

COMMONWEALTH of VIRGINIA

Department of Health

Marissa J. Levine, MD, MPH, FAAFP State Health Commissioner

Office of Licensure and Certification

TYY 7-1-1 OR 1-800-828-1120 9960 Mayland Drive, Suite 401 Henrico, Virginia 23233-1485 Fax (804) 527-4502

June 27, 2017

Ms. Karen Pohl, Administrator Newport News Nursing & Rehab 12997 Nettles Drive Newport News, VA 23602

RE:

Newport News Nursing & Rehab

Provider Number 495340

Dear Ms. Pohl:

An unannounced standard survey, ending June 15, 2017, was conducted at your facility by staff from the Virginia Department of Health's Office of Licensure and Certification (the State Survey Agency) to determine if your facility was in compliance with Federal long term care participation requirements for the Medicare and/or Medicaid programs and, if applicable, State licensure regulations. Five complaints were investigated during the survey. One complaint was substantiated, with deficiencies. One complaint was substantiated, with no deficiencies.

All references to regulatory requirements contained in this letter are found in Title 42, Code of Federal Regulations.

Survey Results

The results of this survey are reflected on the enclosed Statement of Isolated Deficiencies, "A" Form and/or the Statement of Deficiencies and Plan of Correction, CMS 2567. All survey findings generated on these forms (including the most recent standard survey and any subsequent revisits or complaint investigations) constitute the facility's current survey report. In accordance with §483.10(g), the current survey report must be made available for examination in a place readily accessible to residents and is disclosable to all interested parties.





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This survey found that your facility was not in substantial compliance with the participation requirements. The most serious deficiency in your facility was a pattern deficiency that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy (S/S of E), as evidenced by the attached CMS-2567L, whereby corrections are required.

Plan of Correction (PoC)

A PoC is not required for deficiencies cited on the Statement of Isolated Deficiencies, "A" Form. Nevertheless, the facility is expected to address and correct all areas of concern noted on this form.

Unless specifically otherwise indicated, a PoC for all certification and licensure deficiencies cited on the Statement of Deficiencies and Plan of Correction (CMS-2567) must be submitted within ten (10) calendar days of receipt of these survey findings to Elizabeth Hudnall, LTC Supervisor, at: Office of Licensure and Certification, Division of Long Term Care Services, 9960 Mayland Drive, Suite 401, Richmond, Virginia 23233.

-If-you-are-participating-in-ePOC, please-submit-your-Plan of Correction through the ePOC website.

To be considered acceptable, the PoC must:

- 1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;
- 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice;
- 3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;
- 4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; and
- 5. Include dates when the corrective action will be completed. (The "outside" date by which all corrections must be made is the 45th calendar day after the survey ended.)

The PoC will serve as the facility's allegation of compliance. If an acceptable plan is not submitted, the State Survey Agency may propose to the Center for Medicare and Medicaid Services (CMS) Regional Office and/or the State Medicaid agency that remedies be imposed immediately within applicable notice requirements.

Informal Dispute Resolution

Following the receipt and review of your survey report, please contact the assigned supervisor to attempt to resolve any problems or concerns you may have about the citations. If those concerns are not resolved, in accordance with §488.331, you have one opportunity to question cited federal certification deficiencies through the Office's Informal Dispute Resolution Process, which may be accessed at "http://www.vdh.state.va.us/OLC/longtermcare/".

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To be given such an opportunity, you are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to: Director, Division of Long Term Care, Office of Licensure and Certification, 9960 Mayland Drive, Suite 401, Richmond, Virginia 23233. To be considered, the IDR request must follow the IDR guidelines and be received at the Office within 10 calendar days of your receipt of the enclosed survey findings.

An incomplete informal dispute resolution process will not delay the effective date of the imposition of any enforcement actions.

Recommended Remedies

Based on the deficiencies cited during the survey, under Subpart F of 42 CFR Part 488 the following remedies may be imposed by the Centers for Medicare and Medicaid Services (CMS) Regional Office and/or the State Medicaid Agency (DMAS):

- Pursuant to §488.408(c)
 - Directed Plan of Correction (PoC) (§488.424).
 - State monitoring (§488.422).
 - Directed In-Service Training (§488.425).
- Pursuant to §488.408(d)
 - Denial of payment for new admissions (§488.417).
 - Denial of payment for all individuals (§488.418).
 - Civil Money Penalty, \$50 \$3,000 per day (§488.430, §488.438), effective on the survey ending date,
- Civil money penalties of \$1,000 \$10,000 per instance of noncompliance.

Informal dispute resolution for the cited deficiencies will not delay the imposition of the enforcement actions recommended (or revised, as appropriate). A change in the seriousness of the noncompliance may result in a change in the remedy selected. When this occurs, you will be advised of any change in remedy.

Please note: This survey cover letter does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services or the Virginia Department of Medical Assistance Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination. If you do not achieve substantial compliance within three (3) months after the last day of the survey identifying noncompliance, §488.417(b) requires the denial of payment for new Medicare or Medicaid admissions. If substantial compliance is not attained within six months from the last day of the survey, §488.412(b) provides that "CMS will and the State must terminate the facility's provider agreement."

Please be advised: The facility must maintain compliance with both the Health and the Life Safety Code requirements in order to continue provider certification.

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Survey Response Form

The Survey Response Form is offered as a method to share your review of the onsite survey process. Please take a moment to complete this evaluation, which is available at:

"http://www.vdh.virginia.gov/OLC/Downloadables/documents/2011/pdf/LTC%20facility%20survey%20respon se%20form.pdf". We will appreciate your participation.

If you have any questions concerning this letter, please contact me at (804) 367-2100.

Sincerely,

Elizabeth Hudnall, LTC Supervisor

Division of Long Term Care

Enclosure

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Joani Latimer, State Ombudsman

Joann Atkins, Dmas (Sent Electronically)

PRINTED: 06/27/2017 FORM APPROVED OMB NO. 0938-0391

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survey Five co survey with 42	y was conduc complaints we y. Correction	Medicare/Medicald standard ted 06/13/17 through 6/15/17 re investigated during the sare required for compliance 83 Federal Long Term Care		Preparation and submission of this plan not constitute and admission, or agreer of the truth or the facts alleged or the co conclusions set forth on the statement of plan of correction is prepared and subm of the requirements under State and Fe	nent by the provider, orrectness of the of deficiencies. The nitted solely because
the tim consis (Resid review F 157 483.10 SS=D (INJUF (g)(14) (i) A fa consul consis repres (A) An results physic (B) A s menta deteric status clinical	ne of the survisted of 16 curdents #1 throused (Residents 90 (g)(14) NOT RY/DECLINE 1) Notification acility must imply the sentative (s) was in injury and clan interventive (significant chall, or psychosoration in health of the signification in the significatio	mediately inform the resident; ident's physician; and notify, or her authority, the resident hen there is- plying the resident which has the potential for requiring on; ange in the resident's physical, ocial status (that is, a lth, mental, or psychosocial threatening conditions or	F 15	 Resident #1 physician was notified urine analysis results. Resident #21 was discharged from facility on 2-3-2017 A quality monitoring tool was compon 6-27-2017 to identify any resid for an urinalysis and to identify any resident who have had a changin condition in the last 30 days. Director of nursing or designee edu on policy and procedure for notifyl of urine analysis results and notifyl on change of conditions. The director of clinical services or d Nurses notes, SBAR's and physician quality monitor to be performed3 the weeks on each shift to ensure con Notification of physician and resportant time weekly for one month then contact the contact was a supportant to the contact was a supportant time weekly for one month then contact was a supportant to the con	the pleted ent's with an order ge cated staff ng physician ng responsible party esignee to monitor orders daily and a cilmes per week for mpliance with usible party and then
a need treatm	d to disconting nent due to ac	ue an existing form of verse consequences, or to orm of treatment); or		The results of the quality monitoring meeting for review, analysis and fu 5. A.O.C. is July 18,2017	g to be discussed at QAPI irther recommendations,

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

TITLE

(X6) DATE

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

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F 157		page 1 transfer or discharge the facility as specified in	F	157			-
	(14)(i) of this sect	notification under paragraph (g) ion, the facility must ensure that mation-specified-in-§483.15(c)(2)-rovided upon request to the			· · · · · · · · · · · · · · · · · · ·		
	physician.	ust also promptly notify the					
		resident representative, if any,					
	(A) A change in ro as specified in §4	oom or roommate assignment 83.10(e)(6); or			- -		
`.		esident rights under Federal or lations as specified in paragraph ction.	•				
	update the addre- phone number of	ust record and periodically ss (mailing and email) and the resident representative(s). ENT is not met as evidenced					
	Based on clinica and facility policy notify the physicia require a need to to deal with a me (Resident #1) and Representative or	I record review, staff interviews review, the facility staff failed to an of a condition that would commence a medical treatment dical problem for 1 resident d failed to notify the Resident f a change in condition for 1 nt #21) in the survey sample of	:				
	regarding the res	ff falled to notify the physician ults of a Urine Analysis/Culture at had resulted in a urinary tract					

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 06/27/2017 FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING 495340 B. WING 06/15/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 12997 NETTLES DRIVE NEWPORT NEWS NURSING & REHAB NEWPORT NEWS, VA 23602 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION ID (X5) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX COMPLETION REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) F 157 Continued From page 2 F 157 infection that required immediate physician intervention for Resident #1. 2. The facility staff failed to notify the Resident Representative of a change in condition requiring physician intervention for Resident #21. The findings include: 1. Resident #1 was admitted to the nursing facility on 6/21/16 with diagnoses that included but was not limited to osteoporosis, chronic pain, joint stiffness and high blood pressure. The most recent Minimum Data Set (MDS) was a Significant Change in Status assessment dated 6/9/17 and coded the resident with a score of 3 out of a possible score of 15 on the Brief Interview for Mental Status (BIMS) which indicated the resident was severely impaired in the skills for daily decision making. The resident required extensive assistance from two staff for bed mobility and transfers. She required extensive assistance of one staff for locomotion on and off the unit, dressing, eating and personal hygiene. The resident was totally dependent on two staff for bathing. The resident was assessed frequently incontinent of bowel and bladder,

The care plan dated 2/9/17 identified Resident #1 had a Urinary tract Infection and antibiotics were initiated on 2/10/17. Isolation precautions were initiated due to *ESBL infection in the urine.

*ESBL (Extended Spectrum Beta-Lactamase) are Gram-negative bacteria that produce an enzyme; beta-lactamase that has the ability to break down commonly used antibiotics, such as penicillins and cephalosporins and render them ineffective

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F 157	Continued From pa for treatment. www.health.gov.nl.c xtended_spectrum_	ca/health/publichealth/cdc//e	F	157			
	bacteria require cor	beta-lactamase-producing stact isolation practices					
	the spread of these potentially cause life Recommendations Control and Preven isolation practices a care system.	nealth-care facility to prevent bacteria, which can e-threatening infections. from the Centers for Disease tion are discussed, including tilized at a multihospital health			- ,		
	indicated "MD awar order for IVANZ 1 G (QD) X (times) 7 da	ated 2/10/17 2:29 a.m. e of results from UTI, gave fram with lidocalne every day ys and she is to be on ains ESBL in the urine."				-	•
	*4VANZ IM (Intramu and the resident wa precautions. The la	dated 2/10-19/17 indicated the scular) was administered daily s maintained on contact st dose of antibiotic was 9/17 and contact precautions 2/19/17.			<u>-</u>	-	·
	certain serious infections and urinary tract, skilled gynecological, pelvicarea) infections, that Ertapenem is in a coarbapenem antibio bacteria. Ertapenem to be mixed with liquintravenously (into a	c, and abdominal (stomach it are caused by bacteria. lass of medications called itics. It works by killing in injection comes as a powder					

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F 157	day intramuscularly of treatment dependence the being treated.	for up to 7 days. The length ds on the type of infection	F	157			
	be located in the ele	4/17 the lab results could not ectronic record, or in the			<u>.</u>	*	
	-physician's commu	nication-binders.					
	Nursing (DON) stat laboratory company UA/C&S. Upon revithe urine sample wareported to the facil Urinary Tract Infecti ESBL resistance du B-Lactamase. Ther validate action on the 2/10/17. The DON's investigate why the	1:00 p.m., the Director of ed she had to call the to obtain a copy of the ew of the results, it Indicated as collected on 1/31/17 and ity on 2/2/17 that resulted in a on (UTI) *Escherichia Coli, e to Extended Spectrum e were no nurse's notes to his abnormal lab result until stated she would have to delay in treatment and delay precautions for ESBL in the					
	commonly found in carried in feces (http://www.mayocli	coli), a type of bacteria the gastrointestinal (GI) tract nic.org/diseases-conditions/uri pasics/causes/CON-2003789				-	
	presented further in in treatment for the the lab called and s Nurse (LPN) #1 to r ESBL/Ecoli of urine lab called the facility the lab. Lab reporte	eximately 10:00 a.m., the DON formation regarding the delay UTI: "On 2/1/17 at 12:15 p.m., coke to Licensed Practical eport urine result of On 2/2/17 at 11:03 a.m., the v and no pick up reported by d they got a voicemail. On urine was faxed by the lab to				-	

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILD		ONSTRUCT	ON		(X3) D	O. 0936-0391 ATE SURVEY OMPLETED
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F 157	had no name of the information. On 2/1 the ESBL infection solution 1 gram IM	ge 5 lab had called the facility. Lab nurse that requested the 0/17 orders were obtained for in the Urine for INVANZ at hour of sleep times 7 days. htinued on 2/20/17." The DON	F	157					
	stated it was the late and abnormal labs physician's immedia she spoke to LPN # failed to follow throughysician to inform obtain further order. lab that was reaching staff and physician expectation that the physician to inform immediate attention physician was called orders and place in communication bind the above was done made contact with the failure of the LPN to abnormal labs delay days and immediates.	ps protocol to call all critical results over that need a late attention. The DON stated and all all critical results over that need a late attention. The DON stated and it was determined she ligh on contacting the him of the abnormal labs and is. The DON stated it was the ligh out for action by the nursing. She stated it was her nurse immediately call the him of any abnormal labs for write on the lab slip, the did with date and time, any the perspective physician's lier. The DON stated, none of a lab he physician. She stated in call the physician with the lab he call the physician with the lab lab late of the lab he physician she stated in call the physician with the lab lab late of the lab l		-					
	called Resident #1's remembered anythit treatment for the ES had any progress not the UA/C&S the phand could not recall sample.	p.m., the DON stated she physician to see if she ng about why the delay in SBL infection, and to see if she otes as to why she ordered ysician had no progress notes why she ordered the urine			-				
	i ne tacility's Policie "Change in Resider	s and Procedures subject: t Condition" with effective							

PRINTED: 06/27/2017 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING 495340 B, WING 06/15/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 12997 NETTLES DRIVE **NEWPORT NEWS NURSING & REHAB** NEWPORT NEWS, VA 23602 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETION DATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX : PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 157 Continued From page 6 F 157 date of 11/30/14 read, in part: Policy: The Clinical Nurse will recognize and appropriately intervene in the event of a change in resident condition. The Physician/Family/Responsible Party will be notified as soon as possible. Procedure:...The Physician/Family/Responsible Party will be notified as soon as possible include but not limited to significant change. accident/incident, change in treatment, transfer, D/C (discharge)...Notification of the Physician and agent/surrogate/ contact person of a significant change in status shall routinely occur during the shift in which it occurs. On 6/15/17 at 3:00 p.m., during the pre-exit meeting with the Administrator and the DON, no further information was provided to the survey team. 2. The facility staff failed to notify the Resident Representative of a change in condition requiring physician intervention for Resident #21. During a complaint investigation the complainant alleged the facility staff failed to notify the Responsible Representative (RR) of a change in condition that occurred on 2/2/17.

Resident #21 was admitted to the facility on 12/16/16 for skilled services. The resident's diagnoses include, but were not limited to recent history of a brain aneurysm (1) status post clipping, subsequent functional quadraplegia (2), tracheostomy (3) and sacral pressure ulcer.

The admission MDS (Minimum Data Set) with an assessment reference date coded the resident as

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F 157 (Continued From pa	ae 7	. 🖫 1	157				
		ort term memory deficits. The	1 1	157				
r	esident was coded fressings, oxygen a	as receiving applications of						
		s dated 2/2/17 and timed for art: "CNA (Certified Nurse						
		atient was warm to touch.	-			<u> </u>		-
Ĺ	Jpon checking vital	s: Temp 101.6, BP 141/80,						
		d sugar 136Called on call				•		- 2
(name). At 11:15 pi	m, the nurse then			₩-		•	* *
, ,	ocumented, "vviii p lurse Practitioner/	out in all orders per (name of NP)."				* · · · · · · · · · · · · · · · · · · ·		
· -T	he ND ordered as	tat chest X-ray, complete				-		
	lood count, and a		-				_	• • • =
Т	he complainant all	eged that on 2/3/17 she and			,			
. 0	ther family had vis	ited with the resident and left			* *			
		iring that time the new unit				•		1 1
		the resident's room and	-					
11	ntroduced hersell, Apparend concorni	The complainant stated she sof the sacral wound odor.					-	
		formed her that the resident's						-
		ng to be taken, due to the					-	
		a fever the night before. The						
F	R was asked by th	ne unit manager if someone						
h	ad called to notify	her of this, she stated no.						
-					•		• •	
		mentation in the clinical record	i					
		oonsible Representative was ent's change in condition on						-
		hat required physician	•			•		
		nge in treatment. At 3:45 pm	•					
.0	n 2/3/17 after the I	ab results were received,						
		ed to send the resident out for						
		m evaluation, at which time						
	ne RR was notified o the hospital.	. The resident was admitted						٠

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F 157 Continued From p	page 8	F 1	57				
	rector of Nursing was	I" I	37				
interviewed. The	above findings was shared.		-				
She was asked if	the facility staff should have						• •
riotified the RR of	the resident's change in						:
condition the nigh	t of 2/2/17. The DON nodded			-			
her head "yes" an	d stated, "It was a change in			_			
eondition".							=
The facility's Polic	ies and Procedures subject:						-
"Change in Reside	ent Condition" with effective						
date of 11/30/14 re	ead, in part:				•		
				•			
Policy: The Clinica	ll Nurse will recognize and				•		,
appropriately inter	vene in the event of a change				-		
in resident condition							
notified as soon as	Responsible Party will be						
notified as soon as	s possible.						
Procedure:The F	Physician/Family/Responsible	-			•		
Party will be notifie	ed as soon as possible include		-		•	•	
but not limited to s	ignificant change.						
accident/incident,	change in treatment, transfer,					-	
D/C (discharge)I	Notification of the Physician and					=,	
agent/surrogate/ c	ontact person of a significant				•		
shift in which it occ	hall routinely occur during the				•		
STITE III WHICH IE OCC	, uis.			• .			
The above finding	s was shared with the						
Administrator, the	Director of Nursing and the			•			
Corporate Nurse d	uring a pre-exit meeting					•	
conducted on 6/15	/17 at 1:30 pm.						
					•		ļ
1 Anguryam Laga	lized abnormal dilatation of a						_
blood vessel usus	illy an artery due to an						
congenital defect of	or weakness of the vessel.		-				
(Source-Taber's C	volopedic Medical Dictionary						

2. Quadraplegia-Paralysis of all four extremities.

Edition 20.)

<u> </u>	TO I OIT WILDIOAITE	A MILDIOAID SERVICES	,		· U	MB NO. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495340	B. WING			C 06/15/2017
NAME OF I	PROVIDER OR SUPPLIER		·	S.	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00/10/2011
NEWPO	RT NEWS NURSING 8	REHAB		l	2997 NETTLES DRIVE IEWPORT NEWS, VA 23602	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	IX	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETION
F 157	Edition 20.) 3. Tracheostomy- T trachea to provide a (Source-Taber's Cy Edition 20.)	clopedic Medical Dictionary, the surgical opening of the and secure an airway. clopedic Medical Dictionary,		157	· · · · · · · · · · · · · · · · · · ·	
F 164 SS=D	PRIVACY/CONFIDE 483.10 (h)(l) Personal prival medical treatment, communications, promeetings of family a does not require the room for each resident has of personal and me provided at §483.70(i)(2) or oth laws. §483.70 (i) Medical records. (2) The facility musinformation contain regardless of the forecords, except when the provided at personal medical records.	has a right to secure and all and medical records. the right to refuse the release dical records except as er applicable federal or state to the the resident's records, rm or storage method of the en release is- or their resident re permitted by applicable law;	:	3. 4.	Registered nurse #2 was educated on 6-16-20 on the policy of providing privacy. Any resident of the facility has the potential to Director of nursing or designee educated staff policy and procedure for providing privacy. The director of clinical services or designee to staff providing privacy and a quality monitor to performed 3 times per week for 4 weeks on e shift to ensure compliance with providing privation 1 time weekly for one month then quarterly the time weekly for one month then quarterly the The results of the quality monitoring to be dismeeting for review, analysis and further record. A.O.C. is July 18,2017	monitor o be ach acy, nereafter.
	(ii) Required by Lav	V' ₁				

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 06/27/2017 FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING COMPLETED С 495340 B. WING 06/15/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 12997 NETTLES DRIVE **NEWPORT NEWS NURSING & REHAB** NEWPORT NEWS, VA 23602 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) COMPLETION PREFIX (EACH CORRECTIVE ACTION SHOULD BE **PREFIX** REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) F 164 Continued From page 10 F 164 (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164,506: (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164,512. This REQUIREMENT is not met as evidenced bv: -Based on observation, staff interview and clinical record review the facility staff failed to provide privacy during the provision of care for 1 of 23 residents in the survey sample. Resident #3. The facility staff failed to close the door completely and pull the privacy curtain during a dressing change for Resident #3. The findings included: Resident #3 was admitted to the facility on 8/29/16 with diagnosis to include, but not limited to; a stage III pressure ulcer to the right outer ankle (1). The current MDS (Minimum Data Set) with an assessment reference date of 4/5/17 coded the

resident as scoring a 13 out of a possible 15 on the Brief Interview for Mental Status, indicating

The physician's orders dated 6/5/17 included a treatment to cleanse the right outer ankle pressure ulcer with normal saline, apply silver

the resident's cognition was intact.

SISTEMENT OF DEPICIENCIES AND PLAN OF CORRECTION (X3) PART SURVING AND PLAN OF CORRECTION (X4) PLAN OF CORRECTION (X5) DATE SURVING COMPLETED C C 06/15/2012 MAND PLAN OF CORRECTION (X5) DATE SURVING COMPLETED C C 06/15/2012 MAND PLAN OF CORRECTION (X5) DATE SURVING COMPLETED C C 06/15/2012 STREET ADDRESS, CITY, STATE JEP CODE 12997 NETTILES DRIVE NEWPORT NEWS NURSING & REHAB (X5) DATE SURVING COMPLETED C C 06/15/2012 12997 NETTILES DRIVE NEWPORT NEWS, VA 23602 (X6) DATE SURVING COMPLETED C C 06/15/2012 12997 NETTILES DRIVE NEWPORT NEWS, VA 23602 FREGULATORY OR LISC IDENTIFYING INFORMATION) F 164 Continued From page 11 hydrogel and a protective dressing once a day. The right ankle dressing change observation was conducted on 6/14/17 at 3:30 pm. The nurse was Registered Nurse #Z. The resident was sitting in a wheelchair, the nurse failed to close the resident door completely and failed to pull the privacy curtain. The observation of failing to provide privacy with closing the door and curtains was shared. The nurse stated, "Yes", when saked if the resident should have been provided privacy. The above observation was shared with the Administrator, the Director of Nursing and the Corporate Nurse stated the facility did not have a policy and provided a phina Performance Improvement audit titled "Dignly & Privacy" revised 3/2014, Question #31 zead, is resident's privacy maintained when doctor, nurse, or staff provide care, or others visit. 1. Stage III Pressure Ulcer-Full thickness tissue loss, Subclueneous fat may be visible but bone, tendon or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May houlded undermining and turneling, (Source: MDS Version 3.0) F 167 F 167 F 167 F 167			A MEDICAID SERVICES						MB NO	<u>. 0938-</u> 0	0391
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NEWPORT NEWS NURSING & REHAB 12997 NETTLES DRIVE NEWPORT NEWS, VA 23602	NAME OF	PROVIDER OR SUPPLIER	<u> </u>		STRE	ET ADDRESS, C	ITY STATE ZIP (CODE	1 06/	15/201	
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provide care, or others visit. 1. Stage III Pressure Ulcer-Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling. (Source: MDS Version 3.0) F 167 483.10(g)(10)(i)(11) RIGHT TO SURVEY F 167		resident door comp privacy curtain. The bed. After the dressing of interviewed. The old privacy with closing shared. The nurse of the resident should. The above observed Administrator, the Exportate Nurse duconducted on 6/15/requested for the properties of the p	letely and failed to pull the e resident's roommate was in change the nurse was poservation of failing to provide the door and curtains was stated, "Yes", when asked if have been provided privacy. Ition was shared with the Director of Nursing and the uring a pre-exit meeting 17 at 1:30 pm. A policy was rovision of privacy during care. Se stated the facility did not rovided a blank Performance titled "Dignity & Privacy" estion #13 read, Is resident's								
(a)(10) The resident has the right to-		1. Stage III Pressur- loss. Subcutaneous tendon or muscle is present but does no loss. May include u (Source: MDS Versi 483.10(g)(10)(i)(11) RESULTS - READII	e Ulcer-Full thickness tissue fat may be visible but bone, not exposed. Slough may be of obscure the depth of tissue ndermining and tunneling. ion 3.0) RIGHT TO SURVEY LY ACCESSIBLE	•	67			- - - 			-

PRINTED: 06/27/2017 FORM APPROVED OMB NO. 0938-0391

		I WILDIOAID SERVICES						
	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED	
		495340	B. WING			004		
NAME OF	PROVIDER OR SUPPLIER	I		ST	REET ADDRESS, CITY, STATE, ZIP CODE	1 06/1	5/2017	
					997 NETTLES DRIVE			
NEWPO	RT NEWS NURSING 8	REHAB						
·				NE	EWPORT NEWS, VA 23602			
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F 167	Continued From pa	ge 12	F 1	67				
	of the facility condu- surveyors and any prespect to the facilit	-		1. 2. 3.	Survey results for the past three years so were made readily accessible on 6-16-20 and notice is posted in facility. Any resident of the facility has the poten Staff educated on 6-16-2017 that survey	117 tlal to be affer results	cted.	
	(g)(11) The facility r	nust			For the past three years must be readily	accessible		
	and family members residents, the result the facility. (ii) Have reports with certifications, and correspecting the facility years, and any plan	eadily accessible to residents, is and legal representatives of its of the most recent survey of the respect to any surveys, complaint investigations made by during the 3 preceding of correction in effect with y, available for any individual est; and		 4. 5. 	and posted and on location of the surve The executive director or designee to m that the posting is readily accessible and and a quality monitor to be performed 3 for 4 weeks on each shift to ensure comp survey results being readily accessible an 1 time weekly for one month then quart The results of the quality monitoring to meeting for review, analysis and further A.O.C. is July 18,2017	onitor posted in faci times per wee pliance with d posted erly thereafter pe discussed a	ek r. at OAPI	
	(iii) Post notice of th areas of the facility accessible to the pu	e availability of such reports in that are prominent and blic.				Pr.		
	information about co This REQUIREMEN by: Based on observati facility staff failed to	not make available identifying omplainants or residents. IT is not met as evidenced ons and staff interview, the post the past three years of acted by Federal or State			• • • • • • • • • • • • • • • • • • •	-		
	The findings include	d:						
	06/13/17 through 06	Observations of the facility on 1/15/17 the facility staff failed						

past three years survey results readily accessible

<u> </u>	TO TOTT WEDIOTALE	A MEDIONID OLIVIOLO					ON	IB NO.	0938-0391
STATEMENT AND PLAN C	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		E CONSTRUCTION		- 1	(X3) DATE	SURVEY
		495340	B. WING					06/1	5/2017
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F 167	Continued From pa	ge 13	F1	167					
	to residents and the	public. A review of the survey	, ,						
		ed by the facility, contained							
		results. There were no notice						-	***
		ecent past three years of the						-	*.
		ilts could be located for							_
	examination.	and bo located to			• • •				
70 WY 1900	-	-							· ·
	During an interview	on 06/15/17 at 1:25 P.M. with							
		he stated I have not been			-				
	here but for a few m	nonths. The Administrator				-			. *
		20 minutes to produce three					-	-	
		y results. When told the	•						-
	survey results did no	ot include the posting of							-
-	where the past three	e years survey results could							
		d, "I will need to look through						ts.	
	the files."	-					•		
	k _o re .					•			
_	meta i su itto i i i es e it								
	I ne racility staff falls	ed to have the survey results							
F 000		ars posted for examination.							
F 226	483.12(b)(1)-(3), 48	(3.95(c)(1)-(3)	F 2	226	•				
SS=E	POLICIES	NT ABUSE/NEGLECT, ETC							
	FOLIGIES -								
	483.12	÷		* .					-
		develop and implement							
	written policies and	procedures that:			•				
	TOTAL POROTO CAME	production that							
	(1) Prohibit and prev	vent abuse, neglect, and							
	exploitation of residence	ents and misappropriation of							
	resident property,	The state of			-				
	• • • •		-						.
	(2) Establish policie	s and procedures to							
	investigate any such	n allegations, and							
	· · · · ·	-			*				
		as required at paragraph							· [
	§483.95,								ļ

	<u>, , , , , , , , , , , , , , , , , , , </u>	CONTRACTOR OF CONTRACTOR				OND NO. US	38-U397
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		E CONSTRUCTION	(X3) DATE SU COMPLE	
		495340	B. WING			C 06/15/	2017
NAME OF F	ROVIDER OR SUPPLIER			S.	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00/13/	2017
NEWPOF	RT NEWS NURSING 8	к КЕНАВ		12	2997 NETTLES DRIVE IEWPORT NEWS, VA 23602		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	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 CO	. (X5) DMPLETION DATE
	the freedom from a requirements in § 4 provide training to t	ge 14 and exploitation. In addition to buse, neglect, and exploitation 83.12, facilities must also heir staff that at a minimum	F2	226	Director of human resources educated on on the policy and procedure the abuse pr		
	educates staff on-				for screening of new hires.		
	exploitation, and mi property as set forth (c)(2) Procedures for neglect, exploitation resident property (c)(3) Dementia ma prevention. This REQUIREMEN by: Based on employe interview and facility staff failed to impler	constitute abuse, neglect, sappropriation of resident at § 483.12. or reporting incidents of abuse, and or the misappropriation of an agement and resident abuse. It is not met as evidenced as personnel file reviews, staffly document review the facility ment their abuse prohibition ares for screening of new hires.		 2. 3. 4. 5. 	Any resident of the facility has the potential to be affected. Quality monitoring tool was completed or hires in last 30 days To ensure compliance with policy and proprescreening new hires. The executive director or designee to mothat all new hires will have prescreening dand a quality monitor to be performed 3 tfor 4 weeks on each shift to ensure complail new hires having prescreening complet 1 time weekly for one month then quarter The results of the quality monitoring to be meeting for review, analysis and further A.O.C. is July 18,2017	cedure on nitor one per policy imes per week lance with ed ly thereafter. e discussed at Q	
	The findings include	ed:				_	
	personnel files were employees the crim (CBC) were not obt follows: 1. CNA (Certified N 3/27/17-CBC scree	inal background checks ained prior to orientation as urse Aide) hired on ning was done on 6/14/17. e (RN) hired on 4/11/17-CBC					
		d employees licensure obtained prior to orientation					

PRINTED: 06/27/2017 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING 495340 B. WING 06/15/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 12997 NETTLES DRIVE **NEWPORT NEWS NURSING & REHAB** NEWPORT NEWS, VA 23602 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION ÌD (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DATE DEFICIENCY) F 226 Continued From page 15 F 226 1. Licensed Practical Nurse (LPN) hired on 5/23/17 not verified until 5/27/17. 2. CNA hired on 3/13/17 not verified until 3/17/17 3. CNA hired on 4/11/17 not verified until 6/14/17 4. RN hired on 4/11/17 not verified until 5/27/17 An interview was conducted with the Human Resource Coordinator (HRC) on 6/14/17 at 1:30 pm. She stated she was fairly new to the facility and had noted in May (2017) that some of the employee files did not contain the required screening. She stated the hire date is the date of orientation. She stated that that the offer of a job is contingent on the screening to include CBC and licensure/ registry verification prior to hire. The facility's Resident Abuse Policy and Procedure with a revision date of 2/1/17 read, in part: Screening-Persons applying for employment with a The Company facility will be screened for a history of abuse, neglect, or mistreating residents to include: Criminal Background check (VA specific: after hire, during orientation). Abuse check with appropriate licensing board and registries, prior to hire. Verify license or registration prior to hire. The above findings was shared with the Administrator, the Director of Nursing and the

SS=D FOR HIGHEST WELL BEING

483.24 Quality of life

Corporate Nurse on 6/15/17 at 1:30 pm. F 309 483.24, 483.25(k)(I) PROVIDE CARE/SERVICES

Quality of life is a fundamental principle that applies to all care and services provided to facility

F 309

PRINTED: 06/27/2017 FORM APPROVED OMB NO. 0938-0301

		& MEDICAID SERVICES	·		OMB NO. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION ING	(X3) DATE SURVEY COMPLETED
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NAME OF F	PROVIDER OR SUPPLIER		L	CIDETADDECO OTIVOTITE IN ACT	06/15/2017
	TO TIDEN ON OUT LIEN			STREET ADDRESS, CITY, STATE, ZIP CODE	
NEWPOF	RT NEWS NURSING 8	REHAB		12997 NETTLES DRIVE	·
	· · · · · · · · · · · · · · · · · · ·			NEWPORT NEWS, VA 23602	'
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	TAG	PROVIDER'S PLAN OF CORREC X (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETION
F 309	Continued From pa	ge 16	F3	109	
		sldent must receive and the		- -	<u> </u>
		e the necessary care and			
		maintain the highest	_		
:		I, mental, and psychosocial			1
		ent with the resident's			!
		essment and plan of care.	. 1	Resident #1 does not currently have any si	gns or symptoms
	· · · · · · · · · · · · · · · · · · ·		2	of-a-urinary-tract-infection-and-does-not-re A quality monitoring tool was completed of	quire isolation.
	483.25 Quality of ca		-	any resident that has had a diagnosis of ur	mary tract infection
		fundamental principle that		requiring isolation in last 30 days.	nut y trace intection
		ent and care provided to	` 3	The second secon	icated staff
		ased on the comprehensive		on policy and procedure of isolation	
-		sident, the facility must ensure	4	and initiation of treatment.	
		ve treatment and care in	. 4	 The director of clinical services or designed that all new hires will have prescreening do 	e to monitor
		ofessional standards of		and a quality monitors to be performed 3 t	imes per policy
		ehensive person-centered		for 4 weeks on each shift to ensure compli-	ance with initiation
		esidents' choices, including		of treatment and need for isolation	
	but not limited to the	e rollowing:		1 time weekly for one month then quarter	y thereafter.
	(k) Pain Manageme	· vat		The results of the quality monitoring to be meeting for review, analysis and further r	discussed at QAPI
		sure that pain management is	5		ecommendations,
		ts who require such services,			
		essional standards of practice.			
		person-centered care plan.			
		poals and preferences.			
		,		- · · · · · · · · · · · · · · · · · · ·	
	(I) Dialysis. The fac	cility must ensure that			
		ire dialysis receive such		-	-
	services, consisten	t with professional standards			
	of practice, the con	prehensive person-centered			
	care plan, and the r	esidents' goals and			
	preferences.	•		-	
	This REQUIREMEN	NT is not met as evidenced		<u>-</u>	
	by:				-
		ecord review, staff interview			-
		view, the facility staff failed to			,
		at a known infection for 1 of 23			
	residents (Resident	:#1) in the survey sample.			

Resident #1's Urine analysis/culture and

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 06/27/2017 FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES

		& MEDICAID SERVICES					·····			OME	NO.	0938-	0391
	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILE		CONSTR	RUCTION					3) DATE	SURVE	Ϋ́
		495340	B. WING								0		
NAME OF	PROVIDER OR SUPPLIER			ST	REETADI	ORESS (UTY ST	TATE 7	P CODE		06/1	5/201	7
NEWPO	RT NEWS NURSING 8	REHAB		129	997 NET	TLES DE	RIVE			•			
(X4) ID PREFIX TAG	! (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	X	(E.	PROVIDE ACH COF SS-REFE	ER'S PL RECTIVERENCE	AN OF O	ON SHO HE APPI	UII D RE	 ГЕ	(Xt COMPLI DAT	
F 309	Continued From pa	ge 17	E 5	309					·				
	sensitivity report inc Infection (UTI) that	licated a Urinary Tract required Antibiotic therapy and i s. The resident did not start	_	,03		- 1				-		. -	
	The findings include		-							-			
	Resident #1 was ad on 6/21/16 with diag not limited to osteop stiffness and high bit The most recent Min Significant Change is 6/9/17 and coded the out of a possible scon Interview for Mental indicated the resident he skills for daily derequired extensive as bed mobility and transvensive assistance on and off the unit, of hygiene. The resident two staff for bathing.	mitted to the nursing facility proses that included but was poresis, chronic pain, joint rood pressure. In Status assessment dated a resident with a score of 3 pore of 15 on the Brief Status (BIMS) which not was severely impaired in recision making. The resident resistance from two staff for			20 - 20 - 20 - 20 - 20 - 20 - 20 - 20 -								
*.	had a Urinary tract In initiated on 2/10/17. Initiated due to *ESE *ESBL (Extended Sp. Gram-negative bacte beta-lactamase that commonly used anti-	2/9/17 identified Resident #1 infection and antibiotics were isolation precautions were is. Infection in the urine. Dectrum Beta-Lactamase) are peria that produce an enzyme; has the ability to break down biotics, such as penicillins and render them ineffective											

www.health.gov.nl.ca/health/publichealth/cdc/.../e

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LTIPLE CONSTRUCTION DING	(X3) DATE SURVEY COMPLETED
		495340	B. WING		C 06/45/2047
	PROVIDER OR SUPPLIER RT NEWS NURSING		·	STREET ADDRESS, CITY, STATE, ZIP CODE 12997 NETTLES DRIVE NEWPORT NEWS, VA 23602	06/15/2017
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		OULD BE COMPLETION
F 309	Continued From p	age 18	F.S	309	-
-	xtended_spectrum				÷ .
	bacteria require co necessary within a the spread of these	n beta-lactamase-producing ontact isolation practices health care facility to prevent bacteria, which can fe-threatening-infections.	-		
	Recommendations Control and Preversisolation practices care system.	s from the Centers for Disease ntion are discussed, including utilized at a multihospital health	-		
	indicated "MD awa order for IVANZ 1 (QD) X (times) 7 d	dated 2/10/17 2:29 a.m. re of results from UTI, gave Gram with lidocaine every day ays and she is to be on tains ESBL in the urine."			
	*IVANZ IM (Intrame and the resident w precautions. The la	dated 2/10-19/17 indicated the uscular) was administered daily as maintained on contact ast dose of antibiotic was 19/17 and contact precautions 2/19/17.			
÷.	certain serious infe and urinary tract, s gynecological, pelv area) infections, th Ertapenem is in a c carbapenem antibi bacteria. Ertapene to be mixed with lic intravenously (into a muscle). It is also day intramuscularly	ric, and abdominal (stomach at are caused by bacteria. class of medications called otics. It works by killing m injection comes as a powder			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILI		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495340	B. WING	i		C
	PROVIDER OR SUPPLIER	REHAB		STRI 1299 NEV	06/15/2017	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION
F 309 -	be located in the ele	4/17 the lab results could not ectronic record, or in the	F	309	- · · · · · · · · · · · · · · · · · · ·	
	physician's commu			-		
	Nursing (DON) stat laboratory company UA/C&S. Upon revithe urine sample wareported to the facil Urinary Tract Infect ESBL resistance duB-Lactamase. Ther validate action on the 2/10/17. The DON sinvestigate why the in initiating contact urine.	1:00 p.m., the Director of ed she had to call the of to obtain a copy of the ew of the results, it indicated as collected on 1/31/17 and lity on 2/2/17 that resulted in a lon (UTI) *Escherichia Coli, le to Extended Spectrum e were no nurse's notes to his abnormal lab result until stated she would have to delay in treatment and delay precautions for ESBL in the		-		
	commonly found in carried in feces (http://www.mayocli	. coli), a type of bacteria the gastrointestinal (GI) tract nic.org/diseases-conditions/uri basics/causes/CON-2003789	-			
	presented further in in treatment for the the lab called and s Nurse (LPN) #1 to r ESBL/Ecoli of urine lab called the facility the lab. Lab reporte 2/2/17 sensitivity of	oximately 10:00 a.m., the DON formation regarding the delay UTI: "On 2/1/17 at 12:15 p.m., poke to Licensed Practical report urine result of . On 2/2/17 at 11:03 a.m., the y and no pick up reported by d they got a voicemail. On urine was faxed by the lab to lab had called the facility. Lab				

	- G WEDTONED OF KAIOFO					- OIMB I	O. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			ONSTRUCTION		(X3) C	OATE SURVEY OMPLETED
	495340	B. WING	3				C 06/15/2017
NAME OF PROVIDER OR SUPPLIER			STREE	ET ADDRESS C	ITY, STATE, ZIP COD		00/13/2017
			i)E	
NEWPORT NEWS NURSING &	& REHAB		i	NETTLES DR		-	
			NEW	PORT NEWS	S, VA 23602		ľ
	ATEMENT OF DEFICIENCIES	ID		PROVIDE	R'S PLAN OF CORR	ECTION	/VE\
	Y MUST BE PRECEDED BY FULL	PREF		(EACH COR	RECTIVE ACTION SI	HOULD BE	(X5) COMPLETION
TAG REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	ì	CROSS-REFE	RENCED TO THE AF	PROPRIATE	DATE
		· · · · · · · · · · · · · · · · · · ·		-	DEFICIENCY)		
			,				
F 309 Continued From pa	age 20	F:	309				
had no name of the	nurse that requested the						
	0/17 orders were obtained for						1
	in the Urine for INVANZ						
	at hour of sleep times 7 days.						•
		-					
	ntinued on 2/20/17." The DON						
	bs protocol to call all critical						
	results over that need a						
	ate attention. The DON stated			ē			· -
	#1 and it was determined she						* *
	ugh on contacting the						
	him of the abnormal labs and						
	s. The DON stated it was the				•		
lab that was reachi	ng out for action by the nursing					•	
	She stated it was her						
expectation that the	e nurse immediately call the						
physician to inform	him of any abnormal labs for						
	n, write on the lab slip, the	.*				• •	. :
	d with date and time, any				-		
	the perspective physician's						
	der. The DON stated, none of				•		
	e and it appeared the lab						
	the physician. She stated						
	call the physician with the						
	yed treatment for at least 8	:					
	e isolation precautions for an						
	d be spread to other residents.	:					}
organism that could	be spread to other residents.	:		-			
On 6/15/17 at 12:20	p.m., the DON stated she			*			
	s physician to see if she						
	ing about why the delay in	:					•
	SBL infection, and to see if she	•			÷ .		
	otes as to why she ordered						
the UA/C&S the ph	nysician had no progress notes	i		-			
	I why she ordered the urine						
sample.							•
•							
On 6/15/17 at 3:00	p.m., during the pre-exit						
meeting with the Ac	dministrator and the DON, no						
	was provided to the survey						

		& MEDICAID SERVICES				OMB NO. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	-	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495340	B. WING			C 06/15/2017
NAME OF F	PROVIDER OR SUPPLIER	<u> </u>	1	STF	REET ADDRESS, CITY, STATE, ZIP CODE	1 00/13/2017
MEMBOR		. mmilan			97 NETTLES DRIVE	
NEWPOR	RT NEWS NURSING 8	& REHAB	1		WPORT NEWS, VA 23602	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	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)	ILD BE COMPLETION
F 309	Continued From pa	ge 21	F 3	09		
	team.					
					-	
	The facility did not littled "Physician Or	nave a policy and procedure ders."				
F 312 SS=D	483.24(a)(2) ADL C DEPENDENT RES	ARE PROVIDED FOR- IDENTS	F3	12		
	activities of daily liv services to maintain personal and oral h This REQUIREMEN by: Based on resident clinical record reviet the facility staff faile Living assistance to hygiene for 1 of 23 sample, Resident # The facility staff fail	NT is not met as evidenced interview, staff interview, we and facility document review to to provide Activities of Daily maintain good personal residents in the survey 15. ed to provide assistance with the #15 consistent with the	· · · · · · · · · · · · · · ·	1. 2. 3.	on 6-27-2017 to identify any resident that not a shower in last 30 days. Director of clinical services or designee on policy and procedure of providing activities of daily living assistance to magood personal hygiene.	ed chat educated staff aintain gnee to monitor g done per policy d 3 times per week npliance with vities of daily living me weekly for one
	The findings include	ed:				
	Resident #15 was a 6/7/14 with diagnos chronic obstructive (1). The current MDS (Nowith an assessmen coded the resident possible 15 on the light formula for the sident possible 15 on the light formula for the light for the light formula for the light	admitted to the facility on es to include, but not limited to pulmonary disease (COPD) Minimum Data Set) a quarterly treference date of 5/24/17 as scoring a 15 out of a Brief Interview for Mental are resident's cognition was			- -	
,	intact. The residen	t was coded as requiring to bathing activity, to include				*

CENTERS FOR MEDICAL	RE & MEDICAID SERVICES			OMB NO. 0938-0391
\$TATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONST A. BUILDING	FRUCTION	(X3) DATE SURVEY COMPLETED
	495340	B. WING		C
NAME OF PROVIDER OR SUPPLIE	R	STREETA	DDRESS, CITY, STATE, ZIP CODE	06/15/2017
NEWPORT NEWS NURSING		12997 NE	TTLES DRIVE RT NEWS, VA 23602	
PREFIX (EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX (TAG CR	PROVIDER'S PLAN OF CORRECTI EACH CORRECTIVE ACTION SHOUI ROSS-REFERENCED TO THE APPRO DEFICIENCY)	DBE COMPLETION
F 312 Continued From full-body bath/sho	•	F 312		
resident had both Care Performand	ered Plan of Care identified the a actual and potential ADL Self be Deficits related to several binclude COPD. The resident			
supervision. The receive staff support through the next the interventions resident with assident's refusal	ower and dress without goal was that the resident will port with all ADLs as needed review date of 8/30/17. One of listed was to provide the istance to bathe daily and PRN a plan of care had entries of the of showers on four occurrences one on 10/11/2016, and one on 3/17/17.			
6/14/17 at 11:15 a staff assisted the #15 stated she had to shower in over normally receives a week and recer	Group Interview conducted on am, the group was asked if the m with their ADL's. Resident ad not been offered assistance a week. She stated she assistance with showers twice only had not been offered one. Idule was reviewed. Resident are scheduled on Tuesdays and a 7-3 shift.			
A follow up interv was conducted o resident's bedsid not sure when he and her last shov She stated this w resident was ask	iew with the resident in private n 6/14/17 at 4:30 pm., at the e. The resident stated she was a shower days were scheduled wer was sometime last week. Was due to lack of staff. The ed if she had refused a shower erday and stated, "No, I was not			

	· · · · · · · · · · · · · · · · · · ·	A MEDIONID OF LANGER					MR NO.	0938-0391
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ı		CONSTRUCTION		(X3) DATE COMI	SURVEY PLETED
		495340	B. WING	·			06/	C 1 5/2017
NAME OF	PROVIDER OR SUPPLIER		<u> </u>	STI	REET ADDRESS, CITY, STATE, Z	IP CODE	1 00/	10/2017
NEWPO	RT NEWS NURSING 8	S REHAB		129	97 NETTLES DRIVE			
112111	TO METTO NOROING C	XICHAD		NE	WPORT NEWS, VA 23602	}	•	
(X4) ID PREFIX TAG	: (EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENCE	TION SHOULD THE APPROP	BF	(X5) COMPLETION DATE
F 312	Continued From pa	age 23	E 1	312				
		al record documentation failed	Γ,	312				
		ident's refusal of a shower or						
		offered/ provided as stated by						
		lent was scheduled to have				,		
		rovided assistance with a						
		6/1.7, Friday 6/9/1.7_and					• • • •	
	Tuesday 6/13/17.					_		
	On CIATIAT +4	and an ataly 4 200 area. He			yans .	•	* * * .	
		oximately 1:00 pm., the 42 unit manager was				•		• • •
		ove findings was shared. She	i					-
		y new to the facility. She						
		found out today that if a	•		n.			e de la companya de l
		shower the CNAs are to fill out		•		• •		
	a pink Skin Observa	ation Sheet and document the	:				_	e e e
		nk sheet is then handed to the			-			
:		stated the charge nurse then				_	. •	
	documents the refu	isal in the clinical record.			<u>.</u> .	. :		_
	On 6/45/47 at 4:00	mm the 7.0 shift CNA						
		pm, the 7-3 shift CNA le #2) who was assigned to				-		· .
		nt yesterday (Tuesday) was				* *		
		e phone. She was asked if the						
		ed with a shower yesterday						
	and stated "No". Ti	he CNA stated she had last						•
		nt with a shower on the			*		-	
		/17. The CNA stated the						
		d a shower yesterday. When			•			
		ported this refusal to the			•		•	
	charge nuise she s	tated, "Probably not".						• • •
	The above findings	was shared during the						
:		anducted on 6/15/17 at 1:30					-	
		tor, the Director of Nursing and	•					
	the Corporate Nurs							
	·							
		1.50				•		
	1. COPD-Chronic a	airflow obstruction. (Source						

CTATELLEL	T OF DEFINE VOICE	I	1			<u> DMB NO. 0938-0391</u>
	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILD		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495340	B. WING	·		С
NAME OF	PROVIDER OR SUPPLIER		L	6.	TREET ADDRESS, CITY, STATE, ZIP CODE	06/15/2017
\$ 1000 F 1000					2997 NETTLES DRIVE	
NEWPO	RT NEWS NURSING 8	REHAB			· · · ·	
()(() 10	OLIAMA DV CTA	TELEVIT OF PERIODENIA (F.		174:	IEWPORT NEWS, VA 23602	-
(X4) ID PREFIX TAG	 (EACH DEFICIENCY 	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROINTERNOY)	DRE COMPLETION
F 312	Continued From pa	ge 24	E o	, 312		Mary and the second professional and the second profession and the sec
		Medical Dictionary, Edition	r c) 12		
	20).	Wedical Dictionary, Edition			-	<u>-</u> .
F 323)-(3) FREE OF ACCIDENT	E 0	323.		
	HAZARDS/SUPER	VISION/DEVICES	1. 0)23.		
		,, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		_		
ė.	(d) Accidents.			1.	- 7	·
	The facility must en	sure-that ⁻	•		on 6-16-2017. A quality monitor tool was put in place on 6-16-2017.	<u> </u>
		<u>.</u>		2.		heen affected
	(1) The resident env	/ironment remains as free		3,	 Director of therapy services or designee 	educated staff
	from accident hazar	ds as is possible; and			on 6-16-2017 on policy and procedure of	care and use of
-	and assistance devi	celves adequate supervision ces to prevent accidents.		4.	Temperature logs daily and a quality mor be performed 3 times per week for 4 week	ee to monitor nitor to eks on each
	appropriate alternati bed rail. If a bed or must ensure correct	e facility must attempt to use ives prior to installing a side or side rail is used, the facility installation, use, and rails, including but not limited nents.	-	5.	shift to ensure compliance with temperat temperature being within range 1 time we month then quarterly thereafter. The res quality monitoring to be discussed at QAI meeting for review, analysis and further A.O.C. is July 18,2017	eekly for one ults of the Pl
	(1) Across the resid	and foundate of materials			- · · · · · · · · · · · · · · · · · · ·	
	from bed rails prior t	ent for risk of entrapment to installation.				·
	(2) Review the risks the resident or resid informed consent pr	and benefits of bed rails with ent representative and obtain ior to installation.	- - -			
٠.	(3) Ensure that the bappropriate for the right This REQUIREMEN by:	ped's dimensions are esident's size and weight. To is not met as evidenced				
	Based on observation facility staff failed to temperatures for the machine and ensure	ons, and staff interview, the consistently record hot water Hydrocollator recorded temperatures were ure's recommended range.		-	· · · · · · · · · · · · · · · · · · ·	

		& MEDICAID SERVICES						OMB NO	. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		NSTRUCTION			(X3) DAT	E SURVEY MPLETED
		495340	B. WING					. 1	C /15/2017
NAME OF I	PROVIDER OR SUPPLIER			STREE	T ADDRESS,	CITY, STATE	ZIP CODE	1 007	13/2017
NEWPO	RT NEWS NURSING 8	REHAB		12997	NETTLES D	RIVE			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECÉDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVID (EACH CO CROSS-REF	ER'S PLAN C RRECTIVE A ERENCED TO DEFICIEN	CTION SHOI THE APPR	JLDBE	(X5) COMPLETION DATE
F 323	Continued From pa	ae 25		00					-
	The findings include		F3	23					
	The indings include	9 0.							
	temperatures for the machine and ensur within the manufact	led to consistently record e hot water Hydrocollator e recorded temperatures ure's recommended range of	·	. •					
	65 -165 Fahrenheit	degrees.				• *			-
	facility on 6/15/17 a temperatures were A review of the Reh Hydrocollator Tempindicated the following 2017 temperatures following dates: Jan 17, 19, 23, 24, 25, 3 For the month of Fewere recorded on the 2, 3, 6, 7, 8, 13, 14, For the month of Mayere recorded. For the month of Aprecorded on the foll 10, 11, 12, 13, 14, 1 For the month of Mayere recorded on the foll 6, 7, 9, 10, 11, 12, 1 For the month of Jurecorded on the foll 6, 7, 8, 9, 10, 11, 12	abilitation Services monthly erature/Cleaning Log ng: For the month of January were recorded on the uary 3, 5, 9, 10, 12, 13, 16, 50 and 31. Abruary 2017 temperatures are following dates: February 1, 16, 21, 22, 23, and 27. Farch 2017 no temperatures were owing dates: April 3, 4, 5, 6, 7, 7, 18, 19, 20, 21, and 27. Fay 2017 temperatures were owing dates: May 1, 2, 3, 4, 5, 3, 14, 15, 16, 17, and 18. The 2017 temperatures were owing dates: June 1, 2, 3, 5, 13, and 14. Ideline last updated 9/06/16 Unit has a built in adjustable nges between 65 and 165 F,							
		perature logs indicated res higher than 165 degrees							

	TATEMENT OF DEFICIENCIES AD PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LTIPLE CO	(X3) DATE SURVEY COMPLETED		
		495340	B. WING)		*****	C 06/15/2017
	PROVIDER OR SUPPLIER RT NEWS NURSING 8	k REHAB	·	12997	ET ADDRESS, CITY, S 7 NETTLES DRIVE 1/PORT NEWS, VA	,	1 00/13/2017
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORRECT CROSS-REFERENC	LAN OF CORRECTIC FIVE ACTION SHOULI CED TO THE APPROF FICIENCY)	DBE COMPLETION
F 323	January 25 - 170-F February 2017 - Fe and 23 (168-F); Fe	January 3 - 170-F, and	F	323			
	19, 20, (170-F; Apr (167-F).	111, 21 (169-F); April 17 , 2, 3, 5, 6, 7, 8, 11, 12, 13, 14	· ·		. '	<u> </u>	
	Rehabilitation Directemperatures on the Hydrocollator mach utilized the Hydroco "Yes." When asked	on 6/15/17 at 9:37 A.M., the stor stated, "We take the e days in which we use the ine." When asked if staff ollator on weekends he stated, had the temperature gauge accuracy he stated, "No".					
F 441 \$S=D	temperatures and r manufacture's guid	e)(f) INFECTION CONTROL,	F	441	 		
1.	(a) Infection preven	tion and control program.			-		
		tablish an infection prevention (IPCP) that must include, at owing elements:	:				
	investigating, and of communicable dise volunteers, visitors, providing services of arrangement based conducted according	eventing, identifying, reporting, ontrolling infections and cases for all residents, staff, and other individuals under a contractual upon the facility assessment to §483.70(e) and following standards (facility assessment					

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1		CONSTRUCTION		(X3) DATE SURVEY COMPLETED			
		495340	B. WING			1	С			
NAME OF S	DOMED OF CURRY	40040	D. 11110				15/2017			
	PROVIDER OR SUPPLIER RT NEWS NURSING 8	3 REHAB		129	REET ADDRESS, CITY, STATE, ZIP CODE 997 NETTLES DRIVE EWPORT NEWS, VA 23602	: : .				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION - DATE			
F 441	implementation is F (2) Written standar	·	F	441	 Registered nurse #2 and LPN # 2 educated on 6-16-2017 On policy and procedure of hand per the CDC guidelines All resident's have the potential 	lwashing as				
	possible communic before they can spi facility; (ii) When and to wh	reillance designed to identify cable diseases or infections read to other persons in the norm possible incidents of ease or infections should be			been affected. 3. Director of clinical services or deducated staff on policy and procedure on handwashing as per the CDC guidelines. 4. The director of clinical services of to conduct a random observation handwashing procedure and a quimonitor to be performed 3 times.	lesignee or designee of RN/ LPN				
	reported; (iii) Standard and to be followed to pr	ansmission-based precautions event spread of infections; isolation should be used for a			4 weeks on each shift to ensure of with handwashing 1 time weekly month then quarterly thereafter. The results of the quality monitor discussed at QAPI meeting for revanalysis and further recommenda A.O.C. is July 18,2017	for one				
·	(A) The type and d depending upon the involved, and (B) A requirement to	uration of the isolation, e infectious agent or organism that the isolation should be the ssible for the resident under the								
	must prohibit emploisease or infected	ces under which the facility oyees with a communicable I skin lesions from direct nts or their food, if direct It the disease; and				- 1 1.				
		ene procedures to be followed direct resident contact.								
	(4) A system for re	cording incidents identified								

12997 NETTI NEWPORT ID P PREFIX (EA	DRESS, CITY, STATE, ZIP CODE	DRF COMPLETION
STREET ADDR 12997 NETTI NEWPORT ID P PREFIX (EA TAG CROS	LES DRIVE NEWS, VA 23602 PROVIDER'S PLAN OF CORRECTIC ACH CORRECTIVE ACTION SHOULI SS-REFERENCED TO THE APPROF	06/15/2017 ON (X5) OBE COMPLETION
12997 NETTI NEWPORT ID P PREFIX (EA TAG CROS	LES DRIVE NEWS, VA 23602 PROVIDER'S PLAN OF CORRECTIC ACH CORRECTIVE ACTION SHOULI SS-REFERENCED TO THE APPROF	DN (X5)
12997 NETTI NEWPORT ID P PREFIX (EA TAG CROS	LES DRIVE NEWS, VA 23602 PROVIDER'S PLAN OF CORRECTIC ACH CORRECTIVE ACTION SHOULI SS-REFERENCED TO THE APPROF	DRF COMPLETION
PREFIX (EA)	ACH CORRECTIVE ACTION SHOULI SS-REFERENCED TO THE APPROF	DRF COMPLETION
F 441		

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 06/27/2017 FORM APPROVED OMB NO. 0938-0301

CENTE	RS FOR MEDICARE	& MEDICAID SERVICES		-	OMB NO. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED
		495340	B. WING_		C 06/15/2017
NAME OF I	PROVIDER OR SUPPLIER	<u></u>		STREET ADDRESS, CITY, STATE, ZIP CODI	: 00/13/201/
			1	12997 NETTLES DRIVE	-
NEWPORT NEWS NURSING & REHAB		REHAB		NEWPORT NEWS, VA 23602	
	0.000		<u> </u>		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETION
F 441	Continued From pa	ne 29	F 44		
	,		Г 4 "	1 4 1	
,		admitted to the facility on sis to include, but not limited	!	<u> </u>	
		ure ulcer to the right outer			
	ankle (1).	are alcer to the right outer	-		-
	The current MDS /	Minimum-Data-Set)-with-an			
		nce date of 4/5/17 coded the		and the second second	
		a 13 out of a possible 15 on		. 	- -
•		or Mental Status, indicating	-2		
	the resident's cogni			-	
				·	
		ers dated 6/5/17 included a			
		e the right outer ankle normal saline, apply silver		and the second second	
		ective dressing once a day.			
	riyorogerana a pro	equive dieasing office a day.			
	The right ankle dre	ssing change observation was	:		
	conducted on 6/14/	17 at 3:30 pm. The nurse was		<u> </u>	
	Registered Nurse (RN) #2. The resident was			
		air. Prior to removal of the		-	·
		placed all dressing supplies			_
		e nurse then put on gloves,			
		4 gauze dressing the tube of		•	
		the spray bottle of normal			-
		or. The nozzle to the normal			
		The nurse then picked these			•
		nd stated, "It's okay it's not			£.
		tube)". She placed the spray normal saline bottle and	_	•	
		nto the roommate's trash can			
		working. The nurse then			
		for a count of 5 seconds and			
		r of gloves. The nurse then			
-		right tennis shoe off, touching	•	-	
		oved hands and then cleansed			
		normal saline and 4 x 4		•	
		then removed the first layer of			•
		ted the dressing change. The			

nurse then removed the gloves, washed her

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING (X3) DATE SURVEY COMPLETED C C A95340 B. WING

NAME OF PROVIDER OR SUPPLIER

NEWPORT NEWS NURSING & REHAB

STREET ADDRESS, CITY, STATE, ZIP CODE

12997 NETTLES DRIVE

NEWPORT NEWS, VA 23602

(X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

ID PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X5) COMPLETION DATE

06/15/2017

F 441 Continued From page 30

hands for a count of 6 seconds, and then assisted the resident to the toilet. After the resident was done, the nurse put on gloves and wiped the residents buttocks with toilet paper. The nurse then assisted the resident to wash hands. The nurse then removed her gloves and washed her hands for a count of 4 seconds and assisted the resident back into the room. Immediately afterwards she placed on gloves to assist the roommate, Resident #6.

The facility policy titled "Hand Washing Technique" with a revision date of 6/1/15 read, in part:

7. Rub hands together vigorously for 15-20 seconds, generating friction to on all surfaces of the hands and fingers. Friction removes more surface organisms than either soap or water...

The above observation was shared with the Director of Nursing on 6/15/17 prior to the pre-exit meeting.

A pre-exit meeting was conducted on 6/15/17 at -1:30 with the Administrator, the Director of Nursing and the Corporate Nurse in attendance. They indicated that they had recently conducted hand washing training and audits with staff in May (2017).

- (1). Stage III Pressure Ulcer-Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling. (Source:MDS Version 3.0)
- 2. The facility staff failed to implement proper hand washing technique and infection control

F 441

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 06/27/2017

CENTE	RS FOR MEDICARE	& MEDICAID SERVICES				O4	FORM APPROVED 1B NO. 0938-0391
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA . IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		NSTRUCTION		(X3) DATE SURVEY COMPLETED
		495340	B. WING				C
NAME OF	PROVIDER OR SUPPLIER			STREE	T ADDRESS, CITY, STATE, ZIP	CODE	06/15/2017
NEWPO	RT NEWS NURSING 8	REHAB		12997	NETTLES DRIVE PORT NEWS, VA 23602	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL	ID PREFI TAG	×	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD E APPROPR	BE COMPLETION
F 441	Continued From pa	an 2d	-				
	•	_	F 4	41			
	for Resident #6.	nd after providing trach care	. * *			-	
	7/22/16 with diagno	dmitted to the facility on ses to include, but not limited ry fallure with tracheostomy				-	
	(2).	<u>.</u>			· · · · · · · · · · · · · · · · · · ·		
	with an assessment coded the resident apossible 15 for the I Status, indicating the moderately impaired Treatments, Proceduresident was checked tracheostomy care is suctioning. On 6/14/17 the nurse assisting the resident #3) with toileting, to buttocks with toilet particularly Afterwards the nurse washed her hands frassisted the roomm nurse then immedian Resident #6 who resuctioning. During the was mouthing word gloved left Index fine trach tube to aide the repositioning, the nurse washed her hands from the nut on a pair of the suction of the nurse then put on a pair of the suction of the nurse then put on a pair of the suction of the nurse then put on a pair of the suction of the nurse then put on a pair of the suction of the nurse then put on a pair of the suction of the suction of the nurse then put on a pair of the suction of the	Minimum Data Set) a quarterly treference date of 3/1/17 as scoring a 12 out of a Brief Interview of Mental e resident's cognition was d. Under Section O. Special dures and Programs the ded off as having received to include oxygen and the (RN #2) was observed in the resident of the program of the resident's paper and gloves on the removed her gloves she or a count of 4 seconds and ate out of the bathroom. The step put on gloves to tend to quired repositioning and track the repositioning the resident is, the nurse then placed her ger over the opening of the per resident to speak. After surse removed the gloves, or a count of 5 seconds and forcen gloves from the nused the left gloved hand to					
_		machine and then placed her ger over the resident's trach					

once more to aide the resident to speak. After

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

	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILE		(X3) DATE SURVEY COMPLETED	
		495340	B. WING	i	· 	C
	PROVIDER OR SUPPLIEF		1	STRI 1299 NEV	06/15/2017	
(X4) ID PREFIX TAG	(EACH DEFICIENC	FATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION
F 441	gloves and washe	age 32 ident, the nurse removed her d her hands for a count of 6 aving the resident's room.	F	441	-	
	The facility policy t	titled "Hand Washing revision date of 6/1/15 read, in	:			
-	part: 7. Rub hands toge seconds, generati the hands and fing	ether vigorously for 15-20 ng friction to on all surfaces of gers. Friction removes more s than either soap or water	:			
		ation was shared with the g on 6/15/17 prior to the pre-exit	•			
	1:30 with the Adm Nursing and the C They indicated tha	was conducted on 6/15/17 at inistrator, the Director of orporate Nurse in attendance. It they had recently conducted ning and audits with staff in May				
	trachea to provide	y-The surgical opening of the and secure an open airway. Encyclopedic Medical 20)				
	on 6/21/16 with dia	s admitted to the nursing facility agnoses that included but was oporosis, chronic pain, joint blood pressure.				
	Significant Change 6/9/17 and coded out of a possible s	Minimum Data Set (MDS) was a in Status assessment dated the resident with a score of 3 core of 15 on the Brief al Status (BIMS) which				•

		AND HUMAN SERVICES & MEDICAID SERVICES				FOR	D: 06/27/2017 M APPROVED O: 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT	TIPLE CONSTRUCTION		(X3) D	ATE SURVEY OMPLETED
		495340	B. WING				C 6/4 = /2 0.4 =
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, C	ITY, STATE, ZIP CO	DDE .	6/15/2017
NEWPOI	RT NEWS NURSING 8	к пенав		12997 NETTLES DR NEWPORT NEWS	RIVE	"-	
(X4) ID PREFIX TAG	-(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH COR	ER'S PLAN OF COR RECTIVE ACTION RENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 441	Continued From pa	ge 33	F 4	41			
	indicated the reside	nt was severely impaired in		F.,		• .	
		ecision making. The resident					
		assistance from two staff for			-		
		insfers. She required			_		
		e of one staff for locomotion dressing, eating and personal	i				
		ent was totally dependent on	:	· · ·			- m
		The resident was assessed	1				
-		nt of bowel and bladder.	. •			·. 	
	The care plan dated	d 2/9/17 Identified Resident #1	1	, ·			
		Infection and antibiotics were					
**		Isolation precautions were BL infection in the urine.		V			-
	*ESBL (Extended S	pectrum Beta-Lactamase) are		•		-	••
		teria that produce an enzyme;				-	÷
		t has the ability to break down	i	•	• .	-	
		ibiotics, such as penicillins		-	-		- 1
	and cephalosporins for treatment.	and render them ineffective	: "				
		ca/health/publichealth/cdc//e	1			÷ .	
-	xtended_spectrum_			-			
***	-		-	•			
٠.		beta-lactamase-producing tact isolation practices					
**		nealth care facility to prevent					
		bacteria, which can					
		e-threatening infections.	:				
:	Recommendations	from the Centers for Disease		•			
		tion are discussed, including	•				
		itilized at a multi-hospital			•	.•	
	health care system.						
	https://www.ncbi.nlr	m.nih.gov/pubmed/21160300		-			

The nurse's notes dated 2/10/17 2:29 a.m. indicated "MD aware of results from UTI, gave order for IVANZ 1 Gram with lidocaine every day

(QD) X (times) 7 days and she is to be on

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

		A MEDICAID SERVICES			OMB NO. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION				FIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED
· · · · · · · · · · · · · · · · · · ·		495340	B. WING		C 06/15/2017
*	PROVIDER OR SUPPLIER RT NEWS NURSING 8	& REHAB		STREET ADDRESS, CITY, STATE, ZIP CO 12997 NETTLES DRIVE	DE
				NEWPORT NEWS, VA 23602	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL BC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF ((EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AL DEFICIENCY)	SHOULD BE COMPLETION
F 441	Continued From pa	ge 34	F 44	41	The state of the s
·	isolation-urine conta	ains ESBL in the urine."			1871 - 1
	*IVANZ IM/Ertapene administered daily a	dated 2/10-19/17 indicated the em (Intramuscular) was and the resident was act precautions. The last dose	: ' :	***************************************	
	of antibiotic was add	ministered on 2/19/17 and were discontinued 2/19/17.			
	*IVANZ/Ertapenem certain serious infectand urinary tract, sk gynecological, pelvi area) infections, that Ertapenem is in a carbapenem antibio bacteria. Ertapenem to be mixed with liquintravenously (into a muscle). It is also day intramuscularly of treatment dependent to be ing treated. On 6/13/17 and 6/14	injection is used to treat otions, including pneumonia in, diabetic foot, c, and abdominal (stomach t are caused by bacteria. ass of medications called tics. It works by killing injection comes as a powder uid to be injected a vein) or intramuscularly (into may be given once or twice a for up to 7 days. The length is on the type of infection			
	be located in the ele physician's commun On 6/14/17 around	ectronic record, or in the			
•	laboratory company UA/C&S. Upon reviet the urine sample was reported to the facility Urinary Tract Infecti (E.Coli), ESBL resis Spectrum B-Lactam	to obtain a copy of the ew of the results, it indicated as collected on 1/31/17 and ty on 2/2/17 that resulted in a on (UTI) *Escherichia Colitance due to Extended ase. There were no nurse's	_ ·		

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CEIVIE	KO FOR MEDICARE	A MEDICAID SERVICES				OMB	NO. 0938-0391
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTION	(X3)	DATE SURVEY COMPLETED
		495340	B. WING			1	C 06/15/2017
NAME OF	NAME OF PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		00/10/2011
NEWDO				129	997 NETTLES DRIVE		
NEVVPO	RT NEWS NURSING 8	KEHAB			WPORT NEWS, VA 23602		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES			PROVIDER'S PLAN OF CORREC	rion	
PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 441	Continued From pa	ge 35	F 4	144			
	•	The DON stated she would		r= r 1			
		why the delay in treatment				*	-
		ng contact precautions for		٠	ي. د د د د د د د د د د د د د د د د د د د		-
	ESBL in the urine.	-	<u>-</u>		<u> </u>		
			_			-	
	*Escherichia-coli-(E	coli), a-type-of-bacteria			<u> </u>		
-		the gastrointestinal (GI) tract	:	•	·		
	carried in feces		: -	٠		- '	, to -
-		nic.org/diseases-conditions/uri			•		
		basics/causes/CON-2003789	!				
_	2)						
	On 6/16/17 of onne	oximately 10:00 a.m., the DON					- 1
		formation regarding the delay	-				
		UTI: "On 2/1/17 at 12:15 p.m.,					
		poke to Licensed Practical	!		. –		· The control of
	Nurse (LPN) #1 to						
*		. On 2/2/17 at 11:03 a.m., the			. -		
	lab called the facilit	y and no pick up reported by	:			-	·
. '		d they got a voicemail. On	:			17 25 0	. •
		urine was faxed by the lab to	· .			1 2	
		lab had called the facility. Lab					
		nurse that requested the					
		0/17 orders were obtained for	!				
		in the Urine for INVANZ at hour of sleep times 7 days.	:				
		at flour or sleep times 7 days. It inued on 2/19/17." The DON	į	_			
		o's protocol to call all critical	i				
		results over that need a		-	=	·	
		ate attention. The DON stated				-	
		1 and it was determined she				-	
		igh on contacting the				-	
		him of the abnormal labs and					
		s. The DON stated it was the			•		-
		ng out for action by the nursing	١.	-			
		She stated it was her					
		nurse immediately call the	***	-			
		him of any abnormal labs for					•
	immediate attentior	, write on the lab slip, the					

PRINTED: 06/27/2017 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING _ COMPLETED 495340 B. WING 06/15/2017

NEWPORT NEWS NURSING & REHAB

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

12997 NETTLES DRIVE

NEWPORT NEWS, VA 23602

(X4) ID SUMMARY STATEMENT OF DEFICIENCIES
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL
TAG REGULATORY OR LSC IDENTIFYING INFORMATION)

ID PREFIX -TAG

F 441

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

(X5) COMPLETION DATE

F 441 Continued From page 36

physician was called with date and time, any orders and place in the perspective physician's communication binder. The DON stated, none of the above was done and it appeared the lab made contact with the physician. She stated failure of the LPN to call the physician with the abnormal labs delayed treatment for at least-8 days and immediate isolation precautions for an organism that could be spread to other residents.

On 6/15/17 at 12:30 p.m., the DON stated she called Resident #1's physician to see if she remembered anything about why the delay in treatment for the ESBL infection, and to see if she had any progress notes as to why she ordered the UA/C&S; the physician had no progress notes and could not recall why she ordered the urine sample.

On 6/15/17 at 3:00 p.m., during the pre-exit meeting with the Administrator and the DON, no further information was provided to the survey team.

The facility staff stated they followed the Centers for Disease Control and Prevention: "For ESBL/ECOLI infection use Contact Precautions for diapered or incontinent persons for the duration of Illness or to control institutional outbreaks."

https://www.cdc.gov/infectioncontrol/guidelines/is olation/index.html

https://www.cdc.gov/infectioncontrol/pdf/guidelines/isolation-guidelines.pdf

4. The facility staff failed to practice adequate hand hygiene during wound care for Resident #5.

Resident #5 was admitted to the nursing facility

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

		A MEDICAID SERVICES	Ţ	·-···			<u>)MB NO. 0938-0391</u>	
	T OF DEFICIENCIES DF CORRECTION -	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTR			(X3) DATE SURVEY COMPLETED	
	-	495340	B. WING			<u> </u>	C 06/15/2017	
NAME OF	PROVIDER OR SUPPLIER		<u>'</u>	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE	1 00/13/2017	
NEWPO	RT NEWS NURSING 8	REHAB		12997 NETTLES DRIVE NEWPORT NEWS, VA 23602				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(E/	ACH CORRECTIVE SS-REFERENCED	N OF CORRECTION E ACTION SHOULI O TO THE APPROF CIENCY)	D.BE COMPLETION	
F 441	Continued From pa	ge 37	F 4	11	-			
		agnoses that included but not	1 24	1 [
	limited to Alzheimer	's disease, anemia, chronic						
	kidney disease and		-					
	indiray dibodoo dira	nae on neopioo.						
	The Annual Minimu	m Data Set assessment dated			• •			
		sident with short and long		*	: <u> </u>	· 		
	term memory and n	noderately impaired in the						
		ily decision making. The	, F				ا مارين کارون کارون	
		to have one *Stage III	÷					
	pressure ulcer and ulcer.	one *Unstageable pressure						
	1.46		-			•		
		ulcer has full thickness loss.		-		_		
	Subcutaneous fat m	nay be visible but bone,	<u>.</u>					
•	tendon or muscle. S	Sough (soft dead yellow/tan	1 4 =				- 1 1 N T	
	tissue) may be pres	ent, but does not obscure the			-		+ +	
		. May include undermining				.		
	and tunneling (http://	,	÷					
•.		ure ulcer has slough or						
	Eschar (hard black	dead adherent tissue) that is			-	•	Francisco de la composición dela composición de la composición de la composición de la composición de la composición dela composición dela composición dela composición de la composición de la composición de la composición dela composici	
	known, but unable t	o stage due to slough or				-	The second of the second	
- '	eschar (http://www.i	npuap.org/)			-		•	
	During observation	of Resident #5's wound care						
	that was conducted	on 6/14/17 at 3:00 p.m.,		÷				
	Licensed Practical N	Nurse #2 washed her hands	: '' · · · · · · · · · · · · · · · · · ·					
	three times during t	he process of wound care.						
	During-these observ	vations of hand washing/hand	1				= .	
	hygiene, she held h	er hand under the water with		-				
	soap for approxima	tely 3-4 seconds and turned						
	off the faucet with the	ne same paper towel she used	į	*			t value of the second	
	to dry her hands.						-	
		•						
	On 6/15/17 at 3:00	o.m., during the pre-exit					·	
	meeting with the Ad	ministrator and the DON. The		į.				
	DON stated she exp	pected the standard be						
		ling handwashing to include					•	
	noid the hands unde	er water, rubbing hands						

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

STATEMEN	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	T			OMB NO. 0938-0391
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495340	B. WINC	3		С
NAME OF PROVIDER OR SUPPLIER NEWPORT NEWS NURSING & REHAB				1	STREET ADDRESS, CITY, STATE, ZIP CODE 12997 NETTLES DRIVE NEWPORT NEWS, VA 23602	06/15/2017
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	ΊΧ	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	D.BE CONT. ETT.
F 441 F 465 \$S=E	vigorously to exhibit seconds and anoth the faucet.	ge 38 friction for at least 15-20 er paper towel used to turn off L/SANITARY/COMFORTABL		441 465		
	sanitary, and comforesidents, staff and (5) Establish policies applicable Federal, regulations, regardinand smoking safety non-smoking reside. This REQUIREMEN by: Based on observatifacility staff failed to doors were in good in the staff staff failed to doors were in good in the staff staff staff failed to doors were in good in the staff st	ovide a safe, functional, rtable environment for the public. s, in accordance with State, and local laws and smoking, smoking areas, that also take into account		2.	The dryer outside vent has been cleaned a is free from lint and debris and the missing tiles were replaced on 6-15-2017. The doors 318,323,325,327,328 and 339 w Any resident of the facility has the potential Maintenance staff cleaned the outside vent monitoring tool to be utilized to check vent doors in center have been checked for sharmonitoring tool to be used for checking different maintenance director or designee to a quality monitor to be performed 3 times perfor 4 weeks on each shift to ensure complied vent being free from lint and debri and also be checked for sharp edges1 time weekly for the quarterly thereafter. The results of the tobe discussed at QAPI meeting for review further recommendations. A.O.C. is July 18,2017	ill be replaced. If to be affected, It and a quality It daily and all If edges and quality Oors for sharp edges. If edges and edges and edges. If edges and edges and edges. If edges and edges and edges and edges and edges and edges. If edges and
	A.M. on 6/15/17 the Rosewood Unit were jagged edge doors: I 328 and 339. The Laundry dryer rooutside vent which widebrls. The vent doo and exposed to the common terms of the common term	ental observations at 9:37 following rooms on the observed to have sharp Rooms 318, 323, 325, 327, oom was observed to have an as clogged with lint and rewas observed to be open outside. The dryer area was ge amounts of lint, trash and				

		AND HUMAN SERVICES & MEDICAID SERVICES			PRINTED: 06/27/2017 FORM APPROVED
STATEMENT	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED
		495340	B, WING		C
NAME OF	PROVIDER OR SUPPLIER		L	REET ADDRESS, CITY, STATE, ZIP CODI	06/15/2017
NEWPOI	RT NEWS NURSING 8	REHAB	1	97 NETTLES DRIVE WPORT NEWS, VA 23602	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETION
F 465	Continued From pa	ge 39	F 465		
	arnounts of lint, tras	as observed to have large sh and debris. The front of vas observed to have chipped	· ·		
	she was asked whe	with the laundry room staff, on the last time the dryer and een cleaned and she stated,			
F 514 - \$\$=D	were in good repair clean and free of de 483.70(i)(1)(5) RES -RECORDS-COMPI		F 514		
	(i) Medical records. (1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are-		1. 2. 3.	quality monitoring tool to be perfo for 4 weeks on each shift to ensure of missing documentation 1 time week	ays was done 6-26-2017. otential to be affected, esignee to complete rmed 3 times per week compliance with ly for one month
	(i) Complete; (ii) Accurately docu	i) Complete; ii) Accurately documented;		then quarterly thereafter. The resulto be discussed at QAPI meeting for further recommendations. A.O.C. is July 18,2017	
	(iii) Readily accessible; and		4,	7.0.0. IS JULY 10,2017	
	(iv) Systematically of	organized			•
	(5) The medical rec	ord must contain-			e e e
	(i) Sufficient Informa	ation to Identify the resident;			
	(ii) A record of the r	esident's assessments;			

PRINTED: 06/27/2017 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING С 495340 B. WING 06/15/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 12997 NETTLES DRIVE **NEWPORT NEWS NURSING & REHAB** NEWPORT NEWS, VA 23602 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ·ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) F 514 Continued From page 40 F 514 (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State: (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483,50. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, clinical record_review and facility document_review, the facility staff failed to maintain a complete and accurate medical record for 1 of 23 residents in the survey sample, Resident #10. The facility staff failed to complete the documentation on the Treatment Administration Record (TAR) for treatments ordered for Resident #10. The findings included: Resident #10 was admitted to the facility-on 4/17/17. Diagnoses for Resident #10 included but not limited to, high blood pressure, cancer, and blindness.

The most recent Minimum Data Set with an assessment reference date of 5/5/17, coded Resident #10 with a score of 9 out of possible 15 on the Brief Interview for Mental Status (BIMS), indicating Resident #10 was moderately impaired in the skills needed for daily decision making.

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Oral care frequently every shift - missed documentation on 4/23 evening shift

Pressure reducing mattress check every shift adequate condition every shift - missed documentation on 4/23 evening shift

Stool sample/specimen every shift - missed documentation on 4/19 day shift; 4/17, 4/23, 4/25,

PRINTED: 06/27/2017 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING COMPLETED 495340 B. WING 06/15/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 12997 NETTLES DRIVE **NEWPORT NEWS NURSING & REHAB** NEWPORT NEWS, VA 23602 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID - (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX . (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DATE DEFICIENCY) F 514 Continued From page 42 F 514 4/26, 4/28 evening shift; 4/18 and 4/26 night shift Wheelchair cushion check every shift for proper condition - missed documentation on 4/23 evening shift. B. May 2017 Treatment Administration Record: Cleanse peg site with soap and water daily, apply clean dry dressing qd (dally) every day shift missed documentation on 5/5 and 5/9 at 9:00 am Barrier Cream to buttocks with each incontinent episode each shift as prevention - missed documentation on 5/5 and 5/9 day shift; 5/6, 5/9 and 5/30 evening shift Enteral - Check for placement every shift by auscultation and aspiration - missed documentation on 5/5 and 5/9 day shift; 5/6, 5/9 and 5/30 evening shift Enteral - Elevate head of bed as per policy every shift - missed documentation on 5/5 and 5/9 day shift: 5/6, 5/9, and 5/30 evening shift

Oral care frequently every shift - missed documentation on 5/5 and 5/9 day shift; 5/6, 5/9.

and 5/30 evening shift

Pressure reducing mattress check every shift

Pressure reducing mattress check every shift adequate condition every shift - missed documentation on 5/5 and 5/9 day shift; 5/6. 5/9 and 5/30 evening shift

(Brand name) heels bilaterally - missed documentation on 5/30 day shift

Turn and position frequently every 1-2 hours

PRINTED: 06/27/2017 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING COMPLETED 495340 B. WING 06/15/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 12997 NETTLES DRIVE **NEWPORT NEWS NURSING & REHAB** NEWPORT NEWS, VA 23602 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX COMPLÉTION REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) F 514 Continued From page 43 F 514 every shift - missed documentation on 5/30 evening shift Wheelchair cushion check every shift for proper condition - missed documentation on 5/5 and 5/9 day shift; 5/6, 5/9 and 5/30 evening shift. C. June 2017 Treatment Administration Record: Cleanse peg site with soap and water daily, apply clean dry dressing qd (daily) every day shift rnissed documentation on 6/12 night shift Cleanse sacrum (4) with NS (Normal Saline) apply (name of medication) and cover with dry dressing change daily and PRN (5) one time a day - missed documentation on 6/2 at 10:00 am PEG tube - change syringe daily every night shift - missed documentation on 6/12 night shift -Barrier Cream to buttocks with each incontinent episode each shift as prevention - missed documentation on 6/2 day shift; 6/12 night shift. Enteral - Check for placement every shift by auscultation and aspiration - missed documentation on 6/2 day shift; 6/12 night shift.

6/12 night shift.

Enteral - Elevate head of bed as per policy every shift - missed documentation on 6/2 day shift;

Oral care frequently every shift - missed documentation on 6/2 day shift; 6/12 night shift.

Pressure reducing mattress check every shift adequate condition every shift - missed

documentation on 6/2 day shift; 6/12 night shift.

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NEWPORT NEWS NURSING & REHAB

NEWPORT NEWS, VA 23602

(X4) ID PREFIX TAG

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

ID PREFIX TAG

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

(X5) COMPLETION DATE

F 514 Continued From page 44

F 514

(Brand name) heels bilaterally - missed documentation on 6/2 day shift; 6/12 night shift.

Turn and position frequently every 1-2 hours every shift - missed documentation on 6/2 day shift; 6/12 night shift.

Wheelchair cushion check every shift for proper condition - missed documentation on 6/2 day shift; 6/12 night shift.

On 6/14/17 at 12:00 pm, (Registered Nurse) RN #1, Nurse Manager, was interviewed and discussed the incomplete documentation on the Treatment Administration Records. She stated that, as Nurse Manager, she expected the nurses to complete the TARs 100%. When asked who was responsible for making sure the documentation was 100% complete, she stated that Nurse Managers are responsible, validated by the DON (Director of Nursing). She stated that TARS are monitored for completion at the end of day shift before the nurses leave and the following day for the evening and night shift. She stated, "Nurses are supposed to document. It is basic nursing."

On 6/15/17 at 8:20 am, an interview was conducted with the DON in regards to the facility process to ensure completion of documentation on the TARs. She stated that nurses were expected to check for the "green light" (in the electronic medical record, green light means that documentation has been signed off) at the end of each shift. She stated that in the morning meeting, she and the clinical staff attending would check all the records for completion and would call the nurses back to fill in the incomplete

PRINTED: 06/27/2017 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING COMPLETED 495340 B. WING 06/15/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 12997 NETTLES DRIVE **NEWPORT NEWS NURSING & REHAB** NEWPORT NEWS, VA 23602 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION ID (X5) --COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) F 514 Continued From page 45 F 514 documentation. According to the DON, the electronic medical records have been audited on an ongoing basis and had seen some improvement in nursing documentation. On 6/15/17 at 10:00 am, the facility Administrator provided a copy of the policy and procedure titled "Daily Skilled Nursing Progress Note" effective 11/30/14 with a revision date of 4/14/17. Completion of the Treatment Administration Record was not addressed in this policy. The facility did not have any other policy thataddressed documentation, according to the Regional Director of Clinical Services. The Administrator, DON and the Regional Director of Clinical Services were made aware of these findings on 6/15/17 at approximately 1:30 pm, no further information was provided. Definition: (1) Enteral - of, relating to, or affecting the intestines (Source: http://c.merriam-webster.com/medlineplus/enteric (2) Auscultation - Auscultation is usually done

(Source:

using a tool called a stethoscope. Health care providers routinely listen to sounds of the body.

https://medlineplus.gov/ency/article/002226.htm)

https://medlineplus.gov/ency/article/002937.htm)

(3) Peg tube - tube through the skin and the stomach wall. It goes directly into the stomach.

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