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 _____	R-C 03/28/2019

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
{E 000}	Initial Comments	{E 000}		
{F 000}	INITIAL COMMENTS An unannounced Medicare/Medicaid revisit to the standard survey conducted 2/4/19 through 2/7/19, was conducted 3/27/19 through 3/28/19. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care Requirements. One complaint was investigated during the survey. The census in this 120 certified bed facility was 105 at the time of the survey. The survey sample consisted of 7 current Resident reviews (Residents #101-#105, #108 and #110) and 4 closed record reviews (Residents #106, #107, #109 and #111).	{F 000}	RECEIVED APR 17 2019 VDH/OLC	
{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 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;	{F 622}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature] LNHA	Administrator	4-12-2019

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

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{F 622}	Continued From page 1 (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. 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	{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. Residents 101, 109 and 110 upon D/C to the hospital did not have a care plan, to include their goals, sent with them upon transfer to the 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, the resident Care Plan, the resident's medication list and Notice of Bed Hold Policy. Packets have been developed for each nursing unit for quick 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 Director of Nursing on the information required to be sent for a resident upon D/C to the hospital. Resident D/C's will be audited the following business day after a D/C using the Unexpected Hospitalization Audit Tool on an ongoing basis for one (1) month. 4. The audit will be reviewed during the monthly QAPI Meeting. 5. Date of Correction: 4/17/2019	

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{F 622}	Continued From page 2 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 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 to send a copy of the Resident's Care Plan for three residents (Resident #101, #109 and #110) after being transferred to the hospital. 1. The facility staff failed to send Resident #101's care plan to include their goals when discharged to the hospital on 03/09/19.	{F 622}		

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{F 622}	Continued From page 3	{F 622}		

2. The facility staff failed to send Resident #109's care plan to include their goals when discharged to the hospital on 03/10/19.

3. The facility staff failed to send Resident #110's care plan to include their goals when discharged to the hospital on 03/12/19.

The findings included:

1. Resident #101 was originally admitted on 10/04/18. Diagnosis for Resident #101 included but not limited to Dementia without behavioral disturbances. The current Minimum Data Set (MDS), a quarterly assessment with an Assessment Reference Date (ARD) of 01/23/19 coded the resident with short and long-term memory problems and cognitive skills severely impaired-never/rarely made decisions.

On 03/09/19, an SBAR was completed including the following information:
-Situation: Un-witness fall with head injury.
-Background: Alert x 1, pleasantly confused. Dx: Dementia, Generalized weakness, Mild cognitive impairment, Major depression and Repeated falls.
-Assessment: Resident fell at approximately 2:25 p.m., in room, found in doorway with head injury. Purulent bright, red bloody drainage. First aid administered with pressure applied and dressing in place. Pressure continue to be applied to head injury. VS: BP (138/95), P (111), R (22), Temp (99.9) with Saturation at (96%) on room air; 911 called by co-worker at 2:32 p.m.
-Response: 911 arrived for transport via stretcher to local hospital.

On 03/28/19 at approximately 10:25 a.m., the

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{F 622}	Continued From page 4	{F 622}		

Administrator asked this surveyor if she was waiting for any paperwork. The surveyor said the Director of Nursing (DON) was trying to locate in Resident #101's medical record to see if her care plan was sent on 03/09/19 when she was transferred to the hospital. The Administrator stated, "We have packets already made up in advance on both units with the required paperwork for our Plan of Correction (POC)." He said, when a resident is being sent out to the hospital, the nurse will pull the packet and complete the paperwork inside. On the same day at 10:30 a.m., the Administrator and surveyor went to Unit 1. The packets were located at the nurse's station in a large envelope. Inside the packets was a bed hold notice and a Interact Form." The surveyor asked the Administrator, "When a resident goes out to the hospital, is the care plan being sent or the Interact Form" he replied, "The Interact Form."

On the same day at approximately 10:35 a.m., the surveyor asked RN #1, "When a resident is being sent to the hospital, is their care plan being sent with them or the Interact Form?" she replied, "The Interact Form."

On 03/28/19 at approximately 12:20 p.m., a briefing was held with the facility administration. The surveyor asked, "When a resident is been sent to the hospital, is their comprehensive care plan that contains their care plan goals being sent with them?" The Regional Director of Clinical Services said the Interact Form is sent. The surveyor asked, "What is the Interact Form?" She said it is a communication tool used between the nursing home and the hospital; it provides a snap shot of the resident. Resident #101 had an Interact Form completed on 03/09/19 when she

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{F 622}	Continued From page 5 was transferred to the hospital. The completed Interact Form was reviewed with the facility administration. The surveyor asked, "Did the Interact Form include the Comprehensive Care Plan Goals for Resident #101." The Regional Director of Clinical Services replied, "It has the potential to include the resident care plan goals depending on which nurse is completing the form." The surveyor asked, "Did Resident #101's Interact Form that was completed on 03/09/19 when Resident #101 was sent to the hospital included her Comprehensive Care Plan Goals" she replied, "No." 2. Resident #109 was originally admitted to the facility on 10/01/18 and was discharged to an acute hospital on 02/09/19. Diagnoses for Resident #109 included alcohol abuse and muscle weakness. The admissions Minimum Data Set assessment dated 01/31/19 with an assessment reference date of 1/24/19, coded Resident #109 with a score of 12 out of possible 15 on the Brief Interview for Mental Status (BIMS) which indicated the resident's cognition was moderately impaired. On 03/28/19 Resident #109's clinical records were reviewed. The nursing progress notes stated that on 03/10/19 at 15:53 (3:53 p.m.) a Change Of Condition was noted. An SBAR (Situation, Background, Assessment, Response) was completed and included that the resident was unresponsive. It included that a nursing home to hospital form was filled out and faxed to the hospital, a called was placed to MD and Responsible party.	{F 622}		

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{F 622}	Continued From page 6	{F 622}		

On 03/28/19 the DON was asked for copy of forms faxed to the emergency room for Residents #109. All required forms were given to the surveyor except the Comprehensive Personal Care Plan.

On 03/28/19 the Regional Nurse was asked to provide a copy of the Comprehensive Care Plan. She stated that the interact form that was faxed to the hospital list primary goals at the time of transfer acts as the Comprehensive Care Plan.

On 03/28/19 at approximately 12:20 p.m., a briefing was held with the facility's administration. The surveyor asked, "When a resident has been sent to the hospital, is their comprehensive care plan goals being sent with them?" The Regional Director of Clinical Services said the "Interact Form" is sent. The surveyor asked, "What is the Interact Form?" she said it is a communication tool between the nursing home and the hospital. Resident #109's Interact Form that was completed when Resident #109 was transferred to the hospital on 03/10/19 was reviewed with the facility's administration. The surveyor asked, "Did the Interact Form include the Comprehensive Care Plan goals for Resident #109?" The Regional Director of Clinical Services replied, "It has the potential to include the resident care plan goals depending on which nurse is completing the form." The surveyor asked, "Did Resident #109's Interact Form completed on 03/10/19 when she sent to the local hospital included her comprehensive care plan goals" she replied, "No."

3. Resident #110 was originally admitted to the facility on 06/30/16 and was discharged to an

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{F 622}	Continued From page 7	{F 622}		

acute hospital on 02/09/19. Then returned to the facility on 03/12/19. Diagnoses for Resident #110 included unspecified Dementia, Major Depressive Disorder and muscle weakness.

The admissions Minimum Data Set assessment dated 01/31/19 with an assessment reference date of 02/14/19, coded Resident #110 as having long term memory problems and cognitive skills for daily decision making as modified Independence.

On 03/28/19 a review of Resident #110's clinical records were reviewed. The nursing progress notes stated that on 03/12/19 at 18:51 a Change Of Condition was noted. An SBAR (Situation, Background, Assessment, Response) was completed. The Resident had fallen, was seen lying on the floor in the hallway; had a laceration to the left side of her head and a small laceration to her left outer eye. The notes revealed that the resident was transported to a local hospital. States that a nursing home to hospital form was filled out and faxed to the hospital, a called was placed to MD and Responsible party.

Progress notes that resident returned to the facility on 03/12/19 at 2147 via stretcher from the local hospital.

On 03/28/19 the DON was asked for copy of forms faxed to the Emergency room on Resident #110. All required forms were given to the surveyor except the Comprehensive Personal Care Plan.

On 03/28/19 the Regional Nurse was asked to provide a copy of the Comprehensive Care Plan. She stated that the interact form that was faxed

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{F 622}	Continued From page 8 to the hospital list primary goals at the time of transfer acts as the Comprehensive Care Plan On 03/28/19 at approximately 12:20 p.m., a briefing was held with the facility's administration. The surveyor asked, "When a resident is been sent to the hospital, is their comprehensive care plan goals being sent with them?" The Regional Director of Clinical Services said the Interact Form is sent. The surveyor asked, "What is the Interact Form?" She said it is a communication tool between the nursing home and the hospital. Resident #110's Interact Form that was completed when Resident #110 was transferred to the hospital on 03/12/19 was reviewed with the facility's administration. The surveyor asked, "Did the Interact Form include the Comprehensive Care Plan goals for Resident #110?" The Regional Director of Clinical Services replied, "It has the potential to include the resident care plan goals depending on which nurse is completing the form." The surveyor asked, "Did Resident #110's Interact Form completed on 03/12/19 when she sent to the local hospital included her comprehensive care plan goals?" She replied, "No."	{F 622}		