State of Virginia

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	VA0035	A. BUILDING: _____ B. WING _____	C 02/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PORTSMOUTH HEALTH AND REHAB	900 LONDON BOULEVARD PORTSMOUTH, VA 23704

(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) COMPLETE DATE
F 000	Initial Comments An unannounced biennial State Licensure Inspection was conducted 02/4/19 through 02/7/19. The facility was not in compliance with the Virginia Rules and Regulations for the Licensure of Nursing Facilities. 1 complaint was investigated during the survey. The census in this 120 licensed bed facility was 10 at the time of the survey. The survey sample consisted of 34 current Resident reviews and 7 closed record reviews.	F 000		
F 001	Non Compliance The facility was out of compliance with the following state licensure requirements: This RULE: is not met as evidenced by: The facility was not in compliance with the following Virginia Rules and Regulations: 12VAC5-371-150 (G) Resident Rights Based on staff interviews, and review of the facility's policy, the facility staff failed to have a staff member registered with the Department of State Police to receive notifications of the registration or re-registration of any sex offender within the same or contiguous zip code area in which the facility is located. The findings included: On 2/6/19 at approximately 4:10 p.m., an interview was conducted with the Admissions Director. The Admissions Director provided information in which she gathers regarding whether potential residents are registered sex offenders, evidence that she provides each	F 001	F001 To remain in compliance with all federal and state regulations, the center has taken or will take the actions set forth in the following plan of correction: 1. The Administrator received his registration immediately. 2. All residents have the potential to be affected by this practice. Sex Offender information is being received daily and is being reviewed by the administrator; notifications are forwarded to the Leadership Team for their review. 3. The Administrator or designee will review received notices from the previous day as a follow-up at the daily Morning PPS Meetings 4. A review of this "process" will be added to the facility Safety Program by the Administrator; to be reviewed during QAPI Meetings on an ongoing basis to assure continuity of the process. 5. Date of Correction: 3/9/2019	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed — TITLE: Administrator — (X6) DATE: 2-27-19

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F 001	Continued From page 1	F 001		

resident and prospective residents information on how to access the sex offenders registry and their acknowledgement of receiving the information.

The Admissions Director was also asked for information regarding the facility's protocol for receiving notification of the registration or re-registration of sex offenders from the Sex Offender's Registry within the same or contiguous zip code. The Admissions Director stated she doesn't receive the notification but the Administrator did, for the previous Administrator had share the information with her from time to time.

An interview was conducted with the Administrator at approximately 4:25 p.m., the Administrator stated he would have to find out who was receiving the sex offenders information for he wasn't receiving it. At approximately 6:30 p.m., the Administrator present a registration form indicating he had registered on 2/6/19 to begin receiving sex offenders notifications within the same or contiguous zip code of the facility. The Administrator stated since his employment (September 2018), with the facility, he had not received the notifications.

The facility staff was asked to provide their policy on registration to receive Sex Offender notification within their zip code. The Chief Clinical Officer stated they have no policy for they follow the State Regulation.

The above information was shared with the Administrator, Director of Nursing and Regional Director and Chief Clinical Officer on 2/7/19, at approximately 5:40 p.m. The Administrator stated effective 2/6/19, they were receiving the automatic updates from the Department of State

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F 001	Continued From page 2	F 001		

Police Sex Offenders Registry. No further information was provided by the facility staff.

The facility was not in compliance with the following cross-referenced regulations:

COV 32.1-126.01 A. Management and Administration. Cross Reference to F607.	Cross Reference to F607
12 VAC 5-371-170 A. Quality assessment and assurance. Cross Reference to F868.	Cross Reference to F868
12 VAC 5-371-180 A. Infection Control. Cross Reference to F880.	Cross Reference to F880
12 VAC 5-371-210 B. Nurse Staffing. Cross Reference to F727.	Cross Reference to F727
12 VAC 5-371-250 C., A., G. Resident Assessment. Cross Reference to F641.	Cross Reference to F641
12 VAC 5- 371-370 A. Maintenance and Housekeeping. Cross reference to F557, F584.	Cross reference to F557 and F584
12VAC 5-371-220 (D) Nursing Services. Refer to F-677.	Cross reference to F677

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E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 02/04/19 through 02/07/19. Corrections are required for compliance with 42 CFR Part 483.73, Required for Long-Term Care Facilities. No emergency preparedness complaints were investigated during this survey.	E 000		
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 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.	E 039	E039 To remain in compliance with all federal and state regulations, the center has taken or will take the actions set forth in the following plan of correction: 1. The Joint Team from the October 22, 2018 Table Top Exercise met on February 15, 2019; the After Action Summary was reviewed, developed and it is documented. 2. All residents have the potential to be affected by this practice. 3. The most current facility-based exercise and After Action Plan will be reviewed during the Monthly Employee Communication and Recognition Meeting by the Administrator or designee and the Monthly Resident Council Meetings by the Resident Activity Director or designee to assure the continuous re-education and updating of staff. 4. Updates presented to the staff will be presented and discussed at the Monthly QAPI Meetings. 5. Date of Correction: 3/9/2019	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed	Administrator	2-27-19

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 039	Continued From page 1 (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 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 record review and staff interview the facility staff failed to have documentation to include an analysis and response after the facility's emergency preparedness table top exercise on October 22, 2018 regarding severe weather. The findings included:	E 039		

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E 039	Continued From page 2 During an interview with the facility Administrator on 2/7/19 at approximately 12:45 P.M., he was asked for documentation that included his analysis and response from the emergency preparedness table top exercise completed on October 22, 2018 regarding severe weather. The Administrator stated, "We did the table top but there was no analysis or response that was documented from the exercise." On 2/7/19 at 5:40 P.M. a pre-exit conference was held with the Administrator, the Director of Nursing, the Regional Director of Clinical Services and the Chief Clinical Officer where the above information was shared. No further information was provided prior to exit.	E 039		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 02/04/19 through 02/07/19. Significant corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. 1 complaint was investigated during the survey. The census in this 120 certified bed facility was 102 at the time of the survey. The survey sample consisted of 34 current Resident reviews and 7 closed record reviews.	F 000		
F 557 SS=D	Respect, Dignity/Right to have Prsnl Property CFR(s): 483.10(e)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(2) The right to retain and use personal	F 557		

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F 557	Continued From page 3 possessions, including furnishings, and clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other residents. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and clinical record review the facility staff failed for 1 of 41 residents in the survey sample (Resident #67) to deliver personal laundry in a timely manner, therefore violating his dignity and rights as an individual. A resident council meeting was held in the resident dining hall on 02/05/19 at 10:30 AM. Twelve residents attended the meeting. The residents chief complaint was that they were not receiving their personal laundry on time. Resident #67 stated that it took him a week before he received his laundry on several occasions. Some residents stated that although the laundry is done daily, they may not receive their personal laundry until a week later. The findings included: Resident #67 was admitted to the facility on 10/11/2016 with diagnoses to include cerebrovascular disease, difficulty in walking, and cerebral infarction. The current MDS, an annual assessment with an assessment reference date of 09/10/18 coded Resident # 67 with a 12 out of 15 on the Brief Interview for Mental Status (BIMS) which indicated moderate cognitive impairment. The resident was dependent on one staff for bed mobility and transfers and chair bound. Resident # 67 had range of motion limitations on both	F 557	F557 To remain in compliance with all federal and state regulations, the center has taken or will take the actions set forth in the following plan of correction: 1. Resident 67 and/or the responsible party will be assured of his personal laundry being returned within 48 hours. 2. To identify other residents who may be affected by late return of personal laundry, the Director of Housekeeping and Laundry will document incoming personal laundry and the return time back to the resident to assess and assure residents are receiving their personal laundry within 48 hours. 3. In-Service Training will be conducted for the Environmental Services and Nursing Department staff regarding the Personal Laundry Process. The Resident Council will be kept informed of the in-service training provided regarding the Personal Laundry Process. 4. The Director of Housekeeping and Laundry or designee will audit Personal Laundry turn-around times for four (4) weeks on Wednesdays for incoming personal laundry and delivery back to the resident by Friday. A sample of 10 residents per nursing unit, per week, will be used for the audit. Review and analysis will be presented and discussed at the Monthly QAPI Meetings. 5. Date of Correction: 3/9/2019	

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F 557	Continued From page 4 upper and lower extremities. The care plan with a review date of 9/21/18 identified as a problem that resident has impaired mobility and incontinence episodes of bowel and bladder. The intervention is to provide thorough skin care after incontinent episodes and apply barrier cream. On 02/05/19 at 11:00 AM Resident #67 stated during the Resident Council meeting that it's taking a week to get his laundry back. He said that this happened twice. Resident #67 stated it's a staffing problem because they pull housekeeping to deliver the laundry because they are short of laundry workers. On 02/06/19 at 09:19 AM an interview was held in the laundry room with Other staff #2. She explained that they have only two laundry workers at the present time working because the third laundry person is currently on medical leave. She stated that they work two shifts to complete the laundry. The first shift is from 3:30 AM to 12:00 PM Monday through Saturday and the second shift runs from 12:00 PM to 6:00 PM Monday through Saturday. The daily routine is once the soiled laundry is placed in the bin in soiled utility, the laundry is separated, washed, dried, folded, then put on laundry cart and delivered to the floor. Personal laundry is done with only one or two loads per day. Clothing will be placed on a cart, someone will pick clothing up, take to a clean storage room to hang the clothing on a rack and deliver clothing to the residents rooms. She also stated that sometimes they will have to stop washing and drying the laundry to allow the clean linen room to "catch up."	F 557		

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F 557	Continued From page 5 During the above interview a visual observation of the laundry room showed there were three dryers and two washing machines, there was linen folded up and placed inside the linen carts. There was a table approximately 6 feet long with unfolded personal clothing piled up awaiting pick up. Other staff #2 was asked how long have the clothes been sitting on the back table. She said at least a day but due to the laundry room having a staff shortage they have cross trained housekeeping to help get the laundry to the residents rooms when they can help out. On 02/06/19 at 09:59 AM a brief interview was conducted with Other staff #12, (housekeeper and crossed trained clean linen employee) concerning her role in delivering the residents personal laundry. She states that once she gets the resident clothing from off the table in the laundry room, she will bring the laundry to clean linen, hang the clothing on a portable clothing rack and take the laundry to the resident rooms right away. On 02/06/19 at 10:07 AM a brief interview was conducted with Other staff #3. He stated that he was cross trained to help out in the laundry due to their shortage. He was asked how long did it take the residents to get their personal laundry returned to the floor. He stated that the laundry is usually backed up three to four days due to the staffing shortage and that the problem has been ongoing. 02/06/19 11:29 AM Resident #67 said he's spoken to Other staff #4 (account manager of housekeeping) two times concerning his laundry. She told him that she will do better. He stated it's a staffing problem because they have to pull	F 557		

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F 557	Continued From page 6 housekeeping to deliver the laundry. On 02/06/19 4:30 PM Resident #67 stated that he spoke to the supervisor concerning the his laundry. He said that she told him that she was sorry but it will get better. The resident was asked how did it make him feel not getting his clothing back for a week. He stated that "because he had to wear shorts he didn't come out of his room much because he was cold wearing the shorts." He also stated "because he wears briefs and sometimes has accidents he became worried about what was left to wear." On 02/06/19 at approximately 4:40 PM a brief interview was conducted with CNA (Certified Nursing Assistant) #5 on Unit 2 concerning the residents personal laundry. She explained that waiting 4-5 days for the laundry to be available is an ongoing issue. Sometimes they will have to contact the unit nurse so she can go to the laundry room to get the residents clothing. Sometimes other staff members will have to go to the laundry room to pick up clothing. On 2/6/19 at 10:25 AM, an interview was held with Other staff #4, She stated that she's only been the account manager of housekeeping and laundry supervisor at the facility since January 2019. She said that she will hire more people but until then she has cross trained the housekeeping and laundry staff as back up. She also stated that on average it's taking 3-5 days getting the personal laundry back to the residents. unit 1 unit 2 have no space and man power is limited. She stated that if they had a third laundry person the laundry would be done in a timely manner but because a person is on leave.	F 557		

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F 557	Continued From page 7 02/06/19 12:35 PM the laundry supervisor, Other staff #4 was asked going forward what was her expectations concerning the personal laundry; Other staff #4 stated "my expectations is that the laundry be delivered within 48 hours." On 02/07/19 at 10:15 AM Other staff #4 presented the surveyor with the resident monthly census report showing the population of residents receiving personal laundry services. The December 2018 census report shows 104-110 residents received laundry services. The January 2019 Census report shows 103-109 residents received laundry services. The February 2019 census report showed that laundry was provided 101-102 residents. She said that very few residents are receiving laundry services provided by their family members. On 02/07/19 at 5:40 PM a pre-exit interview was held with the Administrator, the Acting Director of Nursing, the Regional Director of Clinical Services and the Chief Clinical Officer. The Administrator commented that he would expect the laundry to be washed, dried and delivered to the residents within twenty four hours. A booklet was given in place of a laundry service policy entitled " Management of the Laundry" on page 79, Delivery Of Personal Laundry, states "The rack of hung clothing and folded linen should be delivered daily.	F 557		
F 582 SS=D	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing	F 582		

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F 582	Continued From page 8 facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or	F 582	F582 To remain in compliance with all federal and state regulations, the center has taken or will take the actions set forth in the following plan of correction: 1. Resident 411 and Resident 412 were not in receipt of their NOMNC and this cannot be corrected. A review of the residents account will be conducted to make sure dates of D/C are correct and appropriate charges are reconciled. To assure residents receive timely notice of D/C plans from skilled nursing services, the resident's progress towards achieving goals and potential discharge from skilled services and or the facility are reviewed daily and communicated to the resident. When a D/C date is identified residents covered thru the Medicare Part A or a Medicare Managed Care company are issued a NOMNC at least 48 hours prior to discontinuation of skilled coverage. 2. Residents receiving skilled services are at risk for not receiving a NOMNC. The Social Worker or designee will document daily anticipated dates of D/C and subsequent receipt of the NOMNC or substitute letter. 3. The MDS Coordinators, the Business Office Manager and the Social worker will be re-educated by the Administrator of the special time frames and communications necessary for D/C's and the issuance of the NOMNC. 4. The Business Office Manager or designee will audit 25% of the monthly D/C's for four (4) weeks to assure the resident received a timely NOMNC letter based on the resident's anticipated last day of covered service. Review and analysis will be presented and discussed at the Monthly QAPI Meetings. 5. Date of Correction: 3/9/2019	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495149	A. BUILDING _____ B. WING _____	C 02/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PORTSMOUTH HEALTH AND REHAB	900 LONDON BOULEVARD PORTSMOUTH, VA 23704

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F 582	Continued From page 9 discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff interviews and facility documentation, the facility staff failed to ensure Medicare Beneficiary Notices, were issued to 2 of 41 residents (Residents #411 and #412) in the survey sample. 1. Resident #411 was not issued a Notice of Medicare Provider Non-Coverage form (NOMNC). The NOMNC informs the beneficiary of his or her right to an expedited review of a services termination. 2. Resident #412 was not issued a Notice of Medicare Provider Non-Coverage form. The findings included: 1. Resident #411 was admitted to the nursing facility on 09/27/18. Resident #41 was discharged home on 10/17/18. Resident diagnosis included but not limited to Congestive Heart Failure. The Minimum Data Set (MDS) 14-day assessment dated 10/11/18 coded the resident with a 15 out of a possible score of 15 on the Brief Interview for Mental Status (BIMS) which indicated the resident was intact in the skills needed for daily decision making.	F 582		

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F 582	Continued From page 10 On review of the Beneficiary Notification Checklists provided by the facility to surveyor, it was noted that Resident #411 was not listed for having been issued the NOMNC (Notice of Medicare Provider Non-Coverage- form CMS-10123). Resident #411 started a Medicare Part A stay on 09/27/18 and the last covered day of that stay was 10/16/18. Resident #411 was discharged from Medicare Part A services before benefit days were exhausted and should have been issued a NOMNC (CMS-10123). Resident #411 had only used 20 days of her Medicare Part A services. An interview was conducted with the Assistant Social Worker on 02/06/19 at approximately 9:15 a.m., who stated, "I was unable to locate where (Resident #411) was ever issued a NOMNC." The facility administration was informed of the finding during a briefing on 02/07/19 at approximately 5:40 p.m. The facility did not present any further information about the findings. 2. Resident #412 was admitted to the nursing facility on 07/24/18. Resident #412 was discharged home on 10/17/18. Resident diagnosis included but not limited to muscle weakness. The Minimum Data Set (MDS) 30-day assessment dated 08/21/18 coded the resident with a 03 out of a possible score of 15 on the Brief Interview for Mental Status (BIMS) which indicated severe cognitive impairment. On review of the Beneficiary Notification Checklists provided by the facility to surveyor; it was noted that Resident #412 was not listed for	F 582		

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F 582	Continued From page 11 having been issued the NOMNC (Notice of Medicare Provider Non-Coverage-form CMS-10123). Resident #412 started a Medicare Part A stay on 07/24/18, and the last covered day of this stay was 08/24/18. Resident #412 was discharged from Medicare Part A services before benefit days were exhausted and should have been issued a NOMNC (CMS-10123). Resident #412 had only used 32 days of her Medicare Part A services. An interview was conducted with the Assistant Social Worker on 02/06/19 at approximately 9:15 a.m., who stated, "I was unable to locate where (Resident #412) was ever issued a NOMNC." The facility administration was informed of the finding during a briefing on 02/07/19 at approximately 5:40 p.m. The facility did not present any further information about the findings.	F 582		
F 584 SS=E	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	F 584		

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F 584	Continued From page 12 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 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews, the facility staff failed to maintain a clean, sanitary and homelike environment. The facility staff failed to ensure the privacy curtains were in good repair, heating/air vents in all the rooms were without excessive dust and debris, and toilets were clean, sanitary and homelike. The findings included:	F 584	F584 To remain in compliance with all federal and state regulations, the center has taken or will take the actions set forth in the following plan of correction: 1. Hooks were added to the privacy curtain in Room 1. A privacy curtain was added to Room 7. The ceiling vents above the resident room entrance doors in rooms 6, 8, 9, 10, 11, 23, 26, and 28 were vacuumed and cleaned with a germicidal agent. Rust stains on the toilets in rooms 1-11 are being treated with an agent that eliminates rust from porcelain. The wall paper border was repaired. 2. Other resident rooms can be at risk of the deficient practice. The Director of Housekeeping and Laundry and the Director of Maintenance will re-educate staff via an in-service to the established cleaning and room check procedures to include but not be limited to privacy curtain cleanliness and functionality, dust on vents and rust on toilets. 3. The Director of Housekeeping and Laundry and the Director of Maintenance or designees will audit daily for four (4) weeks using three (3) randomly chosen rooms per corridor, for privacy curtain cleanliness and functionality, dusty vents and toilets with rust stains and wallpaper tears. 4. Review and analysis will be presented and discussed at the Monthly QAPI Meetings. 5. Date of Correction: 3/9/2019	

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F 584	Continued From page 13 The following observations were made with the Maintenance Director on 2/7/19, at approximately 12:30 p.m. Room #1's privacy curtain was missing 7 hooks; therefore when the curtain was drawn it was unable to provide privacy. There was no privacy curtain in room #7. All of the vents above the room entrance doors on unit 2 and rooms 6, 8, 9, 10, 11, 23, 26 and 28 were with thick dark brown dust and debris. The toilets in rooms 1 through 11 were with unsightly rust colored stains. The wall paper border on Wing 1 was peeling and in some areas torn. The facility's Environmental Services Operations Manual revised 6/2016 read; "If cubicle curtains are off hook, repair; have a spare curtain on hand to immediately replace dirty or torn curtains. Have additional hooks available for repair. Vents; wipe every vent with germicide, vents in resident rooms should be cleaned daily as part of the 5&7 step cleaning method. All vents should be checked quarterly. Bathroom cleaning, sanitize commode, tank, bowl and base. Use brush for inside of bowl. Use harsh chemicals, like cleanser or bowl cleaner sparingly". The above observations were shared with the Administrator, Director of Nursing and Regional Director and Chief clinical Officer on 2/7/19 at approximately 5:40 p.m., the Administrator stated the privacy curtains had been taken care of, the environmental staff were obtaining a new product to try to remove the stains from the toilets and	F 584		

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F 584	Continued From page 14 they had been in the process of removing all the wallpaper borders. Staff was observed vacuuming the vents to remove the debris.	F 584		
F 607 SS=D	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(3) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by: Based on review of facility records of employees hired within the last two years, staff interviews, and review of the facility's policy the facility staff failed to implement their policy for screening new employees for abuse, neglect and mistreatment of others for 1 of 25 employees. The facility's staff failed to obtain a criminal history report within 30 days of hire for 1 employee, Employee #6. The findings included: Review of the Employee's #6, personnel file revealed the Criminal History Report was not completed until 09/5/18. Employee # 6, a Certified Nurses Assistant (CNA) was hired on 07/18/18. The criminal history report	F 607	F607 To remain in compliance with all federal and state regulations, the center has taken or will take the actions set forth in the following plan of correction: 1. Employee #6 has a Criminal Background Check. 2. Employee files will be audited to include references, a criminal background check (Virginia State Police Background Check, license/certificate confirmation, abuse registry review (OIG) and the sworn disclosure statement. 3. New hire files will be audited by the Staffing Coordinator or a designee for three (3) months using the Employee File Review Form to assure criminal background checks are received and are on file within 30 days of hire. 4. The audit will be reviewed thru the monthly QAPI Meeting process. 5. Date of Correction: 3/9/2019	

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F 607	Continued From page 15 in the employee's file was dated 09/5/18 which indicated that Employee #6 had worked in the facility greater than 30 days before the criminal history report results were obtained. An interview was conducted with the Human Resources Director on 2/6/19, at approximately 5:45 p.m. The Human Resources Director stated "the report was not obtained in a timely manner therefore all criminal history reports are requested before an employee is allowed to start work and a confirmation is made when an individual reports for orientation". The facility's policy titled "Resident Abuse" in section II Screening reads persons applying for employment with the facility will be screened for a history of abuse, neglect, or mistreating residents to include: (A). References from previous or current employers (with applicant permission). (B). Criminal Background Check. (C). Abuse check with appropriate licensing board and registries, prior to hire. (D). Sworn Disclosure Statement prior to hire. (E). Verify license or registration prior to hire. The above information was shared with the Administrator, Director of Nursing and Regional Director and Chief Clinical Officer on 2/7/19, at approximately 5:40 p.m. No additional information was provided by the facility staff.	F 607		
F 622 SS=D	Transfer and Discharge Requirements CFR(s): 483.15(c)(1)(i)(ii)(2)(i)-(iii) §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- (i) The facility must permit each resident to remain in the facility, and not transfer or	F 622		

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F 622	Continued From page 16 discharge the resident from the facility unless- (A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; (C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident; (D) The health of individuals in the facility would otherwise be endangered; (E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or (F) The facility ceases to operate. (ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose. §483.15(c)(2) Documentation.	F 622	F622 To remain in compliance with all federal and state regulations, the center has taken or will take the actions set forth in the following plan of correction: 1. Resident 30 upon D/C to the hospital did not have a care plan or Bed Hold policy sent with them upon transfer to the hospital ED. There is no opportunity to correct this. Resident 105 upon D/C to the hospital did not have a care plan or Bed Hold policy sent upon transfer to the hospital ED. There is no opportunity to correct this. 2. Resident's requiring D/C to the hospital ED are at risk for this practice. Therefore, procedures have been put in place to assure resident D/C's to the hospital are provided with a Face Sheet, the INTERACT Nursing Home to Hospital Transfer Form for current medical/nursing information which includes care plan information, their medication list and Notice of Bed Hold Policy (as discussed with resident at admission and, if possible, during the D/C to the hospital). Packets have been developed for each nursing unit for easy access. In emergency cases, the above information will be faxed to the hospital emergency room. 3. Licensed Nursing staff have been in-serviced by the Nursing Unit Managers on the information required to be sent for a resident upon D/C to the hospital (Face Sheet, the INTERACT Nursing Home to Hospital Transfer Form, medication list and the Notice of Bed Hold Policy). Resident D/C's will also be reviewed the following business day after a D/C using the Unexpected Hospitalization Audit Tool on an ongoing basis. 4. The audit will be reviewed thru the monthly QAPI Meeting process. 5. Date of Correction: 3/9/2019	

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F 622	Continued From page 17 When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (i) Documentation in the resident's medical record must include: (A) The basis for the transfer per paragraph (c)(1)(i) of this section. (B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s). (ii) The documentation required by paragraph (c)(2)(i) of this section must be made by- (A) The resident's physician when transfer or discharge is necessary under paragraph (c)(1)(A) or (B) of this section; and (B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and	F 622		

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F 622	Continued From page 18 any other documentation, as applicable, to ensure a safe and effective transition of care. This REQUIREMENT is not met as evidenced by: Based on staff interviews, clinical record review and facility documentation review the facility staff failed, for two of 41 residents (Resident #30 and 105) in the survey sample, to send a copy of the Resident's Care Plan after being transferred and admitted to the hospital. 1. The facility staff failed to send Resident #30's care plan when discharged and admitted to the hospital on 12/05/18 and 12/20/18. 2. The facility failed to ensure that Resident #105's Plan of Care Summary was sent upon transfer to the hospital on 12/23/18 and 1/16/19. The findings included: 1. Resident #30 was originally admitted on 04/23/18 with a readmission date of 12/7/18 and 01/09/19. Diagnosis for Resident #30 included, but not limited to, End Stage Renal Disease. The current Minimum Data Set (MDS), a quarterly assessment with an Assessment Reference Date (ARD) of 11/16/18 coded the resident with a 12 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 12/05/18 and 12/20/18=discharged with return anticipated. On 12/05/18, according to the facility's documentation, Resident #30 was admitted to the	F 622		

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F 622	Continued From page 19 local hospital due to recent biopsy to his kidney on 12/03/18. On 12/20/18, according to the facility's documentation, Resident #30 went to a scheduled physician appointment. Resident #30 was transferred and admitted to the hospital for an Urinary Tract Infection (UTI), carbuncle and head abscess. On 02/05/19 at approximately 1:29 p.m., an interview was conducted with Licensed Practical Nurse (LPN) #3 who stated, "We do not send a copy of the resident's care plan when they are transferred out the hospital." She proceeded to say, "I was not aware that the Resident's care plan needed to go out with them when they were being sent out to the hospital." An interview was held with the Regional Director of Clinical Services on 02/05/19 at approximately 11:05 a.m. The surveyor asked, "Are the resident's care plan being sent when they are sent out to the hospital." She replied, "We were just made aware that the staff were not sending the care plan when they were being discharged out to the hospital." She said "staff have already been in-serviced to send the care plan when discharged out to the hospital." On 02/07/19 at approximately, an interview was conducted with the Regional Director of Clinical Services who stated, "I expect for the nurses to complete the Interact Form to be completed and sent out at the time of discharge to the hospital." She proceeded to explain that the interact form gives a snap shot of the resident's plan of care. The Regional Director also said if the nurse is not able to send the resident's interact during his/her	F 622		

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	495149	A. BUILDING _____ B. WING _____	C 02/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PORTSMOUTH HEALTH AND REHAB	900 LONDON BOULEVARD PORTSMOUTH, VA 23704

(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 622	Continued From page 20 discharge then it should be faxed to the hospital. The facility administration was informed of the findings during a briefing on 02/07/19 at approximately 5:40 p.m. The facility did not present any further information about the findings. 2. The facility failed to ensure that Resident #105's Plan of Care was sent upon transfer to the hospital on 12/23/18 and 1/16/19. Resident #105, was an 82 year old admitted to the facility originally on 10/4/18 and re-admitted on 1/18/19 with diagnoses to include but not limited to: *Dementia, *Major Depressive Disorder, and *Hypertension. The most recent comprehensive Minimum Date Set (MDS) assessment was a 5 Day assessment with an Assessment Reference Sate (ARD) of 1/5/19. Resident #105's Brief Interview for Mental Status (BIMS) indicated that the resident has short and long term memory recall issues and is severely cognitively impaired for daily decision making. Resident #105 MDS submit history was also reviewed and is documented in part, as follows: 1. Unplanned Hospital Discharge Assessment with ARD of 12/23/18. 2. Facility Entry Assessment with ARD of 12/29/18. 3. Unplanned Hospital Discharge Assessment with ARD of 1/16/19. 4. Facility Entry Assessment with ARD of 1/18/19. Resident #105's Comprehensive Care Plan was reviewed and included the following facility identified problems for the resident: Assistance	F 622		

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F 622	Continued From page 21	F 622		

required for activities, Potential for drug related complications related to psychotropic and Anti-Depressant medications, Behaviors (refusing care), Imbalanced nutrition, Alteration in elimination of bowel and bladder, At risk for pressure ulcers, Impaired communication due to impaired cognition, Risk for falls, Pain management, and Mobility impairment,

Resident #105's Progress Notes were reviewed and are documented in part, as follows:

12/23/18 22:48 (10:48 P.M.): SBAR (Situation Background Assessment Recommendation) Change of Condition
Situation: lab culture
Background: Dementia, HTN (hypertension) mild cognitive impairment, History of falls and UTI (urinary tract infection) Resident is A/O (alert and oriented) x 1 (person), assist x 1 person with ADL's (activities of daily living), transferring, and toileting.
Assessment: Reading from the lab indicated blood has gram positive cocci in cultures and she's sensitive to vancomycin. VS (vital signs)123/69, 98.9, 80, 20, 98%. Resident was alert and pleasantly confused.
Response: resident was alert and sent out via stretcher to (Name) ER (emergency room) to start treatment. Unit manager made aware.

1/16/19 20:01 (8:01 P.M.): SBAR (Situation Background Assessment Recommendation) Change of Condition
Situation: Resident was found by paramedics lying on the floor with a head injury. Fall was unwitnessed and when asked what happened resident replied she doesn't know how she got in the floor. resident complained of head pain

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F 622	Continued From page 22 related to fall. resident had a hematoma/laceration to the head and was immediately transferred to the ER for further evaluation. On 2/6/19 at 12:21 PM an interview was conducted with Wing 1 Unit Manager LPN #1 regarding whether bed hold and care plan documents are being sent with resident's upon discharge to the Hospital/Emergency room. Wing 1 Unit Manager LPN #1 stated, "This has not been in place, it was just brought to our attention and we were in-serviced on it yesterday. We were not sending bed holds or care plans with the residents when they were sent out." On 2/7/19 at 5:40 P.M. a pre-exit conference was held with the Administrator, the Director of Nursing, the Regional Director of Clinical Services and the Chief Clinical Officer were the above information was shared. The Regional Director of Clinical Services stated, "No care plan summary or bed holds were sent out upon discharge, it wasn't happening and there is no policy." No further information was provided by the facility staff prior to exit.	F 622		
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	F 623		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 623	Continued From page 23 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; 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;	F 623	F623 To remain in compliance with all federal and state regulations, the center has taken or will take the actions set forth in the following plan of correction: 1. Resident D/C information has not been consistently transmitted to the Local Ombudsman. The D/C of resident #30 was transmitted to the Ombudsman. 2. Future transmissions are at risk of not consistently being transmitted to the Local Ombudsman. An audit of the previous 12 months of resident D/C's transmitted to the Ombudsman will be performed by the Medical Records Director or designee to assure the information has been delivered. Going forward, the monthly list of the past month's resident D/C's will be provided to the Local Ombudsman on the 1st business day of every new month by the Social Worker or designee. 3. A monthly record of the D/C's transmitted to the Local Ombudsman will be maintained by the Social Worker or designee, ongoing. The Medical Records Director will complete a monthly audit for the next three (3) month of resident D/C record transmissions to the Local Ombudsman. 4. The audit results will be reviewed as an agenda topic during the monthly QAPI Meeting. 5. Date of Correction: 3/9/2019	

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F 623	Continued From page 24 (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 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	F 623		

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F 623	Continued From page 25 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 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 1 of 41 residents (Resident #30) in the survey sample. The facility staff failed to notify the Office of the State Long-Term Care Ombudsman of Resident #30's transfer to the local hospital on 12/05/18 and 12/20/18. The finding included: Resident #30 was originally admitted on 04/23/18 with readmission dates of 12/7/18 and 01/09/19. Diagnosis for Resident #30 included, but not limited, to End Stage Renal Disease. The current Minimum Data Set (MDS), a quarterly assessment with an Assessment Reference Date (ARD) of 11/16/18 coded the resident with a 12 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 12/05/18 and 12/20/18-discharged with return anticipated. On 12/05/18, according to the facility's documentation, Resident #30 was admitted to the	F 623		

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F 623	Continued From page 26 local hospital due to recent biopsy to his kidney on 12/03/18. On 12/20/18, according to the facility's documentation, Resident #30 went to a scheduled physician appointment. Resident #30 was transferred and admitted to the hospital for an Urinary Tract Infection (UTI), carbuncle and head abscess. On 02/05/19 at approximately at 4:20 p.m., an interview was conducted with the Assistant Social Worker who stated, "I could not locate where the local Ombudsman was notified of Resident #30's discharge out to the hospital on 12/05/18 and 12/20/18." A phone interview was conducted with the local Ombudsman on 02/06/19 at approximately 09:11 a.m. During the interview, the Ombudsman stated, "I do not receive a monthly list of discharges from the facility on a regular basis." The surveyor asked, "When did you receive the list of discharges for the December 2018, he replied, "This morning." On 02/06/19 at approximately 10:14 a.m., the Assistant Social Worker presented a form that was faxed to the Ombudsman dated 02/06/19 at approximately 8:06 a.m. The fax contained Resident #30's December 2018 discharges out to the hospital on 12/05/18 and 12/20/18. The Ombudsman was notified by faxed after the surveyor requested confirmation that the Ombudsman was notified of Resident #30's December 2018 discharges out to the hospital. A meeting was held with the Regional Director of Clinical Services on 02/07/19 at approximately	F 623		

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F 623	Continued From page 27 11:05 a.m., who stated, "The Ombudsman is to be notified of all transfers to include ER visits/hospitalization." The facility administration was informed of the finding during a briefing on 02/07/19 at approximately 5:40 p.m. The facility did not present any further information about the findings.	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- (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	F 625		

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F 625	Continued From page 28 described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on staff interviews, clinical record review and facility documentation review the facility staff failed send a copy of the Bed-Hold Policy for 2 residents (Resident #30 and #105) after being transferred to and admitted to the hospital. 1. The facility staff failed to ensure that Resident #30 was made aware of the facility's bed-hold and reserve bed payment policy upon transfer/discharge to the hospital on 12/05/18 and 12/20/18. 2. The facility failed to ensure that Resident #105 received a written notice of the Bed-Hold Policy upon transfer to the hospital on 12/23/18 and 1/16/19. The finding included: 1. Resident #30 was originally admitted to the facility on 04/23/18 with readmission dates of 12/7/18 and 01/09/19. Diagnosis for Resident #30 included, but not limited to, End Stage Renal Disease. The current Minimum Data Set (MDS), a quarterly assessment with an Assessment Reference Date (ARD) of 11/16/18 coded the resident with a 12 out of a possible score of 15 on the Brief Interview for Mental Status (BIMS) indicating moderate cognitive impairment. The Discharge MDS assessments were dated for 12/05/18 and 12/20/18-discharged with return anticipated. On 12/05/18, according to the facility's documentation, Resident #30 was admitted to the	F 625	F625 To remain in compliance with all federal and state regulations, the center has taken or will take the actions set forth in the following plan of correction: 1. Resident 30 upon D/C to the hospital did not have a care plan or Bed Hold policy sent with them upon transfer to the hospital ED. There is no opportunity to correct this. Resident 105 upon D/C to the hospital did not have a care plan or Bed Hold policy sent upon transfer to the hospital ED. There is no opportunity to correct this. 2. Resident's requiring D/C to the hospital ED are at risk for this practice. Therefore, procedures have been put in place to assure resident D/C's to the hospital are provided with a Face Sheet, the INTERACT Nursing Home to Hospital Transfer Form for current medical/nursing information, their medication list and Notice of Bed Hold Policy (as discussed with resident at admission and, if possible, during the D/C to the hospital). Packets have been developed for each nursing unit for easy access. In emergency cases, the above information will be faxed to the hospital emergency room. 3. Licensed Nursing staff have been in-serviced by the Nursing Unit Managers on the information required to be sent for a resident upon D/C to the hospital (Face Sheet, the INTERACT Nursing Home to Hospital Transfer Form, medication list and the Notice of Bed Hold Policy). Resident D/C's will also be reviewed the following business day after a D/C using the Unexpected Hospitalization Audit Tool on an ongoing basis. 4. The audit will be reviewed thru the monthly QAPI Meeting process. 5. Date of Correction: 3/9/2019	

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F 625	Continued From page 29 local hospital due to recent biopsy to his kidney on 12/03/18. On 12/20/18, according to the facility's documentation, Resident #30 went to a scheduled physician appointment. Resident #30 was transferred and admitted to the hospital for an Urinary Tract Infection (UTI), carbuncle and head abscess. An interview was conducted with Licensed Practical Nurse (LPN) #3 on 02/05/19 at approximately 1:29 p.m. The LPN was asked, 'When a resident is being sent out to the hospital, is the bed hold policy issued during the time of the transfer?" She replied, "No, a bed hold policy is not issued or sent with the resident; I was never informed that we needed to send the bed hold form with them." An interview was conducted with the Assistant Social Worker on 02/06/19 at approximately 8:50 a.m. who stated, "I was unable to locate in the resident's medical record that the bed hold policy was sent with Resident #30 when he was discharged out to the hospital on 12/05/18 and 12/20/18." He said, "But moving forward, the bed hold policy will be sent with them doing their transfer out to the hospital." An interview was conducted with the Regional Director of Clinical Services on 02/07/19 at approximately 11:05 a.m. She stated, "I expect for the bed hold policy to be sent with the resident when being sent out to the hospital." She said someone from the facility should follow up with the resident and or representative the next day to see if they wanted to precede with holding the bed."	F 625		

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F 625	Continued From page 30 The facility administration was informed of the finding during a briefing on 02/07/19 at approximately 5:40 p.m. The facility did not present any further information about the findings. 2. Resident #105 was a 82 year old admitted to the facility originally on 10/4/18 and re-admitted on 1/18/19 with diagnoses to include, but not limited to, Dementia, Major Depressive Disorder, and Hypertension. The most recent comprehensive Minimum Date Set (MDS) assessment was a 5 Day with an Assessment Reference Sate (ARD) of 1/5/19. Resident #105's Brief Interview for Mental Status (BIMS) indicated that the resident has short and long term memory recall issues and is severely cognitively impaired for daily decision making. Resident #105 MDS submit history was also reviewed and is documented in part, as follows: 1. Unplanned Hospital Discharge Assessment with ARD of 12/23/18. 2. Facility Entry Assessment with ARD of 12/29/18. 3. Unplanned Hospital Discharge Assessment with ARD of 1/16/19. 4. Facility Entry Assessment with ARD of 1/18/19. Resident #105's Progress Notes were reviewed and are documented in part, as follows: 12/23/18 22:48 (10:48 P.M.): SBAR (Situation Background Assessment Recommendation) Change of Condition Situation: lab culture Background: Dementia, HTN (hypertension) mild cognitive impairment, History of falls and UTI	F 625		

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F 625	Continued From page 31	F 625		

(urinary tract infection) Resident is A/O (alert and oriented) x 1 (person), assist x 1 person with ADL's (activities of daily living), transferring, and toileting.
Assessment: Reading from the lab indicated blood has gram positive cocci in cultures and she's sensitive to vancomycin. VS (vital signs)123/69, 98.9, 80, 20, 98%. Resident was alert and pleasantly confused.
Response: resident was alert and sent out via stretcher to (Name) ER (emergency room) to start treatment. Unit manager made aware.

1/16/19 20:01 (8:01 P.M.): SBAR (Situation Background Assessment Recommendation) Change of Condition
Situation: Resident was found by paramedics lying on the floor with a head injury. Fall was unwitnessed and when asked what happened resident replied she doesn't know how she got in the floor. resident complained of head pain related to fall. resident had a hematoma/laceration to the head and was immediately transferred to the ER for further evaluation.

On 2/6/19 at 12:21 PM an interview was conducted with Wing 1 Unit Manager LPN #1 regarding whether bed hold and care plan documents were being sent with residents upon discharge to the Hospital/Emergency room. Wing 1 Unit Manager LPN #1 stated, "This has not been in place, it was just brought to our attention and we were in-serviced on it yesterday. We were not sending bed holds or care plans with the residents when they were sent out."

On 2/7/19 at 5:40 P.M. a pre-exit conference was held with the Administrator, the Director of

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PORTSMOUTH HEALTH AND REHAB	900 LONDON BOULEVARD PORTSMOUTH, VA 23704

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F 625	Continued From page 32 Nursing, the Regional Director of Clinical Services and the Chief Clinical Officer were the above information was shared. The Regional Director of Clinical Services stated, "No care plan summary or bed holds were sent out upon discharge, it wasn't happening." No further information was provided by the facility staff prior to exit.	F 625		
F 645 SS=D	PASARR Screening for MD & ID CFR(s): 483.20(k)(1)-(3) §483.20(k) Preadmission Screening for 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	F 645		

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F 645	Continued From page 33 (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. (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:	F 645	F645 To remain in compliance with all federal and state regulations, the center has taken or will take the actions set forth in the following plan of correction: 1. Resident 45 will have a Level 1 PASRR screening added to their file. Resident 88 will have a Level 1 PASRR screening added to their file. 2. Other residents may be at risk of not having or missing a Level 1 PASRR Assessment. An audit of patient files has been completed to assure each resident has a PASRR Assessment. Residents without a PASRR Screening will be assessed by the Social Worker or designee. If a Level 2 screening is indicated, it will be provided thru ASCEND. 3. To prevent recurrence PASRR Screening(s) are now received from the hospital prior to a resident admission to the facility and the screening is filed under "Documents" in the EMR with a hard copy maintained in the Business Office files. An in-service training and orientation to the PASRR Assessment process will be given by the Director of Nursing for the nursing, rehabilitation services and patient activity staff to aid in identifying emerging needs. 4. A bi-monthly audit for three (3) months will be completed of resident admissions by the Medical Records Director to assure admissions data include a PASRR Assessment. The audit results will be reviewed thru the monthly QAPI Meeting process. 5. Date of Correction: 3/9/2019	

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F 645	Continued From page 34 Based on observations, clinical record review, staff interviews and facility documentation, the facility staff failed to ensure a Level I PASRR (Preadmission Screening Resident Review) was conducted prior to admission or within 30 days of admission to the nursing facility for 2 of 41 residents (Residents #45 and #88) in the survey sample with diagnoses of either a mental disorder and or intellectual disability . 1. The facility staff failed to ensure Resident #45, who was identified with a mental illness, had a PASRR completed prior to admission. 2. The facility staff failed to ensure a Level 1 PASRR was completed prior to admission for Resident #88. The findings include: 1. Resident #45 was admitted to the nursing facility on 4/27/15 with diagnoses that included psychotic disorder and major depressive disorder. The most recent Minimum Data Set (MDS) was a annual assessment dated 11/16/18 and coded the resident with a 15 out of a possible score of 15 the Brief Interview for Mental Status (BIMS), which indicated the resident was fully intact with the skills needed for daily decision making. The resident was assessed to have an active diagnosis to include psychotic disorder. The care plan dated initiated on 5/19/15 and revised on 11/29/18 identified a focus area to include verbal abusive behaviors towards facility staff and residents. The goal set by staff for the resident was that the resident would find positive ways to seek attention other that derogatory	F 645		

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F 645	Continued From page 35	F 645		

remarks and negative encounters with staff and peers. Some of the approaches the staff implemented to accomplish this goal included avoidance of situations that would trigger inappropriate verbal behaviors and refer to psychologist and psychiatrist as needed.

On 2/7/19 at 1:30 p.m., Resident #45 was observed in his room watching television sitting in his wheelchair. He stated he sometimes was "intolerable" of staff and residents, but felt he was doing better.

Upon review of the electronic medical record (EMR) and the hard chart clinical record that was kept at the nursing unit, a PASRR could not be located.

On 2/6/19 at 1:30 p.m., the Administrator and the Regional Director of Clinical Services stated they could not locate the PASRR for Resident #45. The Administrator stated it was identified there was a problem with ensuring all residents that entered the facility had a Level I PASRR or one was completed within 30 days of admission to determine if a Level II evaluation was needed. He stated the first initial training for PASRR requirements was held on 1/14/19 at 10:00 a.m. and the next one was held on 2/6/19, but he was unable to attend. The Administrator stated he will have training to certify the staff that will complete Level I PASRR, if a resident did not come from the hospital with a completed one.

On 2/7/19 at 5:40 p.m., a pre-survey exit debriefing meeting was held with the Administrator, Regional Director of Clinical Services and Chief Clinical Officer. The Chief Clinical Officer stated the corporation utilized the

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PASRR training manual dated 2017 as a guide to follow to be compliant with all required PASRR components to include Level I and need to refer for Level II evaluations. No further information was provided prior to survey exit.
2. Resident 388 was admitted to the facility on 9/28/18 with diagnoses to include but not limited to: Schizophrenia, Major Depressive Disorder and Anxiety Disorder.

The most recent comprehensive Minimum Data Set (MDS) was an Admission with and Assessment reference Date (ARD) of 10/5/18. The Brief Interview for Mental Status for Resident #88 was a 15 out of a possible 15 indicating the resident was cognitively intact and capable of daily decision making.

On 2/5/19 at approximately 1:45 P.M. the Assistant Social Worker was asked for a copy of Resident
#88's Level 1 PASRR that was completed prior to admission of 9/28/18 or within 30 days of admission. At approximately 4:30 P.M. the Assistant Social Worker returned to the conference room and stated, "We don't have a PASRR for him."

On 2/7/19 the Regional Director of Clinical Services and this surveyor reviewed Resident #88's thinned medical record for the Resident's Level 1 PASRR but no document was found.

On 2/7/19 at 5:40 P.M. a pre-exit conference was held with the Administrator, the Director of Nursing, the Regional Director of Clinical Services and the Chief Clinical Officer were the above information was shared. The Chief Clinical Officer stated, "We discovered less that 2

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F 645	Continued From page 37 weeks ago that this was a company wide issue and we sent out a training manual and we have started training. He (Resident #88) should have had a PASRR done." No further information was provided by the facility staff prior to exit.	F 645		
F 677 SS=E	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on resident interviews, staff interviews and clinical record review the facility staff failed to provide personal care to include showers for two resident in the survey sample (Resident #30 and #363) who were unable to independently carry out activities of daily living (ADL's). 1. The facility staff failed to ensure Resident #30 was offered and received a scheduled twice-weekly shower to maintain good personal hygiene. 2. The facility failed to ensure that Resident #363 was provided ADL (Activities of Daily Living) Care to include shaving of his beard. The findings included: 1. Resident #30 was originally admitted on 04/23/18 with a readmission date of 12/7/18 and 01/09/19. Diagnosis for Resident #30 included but not limited to Legal Blindness. The current Minimum Data Set (MDS), a quarterly assessment with an Assessment Reference Date	F 677		

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F 677	Continued From page 38 (ARD) of 11/16/18 coded the resident with a 12 out of a possible score of 15 on the Brief Interview for Mental Status (BIMS) indicating moderate cognitive impairment. In addition, the MDS coded Resident #30 total dependence of one with bathing, extensive assistance of one with bed mobility, transfer, dressing and toilet use and physical hygiene for Activities of Daily Living care. The comprehensive care plan dated 05/07/18 with a revision date of 11/12/18 identified Resident #30's with a physical functioning deficit related to: self care impairment and impaired mobility. The goal set for the resident by the staff was that the staff will anticipate and meet all needs through next review. One of the interventions/approaches the staff would use to accomplish this goal included to assist with personal hygiene. An interview was conducted with Resident #30 on 02/05/19 at approximately 8:48 a.m., who stated, "I'm not receiving showers twice a week; I would like them twice a week but would settle for a shower once a week." The resident said, "I would feel so much cleaner." On 02/06/19, the surveyor reviewed the units shower scheduled. Resident #30 was scheduled to have showers given every Tuesday and Friday (7 a.m.-3 p.m. shift). Review of Resident #30's documentation survey report for bathing concluded the following: Showers were not given on the following shower days: November 2018 (11/2, 11/6, 11/9, 11/16, 11/20, 11/23, 11/27 and 11/30/18);	F 677	F677 To remain in compliance with all federal and state regulations, the center has taken or will take the actions set forth in the following plan of correction: 1. Resident 30 has been given a shower based on the resident's shower schedule or the resident's preferred time. Resident 363 has been given a shower based on the resident's shower schedule or the resident's preferred time. Resident 363 was shaved and is offered to be shaved daily or at his preferred schedule. 2. Other residents may be at risk of needing support or changing their routines for assistance with ADL's. Resident's will be scheduled for a shower minimally two (2) times per week or as may be needed or based on preference. Nursing Assistants will offer showers and other needed ADL services per schedule or the resident's preference. Any non-routine scheduled services or refusals will be documented so alternative choices can be considered. 3. Nursing Department staff will be re-educated on ADL Schedules and the management and documentation of refusals or special requests. The TRIO Daily Care Keeper Rounds will include observations and the reporting of resident ADL needs. An audit will be conducted by the Care Keepers for three (3) months of the Care Keeper Rounding Reports for any identified trends or resident preferences regarding their ADL's, to include showers or the shaving needs of residents. 4. The audit results will be presented by the Care Keepers at the Monthly QAPI Meeting. 5. Date of Correction: 3/9/2019	

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F 677	Continued From page 39 December 2018 (12/4, 12/11, 12/14 and 12/18/18); January 2019 (01/11 and 01/15/19); February 05, 2019; The following MDS' were reviewed for rejection of care: Quarterly assessment with an ARD date of 11/16/18, Discharged MDS dated 12/20/18 and 12/05/18 were all coded as no behaviors exhibited. An interview was conducted with Certified Nursing Assistant (CNA) #3 on 02/06/19 at approximately 2:05 p.m. The CNA stated, "I did not give Resident his shower yesterday because he was already up and dressed by the night shift. The surveyor asked, "Was Resident #30 offered his shower since yesterday was his shower day" she replied, "I offered him his shower between 9:30-9:45 a.m., and again on the same day at 2:40 p.m., but he refused." The surveyor asked, "Did you document his refusal or notify the floor nurse, she replied, "No." On 02/07/19 at approximately 11:05 a.m., an interview was conducted with the Regional Director of Clinical Services who stated, "Showers are to be given twice weekly and more often it requested by the resident." An interview was conducted with Wing I (Unit Manager) on 02/07/19 at approximately 11:25 a.m. who stated, "I expect for the CNA's to give showers twice a week and if the resident refuses; they to inform the floor nurse." The floor nurse will speak with the resident and if the resident still refuses then the CNA will offer a complete bed bath. The CNA will document the refusal on a Stop and Watch form and give it to the floor	F 677		

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F 677	Continued From page 40 nurse. The Unit Manager stated, "The care plan will be updated to address the resident's refusal of showers." The facility administration was informed of the findings during a briefing on 02/07/19 at approximately 5:40 p.m. The Interim Director of Nursing (IDON) stated, "If a resident refuse their shower then the CNA must inform the charge nurse. The charge nurse will try a different approach to see if they can get the resident to receive their shower. If the charge nurse is not successful then the unit manager is made aware who will investigate why the resident refused their shower. 2. Resident #363 was admitted to the facility on 01/22/2019. Diagnoses included but were not limited to, Dementia in other Diseases classified elsewhere with Behavioral Disturbance and Major Depressive Disorder. Resident #363's Minimum Data Set (an assessment protocol) with an Assessment Reference Date of 01/29/2019 coded Resident #363 with Short-term memory problems, long-term memory problems, and with modified independence in cognitive skills for daily decision making. In addition, the Minimum Data Set coded Resident #363 as requiring supervision with assistance of 1 with personal hygiene and total dependence with assistance of 1 with bathing. Resident #363 was observed walking around in his room on 02/05/19 at 9:00 a.m. and he had approximately 1/4 inch of unshaved facial hair. On 02/06/19 at approximately 9:00 a.m., Resident #363 was observed walking in the hall with his	F 677		

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F 677	Continued From page 41 face unshaved. On 02/07/19 at 11:00 a.m., Resident #363 was observed walking in the hall and he remained unshaven. On 02/07/19 at approximately 11:05 a.m., an interview was conducted with Certified Nursing Assistant (CNA) #2 and she was asked, "What care did you have to provide Resident #363 this morning?" CNA #2 stated, "He was already up and dressed walking in the hall when I arrived." CNA #2 was asked, "Do you think he needs to be shaved?" CNA #2 replied, "Yes. I need to check and see if he shaves himself and if he uses an electric shaver. I'm PRN and don't work on this side often." CNA #2 also stated, "I have not provided his care yet since he was already up and walking around but I am going to provide his care today and I will shave him." On 02/07/19 at 11:10 a.m., an interview was conducted with LPN #1 (Licensed Practical Nurse) and discussed observing Resident #363 being unshaved during the period of 02/05/19 - 02/07/19. LPN #1 stated that Resident #363 can usually shave himself but she had noticed that morning that he needed to be shaved. She said she asked Resident #363 about shaving but he refused. LPN #1 was asked, "What are your expectations of staff for providing grooming, shaving and ADL's (Activities of Daily Living) for cognitively impaired residents?" LPN #1 responded by saying, "My expectations are for staff to offer assistance several times throughout the day and do a stop and watch. The staff can document refusals so they can be care planned." On 02/07/19 at 11:30 a.m., an interview was	F 677		

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F 677	Continued From page 42 conducted with the Interim Director of Nursing (DON) and discussed observing Resident #363 being unshaved during the period of 02/05/19 - 02/07/19. The Interim DON was asked, "What are your expectations of staff for providing grooming, shaving and ADL's for cognitively impaired residents?" The Interim DON stated, "I expect staff to provide residents with as much assistance as needed with their ADL's, shaving, combing their hair and oral hygiene." The Interim DON also said, "If staff are unable to provide care to the resident because of a behavior then they can try something else and care plan it, try different approaches." On 02/07/19 at 2:30 p.m., Resident #363 was observed walking in hall and he was clean shaven. On 02/07/19 at approximately 5:00 p.m., the Interim DON provided a copy of Resident #363's ADL flow record for the period of 01/01/2019 to 02/07/19. During this period staff did not document any resident refusals of shaving or being shaved on the ADL flow record. On 02/07/2019 at 5:40 p.m. at pre-exit meeting the Administrator, Interim Director of Nursing, Chief Clinical Officer and Regional Director of Clinical Services was informed of the findings. The facility did not present any further information about the findings.	F 677		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains	F 689		

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F 689	Continued From page 43 as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on an Adult Protective Services Report, medical record review, staff interviews and facility document review the facility staff failed to ensure that assessed level of activities of daily living assistance was provide for 1 of 41 Residents in the survey sample to prevent an accident which resulted in harm for Resident #262. For Resident #262, the facility staff failed to use the assessed two person extensive assist for bed mobility during incontinent care on 3/11/18 that resulted in a fall with injury which constituted harm. The findings included: Resident #262 was a 73 year old admitted to the facility on 1/1/15 with diagnoses to include but not limited to: Vascular Dementia, Bipolar Disorder, Partial Traumatic Amputation of Right Upper Arm and Shoulder and Transient Alteration of Awareness. Resident #262's Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 1/16/18 was reviewed. The Brief Interview for Mental Status for Resident #262 was coded as a 3 out of a possible 15 indicating the resident was cognitively impaired and incapable of daily decision making. Under Section G Functional Status the resident was coded as requiring extensive two person physical assist for	F 689	F689 To remain in compliance with all federal and state regulations, the center has taken or will take the actions set forth in the following plan of correction: 1. Resident 262 is no longer a resident of Portsmouth health and Rehab. 2. An audit of residents at risk for special bed mobility and transfer needs, to include two-person assist needs, will be completed jointly by the Director of Nursing and the Nursing Unit Managers; care plans and the resident Cardex will be updated accordingly. 3. In-service training on Bed Mobility and Transfers will be provided to all Nursing Department Staff to include a mandatory "return demonstration" and a written post-test. The training program will be jointly presented by the Nursing and Rehabilitation Services Departments. Education on the function of the Care Planning Process and the Cardex and the importance of following the care plan and Cardex will be provided to all Nursing Department Staff with written post-test. To assure the effectiveness of the training, the Director of Nursing or Designee will audit three (3) Nurse Assistants per week for three (3) months on the use of proper technique for bed mobility and transfers. 4. The audit results will be reviewed and presented by the Director of Nursing at the monthly QAPI Meeting. 5. Date of Correction: 3/9/2019	

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bed mobility (how resident moves to and from lying position, turns side to side, and positions body while in bed or alternate sleep furniture.) Under Section H Bladder and Bowel Resident #262 was coded as always incontinent for bowel and bladder.

A Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 4/11/18 for Resident #262 was also reviewed. The Brief Interview for Mental Status for Resident #262 indicated short and long term memory issues and that the resident was severely cognitively impaired for daily decision making. Under Section G Functional Status the resident was coded as requiring extensive two person physical assist for bed mobility. Under Section H Bladder and Bowel Resident #262 was coded as always incontinent for bowel and bladder. Under Section J Health Conditions Resident #262 was coded as having 1 fall with an injury since admission/entry or reentry or the prior assessment.

The Comprehensive Care Plan for Resident #262 last revised on 1/16/2019 was reviewed and is documented in part, as follows:

Focus: I have a physical functioning deficit related to : Self care impairment, right arm amputee, generalized weakness, impaired cognition. Date Initiated: 2/7/2015 Interventions: Bed mobility assistance as needed, use of siderails to assist. Date Initiated: 2/7/2015

Focus: At risk for further falls related to : History of falls, incontinence of bowel and bladder, use of daily antihypertensive. Date Initiated: 12/9/2016 Interventions: Staff Education, Sent to (Name)

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hospital for eval and treat. Date Initiated: 3/12/2018.

Resident #262's Progress Notes were reviewed and are documented in part, as follows:

3/11/18 17:55 (5:55 P.M.) SBAR (Situation Background Assessment Recommendation)
Change of Condition
Situation: Fall
Background: Traumatic amputation of right arm, old. Alert with confusion noted.
Assessment: CNA (certified nursing assistant) approached this writer and stated that she was caring for resident, giving incontinent care and resident rolled off the bed. This nurse and other charge nurses in room. Resident noted with laceration and hematoma to right side of forehead just above eye. Also noted with blood coming out of mouth. Suctioning of mouth performed, unable to determine where is the injury. Neurocheck WNL (within normal limits).
Response: (Name) Medical Doctor was notified and new order to send resident to (Name) Hospital ER (emergency room) via 911 for eval. 911 was called. 911 personnel did arrive and resident was transported to the ER.

3/12/18 6:40 A.M. General Note
Resident returned from (Name) Hospital ER related to follow up fall from bed. Resident presents with mouth swelling and sutures above his right eye brow. His mouth presents with dried blood around lips and remaining teeth. Bed is lowered to the floor and appears to be resting at this time.

3/13/18 2:38 A.M. General Note
Resident received in bed sleeping. Resident

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F 689	Continued From page 46 status post fall day 2 of 3 and visible injuries noted. 3/13/18 9:23 A.M. General Note Late Entry for 3/12/18-Resident had a fall with injury on 3.11.18. Due to his right arm amputation, resident's ability to assist with repositioning when he is turned for care. Do to this event, he was reassessed and did meet the requirement of side rails. Resident #262's CNA MDS Kardex was reviewed and is documented in part, as follows: ADL: Bed Mobility, Self Performance: Extensive Assistance, Support: Two person physical assist. Vision: Impaired Functional Limitation in Room: Upper Extremity Bowel: Always Incontinent Bladder: Always Incontinent Resident #262's Quarterly Data Collection Tools were reviewed and are documented in part, as follows: 1/16/18: 5. Has the Resident Demonstrated Poor Bed Mobility or Difficulty Moving to a Sitting Position on the Side of the Bed? Yes 6. Does the Resident have Difficulty with Balance or Poor Trunk Control? Yes 9. Is the Resident Currently Using the Side Rails for Positioning and Support? Yes Mobility: Completely Immobile 15. Check all that apply: 1. At this Time, Side Rails are indicated to Provide Safety. 5. Does not have Ambulatory Ability. 6/10/18:	F 689		

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F 689	Continued From page 47 5. Has the Resident Demonstrated Poor Bed Mobility or Difficulty Moving to a Sitting Position on the Side of the Bed? Yes 6. Does the Resident have Difficulty with Balance or Poor Trunk Control? Yes 9. Is the Resident Currently Using the Side Rails for Positioning and Support? Yes Mobility: Completely Immobile 15. Check all that apply: 1. At this Time, Side Rails are indicated to Provide Safety. Resident #262's Facility Fall Investigation dated 3/12/18 was reviewed and is documented in part, as follows: What was the resident doing prior to fall? Getting incontinent care by CNA. Were 2-3 assists used? No What intervention was implemented after the fall? Sent to ER via 911- Needs half SR (side rails) Supervisor Report: 1. Did resident sustain injury? Yes 2. If so, what was the injury and how was it treated? Laceration over right eye. 3. Further investigations of fall required? Yes Fall Committee Review/Recommendations: 3/13/18 Staff education related to side rail removal. Siderail restraint eval. CNA'S Statement Attached to Fall Investigation: (Name) CNA #1 went into (Name) Resident #262's room to check to see if he need to be changed. I was changing him and turn him on his side to clean him up and this is when he fell in the floor, while I was cleaning him.	F 689		

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F 689	Continued From page 48 CNA #1's Employee Progressive Action Memorandum dated 3/11/18 was reviewed and is documented in part, as follows: Employee, (Name) CNA #1 approached charge nurses at 17:40 (5:40 P.M.) notifying of resident in room 32 (Resident #262) had fallen to the floor while performing ADL care. Resident noted on the floor with blood clots from mouth and abrasion to right eyebrow, Resident was suctioned and pressure applied to areas of active bleeding. Resident sent to (Name) hospital emergency department for patient eval. and treat. Patient Diagnosis: Partial Traumatic Amputation of Right Arm, Generalized weakness. A Restraint Assessment dated 3/12/18 for Resident #262 was reviewed and is documented in part, as follows: Diagnosis/Conditions pertaining to Mobility: Partial Traumatic Amputation of Shoulder, Muscle Weakness. Mental/Cognitive Status/Vision/Safety Awareness: Diagnosis: Dementia, resident is not aware of safety at all, he is non-verbal. History of Falls/Injuries: Fall-3/11/18 with facial injuries, the fall was from the bed. Body Alignment Status: Body is stiff, especially his legs. Team Recommendations: Siderails X 2- due to resident inability to bend lower extremities, recent fall from bed with injury.	F 689		

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Resident #262's Hospital Emergency Department Summary dated 3/12/18 was reviewed and is documented in part, as follows:
Date: 3/11/18
Chief Complaint: Fall
ED (emergency department) Triage Notes:
Patient arrived from Portsmouth Health and Rehab complaint of nursing aid rolled patient off bed. Patient only oriented to self, able to follow commands.

On 2/5/19 at 1:53 P.M. an interview was conducted with LPN (Licensed Practical Nurse) #2 who was in charge of Resident #262 on 3/11/18 when his fall and injury occurred. LPN #2 was asked to describe what happened the night Resident #262 fell on the floor. LPN #2 stated, "The CNA was giving care when he fell. She was turning him and he fell off the bed onto the floor. I went in to assess him and he was on the floor. He was bleeding from his head and his mouth. I sent him to the Emergency Room. He was total care, dependent. " LPN #2 was asked how do the CNA's know how much assistance a resident needs with care/ bed mobility? LPN #2 stated, " The aides have a Kardex that tell them what each resident requires for assistance."

On 2/6/19 at 1:37 P.M. a phone interview was conducted with CNA #1, who was the CNA providing incontinent care to Resident #262 when he fell from the bed and was injured on 3/11/18. CNA #1 was asked to describe what happened when Resident #262 fell from his bed. CNA#1 stated, "I go into change him and turned him to the left, there was no siderail so I pulled him towards me then turned him on his side and he just kept moving there was nothing there to stop him. He hit the floor. I was mad and upset

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because the man got hurt. He was bleeding from the mouth and head, I saw a blood clot. It was just me in there no other help, we do it by ourselves. I was upset all night because they took the rails off. They wrote me up, it was an accident. He only had one arm." CNA #1 was asked if another person had been on the other side of the bed would the resident have still fallen and been injured. CNA #1 stated, "No, because that person would have kept him from falling on the floor. I guess I should have gotten some help."

On 2/16/19 at 5:00 P.M. an interview was conducted with the Regional Director of Clinical Services regarding Resident #262's fall with an injury on 3/11/18. Based on the investigation and document review this surveyor asked to the Regional Director of Clinical Services if she felt this fall with an injury to Resident #262 could have been avoided. The Regional Director of Clinical Services stated, 'I agree with you, he should have had 2 person extensive assist as the resident's plan of care called for. The CNA's kardex lets them know the bed mobility status for the resident."

The facility's Fall Prevention Program effective date 1/2017 was reviewed and is documented in part, as follows:
3. The assigned CNA on all shifts need to be held accountable to ensure that the Care Plan to eliminate falls is being implemented.

On 2/7/19 at 5:40 P.M. a pre-exit conference was held with the Administrator, the Director of Nursing, the Regional Director of Clinical Services and the Chief Clinical Officer were the above information was shared. The Chief

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F 689	Continued From page 51 Clinical Officer stated, "We should have followed his plan of care and had 2 person extensive assist for his bed mobility to prevent a fall with an injury to the resident. I hate that this happened but it did and we own it." No further information was provided by the facility staff prior to exit.	F 689		
F 727 SS=D	RN 8 Hrs/7 days/Wk, Full Time DON CFR(s): 483.35(b)(1)-(3) §483.35(b) Registered nurse §483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by: Based on facility information obtained during the Sufficient and Competent Nurse Staffing task, and staff interview, the facility staff failed to staff a Registered Nurse for at least 8 consecutive hours a day, 7 days a week. The facility staff failed to staff a Registered Nurse (RN), for at least 8 consecutive hours on 1/16/19. The findings included: During the nursing staff review for January 1, 2019 through February 6, 2019 the facility staff	F 727	F727 To remain in compliance with all federal and state regulations, the center has taken or will take the actions set forth in the following plan of correction: 1. RN Staffing was not eight (8) hours on 1/16/2019 which cannot be rectified based on the mandatory requirement for a Registered Nurse for minimally eight (8) consecutive hours; seven (7) days per week. 2. Staffing is reviewed on a daily basis with the Staffing Coordinator during the Morning PPS Meeting. The daily review will include report-out of the Registered Nurse scheduled for eight (8) hours seven (7) Days per week. 3. The Director of Nursing has reviewed the RN Staffing Requirement with the facility RN's and also the Staffing Coordinator. A daily audit of the "as worked" daily work schedules for RN hours will be completed by the Director of Nursing or designee for three (3) months. 4. The Staffing Coordinator will present the daily consecutive RN hours scheduled for the day during the Morning PPS Meeting. The audit of the "as worked" hours will be reported by the Director of Nursing. The results of the audit will be reported at the monthly QAPI Meeting. 5. Date of Correction: 3/9/2019	

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F 727	Continued From page 52 was unable to verify RN presence in the facility for at least 8 consecutive hours therefore; further review was indicated on 1/16/19 an RN worked only 7.5 hours (8:56 a.m.- 4:58 p.m.). An interview was conducted with the Staffing Coordinator on 2/7/19, at approximately 5:15 p.m. The Staffing Coordinator stated she was told the Director of Nursing could assume the role of the RN when the scheduled RN didn't work a full 8 hour shift. The above information was shared with the Administrator, Director of Nursing and Regional Director and Chief Clinical Officer on 2/7/19, at approximately 5:40 p.m. The Chief Clinical Officer stated she was aware of the Director of Nursing could only serve as the RN on duty when the facility's occupancy was 60 or less.	F 727		
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. (iii) This provision does not preclude residents from consuming foods not procured by the facility.	F 812		

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F 812	Continued From page 53 §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 observations, staff interview, and facility document review the facility staff failed to store and label food in accordance with food service safety guidelines. The findings included: On 2/4/19 at approximately 6:45 P.M. the Initial Kitchen Inspection was completed. In the Dry Storage Room the following observation was made: 1. Two 22 quart clear containers noted both half full one with corn flakes and one with rice krispies. There were blue lids lying on top of the containers but were not secured to the container. In the Reach in refrigerator the following observation was made: 1. One large package wrapped in clear plastic wrap was observed not labeled or dated. The package contained slices of bacon and ground sausage all mixed together. On 02/05/19 11:40 AM an interview was conducted with the Kitchen Account Manager regarding the package of bacon slices and ground sausage found in the walk-in refrigerator the previous night that was not labeled or dated and the 2 open containers of cereal in the dry storage room. The Kitchen Account Manager stated, "The package of bacon and sausage	F 812	F812 To remain in compliance with all federal and state regulations, the center has taken or will take the actions set forth in the following plan of correction: 1. The storage of dried foods in containers are kept fully covered to prevent dust or dirt from touching any food items. Opened food items are wrapped or stored in covered containers and labeled and dated and arranged to prevent cross-contamination. 2. The risk of unsafe food practices exists so a daily process of monitoring food safety will be initiated with daily regular oversight and rounds and observation during food preparation times by the Food Service Manager and cooks. 3. In-service training on Food Service Safety Guidelines was provided to Dining Services Staff to assure food is handled in a safe and sanitary manner. The Regional Account Manager or designee will audit the reach-in and walk-in Refrigeration Units for the above to assure labeling, dates and that there are no foods arranged with risk for cross-contamination. The audit will be conducted two (2) times per week for three (3) months for the dry storage supply area and the refrigeration units. 4. The audit and tracking results will be reviewed and presented by the Food Services Manager at the monthly QAPI Meeting. 5. Date of Correction: 3/9/2019	

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F 812	Continued From page 54 should have been labeled as to to when it was made and when it expired. The cereal containers should always be keep sealed to keep the food from going stale and to keep any bugs or dirt out of the container." The facility policy titled "Food Storage: Cold Foods" last revised 4/2018 was reviewed and is documented in part, as follows: Policy Statement: All Time/Temperature Control for Safety foods, frozen and refrigerated, will be appropriately stored in accordance with guidelines of the FDA Food Code. 5. All foods will be stored wrapped or in covered containers, labeled and dated, and arranged in a manner to prevent cross contamination. The facility policy titled "Food Storage: Dry Goods" last revised 9/2017 was reviewed and is documented in part, as follows: Policy Statement: All dry goods will be appropriately stored in accordance with the ADA Food Code. 5. All packaged and canned food items will be kept clean, dry, and properly sealed. On 2/7/19 at 5:40 P.M. a pre-exit conference was held with the Administrator, the Director of Nursing, the Regional Director of Clinical Services and the Chief Clinical Officer where the above information was shared. No further information was provided by facility staff prior to exit.	F 812		

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F 868	Continued From page 55	F 868		
F 868 SS=D	QAA Committee CFR(s): 483.75(g)(1)(i)-(iii)(2)(i) §483.75(g) Quality assessment and assurance. §483.75(g)(1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; §483.75(g)(2) The quality assessment and assurance committee must: (i) Meet at least quarterly and as needed to identifying issues with respect to which quality assessment and assurance activities are necessary. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility record review, and review of the facility's policy, the facility staff failed to consistently have required members at each quarterly Quality Assessment and Assurance Committee (QAA) meeting and failed to meet on a quarterly basis for one year. The findings included: A QAPI/QAA interview was held on 02/07/19 at approximately 10:30 AM with the facility Administrator. He presented the following quarterly meeting dates from the facility QAPI plan: 04/27/18, 10/26/18, 02/01/19. The Administrator stated that no meeting was held in July of 2018. The data from the QAPI plan revealed signatures from all required members	F 868	F868 To remain in compliance with all federal and state regulations, the center has taken or will take the actions set forth in the following plan of correction: 1. A QAPI Meeting was missed in July of 2018 and signatures for all meeting attended, to include required attendees, was not obtained. 2. QAPI Meetings will begin with meeting attendance signatures before starting agenda to prevent missing this verification process. The QAPI Meeting schedule will be provided with automatic reminder thru the Outlook software. QAPI Meetings are held on a monthly basis for quality monitoring. The required Quarterly Meetings occur in April, July, October and January per the TRIO QAPI Committee Program. The Quarterly QAPI Meeting will minimally include the Administrator, Director of Nursing and the Medical Director. 3. Leadership Team will be in-serviced on the QAPI process. 4. The QAPI Meeting requirement will be self-monitoring and ongoing. 5. Date of Correction: 3/9/2019	

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	495149	A. BUILDING _____ B. WING _____	C 02/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PORTSMOUTH HEALTH AND REHAB	900 LONDON BOULEVARD PORTSMOUTH, VA 23704

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F 868	Continued From page 56	F 868		

were present during the April 2018 meeting, including more than three other staff members. The meeting held on 10/26/18 listed only one member as being present. The February 2019 meeting did not have the required members present. The Administrator attached a post it note with the following signatures attached to the February 2019 meeting: The Acting Director of Nursing, The Medical Director and other member signatures.

On 02/07/19 at 4:25 PM a discussion was held with the Administrator concerning the QAPI/QA policy. The missed QAPI meeting in July was discussed. He stated "moving forward they will improve."

The facility's policy dated 02/2017 included: the Quality Assurance Committee will meet monthly to review, recommend and act upon activities of the facility, performance action teams and/or departmental activities.

The Procedure included the following: 1. The Administrator will hold the position of chairperson of the Quality Assurance Committee. 2. The Committee may consist of the Medical Director, Administrator, The Director of Nursing and at least three other staff members.

On 02/07/19 at 6:00 PM the above findings were shared with the Administrator, the Acting Director of Nursing, the Regional Director of Clinical Services and the Chief Clinical Officer. An opportunity was given for the facility to present additional information or comment. The Administrator stated that the required members should attend quarterly meetings.

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F 880 SS=C	Continued From page 57 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; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections;	F 880 F 880	F880 To remain in compliance with all federal and state regulations, the center has taken or will take the actions set forth in the following plan of correction: 1. Documentation of the annual review of the TRIO Infection Prevention and Control Policy was not added to the manual in error after a staffing change. The annual review of the Infection Prevention and Control Policy will be added to the policy. 2. Facility residents have the potential to be affected by the deficient practice. The Infection Control and Prevention Policy is reviewed and revised, as needed, minimally on an annual basis. The minimum annual review includes changes as may be needed and it is documented and verified by signature. 3. Verification of the annual review is distributed on a pre-determined schedule for assurance. Management Team will be re-educated on the requirement of an annual review of policy and procedure manuals for changes, updates and signature. 4. Changes and updates to the policy and procedure manuals will be presented at the January QAPI Meeting of each year for review and signature of the Administrator, Medical Director and the Director of Nursing. 5. Date of Correction: 3/9/2019	

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F 880	Continued From page 58 (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 information gleamed during the Infection Prevention and Control Program review and staff interview the facility's staff failed to have an current and active Infection Prevention and Control Program policy. The facility staff failed to sign the Infection Prevention and Control Program policy into effect, effective 1/1/2019.	F 880		

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F 880	Continued From page 59 The findings included: An interview was conducted with the Chief Clinical Officer on 2/6/19 at approximately 2:03 p.m., for she stated she developed the infection control policies for the facility and the Administrator and Director of Nursing were new in their roles. The Chief Clinical Officer stated she reviews the Infection Prevention and Control Program policy annually and it was determined no revision was necessary for 2019. The Chief Clinical Officer further stated the policy was then emailed to the facility for the Administrator to sign as effective for the current year. After searching various locations within the facility the Chief Clinical Officer and the Administrator were unable to locate the emailed or a copy of the signed Infection Prevention and Control Program policy, but they were successful in producing a signed policy for 2017. The Chief Clinical Officer stated apparently something occurred preventing the 2019, Infection Prevention and Control Program policy and the 2018, policy from reaching the current and previous Administrators therefore; they didn't receive, print and sign the policy into effect. The above information was shared with the Administrator, Director of Nursing and Regional Director and Chief Clinical Officer on 2/7/19, at approximately 5:40 p.m. The Chief Clinical Officer stated she would ensure the Infection Prevention and Control Program policy was resent to the Administrator and signed into effect.	F 880		