STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495210	A. BUILDING _____ B. WING _____	07/14/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORFOLK HEALTH AND REHABILITATION CENTER	901 EAST PRINCESS ANNE ROAD NORFOLK, VA 23504

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F 000	Initial Comments An unannounced biennial State Licensure Inspection was conducted 7/12/16 through 7/14/16. Three complaints were investigated. The facility was not in compliance with the Virginia Rules and Regulations for the Licensure of Nursing Facilities. The census in this 180 bed facility was 126 at the time of the survey. The survey sample consisted of 22 current resident reviews (Residents #1 through 22). The facility was not in compliance with the following Virginia Rules and Regulations for the Licensure of Nursing Facilities.	F 000		
F 001	Non Compliance The facility was out of compliance with the following state licensure requirements: This RULE: is not met as evidenced by: The facility was not in compliance with the following Virginia Rules and Regulations for the Licensure of Nursing Facilities. 12 VAC 5-371-300 (B) Pharmaceutical Services Please Cross Reference F431 Dietary and food service program 12 VAC 5-371-340 (A). Cross-Reference to F-371. COV 32.1-138 (A)(10). Please Cross-Reference to F-241 and F-315	F 001	Please reference F431. Please reference F371. Please reference F241 and F315.	8/24/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: interim administrator — (X6) DATE: 7-28-16

State of Virginia

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495210	A. BUILDING _____ B. WING _____	07/14/2016

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F 001	Continued From Page 1	F 001		
	12 VAC 5-371-250 (A). Resident Assessment and Care Plans Please Cross-Reference to F-278		Please reference F278.	8/26/16
	12 VAC 5-371-180 (A). Infection Control Please Cross Reference to F-441		Please reference F441.	
	12 VAC 5-371-280 (A) Resident Activities Please Cross Reference to F248		Please reference F248.	
	12 VAC 5-371-270 (A) Social Services Please Cross Reference F250		Please reference F250.	

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FORM APPROVED
OMB NO. 0938-0391

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

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	495210	A. BUILDING _____ B. WING _____	C 07/14/2016

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F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 7/12/16 through 7/14/16. Three complaints were investigated. Corrections are required for compliance with the following 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. The census in this 180 certified bed facility was 126 at the time of the survey. The survey sample consisted of 27 residents, 22 current Resident reviews (Resident #1 through 22) and 5 closed record reviews (Resident #23 through 27).	F 000		
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observations, clinical record review, facility documentation, and staff interviews the facility staff failed to provide care in a manner that maintained and enhanced the dignity of 1 of 27 resident in the survey sample, Resident #2. The facility staff failed to care for Resident #2 in a manner that maintained and enhanced her dignity by pulling her backwards to a meal while up in a geri-chair. The findings included:	F 241	Resident #2 is receiving care in a manner that maintains and enhances dignity. Residents requiring assistance with transport were reviewed to ensure that they are transported in a manner that maintains and enhances dignity. Education to Nursing staff will be provided on: • Maintaining resident dignity by transporting with their face forward instead of backwards to ensure that they can see where they are going	8/26/16

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

[signature] interim administrator 7-28-16

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

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F 241	Continued From page 1 Resident #2 was a 91 year old admitted to the facility on 11/27/15 with diagnoses to include *Anxiety Disorder, *Dementia, and *Depression. *Anxiety Disorder: a disorder in which anxiety is the most prominent feature. The symptoms range from mild, chronic tenseness, with feelings of timidity, fatigue, apprehension, and indecisiveness, to more intense states of restlessness and irritability that may lead to aggressive acts, persistent helplessness, or withdrawal. *Dementia: A progressive organic mental disorder characterized by chronic personality disintegration, confusion, disorientation, stupor, deterioration of intellectual capacity and function, and impairment of control of memory, judgement and impulses. *Depression: an abnormal emotional state characterized by exaggerated feelings of sadness, melancholy, dejection, worthlessness, emptiness, and hopelessness that are inappropriate and out of proportion to reality. The above definitions were derived from Mosby's Dictionary of Medicine, Nursing, and Health Professions 8th Edition. Resident #2's most recent comprehensive Minimum Data Set (MDS) assessment was a Significant Change with an Assessment Reference Date (ARD) of 5/6/16. The Brief Interview for Mental Status (BIMS) indicated the resident had short and long term memory issues, was severely cognitively impaired and rarely able to make decisions.	F 241	A random weekly audit of resident transportation to ensure that dignity is maintained will be completed by the Unit Manager or designee. Issues noted will be referred to the Quality Assurance Committee for review and recommendation.	

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F 241	Continued From page 2	F 241		

Resident #2's Comprehensive Plan of Care was reviewed and documented in part, as follows:

Focus:
The resident has impaired cognition function/dementia or impaired thought processes related to Disease Process.

Interventions:
*Communication-face the resident when speaking and make eye contact.
*Keep the resident's routine consistent.

On 7/12/16 at 4:35 p.m. CNA #1 was observed pulling Resident #2 backwards in her geri-chair from the nurse's station to the dining room approximately 50 feet. CNA #1 was asked by the surveyor why she pulled the resident backwards into the dining room, CNA #1 stated, "Because it is easier to move her chair like that." The Assistant Director Of Nursing was standing in the door way of the dining room shaking her head from left to right saying no to CNA #1's response.

The surveyor asked the Assistant Director of Nursing if she would like to tell the CNA why the resident should not be pulled backwards. The Assistant Director of Nursing stated, "It is a safety risk for you (CNA) to pull someone backwards, it's not effective for your body ergo-dynamics." The surveyor asked the Assistant Director of Nursing if that was the only reason not to pull a resident backwards and the Assistant Director stated, "Yes it's a safety reason." The Unit Manager RN (Registered Nurse) #1 was asked why would you not pull a resident backwards and he stated, "Because that's a dignity issue."

The facility policy titled "General Care" effective

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	495210	A. BUILDING _____ B. WING _____	C 07/14/2016

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F 241	Continued From page 3	F 241		

date of 2/1/15 documented in part, as follows:

Policy:
Nursing personnel will provide basic nursing care and services following accepted standards of practice guidelines recognized by state boards of nursing as informed by national nursing organizations and as evidenced by hiring individuals who graduate from an approved nursing school and/or nurse aide curriculum and have successfully passed a licensing and/or certification examination.

Procedure:
1. Nursing staff may utilize Mosby's Textbook for Long-Term Care Assistants, current edition, or an approved fundamental skills and concepts textbook as directed.

Mosby's Textbook for Long-Term Care Assistants 7th Edition 2015.

Required Actions That Promote Dignity and Privacy:
Courteous and Dignified Interactions
*Gain the person's attention before interacting with him or her.
*Do not yell at, scold, or embarrass the person.
Courteous and Dignified Care
Promote independence and dignity in dining.
No further dignity policies were available from the facility.

On 7/14/16 at 3:45 p.m. a pre-exit debriefing was held with the Administrator, Director of Nursing, and the Nurse Consultant where the above findings were shared. The Director of Nursing was asked what would she have expected of her staff in regards to moving residents in mobility

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 241	Continued From page 4 devices. The Director of Nursing stated, "I would have expected them to push her forward, because it is a dignity issue, so she could see where she was going." Prior to exit no further information was provided.	F 241		
F 248 SS=E	COMPLAINT DEFICIENCY 483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, facility documentation review, clinical record review the facility staff failed to provide an activity program to meet the interest and need of 1 of 27 residents. (Resident #12) For Resident #12 the facility staff failed to provide individualized one-to-one activities and social group activities for at least a year. The findings included: Resident #12 was initially admitted to the facility on 04/09/2007 and readmitted on 3/17/2014. Diagnoses for Resident #12 included but are not limited to multiple sclerosis (disabling disease of the central nervous system), mononeuropathy(nerve group damage causes a	F 248	Resident #12 is provided individualized one-to-one activities per her preferences. Residents needing one-to-one activities were reviewed to ensure that activities are individualized and preferences are met. Activity staff have developed a tracking system to ensure that activity needs are met. The Administrator or designee will complete a random weekly review of documented activities to ensure that residents are receiving individualized one-to-one per resident preference. Issues noted will be reported to the Quality Assurance Committee for review and recommendation.	8/26/16

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	495210	A. BUILDING _____ B. WING _____	C 07/14/2016

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F 248	Continued From page 5	F 248		

loss of sensation, movement, and function), contracture of muscle, right and left lower legs, and neuromuscular dysfunction of bladder (lacking bladder control due to brain, spinal cord, or nerve condition.

Resident #12's comprehensive assessment Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 4/18/16 coded Resident #12 with no cognitive impairment (BIMS-Brief Interview Mental Status tool- score 15) but total dependence on staff for Activities of Daily Living (transfers, dressing, bathing). Resident #12's range of motion was coded for impairment to one side of the upper extremities and impairment on both sides of the lower extremities. Bowel and bladder not coded on Annual Comprehensive Assessment MDS with presence of a Foley catheter (tubing into bladder to drain urine into a bag) and colostomy (an alternative channel for feces to leave the body into a bag).

On 7/12/16 at approximately 4:00 p.m. Resident #12 was observed in a hospital gown in bed. On 7/13/16 at approximately 12:40 p.m. Resident #12 was observed dressed and sitting in highback wheelchair using adaptive eating utensils for self feeding at the lunch meal. On 7/14/16 at 11:00 a.m. Resident #12 was observed in a hospital gown with food particles on gown from breakfast awaiting morning ADLs (dressing, cleaning, transfer to the wheelchair). During the survey from 7/12/16 to 7/14/16, Resident #12 was not observed participating in an activity, a visit, or out of her room.

On 7/13/2016, Resident #12's clinical record was reviewed. Nursing notes from January 2016 until present did not mention Resident #12

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F 248	Continued From page 6	F 248		

participating in activities or going out of her room. The only physician ordered note dated 5/26/2014 (Order start date) regarding activities documented, "OOB(Out of Bed) in chair (electric) with good cushion, two times a day."

The most current care plan (date initiated 5/27/16 and revised 7/9/16) documented the focus, "maintain/increase social stimulation" and the goal documented read, "Resident [#12] will engage in independent leisure activities and 1:1 [one-to-one interactions] at least 1-2 times [does not identify week or month] to maintain/increase social stimulation by re-evaluation date (8/9/16)." The interventions documented on the most current care plan regarding activities are listed: 1. "Encourage and assist to group activity programs such as religious settings, special events, to maintain interaction, cooperation, socialization with peers (date initiated 5/27/2014, revised 1/8/16)"; 2. "Offer refreshments within diet, spa hurrah, outdoor strolls during visitations (dated initiated 5/27/14 and revised 4/8/15)"; and 3. "Provide with monthly Activity Calendars for planning and information purposes (date initiated 7/16/14)" and no revision date documented.

According to social service progress notes (e-signed by the discharge planner-Others #9) documented on 7/12/16, "[Resident #12] is alert and oriented x 3 [person, place, environment] and is able to make her needs known." Also in this same note it documented that Resident #12 "spends the majority of her time in bed...." Finally, this note reads, Resident #12, "welcomes visitors and is easily engaged in meaningful conversation."

The Activity Director (Others #1) presented a

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	495210	A. BUILDING _____ B. WING _____	C 07/14/2016

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F 248	Continued From page 7	F 248		

quarterly review dated 7/9/2016 documented Resident #12's preference for 1:1 (one-to-one interaction) and to engage in independent leisure activities. Resident #12's favorite activities were documented to be, "watching TV and reading." There were no specific types of programs mentioned or books. The section on this Quarterly Review entitled "Activity Plan Review" documented that "goals were not met but resident progress achieved."

A calendar was submitted by the current Activity Director with the names of all residents (combined from the former activity directors list) receiving 1:1 (one-to-one interaction) for July 2016 and Resident #12 was not on this list.

Two quarterly Activity Progress notes were submitted by the Activity Director. The first activity note dated 1/8/16 noted Resident engages in independent leisure pursuits and 1:1 activities 1-2 times per week and the outcomes were documented to be, "Maintain leisure interests, increase group participation for social stimulation." The second Activity Progress note dated 4/8/16 documented Resident #12 engages in leisure pursuits and welcomes 1:1 visits for social stimulation at least 1-2 times per week. Outcomes documented read, "Increase social functioning in group settings."

On 7/12/2016 at approximately 4:00 p.m. Resident #12 was interviewed. Resident #12 stated, "I have MS, my legs are completely stiff and I need constant help." Resident #12 also stated, "My wheelchair is difficult for me to move, I can't do it [use this wheelchair to get around]." Resident #12 on 7/13/16 at 12:40 p.m. stated in regards to use of her arms and hands while

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	495210	A. BUILDING _____ B. WING _____	C 07/14/2016

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F 248	Continued From page 8	F 248		

eating lunch, "I can move my hands to eat but it gets messy on my shirt."

In an interview with the Activity Director on 7/13/16 at 3:24 p.m., the Activity Director stated, "I went to see the resident [#12] last week and spoke with her and she would like to get out more but she thinks her colostomy bag stinks- I did not tell nursing about this but I will." As a result, the Activity Director stated, " I will place her on the 1:1 visit list and offered to bring some activities to her." The Activity Director also stated, "I have not seen her out at an activity and she was not on the 1:1 visit list from the former Activity Director but I am adding her now." During the look back period (the last 30 days 6/1/16 to 7/1/16) it was documented that Resident #12, "did not met goal from 6/5/16 to 6/11/16 to attend or have 1:1 visits".

The activity assistant (Others #2- who works with Resident #12) stated on 7/13/16 at 4:13 p.m., "She [Resident #12] told me she wants 1:1 visits." When asked what role she has with Resident #12, Others #2 stated, "I go into the room for 15 minutes based on how the resident feels, I will give date of week, month, holiday and general information and sometimes do her nails and I will sing a religious song." finally, Others #2 stated, "She [resident #12] likes religious songs, books, and shows" but she did not know any specific favorites or preferences. Others #2 did not know the frequency of her visits to Resident #12's room. Others #2 did say, "Her [Resident #12]' physical decline and mental health prevents her from coming out of her room."

Licensed Practical Nurse (LPN) #6 stated on 7/14/16 at approximately 10:55 a.m., that she had

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 248	Continued From page 9	F 248		

not heard about fixing a wheelchair for Resident #12. She knew it was broken but could not recall when it broke. The unit manager (LPN # 5) also noted Resident #12 wants to get up in her wheelchair daily. LPN #5 stated, "She [Resident #12] used to come out of her room 3-4 times a week and daily for meals (lunch)...now maybe 1-2 times and will decline dining room". When asked the reason, LPN #5 stated, "this slowly happened over time and she [Resident #12] changes her mind."

On 7/14/16 at 11:10 p.m. Resident #12 stated, "I would go out [of this room] but I can't use this wheelchair". Resident #12 also stated, "I had a motorized wheelchair but it is broken for 1-2 years now and they (Facility staff Others #9) took it away and I don't know where it is." Resident #12 stated, "I would go out and participate more in games but its been over a year." Resident #12 mentioned her local family member that visits sometimes.

Resident #12 continued on 7/14/16 at 11:10 a.m. and stated in regards to activities, "I did puzzles, played games, and bingo...I did whatever they were doing, I stopped going out to activities its been a years." Also Resident #12 stated that her favorite TV show were, "game shows, court shows, and religious shows and she reads magazines and guide posts (a religious daily reader but I haven't had anything to read its been a couple of days/weeks not sure- but today they brought me some."

In regards to the activity staff providing 1:1 visits, Resident #12 stated, The former Activity Director did not come in to visit me but now sometimes they will "put the calendar up but I can't see it

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495210	A. BUILDING _____ B. WING _____	C 07/14/2016

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NORFOLK HEALTH AND REHABILITATION CENTER	901 EAST PRINCESS ANNE ROAD NORFOLK, VA 23504

(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 248	Continued From page 10 over there." The activity calendar was observed to be around the corner and out of sight for Resident #12. Resident #12 stated, "I would hear the announcements but...I just stay to myself." Also, "I used to go downstairs to get my hair done but its been 2 months since the hair stylist quit and no there is no reason to go downstairs." Finally Resident #12 stated, "I have not been to a group activity for over a year...I just started staying in here...my wheelchair has been broken..and I don't like the smell of the bag [colostomy bag]". The PA (Physician's Assistant-Others #6) stated on 7/14/16 at 11:15 a.m., Resident #12 stays in room a lot and gets her timing off-maybe because she is always in her room-for example, when asked 'Is it spring today?' she [Resident #12] will not know if it is Spring." Resident #12 became disoriented to time according to the PA. Administrative staff (Admin # 2, 3, 4, 5) including the DON (Director of Nursing) were informed during a briefing on 7/14/16 at 4:10 p.m. The facility did not present any further information about the findings. No policies were presented ,no information was added to show 1:1 visits per Resident #12's interests, and no evidence was presented that Resident #12 attended and participated in groups activity per social need for the entire year prior to survey.	F 248		
F 250 SS=E	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial	F 250		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495210	A. BUILDING _____ B. WING _____	C 07/14/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORFOLK HEALTH AND REHABILITATION CENTER	901 EAST PRINCESS ANNE ROAD NORFOLK, VA 23504

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 250	Continued From page 11 well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, facility documentation review, and clinical record review the facility staff failed to provide medically related social services to maintain the highest practicable physical, mental and psychosocial well being for 1 of 27 residents. (Resident #12) For Resident #12 the facility staff failed to take steps to repair a broken motorized wheelchair to meet the resident's need to self-ambulate for at least one year. The findings included: Resident #12 was initially admitted to the facility on 04/09/2007 and readmitted on 3/17/2014. Diagnoses for Resident #12 included but are not limited to multiple sclerosis (disabling disease of the central nervous system), mononeuropathy(nerve group damage causes a loss of sensation, movement, and function), contracture of muscle, right and left lower legs, and neuromuscular dysfunction of bladder (lacking bladder control due to brain, spinal cord, or nerve condition. Resident #12's comprehensive assessment Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 4/18/16 coded Resident #12 with no cognitive impairment (BIMS-Brief Interview Mental Status tool- score 15) but total dependence on staff for Activities of Daily Living	F 250	8/26/16 Resident #12's motorized wheelchair was found to be irreparable. An order has been obtained from her physician to evaluate for a new motorized wheelchair. Referrals have been sent to two motorized wheelchair companies to evaluate for the new motorized wheelchair. Pending receipt of a new motorized wheelchair, Resident #12 is assisted with wheelchair mobility as needed and has been coming out of her room more often to participate in more activities. Residents with motorized wheelchairs were reviewed to ensure that the motorized wheelchair is in proper working condition on order to maintain the highest practicable physical, mental, and psychosocial well-being of the resident. Nursing staff were educated on: • Completion of work order when motorized wheelchair needs repair Maintenance staff were educated on: • Reporting need for replacement motorized wheelchair to Administrator to ensure that appropriate action is initiated to replace the chair as indicated	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495210	A. BUILDING _____ B. WING _____	C 07/14/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORFOLK HEALTH AND REHABILITATION CENTER	901 EAST PRINCESS ANNE ROAD NORFOLK, VA 23504

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F 250	Continued From page 12	F 250		

(transfers, dressing, bathing). Resident #12's range of motion was coded for impairment to one side of the upper extremities and impairment on both sides of the lower extremities. Bowel and bladder not coded on Annual Comprehensive Assessment MDS with presence of a Foley catheter (tubing into bladder to drain urine into a bag) and colostomy (an alternative channel for feces to leave the body into a bag).

On 7/12/16 at approximately 4:00 p.m. Resident #12 was observed in a hospital gown in bed. On 7/13/16 at approximately 12:40 p.m. Resident #12 was observed sitting dressed in highback wheel chair using adaptive eating utensils for self feeding at the lunch meal. On 7/14/16 at 11:00 a.m. Resident #12 was observed in a hospital gown with food particles on gown from breakfast awaiting morning ADLs (dressing, cleaning, transfer to the wheelchair).

On 7/13/16 and 7/14/16, Resident #12's clinical record was reviewed. On the Medication Review Report an order summary dated 5/26/2014 (order start date) documented, "OOB [out of bed] in electric chair with good cushion two times a day." A verbal physician's order dated 6/7/16 documented "D/c [discontinue] order for power chair". A phone physician's order dated 6/10/16 documented, "Power mobility device evaluation for protocol." According to the Treatment Administration Record for the month of July 2016, with an order dated 3/31/2016 documented, "Device: Assist bars x 2, High-back reclining wheelchair every shift for monitors".

The most current care plan documented the goal as the resident will maintain current level of function in ADL through the review date (the goal

The Unit Manager or designee will complete a random weekly audit to ensure that motorized wheelchairs are functioning properly. Issues noted will be reported to the Quality Assurance Committee for review and recommendation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495210	A. BUILDING _____ B. WING _____	C 07/14/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORFOLK HEALTH AND REHABILITATION CENTER	901 EAST PRINCESS ANNE ROAD NORFOLK, VA 23504

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 250	Continued From page 13	F 250		

was created on 5/27/2014, revised on 5/10/2016, and the target date was 8/9/2016). Also on the care plan the focus was documented, the resident has an ADL self-care performance deficit related to limited mobility, multiple sclerosis (date imitated 5/27/2014 and revised on 4/14/2015). Finally on the care plan under the title, "Interventions" it was documented for devices, "...high back wheelchair with cushion (created 3/8/2016 and revised on 4/13/2016)."

On the same most current care plan Resident #12 was documented to be at risk for falls related to deconditioning, weakness, multiple sclerosis, and contractures to both lower extremities (date initiated 5/27/2014 and revised on 4/14/2016). Under the title, "Interventions" it was documented for devices, "...high back wheelchair with cushion if electric chair is not available)...(date initiated 7/23/2014 and revised 4/26/2016)."

Documentation (a signed check, Medicaid Long Term Care Communication Form, and receipt) provided by the Business Office Manager (BOM) on 7/14/16 confirmed that Resident #12 had an electric wheelchair while in the facility and it was last repaired on 11/7/2013 when the batteries were replaced. No other documentation was given by the facility staff to provide the actual date when the electric wheelchair broke and became inoperable by Resident #12.

On 7/12/2016 at approximately 4:00 p.m. Resident #12 was interviewed. Resident #12 stated, "I have MS, my legs are completely stiff and I need constant help." Resident #12 also stated, "My wheelchair is difficult for me to move, I can't do it [use this wheelchair to get around]." Resident #12 on 7/13/16 at 12:40 p.m. stated in

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495210	A. BUILDING _____ B. WING _____	C 07/14/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORFOLK HEALTH AND REHABILITATION CENTER	901 EAST PRINCESS ANNE ROAD NORFOLK, VA 23504

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 250	Continued From page 14	F 250		

regards to use of her arms and hands while eating lunch, "I can move my hands to eat but it gets messy on my shirt." Finally, on 7/14/16 at 11:10 p.m. stated, "I would go out [of this room] but I can't use this wheelchair". Resident #12 also stated, "I had a motorized wheelchair but it is broken for 1-2 years now and they (Facility staff Others #9) took it away and I don't know where it is." Resident #12 stated, "I would go out and participate more in games but its been over a year."

In an interview with the Therapy Director (Others #3) on 7/13/16 at 9:15 a.m. the Therapy Director stated, Resident #12's power chair was broken and not sure if resident came in with the chair or not. According to the Therapy Director Resident #12 does not require the skills of a therapist and was discharged from therapy services years ago. The Therapy Director also stated, "Socially she is in her room often only comes out to get hair done." No information was presented regarding therapy [discharge summary or any evaluations] for Resident #12 as the documentation was on another system and not easily accessible.

According to the Regional Nurse Consultant (Administration # 5) on 7/14/16 at 10:00 a.m., Resident #12's electric wheelchair is in storage and broken. Administration # 5 stated, "There was no date when it went out for repairs when I asked maintenance". She added, "We are going to fix it."

On 7/14/16 at 10:05 a.m. Others #5 from maintenance staff stated, "If something is broken then we have a work order system and we check this daily in the a.m. and again in the afternoon, and if anything is broken a work order is made."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495210	A. BUILDING _____ B. WING _____	C 07/14/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORFOLK HEALTH AND REHABILITATION CENTER	901 EAST PRINCESS ANNE ROAD NORFOLK, VA 23504

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 250	Continued From page 15	F 250		

Maintenance Director was asked on 7/14/16 at 11:50 a.m. for a work order for Resident #12's wheelchair and none was presented by the facility staff.

On 7/14/16 at approximately 10:55 a.m., Licensed Practical Nurse #6 stated that she had not heard about fixing a wheelchair for Resident #12. Licensed Practical Nurse #6 stated she knew it was broken but could not recall when it broke. The unit manager (LPN # 5) also noted Resident #12 wants to get up in her wheelchair daily. LPN #5 stated, "She [Resident #12] used to come out of her room 3-4 times a week and daily for meals (lunch)...now maybe 1-2 times and will decline dining room". When asked the reason, LPN #5 stated, "this slowly happened over time and she [Resident #12] changes her mind."

According an interview with the PA (Physician's Assistant-Others #6) on 7/14/16 at 11:15 a.m. the PA stated that Resident #12 stays in her room a lot.

According to the BOM on 7/14/16 at approximately 1:00 p.m., "Personal Property can be fixed if maintenance puts in a work order and the bookkeeping calls in a request for a new chair."

An interview was conducted with the Bookkeeper and BOM on 7/14/16 at 1:15 p.m. The bookkeeper stated, "I did request a new chair a year ago or maybe a few years ago bit nothing recently." The BOM added, "If the resident wants a new chair or we can't fix a chair then therapy will assess and find list of companies able to order from, an order must be written, and social services (eligibility worker) notified for approval

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495210	A. BUILDING _____ B. WING _____	C 07/14/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORFOLK HEALTH AND REHABILITATION CENTER	901 EAST PRINCESS ANNE ROAD NORFOLK, VA 23504

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 250	Continued From page 16	F 250		

from Medicaid."

In an interview on 7/14/16 at approximately 1:20 p.m. the Social Service Worker (Discharge Planner) at the facility (Others #9) said, "No process had been started to fix Resident #12's broken wheelchair" and she added, "I can not recall when it was broken." In the same interview, the Director of Social Services at the facility (Others #10) added, "Resident #12 will verbalize her feelings and she is very comfortable with us and we try hard to get her out."

Administrative Staff (#5) stated on 7/14/16 at 1:45 p.m. in regards to the broken wheelchair stated, "We brought it back out of storage".

In a debriefing with Administration and the DON (Director of Nursing) on 7/14/16 at 4:00 p.m. it was stated by the Vice President of Operations, "We will fix this chair."

The BOM presented Manual excerpt entitled "Nursing Facility Provider Manual" last revised on 9/27/2007. This documented covered services and limitations and it read, "Requests for adjustments to patient pay for services or expenses which exceed $500, must be submitted by the local social service worker. The local social services worker sends the request and documentation from the facility, along with the patient income and patient pay information to DMAS for authorization." This was not completed by the facility staff for Resident #12.

The facility administration was informed of the findings during a briefing on 7/14/16 at approximately 4:10 p.m. The facility did not present any further information about the findings.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495210	A. BUILDING _____ B. WING _____	C 07/14/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORFOLK HEALTH AND REHABILITATION CENTER	901 EAST PRINCESS ANNE ROAD NORFOLK, VA 23504

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 250	Continued From page 17 No other policies were presented.	F 250		
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on observation, clinical record review, facility documentation, and staff interviews the facility staff failed to ensure that a Minimum Data	F 278	8/26/16 The 5/4/16 MDS of Resident #16 was modified to reflect accurate coding of isolation precautions. Residents with orders for special infection control precautions were reviewed to ensure that the MDS is coded accurately for isolation precautions. The MDS Coordinators were educated on: • Coding isolation precautions The MDS Consultant will complete a random monthly audit of MDS's for residents with orders for special infection control precautions to ensure that the MDS is coded accurately. Issues noted will be referred to the Quality Assurance Committee for review and recommendation.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495210	A. BUILDING _____ B. WING _____	C 07/14/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORFOLK HEALTH AND REHABILITATION CENTER	901 EAST PRINCESS ANNE ROAD NORFOLK, VA 23504

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 278	Continued From page 18	F 278		

Set (MDS) Resident Assessment accurately reflected the resident status for 1 of 27 residents in the survey sample, Resident #16.

The facility staff failed to ensure that Resident #16's Minimum Data Set (MDS) Comprehensive 5 day Admission Assessment with an Assessment Reference Date of 5/4/16 was coded accurately to include Contact Isolation.

The findings included:

Resident #16 was a 53 year old admitted to the facility on 4/27/16 with diagnoses to include *Osteomyelitis of the left foot, *Methicillin Resistant Staphylococcus Aureus Infection of the left great toe, and *End Stage Renal Disease.

*Osteomyelitis: local or generalized infection of bone and bone marrow, usually caused by bacteria introduced by trauma or surgery, by direct extension from a nearby infection, or via the bloodstream.

*End Stage Renal Disease: a disease condition that is essentially terminal because of irreversible damage to vital tissue or organs. Kidney or renal end stage disease is defined as a point at which the kidney is so badly damaged or scarred that dialysis or transplantation is required for patient survival.

The above definitions were derived from Mosby's Dictionary of Medicine, Nursing, and Health Professions 8th Edition.

*Methicillin Resistant Staphylococcus Aureus Infection (MRSA): is a type pf staph bacteria that is resistant to certain antibiotics called

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495210	A. BUILDING _____ B. WING _____	C 07/14/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORFOLK HEALTH AND REHABILITATION CENTER	901 EAST PRINCESS ANNE ROAD NORFOLK, VA 23504

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 278	Continued From page 19	F 278		

betalactams. These antibiotics include methicillin and other more common antibiotics such as oxacillin, penicillin, and amoxicillin. More severe or potentially life-threatening MRSA infections occur most frequently among patients in healthcare settings.
www.cdc.gov

A review of Resident #16's Progress Notes documented in part, as follows:

Date 4/27/16 at 7:55 p.m.
Resident admitted to [name of facility] from [name, area hospital]. Resident has 2 cm [centimeter] incision with sutures to left great toe. Resident has central line to left chest and fistula to right arm. Resident on contact isolation for MRSA to left great
toe.

Date 4/30/16 at 2:10 p.m.
Continues to be on isolation for MRSA on left foot.

Date 5/1/16 at 2:13 a.m.
Isolation continues related to MRSA.

Date 5/2/16 at 2:59 p.m.
Continues to be on isolation for MRSA left great toe open area.

Date 7/10/16 at 11:26 a.m.
Remains on contact isolation precaution for MRSA to left foot.

Date 7/12/16 at 11:28 p.m.
Continues on IV (intravenous) ABT (antibiotic) for MRSA.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495210	A. BUILDING _____ B. WING _____	C 07/14/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORFOLK HEALTH AND REHABILITATION CENTER	901 EAST PRINCESS ANNE ROAD NORFOLK, VA 23504

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 278	Continued From page 20	F 278		

A current Physician Order on the July 2016 Treatment Administration Record with nursing signatures from 7/1/16-7/13/16 documented in part, as follows:

Contact Isolation MRSA L (left) foot. every shift for isolation.
-ORDER Date- 4/28/16 6:02 a.m.

Resident #16's Comprehensive Plan of Care was reviewed and documented in part, as follows:

Focus:
The resident has Osteomyelitis of the left foot and ankle; currently on IV ABT. Date Initiated: 4/28/16 Revision on: 4/28/16

Interventions:
Precautions (Contact) as ordered.
Date Initiated: 4/28/16 Revision on: 7/12/16

On 7/12/16 at 4:10 p.m. an observation of a Contact Isolation Precaution Sign was made of Resident #16's door documented in part, as follows:

STOP Contact Precautions
Visitors must report to Nursing Station before entering.
*Perform hand hygiene using soap and water and/or alcohol-based rub before entering and before leaving room.
*Wear gown and gloves when entering room or cubicle.
*Bag linen to prevent contamination of self, environment or outside bag.
*Discard infectious trash to prevent contamination of self, environment or outside bag.
revised 12/09

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495210	A. BUILDING _____ B. WING _____	C 07/14/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORFOLK HEALTH AND REHABILITATION CENTER	901 EAST PRINCESS ANNE ROAD NORFOLK, VA 23504

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 278	Continued From page 21	F 278		

A review was completed on Resident #16's Minimum Data Set (MDS) Comprehensive 5 day Admission Assessment with an Assessment Reference Date of 5/4/16. The resident's Brief Interview for Mental Status (BIMS) was a 15 out of a possible 15 indicating the resident was cognitively intact and capable of daily decision making. Under Section N, Medications Received Resident #16 was coded to have received an antibiotic for 7 days of the look back period of the assessment. Under Section O, Special Treatment, Procedures, and Programs Resident #16 was not coded under Isolation or quarantine for active infectious disease even though physician orders, treatments, and diagnoses indicated Contact Isolation was in place due to an active MRSA infection of the resident's left great toe.

On 12/14/16 at 3:00 p.m. an interview was conducted with the facilities Regional MDS Specialist #7 . Regional MDS Specialist #7 was asked why Resident #16 was not coded for Contact Isolation on the (MDS) Comprehensive 5 day Admission Assessment with an Assessment Reference Date of 5/4/16. The Regional MDS Specialist #7 stated, "We decided we did not have the correct documentation and that the admission 5 day assessment was incorrect. We have completed a modification."

The facility policy titled MDS effective date 2/1/15 documented in part, as follows:

Policy: MDS's will be completed according to the most current version of the RAI (Resident Assessment Indicator) Manual.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495210	A. BUILDING _____ B. WING _____	C 07/14/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORFOLK HEALTH AND REHABILITATION CENTER	901 EAST PRINCESS ANNE ROAD NORFOLK, VA 23504

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 278	Continued From page 22	F 278		

Procedure:
1. The MDS is to be completed using the most current item set(s).
7. Each person entering data into MDS will date the MDS on MDS signature page indicating the section(s)/questions each completed attesting to the accuracy of the sections they completed.
8. By signing, staff indicate their knowledge that accuracy of the MDS is essential because that information is used to generate payment for the Medicare patients and data for the Quality Indicators and Quality Measures as well as impacting the facility Medicaid rate.
12. The MDS will be used to develop a plan of care addressing those problems, needs, strengths or potential problems that were identified during the assessment process.

On Page O-4 of the MDS manual it reads:
"O0100M, Isolation for active infectious disease (does not include standard precautions)
Code only when the resident requires transmission-based precautions and single room isolation (alone in a separate room) because of active infection (i.e., symptomatic and/or have a positive test and are in the contagious stage) with highly transmissible or epidemiologically significant pathogens that have been acquired by physical contact or airborne or droplet transmission. Do not code this item if the resident only has a history of infectious disease (e.g., s/p [Status Post] MRSA or s/p C-Diff - no active symptoms). Do not code this item if the precautions are standard precautions, because these types of precautions apply to everyone. Standard precautions include hand hygiene compliance, glove use, and additionally may include masks, eye protection, and gowns. Examples of when the isolation criterion would

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495210	A. BUILDING _____ B. WING _____	C 07/14/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORFOLK HEALTH AND REHABILITATION CENTER	901 EAST PRINCESS ANNE ROAD NORFOLK, VA 23504

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 278	Continued From page 23 not apply include urinary tract infections, encapsulated pneumonia, and wound infections. " On 7/14/16 at 3:45 p.m. a pre-exit debriefing was held with the Administrator, Director of Nursing, and the Nurse Consultant where the above findings were shared. Prior to exit no further information was provided.	F 278		
F 309 SS=E	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observations, resident interview, staff interview, facility documentation review, clinical record review, and in the course of a complaint investigation, the facility staff failed for one resident (Resident #9) of 27 Residents in the survey sample to ensure non pharmacological measures were implemented prior to the use of the as needed pain medication Hydrocodone/Acetaminophen*. *Hydrocodone per Medline Plus: Hydrocodone/Acetaminophen is used to relieve severe pain. Hydrocodone is only used to treat people who are expected to need medication to relieve severe pain around-the-clock for a long	F 309	Resident #9's pain management program has been reviewed and revised to ensure that non-pharmacological interventions are implemented prior to administration of as needed pain medications. Residents with as needed pain medication administration were reviewed to ensure that non-pharmacological interventions are documented prior to administration of the as needed pain medication. Charge Nurses were educated on: • Documentation of non-pharmacological interventions prior to administration of as needed pain medications • Examples of non-pharmacological interventions to address pain	8/26/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495210	A. BUILDING _____ B. WING _____	C 07/14/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORFOLK HEALTH AND REHABILITATION CENTER	901 EAST PRINCESS ANNE ROAD NORFOLK, VA 23504

(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 309	Continued From page 24	F 309		

time and who cannot be treated with other medications or treatments. Hydrocodone extended-release (long-acting) capsules or extended-release tablets should not be used to treat pain that can be controlled by medication that is taken as needed. Hydrocodone/Acetaminophen is in a class of medications called opiate (narcotic) analgesics. It works by changing the way the brain and nervous system respond to pain.

The findings included:

Resident #9 was admitted to the facility on 1/13/14. Diagnoses for Resident #9 included but are not limited to Osteoarthritis (Osteoarthritis is the most common form of arthritis. It causes pain, swelling, and reduced motion in your joints), Chronic Pain Syndrome and Cerebral Vascular Accident (stroke) with Left sided hemiparesis (paralysis).

Resident #9's Quarterly MDS (Minimum Data Set - an assessment protocol) with an ARD (Assessment Reference Date) of 6/25/16 coded Resident #9 with a score of 14 of 15 on BIMS (Brief Interview for Mental Status) indicating no cognitive impairment. In addition, the Quarterly MDS coded Resident #9 as requiring Total Dependence with two staff person assistance for Bathing and Toileting. Resident #9 was coded and having pain almost constantly and was coded as having pain at a scale of 8 of 10.

A Physician order dated 5/3/16 showed Resident #9 was prescribed Hydrocodone/Acetaminophen Tablet 5-325 MG (milligrams) The order read, give one tablet by mouth every 6 hours as needed for chronic pain syndrome.

Random weekly monitoring of documentation of non-pharmacological interventions prior to administration of as needed pain medications will be completed by the Unit Manager or designee. Issues noted will be referred to the Quality Assurance Committee for review and recommendation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495210	A. BUILDING _____ B. WING _____	C 07/14/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORFOLK HEALTH AND REHABILITATION CENTER	901 EAST PRINCESS ANNE ROAD NORFOLK, VA 23504

(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 309	Continued From page 25	F 309		

Resident #9's 5/27/14 Care Plan Focus documented the following: "The resident has chronic pain - L (Left) shoulder pain, leg pain, arthralgia." The Care Plan documented the following interventions:
Administer analgesia per order care as needed
Non Pharmalogical Interventions: positioning, relaxation therapy, pressure relieving cushion, bathing, snacks.
Sling to LUE (left upper extremity) daily to minimize pain; refuses at times.

Resident #9's MAR (Medication Administration Record) documented that she received Hydrocodone/Acetaminophen on the following dates: 6/7/16, 6/24/16, 6/26/16, 6/27/16, and 7/4/16. Review of Resident #9's clinical record did not reveal documentation for non-pharmacological measures prior to use of the administration of Hydrocodone/Acetaminophen.

On 7/14/16 at approximately 12:35 p.m. the DON (Director of Nursing) employee #3 stated, "No documentation for non-pharmacological measures for the date" as the surveyor asked for the following dates: 6/7/16, 6/24/16, 6/26/16, 6/27/16, and 7/4/16. The DON stated, "My expectation is there would be documentation of non-pharmacological measures utilized."

Resident #9 stated on 7/12/16 at approximately 3:00 p.m., "Have pain in my joints." Resident #9 requests a Trapeze bar to help reposition herself to ease pain.

Resident #9 stated on 7/13/16 at approximately 3:00 p.m., "have pain often, I'd like to get in the whirlpool tub but told it has been broken for over

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495210	A. BUILDING _____ B. WING _____	C 07/14/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORFOLK HEALTH AND REHABILITATION CENTER	901 EAST PRINCESS ANNE ROAD NORFOLK, VA 23504

(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 309	Continued From page 26	F 309		

a year. I think it would help with my pain."

LPN (Licensed Practical Nurse) #2 stated on 7/13/16 at approximately 10:55 a.m., "Non-pharmacological measures we use for her (Resident #9) are mattress, one-to-one, turning, snacks, and fluids. Non-pharmacological measures should be used before pain medications and should be documented." LPN #2 was asked what interventions had been done regarding to documentation stating that the mattress was ineffective. LPN #2 stated, "No changes have been done with her mattress, but I can get an order to assess for a different type of mattress."

Review of Policy titled, "General Care" with an effective date of 2/1/15 documented the following: "Nursing personnel will provide basic nursing care and services following accepted standards of practice guidelines recognized by state boards of nursing as informed by national nursing organizations and as evidenced by hiring individuals who graduate from an approved nursing school and/or nurse aide curriculum and have successfully passed a licensing and/or certification. Nursing staff may utilize Mosby's Textbook for Long-Term Care Assistants, ..."

Mosby's Textbook for Long-Term Care Assistants Seventh Edition page 409 documented the following: "Nursing Measures to Promote Comfort and Relieve Pain" (list is not all inclusive)
Position the person in good alignment
Handle the patient gently
Give a back massage
Use touch to provide comfort
Provide soft music to distract the patient

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495210	A. BUILDING _____ B. WING _____	C 07/14/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORFOLK HEALTH AND REHABILITATION CENTER	901 EAST PRINCESS ANNE ROAD NORFOLK, VA 23504

(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 309	Continued From page 27 The facility administration was informed of the findings that non-pharmacological measures were not always implemented prior to the use of pain medications during a briefing on 7/14/16 at approximately 4:15 p.m. The facility did not present any further information about the findings.	F 309		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, facility documentation review, clinical record review the facility staff failed to follow physician's orders for the care and services of a Foley catheter for 1 of 27 residents. (Resident #12) For Resident #12 the facility staff failed to change the Foley catheter in May 2016 according to the physician's orders to change the Foley catheter every month on the last day of the month and the Foley catheter was not properly anchored one time on 7/14/16 at 11:00 a.m. The findings included:	F 315	Resident #12's Foley catheter has been changed as ordered by the physician and tubing is secured by use of an anchor. Residents with orders for a Foley catheter were reviewed to ensure that the Foley has been changed as ordered and the tubing is secured by use of an anchor. Charge Nurses were educated on: • Documentation of completing MD order to change Foley catheter • Use of an anchor to secure Foley catheter tubing A random monthly audit of Foley orders will be completed by the Unit Manager or designee to ensure that the Foley was changed as ordered. A random weekly audit will be completed by the Unit Manager or designee to ensure that the Foley catheter tubing is secured by use of an anchor. Issues noted will be referred to the Quality Assurance Committee for review and recommendation.	7/20/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495210	A. BUILDING _____ B. WING _____	C 07/14/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORFOLK HEALTH AND REHABILITATION CENTER	901 EAST PRINCESS ANNE ROAD NORFOLK, VA 23504

(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 315	Continued From page 28	F 315		

Resident #12 was initially admitted to the facility on 04/09/2007 and readmitted on 3/17/2014. Diagnoses for Resident #12 included but are not limited to multiple sclerosis (disabling disease of the central nervous system), mononeuropathy (nerve group damage causes a loss of sensation, movement, and function), contracture of muscle, right and left lower legs, and neuromuscular dysfunction of bladder (lacking bladder control due to brain, spinal cord, or nerve condition.

Resident #12's comprehensive assessment Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 4/18/16 coded Resident #12 with no cognitive impairment but total dependence on staff for Activities of Daily Living (transfers, dressing, bathing). Resident #12's range of motion was coded for impairment to one side of the upper extremities and impairment on both sides of the lower extremities. Bowel and bladder not coded on Annual Comprehensive Assessment MDS with presence of a Foley catheter (tubing into bladder to drain urine into a bag) and colostomy (an alternative channel for feces to leave the body into a bag).

On 7/12/16 at approximately 4:00 p.m. Resident #12 was observed in a hospital gown in bed with Foley and colostomy bag present. On 7/12/16 at 11:00 a.m. Resident #12 was observed in a hospital gown with food particles on gown from breakfast awaiting morning ADLs (dressing and cleaning). On 7/14/16 at 11:00 a.m. during observation with Licensed Practical Nurse (LPN #6-charge nurse) the Foley catheter was not dated and the anchor was attached to resident's leg but not connected to the Foley tubing. LPN #6 was observed connecting the anchor to the Foley

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495210	A. BUILDING _____ B. WING _____	C 07/14/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORFOLK HEALTH AND REHABILITATION CENTER	901 EAST PRINCESS ANNE ROAD NORFOLK, VA 23504

(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 315	Continued From page 29	F 315		

tubing to secure to Resident #12's leg. On 7/14/16 LPN #5 (the Unit Manager where Resident #12 lives) at 11:05 a.m. observed Foley catheter bag without date and tubing anchored and colostomy in place.

On 7/13/16 and 7/14/16 Resident #12's clinical record was reviewed. The reviewed documented a physician's order dated 10/02/14. The order read, for Resident #12 check Foley anchor q (every) shift. Another physician's order dated 10/30/14 read, Resident #12 was to have Foley catheter changed monthly, one time a day every 1 month starting on the last day of the month for 1 day.

The clinical nursing notes dated for the entire month of May 2016 do not document a Foley catheter change for Resident #12.

A review of Residents #12's Treatment Administration Record (TAR) for the month of May, 2016 documented that Resident #12 did not receive a Foley catheter change per physician's orders.

On 7/12/14 at 4:00 p.m. Resident #12 was interviewed. In the course of this interview it was noted among many things that both the catheter and Foley drainage bags are changed when full. Resident #12 did not like the smell of the bags and decided to remain in her room. Resident #12 stated, "The staff will come in and change the bags when full and when I ask them to because I don't like the smell."

On 7/14/16 at 11:00 a.m. LPN #6 (works daily with Resident #12) stated, "Yes, I change Foley catheters and bags for resident [#12]." LPN #6

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495210	A. BUILDING _____ B. WING _____	C 07/14/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORFOLK HEALTH AND REHABILITATION CENTER	901 EAST PRINCESS ANNE ROAD NORFOLK, VA 23504

(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 315	Continued From page 30	F 315		

also commented that "the current Foley bag was not dated someone forgot to date... I can't say when it was changed last because it was not dated...usually I date it." LPN #6 also stated, "The catheter should be changed monthly but I don't recall if I changed it in May [2016], look on the TAR." In regards to the anchor for this resident (#12), LPN #6 stated, "The anchor was on the leg but I had to twist it [the tabs to secure the tubing] and maybe it moved when the pillow was placed [for positioning and comfort between legs]."

On 7/14/16 at 11:10 a.m. LPN #5 (Unit Manger) stated, "I would strongly suggest that the Foley bag have a date on it, how would anyone know when it was changed if the date is not there?" Also LPN #5 stated, "The expectation is to follow physician's orders for Foley care and services and record on the TAR." LPN #5 also added, "The [Foley catheter] anchor should be checked each shift and it is not anchored properly if the flaps are not on the tubing."

On 7/14/16 at 1:45 p.m., Administrative Staff #5 (Regional Nurse) was interviewed and reported that Resident #12's Foley catheter and colostomy were placed on 5/6/2013 according to hospital discharge records. Administrative Staff #5 stated we [nursing staff] did not document the missed Foley catheter change in May of 2016.

On 7/14/16 at approximately 3:45 p.m. the Director of Nursing (DON) Administrative staff #3 agreed, "Physician's orders should be followed" regarding the changing of the Foley catheter and "Documented on the TAR." In regards to the device that anchors the Foley catheter, the DON stated, "The device should be used as a support in the manner indicated by physician and if

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495210	A. BUILDING _____ B. WING _____	C 07/14/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORFOLK HEALTH AND REHABILITATION CENTER	901 EAST PRINCESS ANNE ROAD NORFOLK, VA 23504

(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 315	Continued From page 31 improper use then the staff will be trained on proper use." According to the facility policy entitled, "Indwelling Urinary Foley Catheter and Drainage Bag Changes" last revision dated 2/1/15 reads: To protect the closed system of urinary bladder drainage and to prevent ascending urinary tract infection, indwelling urinary Foley catheters and drainage bags are changed by the licensed nurse with specific order from the physician defining the frequency of change. Also documented in this facility policy under the heading entitled, "Procedure" it reads; Maintain the integrity of the closed system at all times and Properly secure catheter tubing." The facility administration was informed of the findings during a briefing on 7/14/16 at approximately 4:00 p.m. The facility did not present any further information about the findings.	F 315		
F 329 SS=E	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug	F 329	Residents #3 and #20 are receiving non-pharmacological interventions prior to the administration of as needed Haldol as part of their behavior management program. Residents with as needed psychoactive medication administration were reviewed to ensure that non-pharmacological interventions are documented prior to administration of the as needed psychoactive medication.	8/2C/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495210	A. BUILDING _____ B. WING _____	C 07/14/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORFOLK HEALTH AND REHABILITATION CENTER	901 EAST PRINCESS ANNE ROAD NORFOLK, VA 23504

(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 329	Continued From page 32 therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, facility documentation review, clinical record review, and in the course of a complaint investigation, the facility staff failed to for two residents (Residents #3 and #20) in a survey sample of 27 residents to implement non-pharmacological measures prior to the use of the as needed antipsychotic medication, Haldol* (Haloperidol). *Med Line Plus documents: Haloperidol injection comes as a solution to be injected into a muscle by a healthcare provider. Haloperidol injection is usually given as needed for agitation, motor tics, or verbal tics. If you still have symptoms after you receive your first dose, you may be given one or more additional doses. Haloperidol extended-release injection comes as a solution to be injected into a muscle by a healthcare provider. Haloperidol extended-release injection is usually given once every 4 weeks. Haloperidol injection and haloperidol extended-release injection may help control your symptoms but will not cure your condition.	F 329	Charge Nurses were educated on: • Documentation of non-pharmacological interventions prior to administration of as needed psychoactive medications • Examples of non-pharmacological interventions Random weekly monitoring of documentation of non-pharmacological interventions prior to administration of as needed psychoactive medication will be completed by the Unit Manager or designee. Issues noted will be referred to the Quality Assurance Committee for review and recommendation.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495210	A. BUILDING _____ B. WING _____	C 07/14/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORFOLK HEALTH AND REHABILITATION CENTER	901 EAST PRINCESS ANNE ROAD NORFOLK, VA 23504

(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 329	Continued From page 33	F 329		

1. Resident #3 was admitted to the facility on 12/15/11. Diagnoses for Resident #3 included but are not limited to Advanced Dementia with Behavior Disturbances, Psychotic Disorder (loss of contact with reality) with Hallucinations (hallucination is a perception in the absence of external stimulus that has qualities of real perception), Anxiety Disorder (Generalized anxiety disorder (GAD) is a mental disorder in which a person is often worried or anxious about many things and finds it hard to control this anxiety), and Delusional Disorder (Delusional disorder is an illness characterized by at least 1 month of delusions but no other psychotic symptoms according to the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5). Delusions are false beliefs based on incorrect inference about external reality that persist despite the evidence to the contrary and these beliefs are not ordinarily accepted by other members of the person's culture or subculture. Delusions can be characterized as persecutory (i.e., belief one is going to be harmed by an individual, organization or group), referential (i.e., belief gestures, comments, or environmental cues are directed at oneself), grandiose (i.e., belief that the individual has exceptional abilities, wealth, or fame), erotomanic (i.e., an individual's false belief that another individual is in love with them), nihilistic (i.e., conviction that a major catastrophe will occur), or somatic (i.e., beliefs focused on bodily function or sensation).

Resident #3's Quarterly MDS (Minimum Data Set - an assessment protocol) with an ARD (Assessment Reference Date) of 2/11/16 coded Resident #3 as having a BIMS (Brief Interview for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495210	A. BUILDING _____ B. WING _____	C 07/14/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORFOLK HEALTH AND REHABILITATION CENTER	901 EAST PRINCESS ANNE ROAD NORFOLK, VA 23504

(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 329	Continued From page 34	F 329		

Mental Status) score of 6 of 15 indicating severe cognitive impairment. In addition, the Quarterly MDS coded Resident #3 as requiring Extensive Assistance with one staff person assistance for Dressing. Resident #3 was coded Total Dependence with 1 staff person assistance for Hygiene and Bathing. Resident #3 was coded as always incontinent of bowel and bladder functions.

Resident #3's Physician order dated 11/16/2015 documented Haldol Solution (Haloperidol Lactate) Inject 2.5 mg (milligrams) intramuscularly (IM) every 12 hours as needed for severe agitation.

Resident #3's Care Plan Focus with revision on 11/17/15, documented "The resident is/has potential to be physically aggressive (combative to staff during ADL (activity of daily living) r/t (related to) Dementia with Delusions."
Interventions documented include but are not limited to the following:
Behaviors - Monitor for the following: (specify) itching, picking at skin, restlessness (agitation), Hitting, Increase in complaints, biting, Kicking, spitting, Cussing, Racial Slurs, Elopement, Stealing, Delusions, Hallucinations, Psychosis, Aggression, Refusing Care. Document: "Y" if monitored and none of the above observed. "N" if monitored and any of the above was observed, select chart code "Other/See Nurses Notes" and progress note findings.
Interventions Utilized Before Use of Psychotropic Med/Hypnotic Med (Quiet Environment, Redirection, Reassurance). Document "Y" if not required. "N" if any of the above was utilized, select chart code "Other/See Nurses Notes" and progress note interventions
When the resident becomes agitated: Non

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495210	A. BUILDING _____ B. WING _____	C 07/14/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORFOLK HEALTH AND REHABILITATION CENTER	901 EAST PRINCESS ANNE ROAD NORFOLK, VA 23504

(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 329	Continued From page 35	F 329		

Pharmacological Approaches; Intervene before agitation escalates; Guide away from source of distress; Engage calmly in conversation; If response is aggressive, staff to walk calmly away, and approach later.

Resident #3's Medication Administration Record (MAR) documented Resident #3 received Haldol Solution 2.5 mg IM on the following dates:
4/14/16 at 11:09 p.m.
12/21/15 at 12:40 p.m.
Review of Resident #3's clinical record did not reveal documentation that non pharmacological measures were implemented prior to use of Haldol 2.5 mg injectable medication on the two dates noted above.

Review of Resident #3's clinical Record behavior notes document multiple episodes of behaviors warranting use of haldol and use of non-pharmacological measures prior. (4/15/16, 3/22/16, 1/20/16, 1/16/16)

Resident #3 observed 7/13/16 at approximately 10:30 a.m. refuse to have LPN #3 perform brief change to show surveyor skin on coccyx area.

On 7/14/16 at approximately 12:35 p.m. the DON (Director of Nursing) stated, "No documentation for non-pharmacological measures for the date" as the surveyor asked for the following dates: 4/14/16 and 12/21/15." The DON stated, "My expectation is there would be documentation of non-pharmacological measures utilized." A request was made for the facility policy related to non-pharmacological measures prior to antipsychotic medications.

Unit Manager #5 stated 7/13/16 at approximately

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495210	A. BUILDING _____ B. WING _____	C 07/14/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORFOLK HEALTH AND REHABILITATION CENTER	901 EAST PRINCESS ANNE ROAD NORFOLK, VA 23504

(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 329	Continued From page 36	F 329		

12:55 p.m., "Haldol would be used for severe behaviors such as fussing, hitting, and grabbing. Before giving haldol, we would try to redirect and calm patient by offering a snack. Nurses should document this in nursing notes."

Consultant #5 stated on 7/14/16 at approximately 3:45 p.m., "I noticed that there are missing notes for non-pharmacological measures before haldol."

The policy titled, "Chemical Restraints" with an effective date of 2/1/15 was reviewed. It documented the following: "Non-drug interventions for the targeted behavior should have been attempted and documented onto the clinical record as ineffective."

The facility administration was informed of the findings that non-pharmacological measures were not always implemented prior to the use of the antipsychotic medication Haldol during a briefing on 7/14/16 at approximately 4:15 p.m. The facility did not present any further information about the findings.

2. Resident #20 was admitted to the facility on 10/13/14 with a readmission on 11/3/15. Diagnoses for Resident #20 included but are not limited to Non Alzheimer Dementia (a group of disorders that affect the brain other than Alzheimer's Disease), Anxiety disorder (Generalized anxiety disorder (GAD) is a mental disorder in which a person is often worried or anxious about many things and finds it hard to control this anxiety), Psychotic Disorder (loss of contact with reality) and Pseudobulbar Effect (PBA)-(emotional lability, labile affect, or

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495210	A. BUILDING _____ B. WING _____	C 07/14/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORFOLK HEALTH AND REHABILITATION CENTER	901 EAST PRINCESS ANNE ROAD NORFOLK, VA 23504

(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 329	Continued From page 37	F 329		

emotional incontinence is a type of affect characterized by involuntary crying or uncontrollable episodes of crying and/or laughing, or other emotional displays. PBA occurs secondary to a neurologic disorder or brain injury. Patients may find themselves crying uncontrollably at something.)

Resident #20's Quarterly MDS (Minimum Data Set - an assessment protocol) with an ARD (Assessment Reference Date) of 6/28/16 coded Resident #20 as having short and long term memory problems with moderate impairment in cognitive skills affecting daily decision making. In addition, the MDS coded Resident #20 as Extensive Assistance with one staff person assistance for dressing, eating and bed mobility. Resident #20 was coded as Total Dependence with 1 staff person assistance for bathing. Resident #20 was coded as always incontinent of both bowel and bladder functions.

Resident #20's Physician order dated 5/11/16 documented: Haloperidol Lactate Concentrate 2 mg/ml (milligram/milliliter) Give 1 ml by mouth every eight hours as needed for agitation related to unspecified psychosis not due to a substance or known physiological condition.

Resident #20's Medication Administration Record (MAR) documented Resident #20 receiving Haldol 2 mg on the following dates: 5/3/16, 5/4/16, 5/14/16, 5/29/16, 6/10/16, and 6/12/16.

Resident #20's Care Plan revised 3/11/16 focus area documented the following: "The resident uses psychotropic medications..." The following interventions were documented but not limited to the following:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495210	A. BUILDING _____ B. WING _____	C 07/14/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORFOLK HEALTH AND REHABILITATION CENTER	901 EAST PRINCESS ANNE ROAD NORFOLK, VA 23504

(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 329	Continued From page 38	F 329		

Monitor for behaviors; crying, screaming, Hitting, psychosis, refusing care.
Administer medication per MD (medical doctor) order
Utilize non-pharmacological interventions prior to PRN (as needed) psychotropic drug administration: 1:1, redirection, offer snack, encourage activities.

Review of Resident #20's clinical record did not reveal documentation for non pharmacological interventions prior to haldol administration on the following dates: 5/3/16, 5/4/16, 5/14/16, 6/10/16, and 6/12/16.

Observation of Resident #20 on 7/13/16 at approximately 3:25 p.m. revealed extreme crying episode when surveyor attempted conversation with her. Resident #20 was calmed when CNA (Certified Nursing Assistance) came in and administered applesauce.

On 7/14/16 at approximately 12:35 p.m. the DON (Director of Nursing) stated, "No documentation for non-pharmacological measures for the date" as the surveyor asked for the following dates: 5/3/16, 5/4/16, 5/14/16, 6/10/16, and 6/12/16." The DON stated, "My expectation is there would be documentation of non-pharmacological measures utilized." A request was made for the facility policy related to non-pharmacological measures prior to antipsychotic medications.

Unit Manager #5 stated on 7/13/16 at approximately 12:55 p.m., "Haldol would be used for severe behaviors such as fussing, hitting, and grabbing. Before giving haldol, we would try to redirect and calm patient by offering a snack. Nurses should document this in nursing notes."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495210	A. BUILDING _____ B. WING _____	C 07/14/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORFOLK HEALTH AND REHABILITATION CENTER	901 EAST PRINCESS ANNE ROAD NORFOLK, VA 23504

(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 329	Continued From page 39 The Unit Manager stated that Haldol is often given to Resident #20 for her severe crying episodes that can not be calmed." Consultant #5 stated on 7/14/16 at approximately 3:45 p.m., "I noticed that there are missing notes for non-pharmacological measures before haldol." The policy titled, "Chemical Restraints" with an effective date of 2/1/15 was reviewed. It documented the following: "Non-drug interventions for the targeted behavior should have been attempted and documented onto the clinical record as ineffective." The facility administration was informed of the findings that non-pharmacological measures were not always implemented prior to the use of the antipsychotic medication Haldol during a briefing on 7/14/16 at approximately 4:15 p.m. The facility did not present any further information about the findings.	F 329		
F 354 SS=E	483.30(b) WAIVER-RN 8 HRS 7 DAYS/WK, FULL-TIME DON Except when waived under paragraph (c) or (d) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. Except when waived under paragraph (c) or (d) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. The director of nursing may serve as a charge nurse only when the facility has an average daily	F 354	The facility is currently staffed with 8 consecutive hours of RN coverage. The current Nursing schedule was reviewed to ensure there is RN coverage scheduled for 8 consecutive hours daily. The Staffing Coordinator was educated on ensuring that there are 8 consecutive hours of RN coverage scheduled per day.	8/24/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495210	A. BUILDING _____ B. WING _____	C 07/14/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORFOLK HEALTH AND REHABILITATION CENTER	901 EAST PRINCESS ANNE ROAD NORFOLK, VA 23504

(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 354	Continued From page 40	F 354		

occupancy of 60 or fewer residents.

This REQUIREMENT is not met as evidenced by:
Based on facility document review the facility staff failed to use the services of a registered nurse (RN) for at least 8 consecutive hours a day, 7 days a week.

The findings included:

A review of the as work schedules from April 2016 through July 2016 were reviewed on 7/14/16. The review evidenced there was no RN on duty for at least 8 consecutive hours on the following days:
1. Saturday April 30, 2016.
2. Saturday May 28, 2016.
3. Sunday May 30, 2016.
4. Saturday July 9, 2016.

An interview was conducted with the Director of Nursing (DON) on 7/14/16. The DON stated she had only been in the DON position for 2 weeks. The DON stated the nurse staffing scheduler was also new in her position. The findings of no RN coverage for 8 consecutive hours on 7/9/16 was shared. She stated going forward the expectation would be for the scheduler to notify her if there is no RN coverage for the weekend. The DON also stated she, the Assistant Director of Nursing or another RN will be available if no other RN coverage could be found.

The above findings was shared with the Vice President of Operations,Eastern Region, the DON and the Corporate Nurse at the pre-exit meeting conducted on 7/14/16 at 3:50 p.m.

Posted 24 Hour Staffing hours will be reviewed weekly by the Unit Manager or designee to ensure that there are 8 documented consecutive hours of RN coverage.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495210	A. BUILDING _____ B. WING _____	C 07/14/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORFOLK HEALTH AND REHABILITATION CENTER	901 EAST PRINCESS ANNE ROAD NORFOLK, VA 23504

(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 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observations. staff interviews and facility documentation reviews, the facility staff failed to store, prepare and serve food under sanitary conditions as evidenced by observations on initial tour during the lunch plating of food. An observations were made of a serviceman cleaning a floor drain with a splaying substance within 4 to 5 feet from steam table with food, a heavily soiled condensation pipe from the bottom of the ice machine and a fryer that a large amount of dark brownish/black oil with a large amount of dark brownish/black crumbs in and around the fryer oil. The findings included: The Initial Kitchen Tour was performed on 07/12/16 at approximately 11:40 a.m. Upon entering the kitchen an observation was made of the four person steam table team that was plating the food for the noon meal with a service person snaking out a floor drain with water that was in close proximity to the active steam table team plating the food. The service person was using	F 371	Necessary maintenance service is being completed in food service areas in a sanitary manner. The ice machine and fryer have been cleaned. Items on the drying rack are allowed to dry completely before being moved to storage. Food is being stored, prepared, and served in sanitary conditions. Dietary staff were educated on: • Provision of maintenance services in food service areas in sanitary manner • Cleaning of dietary equipment • Allowing items to dry completely on drying rack prior to moving to storage The RD will complete random monthly rounds on the kitchen to ensure that food is being stored, prepared, and served in sanitary conditions. Issues noted will be referred to the Quality Assurance Committee for review and recommendation.	8/26/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495210	A. BUILDING _____ B. WING _____	C 07/14/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORFOLK HEALTH AND REHABILITATION CENTER	901 EAST PRINCESS ANNE ROAD NORFOLK, VA 23504

(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 371	Continued From page 42	F 371		

water for the snaking and it was spraying the surrounding area with water that was spraying out of the floor drain. The Dietary Manager came out of his office that is located within the kitchen area. The Dietary Manager was then directed to the service person cleaning the drain and was asked how far the floor drain was from the steam table and he responded: "About 4 to 5 feet." The inspection of the freezer unit, walk in refrigerator, dry storage area, dish machine area, the fryer, the drying racks and the ice machine was then completed. The service person was then seen wiping the sprayed water with a paper towel and went to a different area in the kitchen to address another floor drain just as the plating of the food was completed at the steam table.

The following additional observations were made during the Initial Tour:

1. In the Drying rack area with two separate stand alone racks side by side both held cleaned metal items. The Dietary Manager was asked about the two racks and he stated: "The first rack is used for the newly cleaned wet items to dry. The staff then move the dried items to the second rack for storage.". Two large metal mixing bowls were observed on the rack designated for the dried items with multiple droplets of a clear liquid on the outside of the bowls. The Dietary Manager was then directed to the two large bowls and asked if they belonged on the dried rack and he stated: "No, they are still wet."

2. The fryer had a large amount of dark brownish/black oil with a large accumulation of crumbs floating on the top of the oil and around the surrounding inner surface of the fryer. The Dietary Manager was asked about the condition

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495210	A. BUILDING _____ B. WING _____	C 07/14/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORFOLK HEALTH AND REHABILITATION CENTER	901 EAST PRINCESS ANNE ROAD NORFOLK, VA 23504

(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 371	Continued From page 43	F 371		

of the fryer and its contents and he stated: "We haven't used the fryer for a few days." The cleaning schedule for the fryer was requested but was not submitted.

3. Underneath the ice machine a one (1) inch drain pipe coming out of the bottom of the ice machine was observed to have a large build up of brownish colored debris covering the end of the pipe two (2) inches above the floor drain and extended from the opening of the pipe to approximately one and a half (1 1/2) inches up the pipe towards the bottom of the ice machine. The Dietary Manager was asked to observe the area and stated: "That's just a drain for the ice machine. It's just the color of the pipe."

4. The Dietary Manager was then asked about the service person cleaning the floor drain during the plating of the residents' noon meal. He stated: "The maintenance department arranged for the service. I didn't have anything to do with that." When asked if he felt that the spraying water/drain cleaning was a safe proximity during the plating of the food he stated: "I didn't make the arrangements. We had a clogged drain over by the freezer and the drains needed to be cleaned out."

An interview was conducted on 07/13/16 at approximately 8:50 a.m., in the kitchen with the Dietary Manager. The Dietary Manager proceeded to the fryer which was totally cleaned out of the brownish/black oil with the large amount of crumbs that had been observed the previous day. He stated: "I forgot that the fryer was used the night before and had not been cleaned so I had the kitchen crew clean it out. New oil will be put in the fryer before it is used

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495210	A. BUILDING _____ B. WING _____	C 07/14/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORFOLK HEALTH AND REHABILITATION CENTER	901 EAST PRINCESS ANNE ROAD NORFOLK, VA 23504

(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 371	Continued From page 44 again." An observation of the drying rack area was made and the two free standing racks were not in close proximity to each other. The Dietary Manager stated: "I moved the racks so the staff would know one was to be used for drying and the other to be used for storage." He then proceeded to the ice machine. It was observed that the white drain pipe coming from the ice machine was without the brownish black substance. He stated: "I cleaned the pipe myself. I thought that it was just a stain but it came off." In addition to the above the Dietary Manager stated: "I just want you to know that the kitchen floor was cleaned and sanitized last night." He further stated: "If the drains need to be cleaned again I'll make sure that it isn't done during the plating of the food." Administration which consisted of the Administrator and the Corporate RN (registered nurse) consultant was informed of the findings at a briefing on 07/13/16 at approximately 9:10 a.m. No additional information was submitted for review.	F 371		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted	F 431	Resident #19 is receiving medication labeled with appropriate instructions. The PPD vial was replaced, dated when opened and stored appropriately. Orders for ointments, creams, and gels were reviewed to ensure that the order was complete with appropriate instructions. PPD vials were reviewed to ensure that the vial was dated when opened.	8/26/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495210	A. BUILDING _____ B. WING _____	C 07/14/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORFOLK HEALTH AND REHABILITATION CENTER	901 EAST PRINCESS ANNE ROAD NORFOLK, VA 23504

(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 431	Continued From page 45	F 431		

professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.

In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.

The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.

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 ensure drugs were labeled to include appropriate instructions for 1 of 27 residents in the survey, Resident #19 and failed to ensure biological's stored inside one of three medication rooms were dated when opened.

1. A tube of Diclofenac topical gel 1% for Resident #19 did not include appropriate instructions for the application of the gel.

2. Two multi-dose vials of Aplisol-Tuberculin purified protein derivative were not labeled when

F 431

Charge Nurses were educated on:

- Inclusion of site in orders for ointments, creams, and gels
- Dating of vials when opened

The Unit Manager or designee will monitor new orders to ensure that the site is listed as indicated. A random weekly audit of the Medication Room refrigerators will be completed by the Unit Manager or designee to make sure that vials are dated when opened.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495210	A. BUILDING _____ B. WING _____	C 07/14/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORFOLK HEALTH AND REHABILITATION CENTER	901 EAST PRINCESS ANNE ROAD NORFOLK, VA 23504

(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 431	Continued From page 46	F 431		

opened.

The findings included:

1. Resident #19 was originally admitted to the facility on 2/26/13 with a readmission date of 6/9/16 with diagnoses to include chronic pain syndrome, polyosteoarthritis and cognitive deficit related to cerebral vascular disease.

The current MDS (Minimum Data Set) a quarterly with an assessment reference date of 6/16/16 coded the resident as scoring an 8 out of a possible 15 on the Brief Interview for Mental Status (BIMS), indicating the resident had moderately impaired cognition. Under section J. Health Conditions Pain Management the resident was coded as having pain almost constantly that was rated as an 10 out of a possible 10 (zero being no pain and ten as the worst pain).

A medication pass and pour observation for Resident #19 with Licensed Practical Nurse #2 (LPN) was conducted on 7/12/16 at 5:30 p.m. The nurse obtained a tube of Diclofenac topical gel 1%, the tube did not have directions on where to apply the gel. The pharmacy labeled read, apply 1 application transdermally four times a day related to chronic pain syndrome. The nurse then entered the resident's room and asked the resident where he wanted to gel placed. The resident pointed to his left upper chest area, left elbow and left wrist area. After leaving the room, the nurse was asked where is the Diclofenac topical gel supposed to be applied to the resident as the pharmacy label did not have these instructions. The nurse stated, "He usually wants it on his elbows".

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495210	A. BUILDING _____ B. WING _____	C 07/14/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORFOLK HEALTH AND REHABILITATION CENTER	901 EAST PRINCESS ANNE ROAD NORFOLK, VA 23504

(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 431	Continued From page 47	F 431		

On 7/13/16 at 9:45 a.m., LPN #3 was interviewed. She was shown the physician order for the Diclofenac topical gel 1%, printed on the Medication Review Report and the electronic Medication Administration Record (MAR). The physician order dated 6/9/16 read: Diclofenac topical gel 1%, apply 1 application transdermally four times a day related to chronic pain syndrome. The nurse was asked if this was a complete order. After reading the order, she stated, "No, it is an incomplete order...it doesn't say where to apply it...it actually goes to his joints...elbows, knuckles, knees...I will get a clarification order."

The physician clarification order obtained for 7/13/16 read, Diclofenac Sodium Gel 1% Apply 1 application transdermally four times a day related to chronic pain syndrome. Apply to elbows, knees, hands, sternum and rib bones. Document site. (areas of application may be omitted based on resident preference).

During the pre-exit meeting conducted on 7/14/16 the above findings was shared with the acting Administrator (the Vice President of Operations), the Director of Nursing and the Corporate Nurse. An opportunity to provide additional information was provided at this time.

2. On 7/13/16 at 9:40 a.m., the unit 2 third floor medication room was inspected. Accompanying this inspector was Licensed Practical Nurse #1 (LPN). Two opened multi-dose vials of Aplisol-Tuberculin purified protein derivative were found stored inside a small clear plastic labeled bag containing other unopened Aplisol vials. Both

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495210	A. BUILDING _____ B. WING _____	C 07/14/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORFOLK HEALTH AND REHABILITATION CENTER	901 EAST PRINCESS ANNE ROAD NORFOLK, VA 23504

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F 431	Continued From page 48 of these opened vials were not dated when opened. The nurse was asked if the two opened vials should be labeled with an open date, she stated "yes". When asked how long are the vials good for once opened, she stated, "I'm not sure but I will find out". Several minutes later LPN#1 approached this inspector and stated, "It (the Aplisol multi-dose vial) is good for 30 days after opening it, I will discard them". On 7/14/16 at 3:20 p.m., the Corporate Nurse stated multi-dose vials should be dated when opened. The pharmacy Recommended Minimum Medication Storage Parameters (based on manufacturer guidance) last revised 3/31/14 read, in part: Aplisol Injection (tuberculin test) Store in refrigerator at 36-46 degrees Fahrenheit. Protect from light. Date when opened and discard unused portion after 30 days. During the pre-exit meeting conducted on 7/14/16 the above findings was shared with the Vice President of Operations Eastern Region, the Director of Nursing and the Corporate Nurse. An opportunity to provide additional information was provided at this time. No further information was provided prior to exit.	F 431		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495210	A. BUILDING _____ B. WING _____	C 07/14/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 49 to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observations, clinical record review, facility documentation, and staff interviews the facility staff failed to follow infection control	F 441	8/2C/16 Resident #16 is receiving care by staff following infection control practices to prevent the spread of infection. Residents with precautions were reviewed to ensure that appropriate precautions are followed by staff. Charge Nurses and CNAs were educated on: • Proper PPE when entering precaution room Use of appropriate PPE will be monitored on a random weekly basis by the Unit Manager or designee to ensure that appropriate infection control practices are followed to prevent the spread of infection.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495210	A. BUILDING _____ B. WING _____	C 07/14/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORFOLK HEALTH AND REHABILITATION CENTER	901 EAST PRINCESS ANNE ROAD NORFOLK, VA 23504

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F 441	Continued From page 50	F 441		

practices to prevent the spread of infection for 1 of 27 residents in the survey sample, Resident #16.

The facility staff failed to follow posted Contact Isolation Precautions for Resident #16's Methicillin Resistant Staphylococcus Aureus Infection of the left great toe when entering the resident's room.

The findings included:

Resident #16 was a 53 year old admitted to the facility on 4/27/16 with diagnoses to include *Osteomyelitis of the left foot, *Methicillin Resistant Staphylococcus Aureus Infection of the left great toe, and *End Stage Renal Disease.

*Osteomyelitis: local or generalized infection of bone and bone marrow, usually caused by bacteria introduced by trauma or surgery, by direct extension from a nearby infection, or via the bloodstream.

*End Stage Renal Disease: a disease condition that is essentially terminal because of irreversible damage to vital tissue or organs. Kidney or renal end stage disease is defined as a point at which the kidney is so badly damaged or scarred that dialysis or transplantation is required for patient survival.

The above definitions were derived from Mosby's Dictionary of Medicine, Nursing, and Health Professions 8th Edition.

*Methicillin Resistant Staphylococcus Aureus Infection (MRSA): is a type pf staph bacteria that is resistant to certain antibiotics called

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495210	A. BUILDING _____ B. WING _____	C 07/14/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORFOLK HEALTH AND REHABILITATION CENTER	901 EAST PRINCESS ANNE ROAD NORFOLK, VA 23504

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F 441	Continued From page 51	F 441		

betalactams. These antibiotics include methicillin and other more common antibiotics such as oxacillin, penicillin, and amoxicillin. More severe or potentially life-threatening MRSA infections occur most frequently among patients in healthcare settings.
www.cdc.gov

A review was completed on Resident #16's Minimum Data Set (MDS) Comprehensive 5 day Admission Assessment with an Assessment Reference Date of 5/4/16. The resident's Brief Interview for Mental Status (BIMS) was a 15 out of a possible 15 indicating the resident was cognitively intact and capable of daily decision making. Under Section N, Medications Received Resident #16 was coded to have received an antibiotic for 7 days of the look back period of the assessment. Under Section O, Special Treatment, Procedures, and Programs Resident #16 was not coded under Isolation or quarantine for active infectious disease even thought physician orders, treatments, and diagnoses indicated Contact Isolation was in place due to an active MRSA infection of the resident's left great toe.

Resident #16's Comprehensive Plan of Care was reviewed and documented in part, as follows:

Focus:
The resident has Osteomyelitis of the left foot and ankle; currently on IV ABT. Date Initiated: 4/28/16 Revision on: 4/28/16

Interventions:
Precautions (Contact) as ordered.
Date Initiated: 4/28/16 Revision on: 7/12/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495210	A. BUILDING _____ B. WING _____	C 07/14/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORFOLK HEALTH AND REHABILITATION CENTER	901 EAST PRINCESS ANNE ROAD NORFOLK, VA 23504

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F 441	Continued From page 52	F 441		

A review of Resident #16's Progress Notes documented in part, as follows:

Date 4/27/16 at 7:55 p.m.
Resident admitted to Norfolk Healthcare from (name, area hospital). Resident has 2 cm (centimeter) incision with sutures to left great toe. Resident has central line to left chest and fistula to right arm. Resident on contact isolation for MRSA to left great toe.

Date 4/30/16 at 2:10 p.m.
Continues to be on isolation for MRSA on left foot.

Date 5/1/16 at 2:13 a.m.
Isolation continues related to MRSA.

Date 5/2/16 at 2:59 p.m.
Continues to be on isolation for MRSA left great toe open area.

Date 7/10/16 at 11:26 a.m.
Remains on contact isolation precaution for MRSA to left foot.

Date 7/12/16 at 11:28 p.m.
Continues on IV (intravenous) ABT (antibiotic) for MRSA.

A current Physician Order on the July 2016 Treatment Administration Record with nursing signatures from 7/1/16-7/13/16 documented in part, as follows:

Contact Isolation MRSA L (left) foot. every shift for isolation.
-ORDER Date- 4/28/16 6:02 a.m.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495210	A. BUILDING _____ B. WING _____	C 07/14/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORFOLK HEALTH AND REHABILITATION CENTER	901 EAST PRINCESS ANNE ROAD NORFOLK, VA 23504

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 53	F 441		

On 7/12/16 at 4:10 p.m. an observation of a Contact Isolation Precaution Sign was made of Resident #16's door documented in part, as follows:

STOP Contact Precautions
Visitors must report to Nursing Station before entering.
*Perform hand hygiene using soap and water and/or alcohol-based rub before entering and before leaving room.
*Wear gown and gloves when entering room or cubicle.
*Bag linen to prevent contamination of self, environment or outside bag.
*Discard infectious trash to prevent contamination of self, environment or outside bag.
revised 12/09

On 7/12/16 at 4:10 p.m. while completing a medication pass review LPN (Licensed Practical Nurse) #4 asked CNA (Certified Nursing Assistant) #1 to obtain Resident #16's supper tray. CNA #1 returned with Resident #16's supper tray and carried the tray into the resident's room placing it on the bedside table and then exited the room failing to follow any Contact Isolation Precautions. LPN #4 them asked CNA #1 to ask Resident #16 if he wanted vanilla pudding with his medications. CNA #1 again entered Resident #16's room and exited failing to observe or follow any Contact Isolation Precautions. This surveyor asked CNA #1 what should she have done prior to entering the resident's room. CNA #1 stated, "I should have gowned and gloved up, I was rushing." The surveyor asked, "Why should you have gowned and gloved up?" CNA #1 stated, "I should have

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495210	A. BUILDING _____ B. WING _____	C 07/14/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORFOLK HEALTH AND REHABILITATION CENTER	901 EAST PRINCESS ANNE ROAD NORFOLK, VA 23504

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F 441	Continued From page 54	F 441		

gowned and gloved up because he is on isolation and we don't want to spread the infection to others. This is my first survey." The surveyor asked CNA #1 how long she had been a CNA and if she had received any training on Contact Isolation. CNA #1 stated, "I have been a CNA for 2 years and yes I have had training on contact isolation."

The facility policy titled "Transmission Based Precautions" effective date 2/1/15 documented in part as follows:

Policy: The Center initiates transmission based precautions (to include droplet and contact precautions) as recommended by the Center for Disease Control.

Procedure:
1. Transmission based precautions are designed for patients documented as suspected to be infected or colonized with highly transmissible or epidemiologically important pathogens for which additional precautions beyond standard precautions are needed to interrupt transmission.
c. Contact precautions (e.g., MRSA) in addition to standard precautions, for specified patients known or suspected to be infected or colonized with epidemiologically important microorganisms that can be transmitted by direct contact with the patient (hand or skin-to-skin contact that occurs when performing patient-care activities that require touching the patient's dry skin) or indirect contact (touching) with environmental surfaces or patient-care items in the patient's environment.
2. Gloves and Handwashing
a. Perform hand hygiene before entering room and after removing PPE (personal protective equipment) upon room exit.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495210	A. BUILDING _____ B. WING _____	C 07/14/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORFOLK HEALTH AND REHABILITATION CENTER	901 EAST PRINCESS ANNE ROAD NORFOLK, VA 23504

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F 441	Continued From page 55 b. Wear gloves when entering room and whenever touching the patient's intact skin, surfaces or articles in close proximity. 3. Gown In addition to standard precautions, wear a gown (a clean non-sterile, water-resistant gown is adequate) when entering the room. Remove the gown before leaving the patient's environment. On 7/14/16 at 3:45 p.m. a pre-exit debriefing was held with the Administrator, Director of Nursing, and the Nurse Consultant where the above findings were shared. The Director of Nursing was asked what would she have expected of her staff in regards and residents on Contact Isolation. The Director of Nursing stated, "For her to have used her PPE (personal protective equipment) gown and glove before entering the resident's room. She knew what to do and we started inservicing that night." Prior to exit no further information was provided.	F 441		
F 456 SS=D	483.70(c)(2) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility documentation review the facility staff failed to ensure essential equipment was maintained in a safe operating condition. The facility staff failed to wrap the air conditioning	F 456	The lighting in question in the boiler room was removed on 7/14/16. The facility is maintaining the boiler room in safe operating condition. An insulation company is contracted to do wrapping of the pipes in question on 8/3/16. Following the pipe insulation, the Maintenance Director will complete a random weekly observation of the boiler room to ensure that there is no condensation.	8/26/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495210	A. BUILDING _____ B. WING _____	C 07/14/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORFOLK HEALTH AND REHABILITATION CENTER	901 EAST PRINCESS ANNE ROAD NORFOLK, VA 23504

(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 456	Continued From page 56	F 456		

pipes in the boiler room to ensure the condensation would not drip on lighting. The lighting in question was removed immediately (20 minutes) ensuring safety until the company could arrive and wrap the pipes to decrease the amount of condensation.

The findings included:

During the routine general observation tour on 7/14/16 at approximately 12:25 p.m. with Maintenance Director (Others #4) it was observed that the airconditioner pipes above the hanging lighting fixture was dripping condensation onto the protective top of the lighting fixture. It was also observed that several older pipes in the middle of the room were dripping condensation water forming puddles onto the floor.

Immediately, Surveyor #1 and Others #4 went to get Surveyors #2 and #3 and administrative #2 (VP Operation- acting Administrator) with Administrative #6 (Regional Director) to observe the boiler room.

At 12:30 p.m. Administrator #2 stated, "We had a contractor out yesterday to fix the chiller which impacted the common areas (air conditioning). The contractor removed the insulation on the pipe above the lighting fixture to fix the problem with the air conditioning. The company was to return and replace the insulation. This is part of a bigger project we are working to completely, the replacement of old pipes and recovering of pipes in the middle of the room also."

Immediately, The VP had the light fixture removed and capped off the electricity and placed the wire far above the dripping pipe to ensure

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495210	A. BUILDING _____ B. WING _____	C 07/14/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORFOLK HEALTH AND REHABILITATION CENTER	901 EAST PRINCESS ANNE ROAD NORFOLK, VA 23504

(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 456	Continued From page 57	F 456		

safety. A call was placed to the repair company and they immediately came to cover the pipe to prevent further condensation over the fixture.

According to Administer staff #6, the pipes in the middle of the room were not dripping because of yesterdays repair but had been dripping down into two drains located in the corners. The drains were out of reach to assist the puddle clean up. The maintenance Director had the puddles mopped into drains and place buckets on the floor in the middle of the room and under the side where the new drips occurred. All was observed to be safe by 1:00 p.m.

In an interview with Administrative Staff #2 on 7/14/16 at approximately 1:05 p.m. documentation was presented that a proposal was made on 1/6/16 and read "to install new insulation on the chilled water piping mains above the lobby and to remove existing insulation and install new pipe insulation". According to Administrative staff #2 a larger repair needed to occur in order to replace older pipes and reinsulate the pipes in the boiler room.

The facility administration was informed of the findings during a briefing on 7/14/16 at approximately 4:10 p.m. Administrative staff #2 did state, "I agree 100 % that this [old worn pipes, chiller pipes] needs to be maintained in a safe condition." The facility did not present any further information about the findings.