STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495397	A. BUILDING _____ B. WING _____	C 09/07/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CHESAPEAKE	955 HARPERSVILLE RD NEWPORT NEWS, VA 23601

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E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 9/5/18 through 9/7/18. Corrections are required for compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities. No emergency preparedness complaints were investigated during the survey.	E 000		
E 037 SS=C	EP Training Program CFR(s): 483.73(d)(1) (1) Training program. The [facility, except CAHs, ASCs, PACE organizations, PRTFs, Hospices, and dialysis facilities] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected role. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. *[For Hospitals at §482.15(d) and RHCs/FQHCs at §491.12:] (1) Training program. The [Hospital or RHC/FQHC] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency	E 037		

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

Health Services Administrator | 10/24/18

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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E 037	Continued From page 1 procedures. *[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, consistent with their expected roles. (ii) Demonstrate staff knowledge of emergency procedures. (iii) Provide emergency preparedness training at least annually. (iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the procedures necessary to protect patients and others. *[For PRTFs at §441.184(d):] (1) Training program. The PRTF must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) After initial training, provide emergency preparedness training at least annually. (iii) Demonstrate staff knowledge of emergency procedures. (iv) Maintain documentation of all emergency preparedness training. *[For PACE at §460.84(d):] (1) The PACE organization must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing	E 037	1. The Annual Emergency Preparedness (EP) Training with staff has been rescheduled and will be conducted by the Staff Development Director, Administrator and Director of Building and Grounds. 2. Emergency Preparedness Education will be made available through a combination of live and computer based trainings for all staff. A staff roster will be used to ensure that all staff have been educated. 3. Staff will demonstrate knowledge of emergency procedures through return demonstration and on-line testing by Staff Development Director. Staff Development Director re-educated to include EP training during new employee orientation. 4. Documentation of Emergency Preparedness Training will be maintained in the annual training record and electronically for all staff by Staff Development Director. The Staff Development Director and Administrator or designee will review training records and follow up with staff monthly to maintain compliance with training. Any discrepancies will be brought to the QAPI Committee for further evaluation and recommendations. 5. 10/26/18 and ongoing.	

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E 037	Continued From page 2 staff, individuals providing on-site services under arrangement, contractors, participants, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least annually. (iii) Demonstrate staff knowledge of emergency procedures, including informing participants of what to do, where to go, and whom to contact in case of an emergency. (iv) Maintain documentation of all training. *[For CORFs at §485.68(d):](1) Training. The CORF must do all of the following: (i) Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. All new personnel must be oriented and assigned specific responsibilities regarding the CORF's emergency plan within 2 weeks of their first workday. The training program must include instruction in the location and use of alarm systems and signals and firefighting equipment. *[For CAHs at §485.625(d):] (1) Training program. The CAH must do all of the following: (i) Initial training in emergency preparedness policies and procedures, including prompt reporting and extinguishing of fires, protection, and where necessary, evacuation of patients, personnel, and guests, fire prevention, and cooperation with firefighting and disaster	E 037		

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E 037	Continued From page 3 authorities, to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. *[For CMHCs at §485.920(d):] (1) Training. The CMHC must provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least annually. This REQUIREMENT is not met as evidenced by: Based on facility document review and staff interviews the the facility staff failed to provide the Annual Emergency Preparedness Training with staff. The findings included: On 9/7/18 at 2:00 P.M. an interview was conducted with the Administrator and the Director of Buildings and Grounds regarding Emergency Preparedness. Documentation was requested for the annual staff Emergency Preparedness Training. The Director of Buildings and Grounds stated, "We were supposed to have that training in July, but it got pushed out and has not been	E 037		

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E 037	Continued From page 4 done yet." The Staff Training 2018 calendar was reviewed and under July Emergency Prep. was listed as a Mandatory all department inservice. The Administrator stated, "It appears that the training has not been completed." On 9/7/18 at 2:30 P.M. an interview was conducted with Medical/Desk Assistant #4. Medical/Desk Assistant #4 was asked if she had received annual training on Emergency Preparedness. Medical Assistant #4 stated, "I don't recall having any training and I just saw an email about it today." On 9/7/18 at 2:40 P.M. an interview was conducted with Certified Nursing Assistant #1. Certified Nursing Assistant #1 was asked if she had received annual training on Emergency Preparedness. Certified Nursing Assistant #1 stated, "No, I can't recall any training on that." On 9/7/18 at 4:45 P.M. during a pre-exit debriefing with the Administrator and Director of Nursing present the above issues were discussed. Prior to exit no further information was provided.	E 037		
E 039 SS=C	EP Testing Requirements CFR(s): 483.73(d)(2) (2) Testing. The [facility, except for LTC facilities, RNHCIs and OPOs] must conduct exercises to test the emergency plan at least annually. The [facility, except for RNHCIs and OPOs] must do all of the following: *[For LTC Facilities at §483.73(d):] (2) Testing. The LTC facility must conduct exercises to test the emergency plan at least annually, including	E 039		

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E 039	Continued From page 5 unannounced staff drills using the emergency procedures. The LTC facility must do all of the following:] (i) Participate in a full-scale exercise that is community-based or when a community-based exercise is not accessible, an individual, facility-based. If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in a community-based or individual, facility-based full-scale exercise for 1 year following the onset of the actual event. (ii) Conduct an additional exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based. (B) A tabletop exercise that includes a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed. *[For RNHCIs at §403.748 and OPOs at §486.360] (d)(2) Testing. The [RNHCI and OPO] must conduct exercises to test the emergency plan. The [RNHCI and OPO] must do the following: (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically relevant emergency scenario, and a set	E 039	1. The notes and actions from the tornado drill of 3/20/18 will be reviewed with participants involved in a Team meeting and an analysis completed. Based on the facility response analysis completed, an action plan will be developed and the Tornado emergency plan will be revised. 2. All safety and leadership team members will be educated on steps to properly complete a facility analysis response. 3. The use of an After Action Report template will be used for subsequent emergency exercises. 4. Director of Building and Grounds, Administrator or designee will review all After Action reports after each exercise for completion. Based on the analysis, an update of the appropriate emergency plan will be discussed in the Safety Committee Any discrepancies will be brought to the QAPI committee for further evaluation and recommendations. 5. 10/26/18 and ongoing	

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E 039	Continued From page 6 of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (ii) Analyze the [RNHCI's and OPO's] response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed. This REQUIREMENT is not met as evidenced by: Based on facility document review and staff interviews the facility staff failed to complete a facility analysis response and revise their emergency plan as needed after a Tornado Drill conducted on 3/20/18. The findings included: On 9/7/18 at 2:00 P.M. an interview was conducted with the Administrator and the Director of Buildings and Grounds regarding Emergency Preparedness. The Administrator stated that the facility had completed a Tornado Drill on 3/20/18; the facility documentation was reviewed by the surveyor. The Surveyor asked for the facility's analysis response and any revisions that were added to their Emergency Preparedness Plan after the Tornado Drill 3/20/18. The Administrator stated, "I do no see where an analysis or any revision was done. They just did the Tornado Drill." On 9/7/18 at 4:45 P.M. during a pre-exit debriefing with the Administrator and Director of Nursing present the above issues were discussed. Prior to exit no further information was provided.	E 039		
F 000	INITIAL COMMENTS	F 000		

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F 000	Continued From page 7 An unannounced Medicare/Medicaid standard survey was conducted 9/5/18 through 9/7/18. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. One complaint was investigated during the survey. The census in this 52 certified bed facility was 43 at the time of the survey. The survey sample consisted of 14 current Resident reviews and 3 closed record reviews.	F 000		
F 577 SS=D	Right to Survey Results/Advocate Agency Info CFR(s): 483.10(g)(10)(11) §483.10(g)(10) The resident has the right to- (i) Examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility; and (ii) Receive information from agencies acting as client advocates, and be afforded the opportunity to contact these agencies. §483.10(g)(11) The facility must-- (i) Post in a place readily accessible to residents, and family members and legal representatives of residents, the results of the most recent survey of the facility. (ii) Have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding years, and any plan of correction in effect with respect to the facility, available for any individual to review upon request; and (iii) Post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public.	F 577	1. A resident council meeting was held and residents were made aware of the location of the survey results for their review as well as any visitors. The review of the survey location information was documented in the Resident Council Meeting Minutes by the Social Worker (completed 9/7/18). 2. All residents and their responsible parties will be notified in writing by the DON of the most current survey results and the location of the results of the past three surveys (completed 9/28/18). 3. Residents will be educated by the Social Worker at every council meeting of the location of the survey results and will be reminded that they are encouraged to share the results with their family members and visitors. The review of the location of results will be documented in the monthly Resident Council Minutes by the Social Worker. 4. DON, or designee, will review minutes monthly X 3 months to ensure information is provided to residents. Any discrepancies will be brought to the QAPI committee for further evaluation and recommendations. 5. 10/26/18 and ongoing	

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F 577	Continued From page 8 (iv) The facility shall not make available identifying information about complainants or residents. This REQUIREMENT is not met as evidenced by: Based on observations and information obtained during the group interview, the facility staff failed to ensure Residents were knowledgeable of where the most recent survey and plan of correction results could be found. The facility staff failed to ensure residents knew where the most recent survey results were located. The findings include: During the group interview conducted 9/6/18, at approximately 10:00 a.m., 6 residents were present. All of the residents in the group interview were unable to verbalize the location of the State survey results and that they were unaware they could exam the results at will. Two random Resident interviews (Resident #23 and 1 random resident not in the group interview), were also conducted and the individuals stated they too were unaware the survey results were transmitted to the facility after the survey concluded, it was their right to examine the results, the posting of the location of the survey results and the facility's plan of correction could be examined at will, without asking. An interview was conducted with the Activity Director after the group interview on 9/6/18 at approximately 10:25 a.m. The Activity Director stated the posting of the location of the survey results was in the main corridor, immediately outside the activity room door.	F 577		

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F 577	Continued From page 9 Two surveyors observed the survey results posting in the location as stated by the Activity Director. On 9/6/18 at 10:50 a.m., the Director of Nursing stated the facility was cited for the not posting last year therefore; they posted the sign and made 1 year (2017) of survey results immediately available for viewing and the other 2 years (2015 and 2016) were kept at the nurse's station for viewing upon asking. The Director of Nursing stated they understood the above was sufficient meet the requirements. The above findings were shared with the Administrator, Director of Nursing and Unit Manager on 9/6/18 at approximately 6:00 p.m., the Director of Nursing stated, "the survey results posting and been updated and the 3 years of survey results were now together and available to be examined without having to ask for them".	F 577		
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section;	F 623		

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F 623	Continued From page 10 and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how	F 623	1. The two residents identified will have their information faxed to the LTC Ombudsman by the Social Worker (completed 9/20/18). 2. A list of all discharges and /or transfers since the last survey will be reviewed to ensure all notices have been sent to the Local LTC Ombudsman by the Social Worker. 3. Nursing staff will be educated on the NOTOD form to be completed and given to the resident and resident representative, outlining the reason for the transfer by the DON. A note will be documented in the resident record by the nurse and/or social worker that the ombudsman was notified of the resident's transfer and/or discharge. 4. Notifications for Transfers and Discharges will be reviewed weekly for four weeks, and monthly thereafter by the Social Worker to ensure that the Ombudsman has been notified. Any discrepancies will be brought to the QAPI committee for further evaluation and recommendations. 5. 10/26/18 and ongoing	

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F 623	Continued From page 11	F 623		

to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;
(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and
(vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.

§483.15(c)(6) Changes to the notice.
If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available.

§483.15(c)(8) Notice in advance of facility closure
In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate

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F 623	Continued From page 12 relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on resident record review, staff interviews and facility document review, the facility failed to notify the Office of the State Long-Term Care Ombudsman in writing of hospital discharges for 2 of 17 residents (Resident #38 and 24) in the survey sample. 1. The facility staff failed to notify the Office of the State Long-Term Care Ombudsman of Resident #38's transfer and admission to the hospital on 07/02/18. 2. The facility staff failed to notify the Office of the State Long-Term Care Ombudsman of Resident #24's transfer and admission to the hospital on 04/01/18. The findings included: 1. Resident #38 was admitted to the facility on 05/25/18. Diagnosis for Resident #38 included but not limited to *Atrial Fibrillation. The current Minimum Data Set (MDS), a 30-day assessment with an Assessment Reference Date (ARD) of 08/03/18 coded the resident with a 13 out of a possible score of 15 on the Brief Interview for Mental Status (BIMS) indicating no cognitive impairment. The Discharge MDS assessments was dated for 07/02/18 - discharge return anticipated. On 07/02/18, according to the facility's documentation, Resident #38 was found	F 623		

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	495397	A. BUILDING _____ B. WING _____	C 09/07/2018

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F 623	Continued From page 13	F 623		

with his eyes rolling up, extremities were rigid and his arms straight out. Resident's vital signs were; BP (140/80), P (105), R (28-32), T (98.9). Resident #38 was transport to the local Emergency Room (ER) via Emergency Medical Services (EMS). Resident returned to the facility on 07/06/18.

On 09/06/18 at approximately at 11:20 a.m., an interview was conducted with the Social Worker (SW) who stated, "I could not locate where the Ombudsman was notified of Resident #38's transfer and admission to the hospital on 07/02/18."

The facility administration was informed of the finding during a briefing on 09/07/18 at approximately 4:45 p.m. The facility did not present any further information about the findings.

*Atrial Fibrillation is the most common type of arrhythmia. An arrhythmia is a problem with the rate or rhythm of the heartbeat. During an arrhythmia, the heart can beat too fast, too slow, or with an irregular rhythm (Source: www.Nhlbl.nih.gov).

2. Resident #24 was originally admitted to the facility on 04/05/18. Diagnosis for Resident #24 included but not limited to *Hypertension.

The current Minimum Data Set (MDS), a quarterly Assessment Reference Date (ARD) of 07/10/18 coded the resident with a 08 out of a possible score of 15 on the Brief Interview for Mental Status (BIMS) indicating moderate cognitive impairment.

The Discharge MDS assessments was dated for

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F 623	Continued From page 14 04/01/18 - discharge return anticipated. On 04/01/18, according to the facility's documentation, Resident #24 presented in bed shaking, eyes open but unable to communicate. Resident's vital signs were; BP (129/73), P (155), R (24), T (102.3). Resident #24 was transported to the local ER via Emergency Medical Services (EMS). Resident returned to the facility on 04/05/18. On 09/06/18 at approximately at 11:20 a.m., an interview was conducted with the Social Worker (SW) who stated, "I could not locate where the Ombudsman was notified of Resident #24's transfer and admission to the hospital on 04/01/18." The facility administration was informed of the finding during a briefing on 09/07/18 at approximately 4:45 p.m. The facility did not present any further information about the findings. * Hypertension is when your blood pressure, the force of your blood pushing against the walls of your blood vessels, is consistently too high (https://medlineplus.gov/ency/article/007365.htm).	F 623		
F 625 SS=D	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies-	F 625		

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F 625	Continued From page 15 (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on staff interviews, facility documentation review and clinical record review the facility staff failed send a copy of the Bed-Hold Policy for 1 of 17 resident's (Resident #38) after being transferred to the hospital on 07/02/18. The facility staff failed to provide the resident or resident's representative with a written a copy of the bed hold policy. The findings included: Resident #38 was admitted to the facility on 05/25/18. Diagnosis for Resident #38 included but not limited to *Atrial Fibrillation. The current Minimum Data Set (MDS), a 30-day	F 625	1. The resident and RP will be educated on the BedHold policy by the Social Worker (completed 9/21/18). 2. An audit on all residents discharged since 3/17/18 will be conducted by the Social Worker and Nurse Manager or designee and the bedhold policy reviewed (completed 9/21/18). 3. A transfer packet will be created and completed for all transfers and delivered to the resident/RP by the Social Worker. Nursing staff will be educated by the DON on procedures for transferring residents to another facility (completed 9/21/18). 4. Within 24 hours the Social worker or designee will follow up to ensure the bed hold was completed and will maintain log of completion dates. Social Worker will also ensure resident/RP responses are documented in the resident's record and confirm scan copy in chart. Any discrepancies will be brought to the QAPI committee for further evaluation and recommendations. 5. 10/26/18 and ongoing	

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F 625	Continued From page 16 assessment with an Assessment Reference Date (ARD) of 08/03/18 coded the resident with a 13 out of a possible score of 15 on the Brief Interview for Mental Status (BIMS) indicating no cognitive impairment. The Discharge MDS assessments was dated for 07/02/18 - discharge return anticipated. On 07/02/18, according to the facility's documentation, Resident #38 was found with his eyes rolling up, extremities were rigid and his arms straight out. Resident's vital signs were; BP (140/80), P (105), R (28-32), T (98.9). Resident #38 was transport to the local ER via Emergency Medical Services (EMS). Resident returned to the facility on 07/06/18. On 09/06/18 at approximately at 11:20 a.m., an interview was conducted with the Social Worker (SW) who stated, "I could not locate where the resident or their representative were informed of the facility's bed hold policy." The facility policy titled Bed Hold (Last revision: 1/1/12). -It is the Chesapeake's policy to provide all Health Care residents and responsible parties with the Notice of Bed Hold Policy within 24 hours of when the resident is discharged to another medical facility. The facility administration was informed of the finding during a briefing on 09/07/18 at approximately 4:45 p.m. The facility did not present any further information about the findings. *Atrial Fibrillation is the most common type of arrhythmia. An arrhythmia is a problem with the	F 625		

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F 625	Continued From page 17 rate or rhythm of the heartbeat. During an arrhythmia, the heart can beat too fast, too slow, or with an irregular rhythm (Source: www.Nhlbl.nih.gov).	F 625		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s).	F 657		

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F 657	Continued From page 18 An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, clinical record review, and review of the facility's policy the facility staff failed to revise the person centered care plan as the resident's status changed for 1 of 17 residents (Resident #29), in the survey sample. The facility staff failed to revise Resident #29's care plan to include use of a Hoyer lift for transfers. The findings included: Resident #29 was originally admitted to the facility 07/13/18 and the resident has never been discharged from the facility. The current diagnoses included; unspecified dementia with behavior disturbance. The admission Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 07/20/18 coded the resident as not having the ability to complete the Brief Interview for Mental Status (BIMS). The staff interview was coded that the resident's long and short term	F 657	1. The care plan for the identified resident was updated by the Nurse Manager to include use of a Hoyer lift. 2. All care plans will be reviewed by the Nurse Manager for accuracy for changes in mobility / transfer performance and related devices required. 3. MDS Coordinator was re-educated on revising care plans for all residents who experience a change in mobility / transfer performance and related devices required. 4. The interdisciplinary team will review/monitor changes in weekly Risk meetings. DON, or designee, will review care plans for all residents who have experienced a change in mobility / transfer performance. Any discrepancies will be brought to the QAPI committee for further evaluation and recommendations. 5. 10/26/18 and ongoing	

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F 657	Continued From page 19	F 657		

memory were okay and that she has no recall. The resident was also coded for severely impaired daily decision making abilities. In section "G" the resident was coded as requiring total care of 2 people for transfers and exhibiting balance problems during transfers.

The resident's active care plan dated 7/13/18 had a problem which read; (name of resident) requires assistance with Activities of Daily Living (ADL) related to increased weakness, decreased mobility, and increased confusion due to advanced dementia, impaired gait and balance. The goal read; (name of resident) will receive assistance with all ADLs as evidenced by good grooming, neat and clean appearance and be free of body odors daily through next review. The approaches includes; Transfers: resident requires the use of a gait belt and 2 people assistance for transfers.

On 9/6/17 at approximately 11:40 a.m., 2 Certified Nursing Assistant (CNA) were observed transferring Resident
#29 from the bed to a wheelchair using a Hoyer and signage at the resident's door read; "Hoyer with 2 people".

An interview was conducted with the Director of Nursing (DON) on 9/7/18 at approximately 3:50 p.m. The DON stated Resident #29's condition deteriorated to the point she was unable to bear weight; an indication for use of the Hoyer lift. The DON also stated rehabilitation services screened the resident and determined she wasn't a candidate for their services therefore; nursing made the decision to discontinue transfer utilizing a gait belt and begin Hoyer lift transfers. The DON further stated she was unable to locate

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F 657	Continued From page 20 documentation indicating the date the decision was made but it was intervention instituted for the resident's best interest. The DON stated Resident #29's person centered care plan should reflect the change in means of transfers from use of the gait belt to use of the Hoyer lift because; the care plan directs care. The facility's Care Plan policy was requested but not received. The above findings were shared with the Administrator, Director of Nursing and Unit Manager on 9/7/18, at approximately 4:45 p.m. An opportunity was offered for additional information to be presented but none was offered. Definitions: Hoyer lift: a mechanical device used to lift and transfer an individual Gait Belt: a device used by caregivers to transfer individuals with mobility issues	F 657		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices.	F 812		

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F 812	Continued From page 21 (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and facility document review the facility staff failed to store food in accordance with professional standards for food service safety. The food service staff failed to ensure foods stored in refrigerated units were sealed, dated and labeled appropriately. The findings included: On 09/05/18 at 7:15 a.m., during the initial inspection of the kitchen with the Dietary Manager, the following were observed: 1. In the reach in freezer was a box of egg rolls, 2 bags of breaded chicken filets, 3 bags of sweet potato fries, 1 bag of French fries, 1 bag of hash browns, 1 bag of breaded fish fillet, 1 bag of French toast, 1 box of breaded country fried steak and 1 box of clam strips. They were all open, not sealed, and not labeled and not dated. 2. In the reach in refrigerator was an open bag of Parmesan cheese; not labeled and dated. 3. In the Independent reach in refrigerator was 7 single serving banana cream pies, 6 single serving bowels of beets, 12 single serving bowels of potato salad, 3 single serving chocolate cream pies and one salad, all uncovered, not labeled	F 812	1. All items not dated and not sealed were removed and discarded by the Kitchen Manager on 9/5/18. 2. All Kitchen and server staff will be trained by the Director of Culinary Services on the proper procedure for dating, labeling and storage of food items (completed 9/21/18). 3. Daily team huddles/meetings with kitchen and server staff will be conducted by the Dining Services Manager, reinforcing proper labeling and dating (9/21/18 and ongoing). 4. Daily checks of the refrigerators and freezers by the Supervisor on duty will be conducted for two weeks to ensure compliance of procedures. Weekly checks will be conducted for two months by the Executive Chef to ensure compliance. Monthly checks will be conducted for two months by the Director of Culinary Services to ensure compliance, with random checks thereafter. Any discrepancies will be brought to the QAPI committee for further evaluation and recommendations. 5. 10/26/18 and ongoing	

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F 812	Continued From page 22 and not dated. The dietary manager stated that all food items should be dated when opened. The dietary manager instructed the kitchen manager to discard all food items that were open and not dated. On the same day at 7:45 a.m., an interview was conducted with the kitchen manage who stated, "Food items should be dated after they have been opened." The facility's policy titled Food Storage (Last Revision date: 8/30/13). -Prepared food stored in the refrigerator until service shall be date with an expiration date. Such foods will be tightly sealed with plastic wrap, foil or a lid. The facility Administration was informed of the findings during a briefing on 09/07/18 at approximately 4:45 p.m. The Director of Culinary Services stated, "All food items should be dated and labeled when open." The facility did not present any further information about the findings.	F 812		
F 867 SS=D	QAPI/QAA Improvement Activities CFR(s): 483.75(g)(2)(ii) §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; This REQUIREMENT is not met as evidenced by: Based on staff interviews, facility documentation review, the facility staff failed to ensure the	F 867		

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F 867	Continued From page 23 Quality Assessment and Assurance (QAA) committee had a physician present during their quarterly meeting on 4/26/18. The findings included: On 09/07/18 at approximately 3:30 p.m., an interview was conducted with the Administrator and Director of Staff Development and QA. The facility's sign-in sheets were reviewed for their Quality Assessment and Assurance meetings on 10/26/17, 1/25/18, 4/26/18, and 7/26/18. The sign-in sheet reviewed for 4/26/18 showed no documentation that a Physician was in attendance. The facility was not able to provide documentation from the Quality Assessment and Assurance meeting notes that a Physician was in attendance. The facility policy titled Quality Assurance Performance Improvement Committee (Revision date: 4/27/17. -Specific Procedures/Requirements in part: 4. The facility will maintain a QAPI committee consisting at a minimum of: a. The director of nursing services b. The Medical Director or his or her designee c. At least three other member of the facility's at least one of who must be the administrator, owner, a board member or other individual in a leadership role. 6. The committee will meet at least quarterly and as needed to coordinate and evaluate activities under the QAPI program. The facility administration was informed of the findings during a briefing on 09/07/18 at	F 867	1. The physician will be re-educated by the Administrator or designee on the importance and expectation of his presence/or designee at each quarterly QAPI meeting. 2. The Administrator will meet with physician to review the current schedule of the QAPI meetings to adjust dates/times as needed to ensure regulatory compliance. 3. The physician will be educated to notify the Administrator within 48 hours if adjustments are required for meeting attendance or a designee appointed. The QA Director will send the physician meeting reminders one week in advance. 4. The Administrator/Designee will monitor compliance by ensuring physician is present quarterly. Any discrepancies will be brought to the QAPI committee for further evaluation and recommendations. 5. 10/26/18 and ongoing	

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F 867	Continued From page 24 approximately 4:45 p.m. The facility did not present any further information about the findings.	F 867		
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported;	F 880	1. A water management policy will be developed by the Director of Building and Grounds in collaboration with a Life Safety Consultant. 2. All staff will be educated on the new water management policy by the Building and Grounds Director and the proper practice of infection control by the Staff Development Director and DON to maintain a safe and sanitary environment. 3. The water will be tested initially by the Life Safety Consultant who will educate/certify the Building and Grounds Director/Designee to continue the water testing process. A testing schedule will be developed by the Building and grounds Director. 4. The Building and Grounds Director/Designee will monitor the water testing to ensure compliance by auditing the testing schedule. 5. 10/26/18 and ongoing	

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THE CHESAPEAKE	955 HARPERSVILLE RD NEWPORT NEWS, VA 23601

(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 880	Continued From page 25 (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which 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; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on staff interview, and facility document review, the facility staff failed to implement a water management policy and procedure to reduce the risk of growth and spread of Legionella and other opportunistic pathogens in building water system and failed maintain an infection control program to provide a safe,	F 880	1. The disposable suture kit was removed from the resident's treatment cart by the treatment nurse (completed 9/6/18). 2. All residents who have treatments will have their supplies reviewed for multiple use by the Nurse Manager. 3. All professional nursing staff will be educated by the DON/Designee to read all packaging instructions for single use vs. multi-use prior to treatment. 4. Wound supply set up will be observed by Nurse Manager during one treatment administration for each nurse. The Nurse Manager will monitor randomly thereafter. Any discrepancies will be brought to the QAPI committee for further evaluation and recommendations. 5. 10/26/18 and ongoing	

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F 880	Continued From page 26 sanitary environment to prevent the development and transmission of disease and infection for 1 of 17 residents (Resident #29) in the survey sample. 1. The facility staff failed to implement a water management policy and procedure to reduce the risk of growth and spread of Legionella 2. The facility staff failed to maintain good infection control practices during wound care for Resident #29. The findings included: 1. An interview was conducted with the Director of building and grounds on 09/07/18 at approximately 12:45 p.m. He (Director of building and grounds) stated, "As of right now, we are still in the process of creating the policy of Legionella." He proceeded to say, "We have a consultant, so we are waiting for him to help us finalized our policy." The director of building of grounds stated, "We do have a Legionella process but has not been implement at this time." The surveyor asked, "Are water testing being done" he replied, "We are not doing water testing at this time." There was no documentation that the facility specifies testing protocols and acceptable ranges for control measures, and documents the results of testing and corrective actions taken when control limits are not maintained. The facility administration was informed of the finding during a briefing on 09/07/18 at approximately 4:45 p.m. The facility did not present any further information about the findings. The facility's policy titled Water Management	F 880		

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F 880	Continued From page 27 Program to Prevent *Legionnaire's Disease read in part: 1. The facility will develop and maintain a water management program that includes the following elements. a. Establish a water management team. b. Describe the building water system used test and diagrams. c. Identify areas where Legionella could grow and spread. d. Describe where control measures would be applied, monitor and log compliance quarterly. e. Establish ways to respond when control measure are not met. f. Monitor the program for effectiveness. g. Document all activities (monitoring, response to variances, etc). 2. The water management program will be reviewed at least annually and as needed. 3. As part of the facility's overall infection control program, the facility will maintain educational and resources information on Legionnaire's Disease to include information on signs/symptoms, testing, transmission, and treatment etc... *Legionnaire's disease is a serious type of pneumonia caused by bacteria, called Legionella that live in water. Legionella can make people sick when they inhale contaminated water from building water systems that are not adequately maintained. 2. Resident #29 was originally admitted to the facility 07/13/18 and has never been discharged. The current diagnoses included; unspecified dementia with behavior disturbance and a pressure ulcer of the left *ischium.	F 880		

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F 880	Continued From page 28 The admission Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 07/20/18 coded the resident as not having the ability to complete the Brief Interview for Mental Status (BIMS) therefore; the staff interview was conducted. The staff interview indicated the resident's long and short term memory were okay and she had no recall. The resident was also coded for severely impaired daily decision making abilities. In section "G" the resident was coded as requiring total care of 2 people for transfers, total care of one person with locomotion and bathing, extensive assistance of 2 people with bed mobility, dressing, toileting, and personal hygiene, as well as requiring extensive assistance of 1 person with eating. In section "M", Skin Conditions; the MDS assessment was coded that the resident was admitted to the facility with an unstageable pressure ulcer with eschar. Resident # 29 had an appointment on 09/05/18 at the wound care clinic. New wound care orders were received. The order read; "every other day and as needed dressing change to the left ischium: Cleanse wound and peri wound with normal saline, pack wound with Aquacel Ag ribbon leaving long tail for easy removal. Cover with fluffed gauze and cover with Allevyn border dressing". The care plan problem dated 07/26/18 read; Pressure Ulcer Present, "the location is the left ischium related to incontinence, poor nutritional intake, decreased mobility". "The goal states "Pressure ulcer will show signs of healing without signs or symptoms of infection through the next	F 880		

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F 880	Continued From page 29 review". The approaches included; "Nurse to measure and monitor wound status progression or deterioration every week, notify MD and family of changes. Treatment as ordered. See POS for current treatments...Wound care clinic per MD order". Resident #29's, wound care was observed 09/06/18, at approximately 11:40 a.m. The Licensed Practical Nurse (LPN) #1, was observed gathering her supplies together to provide wound care. The supplies included; 2 x 2 gauze, 2 normal saline ampules, 1 calcium alginate dressing, 1 package of *Aquacel Ag ribbon and 1 suture removal kit, which was already opened when she removed it from the treatment cart. LPN # 1 placed her supplies on a clean field. She proceeded to remove the soiled dressing and packing from resident # 29's wound to the left ischium; a moderate amount of dark green drainage with a foul odor was observed. The peri wound was intact, the wound bed appeared pinkish around the edges, and the approximate size of the wound was 2 centimeters (length) by 2 centimeters (width) by 1.5 centimeters (depth). LPN # 1, proceeded to clean the left ischium wound, removed her gloves, sanitized her hands, donned gloves, opened the biocclusive dressing, sanitized her hands, donned gloves, removed some of the Aquacel Ag ribbon from the package and began to pack the wound using cotton tip applicators. Once the wound was fully packed, LPN #1, removed the pair of scissors from the opened single use suture kit, cutting the sterile Aquacel Ag ribbon with the scissors from the opened kit and packing the tail of the Aquacel Ag ribbon, which was observed touching the suture	F 880		

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F 880	Continued From page 30 kit package, into the wound. LPN #1 layered 2x2 gauze over the ribbon and completed the dressing change by applying a biocclusive dressing. The facility's Policy entitled Clean Dressing Change dated 1/01/12 indicates that it is The Chesapeake's policy to provide guidelines for the application of clean dressings. Specifically, it is The Chesapeake's policy to perform a dressing change under clean and sanitary conditions, protect the resident from infection and to promote active healing of all wounds. The facility's Procedure states the charge nurse will assemble equipment and supplies that are necessary for the dressing change, including, but not limited to scissors,tape, dressings per resident's physician order and personal protective equipment. The procedure also states that the charge nurse will open supplies, touching only the exterior surface, and organize on the sanitary surface. An interview was conducted on 09/06/18, at 12:00 p.m., with LPN #1. She stated; using scissors from an opened, single use, suture removal kit was "not the right thing to do". LPN # 1 also stated "I thought, should I have gotten another kit or used a pair of my own scissors". She stated that the Director of Nursing (DON), told her that she could have used her own scissors and just cleaned them off instead of taking the scissors from the suture kit. On 09/06/18, at approximately 12:10 p.m., the above findings were shared with the Director of Nursing, who was present during the wound care observation. The DON stated LPN #1 should have used a pair of her own scissors and wiped them off instead of using the scissors from the	F 880		

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F 880	Continued From page 31 opened suture removal kit. Definition: *AQUACEL Ag with Hydrofiber (Aquacel Ag), silver impregnated antimicrobial dressing is a soft, sterile, non- woven pad or ribbon dressing composed of sodium carboxymethylcellulose and 1.2% ionic silver which allows for a maximum of 12mg of silver for a 4 inch x 4 inch dressing. (https://www.healthproductsforyou.com/p-convatec-aquacel-ag-hydrofiber-ribbon-dressing-with-strengthening-fiber-and-ionic-silver.html?msclkid=5463682a06c516b9ee1633b2601d8c64&utm_source=bing&utm_medium=cpc&utm_campaign=WC-Wound%20Care%20Advanced&utm_term=aquacel%20ag%20ribbon&utm_content=Aquacel%20Ag) *Ischium: the area at the lower and back part of the hip bone.	F 880		