STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495127	A. BUILDING _____ B. WING _____	C 11/30/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTMINSTER CANTERBURY CHESAPEAKE	3100 SHORE DRIVE VIRGINIA BEACH, VA 23451

(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
E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 11/28/18 through 11/30/18. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities. No emergency preparedness complaints were investigated during the survey.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 11/28/18 through 11/30/18. 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. One complaint was investigated during the survey. The census in this 95 certified bed facility was 88 at the time of the survey. The survey sample consisted of 36 current Resident reviews and 5 closed record reviews.	F 000		
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview and facility documentation review, the facility staff failed to ensure reasonable accommodation of needs for 2 of 41 residents (Resident #55 and #12) in the survey sample.	F 558	1. The door handles for Resident #55 and Resident #12 were installed to the interior bathroom door on 11/30/18. RECEIVED DEC 28 2018 VDH/OLC	

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

Healthcare Administrator 12-27-18

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495127	A. BUILDING _____ B. WING _____	C 11/30/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTMINSTER CANTERBURY CHESAPEAKE	3100 SHORE DRIVE VIRGINIA BEACH, VA 23451

(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 558	Continued From page 1 1. The facility staff failed to ensure Resident #55 had reasonable accommodation of needs, specifically to have interior bathroom door handles. 2. The facility staff failed to ensure Resident #12 had reasonable accommodation of needs, specifically to have interior bathroom door handles. The findings included: 1. Resident #55 was admitted to the facility on 5/24/18. Diagnosis for Resident #55 included but not limited to Dementia with Behavioral Disturbance, Difficulty in Walking, and Muscle Weakness. Resident #55's Minimum Data Set (MDS) with an Assessment Reference Date of 10/1/18 coded Resident #55 Brief Interview for Mental Status (BIMS) score of 4 out of a possible score of 15 indicating moderate cognitive impairment. During the initial tour on 11/28/18 at approximately 1:30 PM, Resident #12 was observed in her wheelchair in her room accompanied by her daughter. Resident #12 daughter stated, "I am concerned there is no door handle inside mom's bathroom." It was observed there was no door handle to interior bathroom sliding door. During a follow up tour on 11/29/18 at approximately 12:00 PM, it was observed there was still no handle on inside of Resident #12's bathroom door. Interior sliding bathroom doors of 15 rooms on Resident #55's unit were inspected on 11/29/18 for presence of door handles. An interview was conducted on 11/29/18 at approximately 4:00 PM with Director of	F 558	2. Residents who have interior "barn" doors have the potential to be affected. An audit of interior bathroom doors has been completed with no additional opportunities identified. 3. Room turn checklist inspection for long term care residents has been updated to include inspection/placement of interior bathroom door handles. The VP of Development & General Services/designee will educate Staff completing those checklists to include new changes. VP of Development & General Services/designee will audit a sample of long term care resident room turns weekly x 4 weeks, then bi-weekly x 4 weeks, then monthly x 3 months or until resolved. Findings will be reported to the Administrator/designee. 4. The Administrator/designee will report the results monthly in QAPI x 3 months or until resolved.	1.11.19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495127	A. BUILDING _____ B. WING _____	C 11/30/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTMINSTER CANTERBURY CHESAPEAKE	3100 SHORE DRIVE VIRGINIA BEACH, VA 23451

(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 558	Continued From page 2	F 558		

Maintenance who stated, "It is the expectation that each bathroom door has an exterior and interior door handle for entering and exiting the bathroom."

On 11/30/18 at approximately 1:00 PM the above findings were shared with the facility Administrator and the Director of Nursing during a pre-exit conference. The facility Administrator stated, "(Resident #12) handle was removed at resident request and (Resident #55 room) was also removed because they were a friend to (Resident #12) and wanted it done too. We forgot to put the handle back in the room of (Resident #55) when a new resident moved in there." Documentation of resident request to remove door handle was requested, no documentation was available from facility. A policy and procedure for resident room set-up and/or room hardware installation was requested and the facility was unable to provide any policy. The facility shared an email from contractors showing pictures of initial bathroom door hardware installation but did not provide any documentation for removal of interior door handles for Resident #55. No additional information was shared.

2. Resident #12 was admitted to the facility on 7/3/17. Diagnosis for Resident #12 included but not limited to Tremor, Osteoporosis, Asthma, Mild Cognitive Impairment, Legal Blindness, and Diabetes.

Resident #12 Minimum Data Set (MDS) with an Assessment Reference Date of 10/1/18 coded Resident #12 Brief Interview for Mental Status (BIMS) score of 15 out of a possible score of 15 indicating cognitively intact at assessment.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495127	A. BUILDING _____ B. WING _____	C 11/30/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTMINSTER CANTERBURY CHESAPEAKE	3100 SHORE DRIVE VIRGINIA BEACH, VA 23451

(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 558	Continued From page 3	F 558		

During a tour of unit on 11/29/18 at approximately 12:00 PM, interior bathroom sliding doors of 15 resident rooms were inspected for presence of bathroom door handles. At that time it was noted that Resident #12's room was without a bathroom door handle.

An interview was conducted on 11/29/18 at approximately 4:00 PM with Director of Maintenance. The Director of Maintenance and surveyor entered bathroom of Resident #12, sliding bathroom door was closed. The Director of Maintenance stated, "It is the expectation that each bathroom door has an exterior and interior door handle for entering and exiting the bathroom."

On 11/30/18 at approximately 1:00 PM the above findings were shared with the facility Administrator and the Director of Nursing during a pre-exit conference. The facility Administrator stated, "(Resident #12) handle was removed at resident request and (Resident #55 room) was also removed because they were a friend to (Resident #12) and wanted it done too. We forgot to put the handle back in the room of (Resident #55) when a new resident moved in there." Documentation of resident request to remove door handle was requested, no documentation was available from facility. A policy and procedure for resident room set-up and/or room hardware installation was requested and the facility was unable to provide any policy. The facility shared an email from contractors showing pictures of initial bathroom door hardware installation but did not provide any documentation for removal of interior door handles for Resident #12. No additional information was shared.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495127	A. BUILDING _____ B. WING _____	C 11/30/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTMINSTER CANTERBURY CHESAPEAKE	3100 SHORE DRIVE VIRGINIA BEACH, VA 23451

(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 584 SS=D	Continued From page 4 Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to	F 584	1. Resident #57 and #6 equipment were immediately sanitized after the observation on 11/30/18 during survey. 2. Residents with motorized wheelchair and Tube feeding pole have the potential to be affected. A baseline audit was completed for cleanliness of motorized wheelchairs and tube feeding poles. 3. Current nursing staff was educated on cleaning and maintaining motorized wheelchair and tube feeding pole. completed on 12/27/18. Education was added to new hire orientation. Clinical coordinators and/or Staff Development coordinator will conduct random observations. Observations will be conducted at 2 times a week x 4 weeks, then weekly x 4 weeks, then monthly x 3 months or until resolved. Findings will be reported to the DON. 4. The DON or designee will report the results monthly in QAPI monthly x 3 months or until resolved.	1.11.19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495127	A. BUILDING _____ B. WING _____	C 11/30/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTMINSTER CANTERBURY CHESAPEAKE	3100 SHORE DRIVE VIRGINIA BEACH, VA 23451

(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 584	Continued From page 5 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observations, resident interviews and staff interview the facility staff failed to ensure resident equipment was maintained in a sanitary manner for 2 of 41 residents (Residents #57 and #6), in the survey sample. 1. The facility staff failed to ensure Resident # 57's motorized chair was without a white substance to the front of the seat and on the footrest. 2. The facility staff failed to ensure Resident #6's tube feeding pole was without a dried yellow substance to the base of the pole. The finding included: 1. Resident #57 was originally admitted to the facility 2/8/17 and has never been discharged from the facility. The current diagnoses included; coronary artery disease, heart failure, diabetes and high blood pressure. The quarterly Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 10/29/18 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 13 out of a possible 15. This indicated Resident #57's cognitive abilities for daily decision making were intact. In section "G" (Physical functioning) the resident was coded as requiring extensive assistance of 2	F 584		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495127	A. BUILDING _____ B. WING _____	C 11/30/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTMINSTER CANTERBURY CHESAPEAKE	3100 SHORE DRIVE VIRGINIA BEACH, VA 23451

(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 584	Continued From page 6	F 584		

people with bed mobility, transfers, and dressing, as well as limited assistance of 1 person with wheel chair mobility on the unit and supervision of 1 person with wheel chair mobility off the unit.

On 11/28/18, at approximately 1:15 p.m., during the initial screening, Resident #57 was observed in his room listening to a book on tape; his wheel chair was observed parked in the room. A white substance was observed on the seat and the footrest (approximately the size of a dollar bill) of the motorized chair. On 11/29/18 Resident #57 was observed in his room and the motorized wheel chair still had a white substance on the seat and footrest of his wheel chair.

On 11/29/18 at approximately 11:30 a.m., Resident #57 stated because of his visual problems he hadn't noticed the white substance until it was brought to his attention but he would talk to the staff about cleaning it.

At approximately 3:00 p.m., on 11/29/18, Resident #57 was observed on the motorized wheel chair in the main lobby, the white substance was visible to the front of the wheel chair and the footrest.

The facility's policy for wheel chair cleaning was requested but the Director of Nursing stated they didn't have a policy therefore; a wheel chair, walkers and Hoyer sling cleaning schedule was presented. Resident #57's was scheduled for Saturdays.

On 11/30/18 at approximately 1:45 p.m., during the pre-exit briefing the above information was given to the Administrator, Director of Nursing and Corporate Vice President. The Director of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495127	A. BUILDING _____ B. WING _____	C 11/30/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTMINSTER CANTERBURY CHESAPEAKE	3100 SHORE DRIVE VIRGINIA BEACH, VA 23451

(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 584	Continued From page 7	F 584		

Nursing stated the nursing staff reported it was likely the cream which is applied to the resident's legs that was visible on the wheel chair. She further stated Resident #57's wheel chair requires cleaning usually twice weekly.

2. Resident #6 was originally admitted to the facility 3/9/18. The resident had an unplanned discharge from the facility and re-entered the facility 5/24/18. The current diagnoses included; Parkinson's disease and reflux.

The quarterly Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 8/23/18 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 7 out of a possible 15. This indicated Resident #6's cognitive abilities for daily decision making were severely impaired.
In section "G" (Physical functioning) the resident was coded as requiring total care of 1 person with eating. At MDS section "K0510" the resident was coded for receiving nutrition via a feeding tube.

On 11/28/18, at approximately 1:35 p.m., during the initial screening, Resident #6 was observed in his room seated at bedside. The tube feeding pole was observed with a dried pale yellow substance on all legs of the base of the pole. Resident #6 was also visited in his room on 11/29/18 at approximately 3:50 p.m. The feeding was in progress and the pole was again observed with a dried pale yellow substance on the base.

The facility's policy for cleaning resident equipment was requested; the Director of Nursing stated they had no policy for cleaning of tube feeding poles and the policy titled "Tube Feeding"

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495127	A. BUILDING _____ B. WING _____	C 11/30/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTMINSTER CANTERBURY CHESAPEAKE	3100 SHORE DRIVE VIRGINIA BEACH, VA 23451

(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 584	Continued From page 8 didn't address cleaning of tube feeding equipment. On 11/30/18 at approximately 1:45 p.m., during the pre-exit briefing the above information was given to the Administrator, Director of Nursing and Corporate Vice President. The Director of Nursing stated the pole which held the tube feeding should be cleaned when needed.	F 584		
F 636 SS=D	Comprehensive Assessments & Timing CFR(s): 483.20(b)(1)(2)(i)(iii) §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. §483.20(b) Comprehensive Assessments §483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions.	F 636	1. Resident #132 MDS was completed and after the observation on 11/29/18 during survey completed copy given to surveyor as proof of completion. 2. Residents newly admitted to the Hoy Center have the potential to be affected. The MDS assessment schedule has been reorganized to optimize tracking of PPS assessments. 3. Current MDS coordinators were educated on strategic coordination of PPS calendar to track timely completion of MDS.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495127	A. BUILDING _____ B. WING _____	C 11/30/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTMINSTER CANTERBURY CHESAPEAKE	3100 SHORE DRIVE VIRGINIA BEACH, VA 23451

(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 636	Continued From page 9 (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning. (xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS). (xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts. §483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs. (i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.) (iii)Not less than once every 12 months. This REQUIREMENT is not met as evidenced by: Based on clinical record review and staff interviews the facility staff failed to complete the required initial comprehensive assessment timely for 1 of 41 residents (Resident #132), in the survey sample.	F 636	Director of nursing services and/or Administrator will conduct random observations. Observations will be conducted at weekly x 4 weeks, then bi-weekly x 4 weeks, then monthly x 3 months or until resolved. Findings will be reported to the DON. 4. The DON or designee will report the results monthly in QAPI monthly x 3 months or until resolved. 5. Compliance Date:	1.11.19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495127	A. BUILDING _____ B. WING _____	C 11/30/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTMINSTER CANTERBURY CHESAPEAKE	3100 SHORE DRIVE VIRGINIA BEACH, VA 23451

(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 636	Continued From page 10	F 636		

The facility's staff failed to complete Resident #132's admission Minimum Data Set (MDS) assessment within 14 calendar days after admission to the facility.

The findings included:

Resident #132 was originally admitted to the facility 11/15/18 and he has not been discharged. The current diagnoses included; cancer, an infected left 2nd toe and diabetes.

No MDS assessment was observed in the facility's computer system for Resident #132; therefore a copy of the admission MDS assessment was requested. An incomplete admission MDS assessment was provided by the facility's staff on 11/29/18 at approximately 4:15 p.m. The MDS Coordinator stated they were short staffed and unable to get to Resident #132's MDS assessment within the required timeframe. She stated it should have been completed 11/28/18, and she was working on getting it completed.

The uncompleted admission MDS assessment with an assessment reference date (ARD) of 11/22/18 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 10 out of a possible 15. This indicated Resident #132's cognitive abilities for daily decision making were moderately impaired.

Upon arrival to the facility 11/30/18 at 9:00 a.m., Resident #132's MDS assessment had been completed and left for viewing. It was signed 11/29/18.

The CMS guidelines for Comprehensive Assessments are as follows:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495127	A. BUILDING _____ B. WING _____	C 11/30/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTMINSTER CANTERBURY CHESAPEAKE	3100 SHORE DRIVE VIRGINIA BEACH, VA 23451

(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 636	Continued From page 11 OBRA-required comprehensive assessments include the completion of both the MDS and the Care Area Assessments (CAA) process, as well as care planning. Comprehensive assessments are completed upon admission, annually, and when a significant change in a resident's status has occurred or a significant correction to a prior comprehensive assessment is required. They consist of: Admission Assessment, Annual Assessment, Significant Change in Status Assessment, Significant Correction to Prior Comprehensive Assessment. The ARD (Item A2300) is the last day of the observation/look back period, and day 1 for purposes of counting back to determine the beginning of observation/look back periods. For example, if the ARD is set for day 14 of a resident's admission, then the beginning of the observation period for MDS items requiring a 7-day observation period would be day 8 of admission (ARD + 6 previous calendar days), while the beginning of the observation period for MDS items requiring a 14-day observation period would be day 1 of admission (ARD + 13 previous calendar days). (CMS' RAI Version 3.0 Manual, October 2018 Page 2-19). On 11/30/18 at 1:45 p.m., the above findings were shared with the Administrator, Director of Nursing and the Corporate Vice President. The Director of Nursing stated they have no policy because they follow the RAI (Resident Assessment Instrument) manual for MDS completion.	F 636		
F 645 SS=D	PASARR Screening for MD & ID CFR(s): 483.20(k)(1)-(3) §483.20(k) Preadmission Screening for	F 645	1. A PASARR for Resident #24 and Resident #29 was completed on 11/30/18.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495127	A. BUILDING _____ B. WING _____	C 11/30/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTMINSTER CANTERBURY CHESAPEAKE	3100 SHORE DRIVE VIRGINIA BEACH, VA 23451

(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 645	Continued From page 12 individuals with a mental disorder and individuals with intellectual disability. §483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission, (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services; or (ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission- (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability. §483.20(k)(2) Exceptions. For purposes of this section- (i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital.	F 645	2. Residents who reside or admit to the care center have the potential to be affected. A resident census report was reviewed for 11/30/18 and a PASARR was completed if necessary for residents residing in the care center at that time. 3. A policy for obtaining and maintaining PASARRs for current residents has been developed. Administrator/designee will educate involved staff members on above policy. Admissions Director/designee will complete random audits for PASARRs on long term care residents 2 x per week x 4 weeks, then 1 x week for 4 weeks, then monthly x 3 months or until resolved. Findings will be reported to the Administrator/designee. 4. The Administrator/designee will report the results monthly in QAPI x 3 months or until resolved.	1.11.19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495127	A. BUILDING _____ B. WING _____	C 11/30/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTMINSTER CANTERBURY CHESAPEAKE	3100 SHORE DRIVE VIRGINIA BEACH, VA 23451

(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 645	Continued From page 13 (ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual- (A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital, (B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and (C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services. §483.20(k)(3) Definition. For purposes of this section- (i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1). (ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter. This REQUIREMENT is not met as evidenced by: Based on medical record review, facility document review and staff interviews the facility staff failed to ensure a Level I PASARR (Preadmission Screening and Resident Review which is a pre-admission screening for a mental disorder (MD) or intellectual disability) was completed prior to admission or within 30 days of admission for 2 of 41 Residents in the survey sample, Resident #24 and #29. 1. The facility staff failed to ensure a Level I	F 645		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495127	A. BUILDING _____ B. WING _____	C 11/30/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTMINSTER CANTERBURY CHESAPEAKE	3100 SHORE DRIVE VIRGINIA BEACH, VA 23451

(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 645	Continued From page 14	F 645		

PASARR (a pre-admission screening for a mental disorder (MD) or intellectual disability) was completed prior to admission for Resident #24.

2. The facility staff failed to ensure a Level I PASARR was completed prior to admission for Resident #29.

The findings included:

1. Resident #24 was admitted to the facility on 7/14/14 with diagnoses to include Anxiety Disorder and Bipolar Disorder.

The most recent comprehensive Minimum Data Set (MDS) was an Annual assessment with an Assessment Reference Date (ARD) of 1/26/18. The Brief Interview for Mental Status was coded as a 6 out of a possible 15 indicating Resident #24 was cognitively impaired and incapable of daily decision making.

On 11/28/18 at approximately 4:00 P.M. the facility was asked for for Resident #24's PASARR that was completed prior to admission of 7/14/14 or within 30 days of admission.

On 11/29/18 at approximately 1:00 P.M. the Director of Social Services presented a Level I PASARR for Resident #24 that she completed on 11/28/18. The Director of Social Services stated, "I could not find a Level I PASARR for Name (Resident #24) so I did one yesterday."

2. Resident #29 was admitted to the facility on 2/26/13 and re-admitted on 1/22/18 with diagnoses to include Major Depressive Disorder and Bipolar Disorder.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495127	A. BUILDING _____ B. WING _____	C 11/30/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTMINSTER CANTERBURY CHESAPEAKE	3100 SHORE DRIVE VIRGINIA BEACH, VA 23451

(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 645	Continued From page 15 The most recent comprehensive Minimum Data Set (MDS) was an Admission with an Assessment Reference Date (ARD) of 1/26/18. The Brief Interview for Mental Status was coded as a 99 (resident unable to complete the interview). However, the Resident #29 was coded has having short and long term memory recall and was severely impaired in cognition for daily decision making. On 11/28/18 at approximately 4:00 P.M. the facility was asked for for Resident #29's PASARR that was completed prior to admission of 2/26/13 or within 30 days of admission. On 11/29/18 at approximately 1:00 P.M. the Director of Social Services presented a Level I PASARR for Resident #29 that she completed on 11/28/18. The Director of Social Services stated, "I could not find a Level I PASARR for Name (Resident #29) so I did one yesterday." On 11/29/18 at approximately 2:00 P.M. The Administrator presented a policy and procedure titled "Preadmission Screening and Resident Review (PASARR) original date November 29, 2018" to the surveyor and stated, "This is our new PASARR policy and it is effective today." The facility policy titled "Preadmission Screening and Resident Review (PASARR)" original date: November 29, 2018 was reviewed and is documented in part, as follows: PURPOSE/POLICY: The facility observes pre-admission screening requirements: *To ensure that people with known or suspected mental illness or intellectual disabilities are not inappropriately institutionalized or marginalized; to	F 645		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495127	A. BUILDING _____ B. WING _____	C 11/30/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTMINSTER CANTERBURY CHESAPEAKE	3100 SHORE DRIVE VIRGINIA BEACH, VA 23451

(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 645	Continued From page 16 make sure that every individual receives the services and supports that will optimize their success in the least restrictive setting. *To ensure that residents with these specific types of disabilities are admitted or allowed to remain in the facility; only if the facility can provide them with the services they need. PROCEDURE: 1. Preadmission-Level I Screening a. Admissions from a hospital or another provider. i. The Admissions Coordinator will review each prospective resident's medical record for documentation of a Level I (DMAS 95) screening. 1. If the Level I screening does not identify the presence or suspicion of a condition of disability, no further action is necessary. 2. If there has been no Level I screening, the Admissions Coordinator will request that the provider complete the screen and provide a copy to the facility. 3. In the event that the hospital or other provider cannot perform the Level I screening, the facility will complete the screen within the first 30 days of a resident's stay. 6. The results of the Level I screen and the Level II PASARR evaluation will be maintained as part of the resident's medical record. Prior to exit no further information was provided by the facility.	F 645		