REQUIREMED by:  Based on resident clinical record revise ensure 1 of 25 residence the treatment the person-centere services (foot care)	e facility must ensure that a prosthesis is provided care ensistent with professional ce, the comprehensive are plan, the residents' goals a wear and be able to use the NT is not met as evidenced interview, staff interviews, ew, the facility staff failed to dents in the survey sample tent and care in accordance to d care plan to receive Podiatry and assist in making aintain their highest practicable ats #5.				
		failed to follow the Physician's Podiatry (1) consult to manage esident #5.				
	The findings includ	ed:				
		dmitted to the facility on ses to include history of				
	assessment referencesident as scoring	S (Minimum Data Set) with an nce date of 5/18/17 coded the a 15 out of a possible 15 on for Mental Status indicating the was intact.				

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CENTER	RS FOR MEDICARI	E & MEDICAID SERVICES			OI	MB NO	. 0938-0391
	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A, BUILDING		CONSTRUCTION		E SURVEY APLETED		
		495418	B. WING			06	29/2017
	PROVIDER OR SUPPLIER	REHABILITATION CENTER		194	REET ADDRESS, CITY, STATE, ZIP CODE 18 LANDSTOWN CENTRE WAY RGINIA BEACH, VA 23456		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 328	Continued From p	age 30	F 3	28			
1 020	On 5/22/17 the res	sident was examined by the (NP #2) for left great toe pain		20			
	and abrasion. The	resident had complained of					
	abrasion on it and	for the past week with an some redness. The resident					
	area. The physical	ecific trauma or injury to the exam evidenced the resident's positive for pain and redness,					
		It great toe with a large					
	covering, surround	ling mild erythema (redness),					
		palpation (touch)". Impression included: "1. Started Keflex (an					
		great toe abrasion and concern illulitis (2). Podiatry consulted."					
		er Summary Report included 3/17 that read, "Podiatry					
		foot great toe wound w/ hx DM betes) and treatment orders.					
	The treatment order	er was for Silvadene cream 1%					
		e affected area topically every area to left foot great toe, apply					
	Q-tip size amount aid."	daily to affected area with band					
		dent was re-examined by  I). The Impression and Plan Of					
	Care included: "2.	Left great toe wound, odiatry consult as soon as					
	possible regarding	left great toe wound. Continue					
	wound cleanser), p	ft great two with DWC (dermal pat dry, apply Medihoney on					
	wound and cover vand as needed."	with dry sterile dressing daily					
	The nurse practition	oner wrote a second order for a garding the left great toe			5		

Event ID: VTWK11

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CENTE	RS FOR MEDICARE	E & MEDICAID SERVICES		(	OMB NO. 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495418	B, WING		06/29/2017
	PROVIDER OR SUPPLIER	REHABILITATION CENTER	19	REET ADDRESS, CITY, STATE, ZIP CODE 48 LANDSTOWN CENTRE WAY RGINIA BEACH, VA 23456	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION
F 328	Continued From pa	age 31	F 328		
	#1. Under Impress Left great toe wour 2017 was negative Continue Medihone	dent was re-examined by NP sion and Plan of Care read: 3. nd. X-ray was done on June 2, for any acute process. ey local wound care daily. The odiatry consult and has Keflix.			
		great toe Medihoney dressing to every evening and as			
	There was no Podi to review all consu	cal record was reviewed. eatry consult found. A request lts for Resident #5 was made r on 6/28/17. There were no			
	observed sitting up therapy. The reside and was asked abo The resident stated	0 a.m., the resident was in the wheelchair awaiting for ent was wearing blue socks but the left great toe dressing. It was changed last evening. Podiatrist had examined the d he stated, "No".			
		ng change was not observed as it was scheduled on the			
	staff. The last asset 6/27/17. The wour wound to the left g with pink molst tiss	sessed weekly by the nursing essment was conducted on and was described as a diabetic reat toe. The wound presented sue, and scant amount of airgage. The wound measured			

0.8 cm (centimeters) x 0.5 cm and 0.1 cm. No inflammation was noted and the wound progress

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CENTER	RS FOR MEDICARE	& MEDICAID SERVICES				ON	//B NO. 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILDI		STRUCTION		(X3) DATE SURVEY COMPLETED
		495418	B. WING			_	06/29/2017
	ROVIDER OR SUPPLIER	REHABILITATION CENTER		1948 LA	ADDRESS, CITY, STA INDSTOWN CENTR IIA BEACH, VA 2	RE WAY	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		(EACH CORRECTIVE CROSS-REFERENCE)	AN OF CORRECTION Æ ACTION SHOULD E D TO THE APPROPRI CIENCY)	BE COMPLETION
F 328	Continued From pa was stable.	ge 32 p.m., the unit secretary was	F 3	28			
W G	interviewed. She wa process for obtainin stated when a phys she faxes the face s	as asked what was the ig a Podiatry consult. She ician orders a Podiatry consult sheet to the Podiatrist office,			\$ 5		88
	the staff to confirm made available to re consult visits. On 5/ through Resident #9	odiatry office and speaks with a consult. A log book was eview that included Podiatry 23/17, the Podiatrist marked 9's name who was awaiting a he Podiatrist hand wrote that					
	the resident require resident was not Me included a phone no	d a physician referral, as the edicaid. The Podiatrist umber to call to aid in for a Podiatrist consult. The					
	unit secretary stated care and they need She stated she was required the referra handwritten note lef	d the resident is managed authorization for a referral. not aware that the resident I as she had not read this it by the Podiatrist. She stated Medicaid she could get the					
	nursing could have on this. Later that s followed up and sta resident was Medic	n as tomorrow. She stated also assisted with following up same day, the unit secretary ted to this surveyor that the aid approved on 6/23/17 and					
	office. She had not resident being Medi						
		ve findings was shared with ing, the Assistant Director of rporate Nurse.					
		pm, the NP was interviewed. not quite clear if the					

Podiatrist had seen the resident. She stated she

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		A MILDICAID SERVICES			<u>0MB NO. 0938-0391</u>
STATEMEN' AND PLAN	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 =	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495418	B. WING		06/29/2017
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 00/23/2017
PRINCE	SS ANNE HEALTH & I	REHABILITATION CENTER		1948 LANDSTOWN CENTRE WAY	
		CENTER CENTER		VIRGINIA BEACH, VA 23456	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROPERTIES OF CROSS OF CORRECT (CORRECT)	D BE COMPLETION
F 328	Continued From pa	GP 33	E 000		
1 020	had requested the I resident was a diab Podiatrist to evalua	ge 33 Podiatry consult as the etic. The NP wanted the te and assess the foot wound, tment plan for possible	F 328	3	
	prevention of condit	ignosis, treatment, and tions of human feet. (Source Medical Dictionary Edition 20).			
F 356 SS=B	subcutaneous tissur legs, are the most of Cyclopedic Medical	ading bacterial infection of the e. The extremities esp. the common sites. (Source Taber's Dictionary Edition 20). STED NURSE STAFFING	F 356	Daily nurse staffing information records are now maintained for review.	8 9 17
	the following informa	nformation ents. The facility must post ation on a daily basis:		The Staffing Scheduler is maintaining the daily nurse staffing information records in a designated location.	
	<ul><li>(i) Facility name.</li><li>(ii) The current date</li></ul>			The Staffing Scheduler has been educated on maintaining the daily	
	by the following cate	r and the actual hours worked egories of licensed and		nurse staffing information records for 18 months.	
	resident care per sh	staff directly responsible for ift:		The Administrator will complete a random weekly audit to ensure	
	(A) Registered nurse			that the daily nurse staffing information records are completed	
		al nurses or licensed s defined under State law)		and stored in a designated location. Issues noted during the	
	(C) Certified nurse a	ides.		audits will be referred to the Quality Assurance Committee for	

review and recommendation.

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CENTE	13 FUR MEDICARE	A MEDICAID SERVICES					או מועול	<u>. 0936-039</u> 1
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD			(X3) DATE SURVEY COMPLETED		
		495418	B. WING				06	/29/2017
NAME OF I	PROVIDER OR SUPPLIER			STF	REET ADDRESS, CITY, STATE, Z	IP CODE	•	
			ł	194	8 LANDSTOWN CENTRE WA	Y		
PRINCES	SS ANNE HEALTH &	REHABILITATION CENTER			RGINIA BEACH, VA 23456			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE	CORRECTION SHOUL	D BE	(X5) COMPLETION DATE
F 050								
F 350	Continued From pa	_	F3	56				
	(iv) Resident censu	IS.						
	(2) Posting require	ments.						
	specified in paragra	post the nurse staffing data aph (g)(1) of this section on a eginning of each shift.						
(	(ii) Data must be p	osted as follows:						
	(A) Clear and read	able format.					¥3	
	(B) In a prominent residents and visito							
	The facility must, u make nurse staffing	o posted nurse staffing data. pon oral or written request, g data available to the public not to exceed the community						
	facility must mainta staffing data for a r required by State la This REQUIREMEI by: Based on staff into review, the facility s	ention requirements. The in the posted daily nurse ninimum of 18 months, or as aw, whichever is greater.  NT is not met as evidenced erview and facility document staff failed to retain the daily mation records for 18 months.						
	was requested cop records filed from a The facility provide June 2016 through these records cond	oximately 11:45 am, the facility ies of the daily nurse staffing lanuary 2016 through 6/27/17. d copies of the records from 6/28/17. During the review of lucted on 6/28/17 at 0 pm, it was found that there						

were missing records of the daily nursing staffing

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CENTE	RS FOR MEDICARE	& MEDICAID SERVICES				OMB NO	0. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTION	(X3) DA	ATE SURVEY DMPLETED
I		495418	B. WING				6/29/2017
	PROVIDER OR SUPPLIER	REHABILITATION CENTER		194	REET ADDRESS, CITY, STATE, ZIP CODE 8 LANDSTOWN CENTRE WAY RGINIA BEACH, VA 23456	1 00	3/25/2017
(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 356	21, 25, 26, 27, 28 September - 2, 3, 4 20, 21, 24, 25, 26, 3 October - 1, 2, 3, 4 16, 19, 20, 21, 22, 3 November - 1, 4, 5, 16, 17, 19, 20, 23, 3 December - 1, 2, 3,	ws:  (3, 24, 25, 11, 12, 13, 14, 15, 16, 17, 20, 15, 8, 10, 13, 14, 17, 18, 19, 30, 5, 6, 7, 8, 9, 10, 11, 12, 15, 23, 26, 27, 28, 29, 30, 31, 6, 7, 8, 10, 11, 12, 13, 14, 15,	F3	56			
	February - no recor March - 1, 2, 3, 4, 5 15, 19, 28, 29, 30, 3	for the entire month d for the entire month , 6, 7, 8, 9, 10, 11, 12, 13, 14, 31 3, 9, 10, 11, 12, 13, 30					
	conducted with the that the former Staf responsible for kee information records facility. The office w	ipm, an interview was Administrator and she stated fing Scheduler who was bing the nurse staffing no longer worked at the as also moved to another re unable to locate the missing					
	stated, when asked the records of the n 18 months. She sta	om, the Corporate Nurse , that the facility should keep urse staffing information for ted that they have searched t failed to find the missing					

records.

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CENTE	RS FOR MEDICAR	E & MEDICAID SERVICES			OMB NO. 0938-0391
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495418	B: WING		
NAME OF	PROVIDER OR SUPPLIEF			STREET ADDRESS, CITY, STATE, ZIP CODE	06/29/2017
PRINCE	SS ANNE HEALTH &	REHABILITATION CENTER	:	1948 LANDSTOWN CENTRE WAY VIRGINIA BEACH, VA 23456	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORRECT X (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRODEFICIENCY)	LD BE COMPLETION
F 356	(DON) provided a	age 36 pm, the Director of Nursing copy of the facility policy and ed, "General Documents" with	F 3	56	
	an effective date on "(Name of facility of maintains a record General Documen part, "1. The follow be timely implemental part of the state of the st	f 5/1/17. The policy stated, ompany) has established and s retention schedule for ts." The procedure stated, in ing retention schedules are to nted for General Documents: affing Report Form (CMS). (18			
F 425 SS=D	Administrator, DOI made aware of the information was pro-	ARMACEUTICAL SVC -	F 4.	Resident #20 was discharged from the facility.	8/9/17
	pharmaceutical ser that assure the acc dispensing, and ad biologicals) to mee (b) Service Consult	facility must provide vices (including procedures urate acquiring, receiving, ministering of all drugs and the needs of each resident.  ation. The facility must e services of a licensed		Current residents will be reviewe to ensure that medications are available as ordered.  Nurses will be educated on ordering of medications, use of the stat box for newly ordered medications, and reordering of medications.	
	provision of pharma This REQUIREMEI by: Based on a complarecord review and s falled to ensure me	tation on all aspects of the acy services in the facility; NT is not met as evidenced aint investigation, closed staff interview, the facility staff dications were available for ent #20) in the survey sample		The Director of Nursing/Assistant Director of Nursing will complete random weekly audit of availabilit of medications. Issues noted during the audits will be referred to the Quality Assurance Committee for review and	a

recommendation.

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CENTER	<u>RS FOR MEDICARE</u>	& MEDICAID SERVICES			<u>)MB NC</u>	<u>). 0938-</u> 0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		FIPLE CONSTRUCTION  NG		TE SURVEY MPLETED
		495418	B. WING		06	/29/2017
	PROVIDER OR SUPPLIER	REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1948 LANDSTOWN CENTRE WAY VIRGINIA BEACH, VA 23456		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION ( (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROVIDENCY)	D BE	(X5) COMPLETION DATE
F 425	Continued From pa	age 37	F 4	25		
	The findings includ	ed:				
	10/11/16 with diagr hypertension, musc (gastroesophageal	re-admitted to the facility on noses of type two diabetes, cle weakness, GERD reflux disease), and cardio				
		The facility failed to provide ner insulin medication.				
	dated 10/18/16 indicassessed in the are Interview for Mental Indicating no cognit Activities of Daily (/ assessed as requir	ntry Minimum Data Set (MDS) cated this resident was ea of Cognitive Patterns- Brief I Status (BIMS) score as a 15 tive impairment. In the area of ADL) this resident was ing Extensive assistance in the dressing and toilet use.				
	Focus- The resider The resident will be symptoms of hyper	n dated 9/13/16 indicated: at has Diabetes Mellitus. Goal- e free from any sign or glycemia. Interventions- ns as ordered by doctor.				
	lantus SoloStar Sol (insulin Giargine) in	lated 10/11/16 indicated: ution Pen-injector 100 unit/ML sject 25 unit subcutaneously at type 2 Diabetes Mellitus ns.				
	(MAR) for the mont on 10/14/16 at the Resident #20's insu administered as ore	dication Administration Record th of October 2016 indicated 2100 hour (9:00 P.M.) hour ulin medication was not dered. A chart code indicated other see progress notes.				

A Progress Note dated 10/14/16 at 21:59 P.M.

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		THE WILLIAM OF TANKER					MB NO. 0938-0391
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	A. BUILD		CONSTRUCTION		(X3) DATE SURVEY COMPLETED
		495418	B. WING				06/29/2017
NAME OF	PROVIDER OR SUPPLIER			STR	EET ADDRESS, CITY, STATE, 2	IP CODE	1 0012012011
PRINCE	SS ANNE HEALTH & I	REHABILITATION CENTER			B LANDSTOWN CENTRE WA		
				VIR	GINIA BEACH, VA 23456	į	
PREFIX TAG	(EACH DEFICIENCY	NTEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE	TION SHOULD THE APPROP	DBE COMPLETION
F 425	Continued From pa	150 39		,			
1 420		_	F 4	125			
	nursing indicated: "	Lantus SoloStar solution					
	Pen-injector 100 Ur	nit/ML (milliliter) Inject 25 unit					
	subcutanously at be	edtime related to Type 2					
	Diabetes mellitus w	ithout complications. Note					
	Text: On order."	•					
	During an interview	on 6/29/17 at 9:37 A.M. with					
		sing, she stated, the insulin					
		dered because it was not					
	available at the time	"					
	A facility policy for F	Receiving pharmacy products					
	and services from r	pharmacy dated 2013					
		should ensure medications					
	orders include medi	ication name, strength, dose,					
	route frequency in	disation for use the sales					
	modication array in	dication for use (to reduce					
	medication errors) a	and stop order, or					
	administration para	meters, if any."			4		
	TI 6 333 4 66 6 18				A.		}
	The facility staff faile	ed to provide one resident					
	medications as orde	ered by the physician.					
	Complaint Deficience						
F 496	483.35(d)(4)-(6) NU	RSE AIDE REGISTRY	F 49	96			
SS=E	VERIFICATION, RE	TRAINING			CNA#1 is currently certif	ied by the	alala
					Virginia Board of Nursin	g to	911111
	d)(4) Registry verific	ation			practice in the state of \		'   ' '
	-)( -) - 10 3.0 11 3 - 0.1110				processes in the state of v	ııgııııa.	
	Refore allowing an in	ndividual to serve as a nurse			Employee records were	contournal	
	aide a facility must	receive registry verification					
	that the individual ha	s mot compatency custom			to ensure that all CNAs a		
	requirements until	as met competency evaluation			currently certified by the	: Virginia	
	requirements unless	<b>-</b>			Board of Nursing to prac		
	A) The best objects	full firm			state of Virginia or are w		
	(I) I ne individual is a	full-time employee in a					
	training and compet	ency evaluation program			120-day period to obtain	the	
	approved by the Sta	te; or			Virginia certification.		

## DEPARTMENT OF HEATTH AND HIMAN CERVICES

PRINTED: 07/07/2017

		& MEDICAID SERVICES			ORM APPROVE 3 NO: 0938-039	
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI	IPLE CONSTRUCTION (X	(X3) DATE SURVEY COMPLETED	
_		495418	B. WING	70 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 -	06/29/2017	
	PROVIDER OR SUPPLIER  SS ANNE HEALTH & F	REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1948 LANDSTOWN CENTRE WAY VIRGINIA BEACH, VA 23456		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION TE DATE	
F 496	(ii)The individual ca recently successfull competency evalua evaluation program has not yet been individual actually be (d)(5) Multi-State re Before allowing an i aide, a facility must	n prove that he or she has y completed a training and tion program or competency approved by the State and cluded in the registry.  You up to ensure that such an ecomes registered.	F 49	The HR Manager will be educated on reviewing certification upon hire to ensure that certification in the state of Virginia is current or is flagged to alert staff prior to the 120 day requirement.		

(d)(6) Required retraining

If, since an individual's most recent completion of a training and competency evaluation program, there has been a continuous period of 24 consecutive months during none of which the individual provided nursing or nursing-related services for monetary compensation, the individual must complete a new training and competency evaluation program or a new competency evaluation program. This REQUIREMENT is not met as evidenced

(2)(A) or 1919(e)(2)(A) of the Act the facility

believes will include information on the individual.

by:

Based on staff interview and facility document review, the facility staff failed to meet the requirements of the Virginia Board of Nursing Regulations Governing Certified Nurse Aides (CNA) to practice as a CNA in the state of Virginia.

CNA #1 failed to submit the required application by endorsement for an out of state nurse aide certification to the Virginia Board of Nursing to practice as a CNA in the state of Virginia.

The HR Manager will complete a random monthly audit to ensure that CNA staff are currently certified by the Virginia Board of Nursing to practice in the state of Virginia or remain within the 120day period to obtain the Virginia certification. The Regional HR Manager will complete a random quarterly audit to ensure that CAN staff are currently certified by the Virginia Board of Nursing to practice in the state of Virginia or remain within the 120 day period to obtain the Virginia certification. Issues noted during the audits will be referred to the Quality Assurance Committee for review and recommendation.

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CENTE	RS FOR MEDICARI	E & MEDICAID SERVICES				OMB NO	0.0938-0391
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTION	(X3) DA	ATE SURVEY OMPLETED
		495418	B. WING			0.0	6/29/2017
	PROVIDER OR SUPPLIER	REHABILITATION CENTER		194	REET ADDRESS, CITY, STATE, ZIP CODE 18 LANDSTOWN CENTRE WAY RGINIA BEACH, VA 23456		112312011
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 496	On 6/29/17 at appremployee records CNA #1's nurse aid the state of Georgi Registry verification. Human Resources CNA #1's original cand the expiration no Virginia nurse a found on file. CNA On 6/28/17 at 1:05 conducted with the was an oversight of entering the data into enter the correct required certification the system. This has recognize CNA #1's date and conseque updated. She state and according to Coby endorsement for did not pursue to on 6/29/17, CNA #1 phone but there was last attempt to confide 2:15 pm but still un On 6/29/17 at apprent administrator was apolicy for newly hire	roximately 10:00 am, the were reviewed and found that de certification was issued in ita. The Georgia Nurse Aide on record provided by the facility is (HR) Manager stated that certification date was 6/18/04 date was 6/18/18. There was aide registry verification record #1 was hired on 10/19/16.  In pm, an interview was the HR Manager who stated that it on the former HR Manager into the HR system. She failed to information on CNA #1's on due date of 120 days into ad caused the system to not is nurse aide certification due ently, was not flagged to be ently was not flagged		196			
		pm, the Director of Nursing ewed and was asked about the					

facility process on how the facility ensured a

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	TO TOTAL STORY	A MEDIONID OFICEO			_ OMB NO. 0938-0391
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495418	B. WING_		06/29/2017
		REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1948 LANDSTOWN CENTRE WAY VIRGINIA BEACH, VA 23456	1 00/29/2017
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHO (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	DULD BE COMPLETION
F 496	stated that HR usual certification status a Department. In rega status, she stated th	was current and valid. She ally checked the nurse aide and then notified the Nursing ards to CNA #1's certification at she was just informed "an ed that CNA #1 was taken off	F 49	6	
F 514 SS=E	Administrator, DON made aware of the a information was pro 483.70(i)(1)(5) RES RECORDS-COMPL LE  (i) Medical records.	ETE/ACCURATE/ACCESSIB	F 51	4 Resident #5's TAR is currently documented in an accurate manner.	8 9 17
	standards and pract maintain medical red are-	ith accepted professional ices, the facility must cords on each resident that		Residents with orders for TED he were reviewed to ensure that the documentation on the TAR is accurate.	ose ne
	(i) Complete;			Nurses will be educated on	
	(ii) Accurately docum	•		accurate documentation of completion of physician/designe	
	(iii) Readily accessib			orders.	:e
	(iv) Systematically or	ganized		The DON/designee will complete	e a
	(5) The medical reco	ord must contain-		random weekly audit of documentation to ensure that	
	(i) Sufficient information	tion to identify the resident		physician/designee orders are accurately documented. Issues	
	(ii) A record of the re	sident's assessments,		noted will be referred to the	
	(iii) The comprehens provided,	ive plan of care and services		Quality Assurance Committee for review and recommendation.	,

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CENTER	<u>RS FOR MEDICARE</u>	& MEDICAID SERVICES			OMB NO	<u>0. 0938-039</u> 1
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI	TIPLE CONSTRUCTION ING		TE SURVEY
		495418	B. WING		06	5/29/2017
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COI		7/20/2017
DDINCE	S AMNE HEALTH & D	REHABILITATION CENTER		1948 LANDSTOWN CENTRE WAY		
FINITOL	33 ANNE HEALIN & I	CHABIENATION CENTER		VIRGINIA BEACH, VA 23456		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CORR  (EACH CORRECTIVE ACTION S  CROSS-REFERENCED TO THE AF  DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 514	Continued From pa	ge 42	F 5	14		178
	and resident review	ny preadmission screening vevaluations and ducted by the State,				
	(v) Physician's, nurs professional's prog	se's, and other licensed ress notes; and				i
	services reports as	ology and other diagnostic required under §483.50. NT is not met as evidenced				
	Based on observat interview, and clinic staff failed to ensur-	ions, resident interviews, staff al record review the facility e 1 of 25 residents in the cal record was accurate,				ł
	Administration Reco	ailed to ensure the Treatment ord (TAR) for June 2017 was e of TED hose sease stockings) for Resident				
	The findings include	ed:				
	5/11/17 with diagno congestive heart fai (DVT-blood clots) o (inferior vena cava)	Imitted to the facility on ses to include history of lure, deep vein thrombosis f lower extremity with IVC filter placement and diabetes.				
	assessment referer resident as scoring	S (Minimum Data Set) with an nce date of 5/18/17 coded the a 15 out of a possible 15 on or Mental Status indicating the was intact.				

The Physician Order Summary Report included

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CENTER	& MEDICAID SERVICES			OMB NO	0. 0938-0391		
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILD		CONSTRUCTION		TE SURVEY
		495418	B. WING			06	5/29/2017
	PROVIDER OR SUPPLIER	REHABILITATION CENTER		1948	EET ADDRESS, CITY, STATE, ZIP CODE B LANDSTOWN CENTRE WAY GINIA BEACH, VA 23456		
(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	(X5) COMPLETION DATE
F 514	an order dated 5/31 (compression stock lower extremity. If nuse Ace wraps from for edema and rem date was 6/1/17.  On 6/2/17 the resid Nurse Practitioner (bilateral (both) lower weight gain. The piresident's lower ext (1) to both lower leg than the right. The patient states that he compression stocki Of Care included: 1 edema. Venous PV (Peripheral vascula presence of blood opatient has thrombod daily as ordered.  On 6/5/17 the resid NP. The lower extredema, improved from the stock of the state	/17 that read, "TED sings) to be apply to bilateral tot able to tolerate they may notes to knees one time a day ove per schedule". The start the ent was examined by the NP #1) for the swelling of the extremities and continued the hysical exam evidenced the remities had significant edemants with the left being greater NP documented, "the the has not yet received the ngs". Impression and Planta. Bilateral lower extremities in laberature to show for elots). Please make sure the the nembolic disease stockings on the emities had mild to moderate om previous exam on 6/2/17.	F	514			
	compression stocki Impression and Pla Bilateral lower extre congestive heart fai We will increase La (by mouth) b.i.d (tw	d, "He is not wearing ngs at this time". The n Of Care included: 1. mity edema, history of lure. Continue daily weights. six to 40 mg (milligrams) P.O. ice a day). 5. Bilateral lower ontinue thromboembolic is ordered please.					
	On 6/16/17 the resid	dent was re-examined by the					

NP. The NP documented, "He states they are weighing him daily, however, he is not wearing his

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F 514 Continued From page 44 compression stockings today as he states he does not have any at all." "Physical Examination:Extremities:He does have mild pitting edema note to bilateral lower extremities." Impression and Plan Of Care: 1. Bilateral lower extremity edema. Continue daily weights. Please make sure the patients' TED stockings are applied daily as ordered. I did speak with his day nurse, (name of RN #2), today in regard to this and to ensure the patient has compression stockings on daily again.  A physician order dated 6/16/17 read, "Please make sure pt's (patient's) TED hose are applied daily as ordered.  On 6/27/17 at 4:30 p.m., the resident was observed sitting in his room in a wheelchair. The resident was wearing blue socks, and presented with edema to both legs, the left greater than the right. The resident was wearing blue socks, and presented the NP had also questioned him about them.  On 6/28/17 at 10:30 a.m., sitting up in the wheelchair awaiting for therapy. He did not have TED hose on. At 1:00 p.m., the resident was observed in his room, in the bed. The resident did not have TED hose on.  The TAR (Treatment Administration Record) for the month of June 2017 was reviewed. It had an entry for the daily application of the TED hose on at 9 am and the removal of the TED hose on at 9 am and the removal of the TED hose on	CENTEI	RS FOR MEDICARE	E & MEDICAID SERVICES				OI	MB NO. 0938-0391
NAME OF PROVIDER OR SUPPLIER  PRINCESS ANNE HEALTH & REHABILITATION CENTER  (X4 ID)  SUMMARY STATEMENT OF DEFICIENCES  (X4 ID)  PRIERIX  EACH IDENCINCENCY MUST BE DEFICIENCES  TAG  CONTINUED TO BE CONTINUED TO SET OF SE				1, ,		ONSTRUCTION	•	
PRINCESS ANNE HEALTH & REHABILITATION CENTER    1948 LANDSTOWN CENTRE WAY   1948 LANDS			495418	B. WING				06/29/2017
PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX TAG CROSS-REFERNCE TO THE APPROPRIATE DEFICIENCY)  F 514  Continued From page 44 compression stockings today as he states he does not have any at all." "Physical Examination:Extremities:He does have mild pitting edema note to bilateral lower extremities: "Impression and Plan Of Care: 1. Bilateral lower extremity edema. Continue daily weights. Please make sure the patients' TED stockings are applied daily as ordered. I did speak with his day nurse, (name of RN #2), today in regard to this and to ensure the patient has compression stockings on applied daily again.  A physician order dated 6/16/17 read, "Please make sure pt's (patient's) TED hose are applied daily as ordered.  On 6/27/17 at 4:30 p.m., the resident was observed sitting in his room in a wheelchair. The resident was wearing blue sooks, and presented with edema to both legs, the left greater than the right. The resident was asked about the TED hose. He stated, 'I never got those.' He stated the NP had also questioned him about them.  On 6/28/17 at 10:30 a.m., sitting up in the wheelchair awaiting for therapy. He did not have TED hose on. At 1:00 p.m., the resident was observed in his room, in the bed. The resident did not have TED hose on. At 1:00 p.m., the resident was observed in his room, in the bed. The resident did not have TED hose on at 9 am and the removal of the TED hose on at 9 am and the removal of the TED hose on at 9 am and the removal of the TED hose on at 9 am and the removal of the TED hose on at 9 am and the removal of the TED hose on the presented the presented the presented the removal of the TED hose on at 9 am and the removal of the TED hose on the presented the presented the presented the removal of the TED hose on at 9 am and the removal of the TED hose on the presented the presented the presented the presented the presented the presented the treatment and presented the					1948	LANDSTOWN CENTR	E WAY	
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evening at 9 pm. Each day from 6/1/17 through 6/28/17 the day shift nursing staff had initialed	F 514	compression stock does not have anyExtremities:He note to bilateral low and Plan Of Care: edema. Continue do sure the patients' Tas ordered. I did spof RN #2), today in the patient has conagain.  A physician order do make sure pt's (patient) as ordered. On 6/27/17 at 4:30 observed sitting in resident was wearing with edema to both right. The resident hose. He stated, "It the NP had also quered on 6/28/17 at 10:30 wheelchair awaiting TED hose on. At 1 observed in his roodid not have TED heart y for the daily a at 9 am and the rerevening at 9 pm. E	cings today as he states he at all." "Physical Examination: does have mild pitting edema ver extremities." Impression 1. Bilateral lower extremity laily weights. Please make ED stockings are applied daily beak with his day nurse, (name regard to this and to ensure appression stockings on daily lated 6/16/17 read, "Please tient's) TED hose are applied p.m., the resident was his room in a wheelchair. The applied socks, and presented allegs, the left greater than the was asked about the TED in ever got those". He stated destioned him about them.  10 a.m., sitting up in the ground for the the application of the TED hose on moval of the TED hose every each day from 6/1/17 through	F5	i14			

that the TED hose were applied, to include RN#2 initials. The evening shift nursing staff signed that the TED hose were removed twenty two out

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CENTERS FOR MEDICARE & MEDICAID SERVICES							MB NO. 0938-0391	
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
		495418	B. WING			06/	/29/2017	
NAME OF PROVIDER OR SUPPLIER PRINCESS ANNE HEALTH & REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZI 1948 LANDSTOWN CENTRE WA VIRGINIA BEACH, VA 23456	ATE, ZIP CODE RE WAY		20/2017	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		TON SHOULD THE APPROPE	BE	(X5) COMPLETION DATE	
F 514	On 6/28/17 at 3:50 She was asked how hose are on Resider goes into the room asked if the resider stated, "Yes, when RN #2 had initialed TED hose were on, RN #2 went to the rwas not wearing an about the TED hose never got them". Rin the resident's room stored somewhere, found. The RN and resident's room. RI were available in the RN #2 then went in Stored inside the suplastic bin containing stockings of various of TED hose and a tape to measure the ensure for proper si resident's room.  On 6/28/17 the about the Director of Nurs Nursing and the Co The facility staff failed Plan of Care for the and inaccurately do	p.m., RN #2 was interviewed. v does she ensure the TED ent #9. She stated when she she checks for them. When at had on TED hose today she I went in there they were on". on the TAR for today that the when in fact they were not. resident's room, the resident by TED hose. RN #2 inquired and the Resident stated, "I N #2 then checked all drawers om to ensure they were not there were no TED hose this surveyor then left the N #2 was asked if TED hose building, she stated, "Yes". to the medical supply room. upply room on a shelf with a ng multiple TED hose s sizes. RN #2 grabbed a pair disposable paper measuring e resident's calf and leg to ize. The RN then went to the ve findings was shared with ing, the Assistant Director of	F 5	114				

1. Edema-A local or generalized condition in

use.

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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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NAME OF PROVIDER OR SUPPLIER PRINCESS ANNE HEALTH & REHABILITATION CENTER				1948	ET ADDRESS, CITY, LANDSTOWN CEI GINIA BEACH, V	NTRE WAY			
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v a	amount of tissue flu	nge 46 ues contain an excessive uid. (Source Taber's I Dictionary Edition 20).	F	514					