STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495418	A. BUILDING _____ B. WING _____	C 03/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRINCESS ANNE HEALTH & REHABILITATION CENTER	1948 LANDSTOWN CENTRE WAY VIRGINIA BEACH, VA 23456

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 03/12/19 through 03/15/19. Corrections are required for compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities. No emergency preparedness complaints were investigated during the survey.	E 000		
E 018 SS=C	Procedures for Tracking of Staff and Patients CFR(s): 483.73(b)(2) [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually.] At a minimum, the policies and procedures must address the following:] (2) A system to track the location of on-duty staff and sheltered patients in the [facility's] care during an emergency. If on-duty staff and sheltered patients are relocated during the emergency, the [facility] must document the specific name and location of the receiving facility or other location. *[For PRTFs at §441.184(b), LTC at §483.73(b), ICF/IIDs at §483.475(b), PACE at §460.84(b):] Policies and procedures. (2) A system to track the location of on-duty staff and sheltered residents in the [PRTF's, LTC, ICF/IID or PACE] care during and after an emergency. If on-duty staff and sheltered residents are relocated during the emergency, the [PRTF's, LTC, ICF/IID or PACE] must document the specific name and location of	E 018		4/29/19

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

Electronically Signed | 04/01/2019

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495418	A. BUILDING _____ B. WING _____	C 03/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRINCESS ANNE HEALTH & REHABILITATION CENTER	1948 LANDSTOWN CENTRE WAY VIRGINIA BEACH, VA 23456

(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 018	Continued From page 1 the receiving facility or other location. *[For Inpatient Hospice at §418.113(b)(6):] Policies and procedures. (ii) Safe evacuation from the hospice, which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s) and primary and alternate means of communication with external sources of assistance. (v) A system to track the location of hospice employees' on-duty and sheltered patients in the hospice's care during an emergency. If the on-duty employees or sheltered patients are relocated during the emergency, the hospice must document the specific name and location of the receiving facility or other location. *[For CMHCs at §485.920(b):] Policies and procedures. (2) Safe evacuation from the CMHC, which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s); and primary and alternate means of communication with external sources of assistance. *[For OPOs at § 486.360(b):] Policies and procedures. (2) A system of medical documentation that preserves potential and actual donor information, protects confidentiality of potential and actual donor information, and secures and maintains the availability of records. *[For ESRD at § 494.62(b):] Policies and procedures. (2) Safe evacuation from the dialysis facility, which includes staff responsibilities, and	E 018		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495418	A. BUILDING _____ B. WING _____	C 03/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRINCESS ANNE HEALTH & REHABILITATION CENTER	1948 LANDSTOWN CENTRE WAY VIRGINIA BEACH, VA 23456

(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 018	Continued From page 2 needs of the patients. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility staff failed to train facility staff in tracking system used as part of the facility's Emergency Preparedness Plan. The findings included: During the Emergency Preparedness review with the Administrator and the Maintenance Director on 3/14/19 at 10:00 A.M. they were asked if the facility staff had received training on the Emergency Preparedness Plan for tracking. The Administrator stated, "Yes staff know the tracking system." During an interview on 3/15/19 at 9:25 A.M. with Staff Person Registered Nurse (RN) #1, she stated she had not had training with the facility's Emergency Preparedness tracking system. During an interview on 3/15/19 at 9:36 A.M. with Staff Person RN #2 she was asked if she could describe the facility's Emergency Preparedness tracking system during an emergency and she stated she did not know, nor had she had any training on the tracking system. During an interview on 3/15/19 at 9:52 A.M. with Staff Person Licensed Practical Nurse (LPN) #5 she was asked had she had training on the facility's Emergency Preparedness tracking system. LPN #5 stated, "No she had not had any training and did not know how the tracking system worked." During an interview on 3/15/19 at 10:03 A.M. with	E 018	The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. 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. The following plan of correction constitutes the centers allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated. E018 1. Facility staff have been trained in the tracking system used as part of the facility□s Emergency Preparedness Plan. 2. The facility has an Emergency Preparedness Plan which includes a tracking system. 3. Facility staff will be educated on: " Tracking system for the Emergency Preparedness Plan " Location of the written Emergency Preparedness Plan on each Unit 4. Administrative staff will complete a random interview with staff to ensure that staff are knowledgeable of the tracking system used as part of the facility□s Emergency Preparedness Plan. 5. Issues noted during the random weekly review will be presented to the Quality Assurance Committee for review and recommendation.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495418	A. BUILDING _____ B. WING _____	C 03/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRINCESS ANNE HEALTH & REHABILITATION CENTER	1948 LANDSTOWN CENTRE WAY VIRGINIA BEACH, VA 23456

(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 018	Continued From page 3 the Assistant Director of Nursing (ADON), he was asked had he had training on the facility's Emergency Preparedness tracking system during an emergency. The ADON stated, "No he had not had any training on the tracking system nor had he taken an Emergency Preparedness Plan training." The facility staff failed to train staff on the facility's Emergency Preparedness tracking system.	E 018		
E 037 SS=C	EP Training Program CFR(s): 483.73(d)(1) (1) Training program. The [facility, except CAHs, ASCs, PACE organizations, PRTFs, Hospices, and dialysis facilities] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected role. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. *[For Hospitals at §482.15(d) and RHCs/FQHCs at §491.12:] (1) Training program. The [Hospital or RHC/FQHC] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of the training.	E 037		4/29/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495418	A. BUILDING _____ B. WING _____	C 03/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRINCESS ANNE HEALTH & REHABILITATION CENTER	1948 LANDSTOWN CENTRE WAY VIRGINIA BEACH, VA 23456

(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 037	Continued From page 4 (iv) Demonstrate staff knowledge of emergency procedures. *[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, consistent with their expected roles. (ii) Demonstrate staff knowledge of emergency procedures. (iii) Provide emergency preparedness training at least annually. (iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the procedures necessary to protect patients and others. *[For PRTFs at §441.184(d):] (1) Training program. The PRTF must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) After initial training, provide emergency preparedness training at least annually. (iii) Demonstrate staff knowledge of emergency procedures. (iv) Maintain documentation of all emergency preparedness training. *[For PACE at §460.84(d):] (1) The PACE organization must do all of the following: (i) Initial training in emergency preparedness	E 037		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495418	A. BUILDING _____ B. WING _____	C 03/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRINCESS ANNE HEALTH & REHABILITATION CENTER	1948 LANDSTOWN CENTRE WAY VIRGINIA BEACH, VA 23456

(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 037	Continued From page 5 policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, contractors, participants, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least annually. (iii) Demonstrate staff knowledge of emergency procedures, including informing participants of what to do, where to go, and whom to contact in case of an emergency. (iv) Maintain documentation of all training. *[For CORFs at §485.68(d):](1) Training. The CORF must do all of the following: (i) Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. All new personnel must be oriented and assigned specific responsibilities regarding the CORF's emergency plan within 2 weeks of their first workday. The training program must include instruction in the location and use of alarm systems and signals and firefighting equipment. *[For CAHs at §485.625(d):] (1) Training program. The CAH must do all of the following: (i) Initial training in emergency preparedness policies and procedures, including prompt reporting and extinguishing of fires, protection, and where necessary, evacuation of patients, personnel, and guests, fire prevention, and	E 037		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495418	A. BUILDING _____ B. WING _____	C 03/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRINCESS ANNE HEALTH & REHABILITATION CENTER	1948 LANDSTOWN CENTRE WAY VIRGINIA BEACH, VA 23456

(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 037	Continued From page 6 cooperation with firefighting and disaster authorities, to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. *[For CMHCs at §485.920(d):] (1) Training. The CMHC must provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least annually. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility staff failed to have an initial training in Emergency Preparedness policies and procedures to existing staff. The findings included: During an interview with the Administrator and the Maintenance Director on 3/14/19 at 10:00 A.M. the Maintenance Director stated, the Emergency Preparedness Plan went into effect on November 27, 2017. The facility staff failed to have an initial training in	E 037	E037 1. An initial training on Emergency Preparedness has been completed. 2. The facility will complete training on Emergency Preparedness on an annual basis and during orientation. 3. Facility staff will be educated on: " Emergency Preparedness 4. Administrative staff will complete a random interview with staff to ensure that staff are knowledgeable of Emergency Preparedness. 5. Issues noted during the random weekly review will be presented to the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495418	A. BUILDING _____ B. WING _____	C 03/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRINCESS ANNE HEALTH & REHABILITATION CENTER	1948 LANDSTOWN CENTRE WAY VIRGINIA BEACH, VA 23456

(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 037	Continued From page 7 Emergency Preparedness Training Program. A review of staff Training Transcripts indicated: Staff person Assistant Director of Nursing (ADON) had not had initial training in the facility's Emergency Preparedness Plan. During an interview with the ADON on 3/15/19 at 10:03 A.M., the ADON stated he had been employed at the facility for about two and a half years. A review of staff Registered Nurse (RN) #2 training transcript indicated she had not had initial training in the facility's Emergency Preparedness Plan. During an interview with RN #2 on 3/15/19 at 9:36 A.M., RN #2 stated she had been employed at the facility for 3 years. A review of Staff RN #1 training transcript indicated she had not had initial training in the facility's Emergency Preparedness Plan. During an interview with RN #1 on 3/15/19 at 9:25 A.M., RN #1 stated she had been employed at the facility for about 2 years. The facility staff failed to have an Initial training in Emergency Preparedness.	E 037	Quality Assurance Committee for review and recommendation.	
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 03/12/19 through 03/15/19. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. Eight complaints were investigated during the survey. The census in this 120 certified bed facility was 118 at the time of the survey. The survey sample consisted of 46 current Resident reviews and 11	F 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495418	A. BUILDING _____ B. WING _____	C 03/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRINCESS ANNE HEALTH & REHABILITATION CENTER	1948 LANDSTOWN CENTRE WAY VIRGINIA BEACH, VA 23456

(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 000	Continued From page 8 closed record reviews.	F 000		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically	F 580		4/29/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495418	A. BUILDING _____ B. WING _____	C 03/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRINCESS ANNE HEALTH & REHABILITATION CENTER	1948 LANDSTOWN CENTRE WAY VIRGINIA BEACH, VA 23456

(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 580	Continued From page 9 update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, it was determined that facility staff failed to notify the physician for missed doses of medication for three of 57 residents in the survey sample, Resident #347, #82, and #21. 1. Facility staff failed to notify the physician when Resident #347 missed her first dose of IV (intravenous) antibiotics. 2. Facility staff failed to notify the physician when Resident #82 did not receive her full course of antibiotics. 3. Facility staff failed to notify the physician when Resident #21 missed two doses of her scheduled eye drops on 3/1/19 and 3/5/19. The findings include: 1. Resident #347 was admitted to the facility on 10/25/17 with diagnoses that included but were not limited to sepsis, muscle weakness and	F 580	F580 1. Resident #347 was discharged on 10/26/17. Residents #82 and #21 are receiving their medications. 2. A process is in place for residents to receive all medications. If medications are missing, the MD will be notified. 3. Charge Nurses will be educated on: " Pharmacy policy on re-ordering medications " Utilizing in house STAT box " Notifying MD when missing medications " Assigning appropriate times for new medication orders 4. A registered nurse will complete a random weekly review of residents with meds not available and follow up with the pharmacy and/or MD with concerns and documentation of medication administration 5. Issues noted during the random weekly review will be presented to the Quality Assurance Committee for review	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495418	A. BUILDING _____ B. WING _____	C 03/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRINCESS ANNE HEALTH & REHABILITATION CENTER	1948 LANDSTOWN CENTRE WAY VIRGINIA BEACH, VA 23456

(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 580	Continued From page 10 osteomyelitis of the sacral and sacrococcygeal region. Resident #347 was sent to the hospital on 10/26/17 therefore an MDS (minimum data set assessment) was not completed. Review of Resident #347's admission orders dated 10/25/17 documented the following order: "Vancomycin HCL (1) solution Reconstituted Use 1 gram intravenously one time a day for MRSA until 12/1/17." Review of Resident #347's October 2017 MAR (medication administration record) revealed that Resident #347 missed her 0600 a.m. dose of vancomycin. A "9" was coded on the MAR indicating a nursing note was written. Review of Resident #347's nursing note documented the following: "medication unavailable." There was no evidence that the physician was notified of the missed dose of Vancomycin on 10/26/17. On 3/14/19 at 10:20 a.m., an interview was conducted with LPN (Licensed Practical Nurse) #1, the nurse who worked the 11 p.m.-7 a.m. shift on 10/25/17. When asked the process for ordering medications for new admissions, LPN #1 stated that as soon as the resident enters the building, medication orders are faxed over to the pharmacy. LPN #1 stated that nurses should also call pharmacy to follow up on medications to ensure they will be available for their next ordered dose. LPN #1 stated that nurses can also order medications STAT. LPN #1 stated that if the medication is still not available when it's due to be administered, she would make the on-call physician aware so that he can order an	F 580	and recommendation.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495418	A. BUILDING _____ B. WING _____	C 03/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRINCESS ANNE HEALTH & REHABILITATION CENTER	1948 LANDSTOWN CENTRE WAY VIRGINIA BEACH, VA 23456

(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 580	Continued From page 11 alternative. LPN #1 stated that she was not the nurse who conducted Resident #347's admission. On 3/15/19 at 9:00 a.m., an interview was conducted with ASM (Administrative Staff Member) #2, the DON (Director of Nursing). ASM #2 stated that some IV (intravenous) medications are in the STAT box that can be mixed. ASM #2 stated that medication should be in the building when it is due and if not, the medication should be requested from pharmacy STAT and the physician should be notified. ASM #2 stated that the physician would then reprogram the antibiotic order or extend the order. The STAT box list was requested. On 3/15/19 at 9:50 a.m., ASM #2 presented the IV STAT Box list. Vancomycin 1 gram was in the STAT box. On 3/15/19 at 9:54 a.m., further interview was conducted with LPN #1. When asked why she did not administer Resident #347's Vancomycin on 10/26/17, LPN #1 stated that she could not remember Resident #347's antibiotics. LPN #1 stated, "I know her daughter was refusing a lot of things. I am not sure. Maybe the daughter refused it?" When asked if IV Vancomycin was in the STAT box, LPN #1 stated, "Yes, usually. I don't know the dose on the top of my head. It might not of been there." LPN #1 stated there had to have been a reason why she did not administer the Vancomycin. When asked if the physician was notified that the IV Vancomycin was not administered, LPN #1 stated, "Honestly, I can't tell you." LPN #1 stated that a nursing note should have been written if the physician was notified. LPN #1 stated that there was a lot going on that shift because the daughter was going	F 580		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495418	A. BUILDING _____ B. WING _____	C 03/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRINCESS ANNE HEALTH & REHABILITATION CENTER	1948 LANDSTOWN CENTRE WAY VIRGINIA BEACH, VA 23456

(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 580	Continued From page 12 back and fourth about sending the resident to the hospital. On 3/15/19 at 12:25 p.m., an interview was conducted with OSM (Other Staff Member) #8, the nurse practitioner. When asked if she would expect to be notified if a resident misses a dose of an antibiotic, OSM #8 stated that she would expect to be notified. OSM #8 stated that some medications were in the STAT box and she would direct the nurse to obtain the medication from there. OSM #8 could not recall being notified of the missed antibiotic. OSM #8 stated that the on-call physician was made aware of the Resident's acute issues with her blood pressure and respiratory status. OSM #8 stated that she was supposed to see the resident the following day but that the resident had been sent out to the hospital. On 3/15/19 at 1:52 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the DON (Director of Nursing), and Corporate staff member #1 were made aware of the above concerns. A policy could not be provided on MD (medical doctor) notification. COMPLAINT DEFICIENCY 2. Facility staff failed to notify the physician when Resident #82 did not receive her full course of antibiotics. Resident #82 was admitted to the facility on 6/8/17 and readmitted on 2/14/19 with diagnoses that included but were not limited to ESBL (extended spectrum beta-lactamase) bacteria in urine, muscle weakness, difficulty walking, and atrial fibrillation. Resident #82's most recent MDS	F 580		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495418	A. BUILDING _____ B. WING _____	C 03/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRINCESS ANNE HEALTH & REHABILITATION CENTER	1948 LANDSTOWN CENTRE WAY VIRGINIA BEACH, VA 23456

(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 580	Continued From page 13	F 580		

(minimum data set) assessment was a five day scheduled assessment with an ARD (assessment reference date) of 2/21/19. Resident #82 was coded as being cognitively intact in the ability to make daily decisions scoring 15 out of possible 15 on the BIMS (Brief Interview for Mental Status) exam.

Review of Resident #82's most recent POS (physician order summary) revealed the following order: "Nitrofurantoin Macrocrystal (Macrobid) (1) 100 MG capsule; Give 1 capsule by mouth every 12 hours for ESBL UTI (urinary tract infection) for 7 days." The medication was ordered on 3/1/18.

Review of Resident #82's March 2019 MAR (medication administration record) revealed that Resident #82 missed her 9 am dose of Macrobid on 3/2/19 and 3/3/19.

The following note was documented for 3/2/19, "medication not available."
The following note was documented for 3/3/19, "med on order."

Review of the facility's STAT emergency medication list revealed that Macrobid 100 MG was in the STAT box.

Further review of Resident #82's clinical record failed to evidence that the physician was made aware of the two missed doses of Macrobid.

Review of the physician notes failed to evidence that the physician was made aware of the two missed doses of Macrobid.

On 3/14/19 at 10:46 a.m., an interview was conducted with RN (registered nurse) #1. When

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495418	A. BUILDING _____ B. WING _____	C 03/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRINCESS ANNE HEALTH & REHABILITATION CENTER	1948 LANDSTOWN CENTRE WAY VIRGINIA BEACH, VA 23456

(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 580	Continued From page 14	F 580		

asked the process if she were to administer a medication that was not in the medication cart, RN #1 stated that she would first check the STAT box and if the medication is not in the STAT box, she would order the medication STAT from pharmacy. RN #1 stated that she would then reschedule the medication for a different time. When asked if Macrobid was in the STAT box, RN #1 stated, "Yes, we have that in the STAT box." When asked if anyone was notified if the resident's medication was not available resulting in the resident missing their dose of medication, RN #1 stated that the physician should be notified. RN #1 stated that the physician may give a new order. When asked if it should be documented anywhere in the clinical record that the physician was notified, RN #1 stated that it should be documented in the nursing notes if the physician was notified. RN #1 stated that it looked like Resident #82 did not receive her full dose of Macrobid.

On 3/14/19 at 2:40 p.m., an interview was conducted with ASM (administrative staff member) #3, the physician assistant. ASM #3 stated that the nurses generally let her know if a resident did not receive medication. ASM #3 stated that she did not remember being notified of the missed antibiotic doses. ASM #3 stated that if she was made aware, she would have adjusted the administration dates on the antibiotics so that the resident received the full seven day course. ASM stated that she didn't think the missed doses of Macrobid would have made a difference either way because the same "bug" was found on a repeat culture.

On 3/14/19 several attempts were made to reach the nurses responsible for not administering

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495418	A. BUILDING _____ B. WING _____	C 03/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRINCESS ANNE HEALTH & REHABILITATION CENTER	1948 LANDSTOWN CENTRE WAY VIRGINIA BEACH, VA 23456

(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 580	Continued From page 15	F 580		

Macrobid. They could not be reached for an interview.

On 3/15/19 at 1:52 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the DON (Director of Nursing), and Corporate staff member #1 were made aware of the above concerns. A policy could not be provided on medication administration. A policy could not be provided on MD (medical doctor) notification.

In Potter and Perry's, Basic Nursing, Essential for Practice, 6th edition, pages 56-59 documents the following information: "Failure to monitor the patient's condition appropriately and communicate that information to the physician or health care provider are causes of negligent acts. The best way to avoid being liable for negligence is to follow standards of care, to give competent health care, and to communicate with other health care providers. The physician or health care provider is responsible for directing the medical treatment of a patient."

(1) Macrobid is an oral antibiotic widely used either short term to treat acute urinary tract infections or long term as chronic prophylaxis against recurrent infections. This information was obtained from The National Institutes of Health. https://livertox.nih.gov/Nitrofurantoin.htm.

3. For Resident #21, facility staff failed to notify the physician when she missed two doses of her scheduled eye drops on 3/1/19 and 3/5/19.

Resident #21 was admitted to the facility on 7/8/15 and readmitted on 6/16/17 with diagnoses that included but were not limited to high blood pressure, atrial fibrillation, macular degeneration,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495418	A. BUILDING _____ B. WING _____	C 03/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRINCESS ANNE HEALTH & REHABILITATION CENTER	1948 LANDSTOWN CENTRE WAY VIRGINIA BEACH, VA 23456

(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 580	Continued From page 16	F 580		

and osteoporosis. Resident #21's most recent MDS (minimum data set) assessment was an annual assessment with an ARD (assessment reference date) of 12/31/18. Resident #21 was coded as being cognitively intact in the ability to make daily decisions scoring 15 out of 15 on the BIMS (Brief Interview for Mental Status) exam.

On 3/13/19 at 2:36 p.m., a group interview was conducted with six residents. Resident #21 had stated that sometimes she does not receive her eye drops at night.

Review of Resident #21's most recent POS (physician order summary) revealed the following order:
"Xalatan Solution (1) 0.005% (percent) Instill 1 drop in right eye at bedtime for glaucoma."

Review of Resident #21's March 2019 MAR (medication administration record) revealed that Resident #21 had not received her Xalatan drops on 3/1/19 and 3/5/19. A "9" was coded on the MAR indicating "Other/See nurses notes."

Review of Resident #21's March 2019 nursing notes failed to evidence a note for 3/1/19. A note for 3/5/19 was found that documented the following: "...medication not on hand pharmacy notified."

There was no evidence in the clinical record that the physician was made aware of the two missed doses.

Review of Resident #21's comprehensive care plan dated 2/10/16, documented the following:
"The resident has impaired visual function r/t (related to) Macular degeneration, glaucoma per

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495418	A. BUILDING _____ B. WING _____	C 03/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRINCESS ANNE HEALTH & REHABILITATION CENTER	1948 LANDSTOWN CENTRE WAY VIRGINIA BEACH, VA 23456

(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 580	Continued From page 17 patient. Occasionally refuses eyelid cleanser...Interventions: eye drops as ordered." On 3/15/19 at 8:50 a.m., an interview was conducted with ASM (administrative staff member) #2, the DON (Director of Nursing). When asked what "9" meant on the MAR, ASM #2 stated that it looked like the eye drop wasn't given. ASM #2 agreed that she could not find a note for 3/1 but that the eye drop was not available from pharmacy on 3/5. On 3/15/19 at 9:30 a.m., an interview was conducted with LPN (licensed practical nurse) #6. When asked what "9" meant on the MAR, LPN #6 stated that the code "9" meant that the medication was not given. When asked how we would know why the 3/1/19 eye drop was not given if there is no note documenting the reason why it wasn't given, LPN #6 stated that we wouldn't know. LPN #6 stated that the reason for the missed eye drop on 3/1/19 should have been documented in the clinical record. LPN #6 stated that the physician should have also been notified for both eye drops missed and that a note should also be documented. On 3/15/19 at 12:25 p.m., an interview was conducted with OSM (other staff member) #8, the NP (nurse practitioner). OSM #8 stated that she could not recall being made aware about the missed eye drops. OSM #8 stated that the staff could have told her in passing but that she did not remember. On 3/15/19 at 1:52 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the DON (Director of Nursing), and Corporate staff member #1 were made aware of the above	F 580		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495418	A. BUILDING _____ B. WING _____	C 03/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRINCESS ANNE HEALTH & REHABILITATION CENTER	1948 LANDSTOWN CENTRE WAY VIRGINIA BEACH, VA 23456

(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 580	Continued From page 18 concerns. (1) Xalatan Solution is indicated for the reduction of elevated intraocular pressure in patients with open-angle glaucoma or ocular hypertension. This information was obtained from The National Institutes of Health. https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=f4e73059-5ba0-4d73-9ea1-09d8d654e844.	F 580		
F 585 SS=D	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the	F 585		4/29/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495418	A. BUILDING _____ B. WING _____	C 03/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRINCESS ANNE HEALTH & REHABILITATION CENTER	1948 LANDSTOWN CENTRE WAY VIRGINIA BEACH, VA 23456

(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 585	Continued From page 19 provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations; (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source,	F 585		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495418	A. BUILDING _____ B. WING _____	C 03/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRINCESS ANNE HEALTH & REHABILITATION CENTER	1948 LANDSTOWN CENTRE WAY VIRGINIA BEACH, VA 23456

(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 585	Continued From page 20 and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on resident interviews, staff interview, clinical record review, the facility staff failed to make prompt efforts to resolve a concern voiced by 1 of 57 residents in the survey sample (Resident #249). The facility staff failed to investigate and trouble shoot Resident #249's concerns about her Bipap machine. The findings included:	F 585	F585 1. Resident #249 is receiving Bipap therapy without concerns. 2. Residents receiving Bipap therapy were reviewed to ensure that there are no concerns. 3. Charge Nurses will be educated on: " Prompt investigation and trouble-shooting concerns regarding Bipap therapy 4. A registered nurse will complete a	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495418	A. BUILDING _____ B. WING _____	C 03/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRINCESS ANNE HEALTH & REHABILITATION CENTER	1948 LANDSTOWN CENTRE WAY VIRGINIA BEACH, VA 23456

(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 585	Continued From page 21 Resident #249 was originally admitted to the facility 2/27/19 and the resident has never been discharged from the facility. The current diagnoses included; a rise in arterial carbon dioxide respiratory failure, likely due to obstructive sleep apnea. The admission Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 3/6/19 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 15 out of a possible 15. This indicated Resident #249's cognitive abilities for daily decision making were intact. In section "G" (Physical functioning) the resident was coded as requiring set-up assistance with eating, limited assistance with personal hygiene, extensive assistance of one person with dressing and toileting, extensive assistance of two people with bed mobility and transfers and total care of one person with bathing. In section "O100G2" the resident was coded as utilizing a non-invasive mechanical ventilator (Bipap). The physician order summary revealed an order dated 3/5/19, for Bipap hour of sleep and as needed inspiratory pressure equals 18, expiratory pressure equals 10; at bedtime for acute hypercapnia with respiratory failure. The care plan dated 2/28/19, had a problem which read; the resident has altered respiratory status/difficulty breathing related to respiratory failure. The goal read; the resident will have no complications related to shortness of breath through the next review 3/15/19. The interventions included; Bipap settings inspiratory pressure equals 18, expiratory pressure equals	F 585	random weekly review of residents with Bipap therapy to ensure that there are no unresolved concerns. 5. Issues noted during the random weekly review will be presented to the Quality Assurance Committee for review and recommendation.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495418	A. BUILDING _____ B. WING _____	C 03/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRINCESS ANNE HEALTH & REHABILITATION CENTER	1948 LANDSTOWN CENTRE WAY VIRGINIA BEACH, VA 23456

(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 585	Continued From page 22 10; via full face every night and as needed. Monitor/document changes in orientation, increased restlessness, anxiety and air hunger. Oxygen settings via nasal prongs at one liter, continues. On 3/12/19, at approximately 12:35 p.m., an interview was conducted with Resident #249's responsible party and the resident. The responsible party stated her mother was hospitalized for the flu and suffered cardiac complications during the hospitalization which resulted in system failures. She stated one of the complications is the reason the resident is currently on the Bipap. The responsible party further stated there had been problems with the Bipap machine. Resident #249 stated after the mask is applied the nurse turns the machine on and the machine squeezes her face tightly and results in discomfort. She stated her son had spoken with the male nurse about the discomfort she experienced while on the Bipap and her son asked him to have the machine adjusted to make the mask more comfortable. The resident also stated her son told her it was extremely important for her to utilize the Bipap even if there was discomfort because when she didn't have sufficient oxygen in the hospital she was unable to answer questions appropriately and her speech didn't make sense. The responsible party also stated as you were coming in the man you met going out was someone from the Bipap company who came in and adjusted the settings. The responsible party then stated she was there because her mother often calls her by cell phone for when she uses the call bell for staff assistance she has to wait 30-60 minutes and sometimes more before help to arrives. The resident stated that her son gets off work at 12 midnight and he	F 585		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495418	A. BUILDING _____ B. WING _____	C 03/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRINCESS ANNE HEALTH & REHABILITATION CENTER	1948 LANDSTOWN CENTRE WAY VIRGINIA BEACH, VA 23456

(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 585	Continued From page 23 comes in nightly to check on her as well, especially to ensure they have started the Bipap. Another interview was conducted with Resident #249 on 3/14/19, at approximately 2:45 p.m., with the Assistant Director of Nursing present. Resident #249 told the Assistant Director of Nursing that the Bipap machine was leaking a large amount of water over night and it caused her top to be saturated by morning when the nurse removed the mask at approximately 6:00 a.m. A final interview was conducted with Resident #249 on 3/15/19, at approximately 11:10 a.m., with the Unit Manager present. The resident stated; I will not lie to you, I thought I was going to die. My birthday and my great grandson's birthday is in 6 days and I didn't think I would live to see it. She further stated last night the nurse came in, turned the Bipap machine on and it began to make a funny noise so she turned it off and didn't apply the mask. My son cam in about 1 a.m. and said, mom you didn't put your mask on, you have got to wear the mask when you are in bed. He went and got the nurse and she came in and applied the mask and turned the machine on, and finally my son left. Resident #249 stated over the night a lot of water leaked onto her top, then it began to collect in the mask, she stated she prayed and prayed until she fell asleep and she woke up about 6 a.m. and water was all over her face and she feared she would drown like her brother had, she stated I'm afraid of a lot of water. She further stated she reached for her call bell but it hadn't been clipped to her clothing as usual therefore; it had fallen to the floor at some point during the night. The resident stated she had no idea how she got the strength but, she was able	F 585		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495418	A. BUILDING _____ B. WING _____	C 03/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRINCESS ANNE HEALTH & REHABILITATION CENTER	1948 LANDSTOWN CENTRE WAY VIRGINIA BEACH, VA 23456

(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 585	Continued From page 24 to pull herself up to a sitting position and the water that was all over her face ran down on her top and the water which pooled in the mask moved away from her nose and mouth. She stated she remain seated on the side of the bed until the nurse came in about 7 a.m., removed the mask and turned the Bipap off. The resident stated the Bipap was a new device for her and she doesn't know anything about it, including how to remove it. On 3/15/19, at approximately 2:20 p.m., an interview was conducted by phone with a representative from the respiratory company. He stated if the settings are provided prior to delivery they will program the Bipap machine and even upon delivery they can program the machine if they are aware of the settings otherwise the facility staff told the company they had a person knowledgeable in programming the machines. The respiratory company representative also stated most of their machines are auto setting machines which means when the mask is properly sealed and the machine is turned on and the resident breaths it will interpret the data and self adjust. The representative stated the technician who came in 3/12/19 was there to adjust the setting on the machine based on a request received from the facility staff. The company representative stated he completed an inservice with the facility staff, the documentation the facility provided revealed the in-service was 1/24/19, at 11:30 a.m. The Cpap/Bipap in-service record stated there was hands on instruction, demonstration and explanation of the set-up and function. The persons in-serviced all worked from 7:00 a.m. - 3:00 p.m. or 8:00 a.m. - 5:00 p.m. The respiratory representative stated most likely if there was	F 585		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495418	A. BUILDING _____ B. WING _____	C 03/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRINCESS ANNE HEALTH & REHABILITATION CENTER	1948 LANDSTOWN CENTRE WAY VIRGINIA BEACH, VA 23456

(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 585	Continued From page 25 water leakage the facility staff had overfilled the reservoir above the fill line, the humidifier isn't seated, tubing is properly connected and other connection problems. The Assistant Director of Nursing stated 3/15/17 at approximately 6:00 p.m., the respiratory company was not coming back to the facility to troubleshoot the Bipap machine. The documentation from the resident's concern voiced to the Unit Manager was requested at approximately 3/15/19, at approximately 5:50 p.m. The Director of Nursing stated there was no documentation of the conversation.	F 585		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.	F 609		4/29/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495418	A. BUILDING _____ B. WING _____	C 03/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRINCESS ANNE HEALTH & REHABILITATION CENTER	1948 LANDSTOWN CENTRE WAY VIRGINIA BEACH, VA 23456

(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 609	Continued From page 26 §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on a complaint investigation, clinical record review, staff interviews and facility documentation, the facility staff failed to ensure reporting requirements were met for 2 of 57 residents (Resident #197 & #148) in the survey sample. 1. The facility staff failed to report to the State Survey Agency an allegation of neglect for Resident #197. 2. The facility staff failed to immediately report an allegation of abuse for Resident #147 to the State Survey Agency, and report the results of the investigation to the State Survey Agency within (5) five working days of the incident. The findings include: 1. Resident #197 was admitted to the facility on 8/22/18 with diagnoses that included Parkinson's disease, generalized muscle weakness, osteoarthritis and chronic pain syndrome. The resident was discharged on 8/29/18 and did not return to the nursing facility. The most recent Minimum Data Set (MDS) assessment prior to discharge on 8/29/18 was a 5 day assessment. The MDS coded the resident	F 609	F609 1. Resident #197 was discharged home 8/29/18 and #148 discharged home on 11/17/18. 2. Reports of neglect or abuse are being reported in a timely matter as allegations are received. 3. Charge Nurses will be educated on: " Mandated reporting "Completing a service concern form 4. DON will ensure allegations of abuse or neglect are reported timely. The Administrator will review service concerns on a weekly basis. 5. Issues noted during the random weekly review will be presented to the Quality Assurance Committee for review and recommendation.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495418	A. BUILDING _____ B. WING _____	C 03/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRINCESS ANNE HEALTH & REHABILITATION CENTER	1948 LANDSTOWN CENTRE WAY VIRGINIA BEACH, VA 23456

(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 609	Continued From page 27 with a score of 15 out of a possible score of 15 on the Brief Interview for Mental Status (BIMS) which indicated the resident was intact with the necessary skills for daily decision making. Upon review of the nurse's notes dated 8/28/18 at 1:30 a.m., Resident #197's change in condition during the 3 p.m.-11 p.m. shift resulted in transfer to the local Emergency Department (ED) and admission to local hospital. On 3/13/19 at 12:00 p.m. an interview was conducted with the 3-11 shift Registered Nurse (RN) #1. She stated the resident was brought back to the 300 Unit where he resided by the Licensed Physical Therapy Assistant (LPTA) #1 around 3:00 p.m. on 8/28/18 because the patient was hallucinating. LPTA #1 presented a statement to this surveyor that it was mid morning on 8/28/18 when he remembered bring the resident back to his unit and informed the nurse the resident demonstrated increased confusion and inability to follow commands. RN #1 stated Resident #197 was not eating his dinner and was not himself. She stated completed an SBAR (Situation/Background/Assessment/Recommend ations) report with information to report to the physician related to a change in the resident's condition. The SBAR report detailed the RN assessment to include vital signs and a narrative of the change in condition. The report also indicated some evidence of a GI bleed; stool mixed mucous red colored material. Physician's orders where obtained for a complete blood count (CBC), complete metabolic panel (CMP), urine analysis (UA) with a culture and sensitivity (C&S). The nurse's notes indicated the resident was extremely lethargic during the 3/11 shift. The physician was called with an update at 10:20 p.m.	F 609		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495418	A. BUILDING _____ B. WING _____	C 03/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRINCESS ANNE HEALTH & REHABILITATION CENTER	1948 LANDSTOWN CENTRE WAY VIRGINIA BEACH, VA 23456

(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 609	Continued From page 28 and orders to obtain vital signs every two hours, continue to monitor. The nurse's notes dated 8/29/18 30 minutes after midnight, the resident was arousable but unable to follow simple commands, he was twitching, his temperature was 101.2 (F), but the resident was not able to follow simple commands to swallow Tylenol to treat the temperature per physician's order and there was blood in the stool. The physician was called on 8/29/18 at 1:00 a.m. with this recent physical assessment and orders to send out immediately for evaluation. The resident was sent out to the local ED for evaluation. He was evaluated and admitted to the hospital with a primary diagnoses of *sepsis colitis with suspected Clostridium Difficile (C. Diff) and *acute cysitis. *Sepsis colitis with C. Diff bacteria cause inflammation of the gut or colon-colitis. This can lead to moderate-to-severe diarrhea, and sometimes to sepsis, which can develop as the body tries to fight the infection (https://www.ncbi.nlm.nih.gov/pubmed/27617672) . *Acute cystitis is an infection of the bladder or lower urinary tract (https://www.ncbi.nlm.nih.gov/books/NBK459322/) The Assistant Director of Nursing (ADON) joined the above interview on 3/13/19 at 12:45 p.m. He stated the resident's wife came to the facility two days later and was concerned that the nursing staff did not care for the resident as they should have throughout the shift and did not get him to the hospital until after 1:00 a.m. on 8/29/18. On 3/13/19 at 1:10 p.m., an interview was	F 609		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495418	A. BUILDING _____ B. WING _____	C 03/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRINCESS ANNE HEALTH & REHABILITATION CENTER	1948 LANDSTOWN CENTRE WAY VIRGINIA BEACH, VA 23456

(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 609	Continued From page 29	F 609		

conducted with the Administrator, the Director of Nursing (DON), ADON and RN #1. The Administrator stated the Resident Representative (RR) did come to the facility on 8/29/18 with concerns that Resident #197 was not promptly provided the proper care prior to being sent out to the hospital on 8/29/18 at approximately 1:00 a.m. The Administrator stated she fully investigated the RR's concerns and concluded the staff acted in accordance with the facility's policy and procedures to provide appropriate care, but she did not think the allegations lodged by the RR indicated she thought the staff neglected Resident #197. She stated Adult Protective Services (APS) came and met with her to investigate the same concerns as the RR, but she could not remember the date of APS' visit.

On 3/14/19 at 11:00 a.m., a telephone interview was conducted with the APS investigator that met with the Administrator on 9/6/18. She stated she informed the Administrator that she would be opening a case for neglect.

During the debriefing on 3/15/19 at 4:48 p.m. the aforementioned issue was reviewed again with the Administrator, DON and the Regional Nurse Consultant. It was determined that they failed to take two opportunities to send a Facility Reported Incident (FRI) to the State survey and certification agency based on the RR (8/29/18) and APS (9/6/18) allegations of neglect of care and services for Resident #197. No further information was provided prior to survey exit.

The facility's policy and procedure titled the Abuse/Neglect/Misappropriation/Crime dated 11/4/16 indicated the Administrator would ensure timely reporting, investigating, and follow-up

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495418	A. BUILDING _____ B. WING _____	C 03/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRINCESS ANNE HEALTH & REHABILITATION CENTER	1948 LANDSTOWN CENTRE WAY VIRGINIA BEACH, VA 23456

(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 609	Continued From page 30 reporting of incidents of alleged/suspected patient abuse, neglect, mistreatment, exploitation, injuries of unknown origin, misappropriation of personal property, or crime against a patient to the State agency and any other appropriate authorities immediately but no later than 2 hours after the allegation is made, if the events that caused the allegation involves abuse or results in serious bodily injury, or not later than 24 hours if the events that caused the allegation do not involve abuse and do not result in bodily injury. 2. Resident #148 was admitted to the facility on 8/18/18 with diagnoses of Cerebral infarction, hemiplegia and hemiparesis history of dysphagia, hyperlipidemia, depression and hypertension. A Facility Reported Incident (FRI) form dated 10/11/18 Indicated: Name of the the State Survey Agency and the office and fax number. The form indicated the facility name the report date of 10/11/18 and the Incident date: 10/10/18. The form included the Resident's name (Resident #148) Injuries, No. In the area titled Incident Type-Allegation of abuse/mistreat was checked. Describe incident, including location, and action taken: "Patient alleged that CNA "abused" her when she went to the ER for an X-ray of her shoulder yesterday." Name of employee involved and their position given. Employee action initiated or taken: removed from her assignment. Date notification provided to: Responsible Party-Self Physician : 10/10/18 APS 10/11/18 (1827) DHP 10/11/18 (1827) Law Enforcement (N/A)	F 609		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495418	A. BUILDING _____ B. WING _____	C 03/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRINCESS ANNE HEALTH & REHABILITATION CENTER	1948 LANDSTOWN CENTRE WAY VIRGINIA BEACH, VA 23456

(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 609	Continued From page 31 Facility internal investigation: Completed on 10/12- Is attached-Yes Name & Title of Reporting Person: signed by Director of Nursing A Fax Cover letter dated 10/12/18 indicated: To:-DHP/APS-From: Director of Nursing Fax numbers: pages 1 Phone: blank - Dates: 10/12/18 Re: FRI Resident #148 - cc: blank Comments: Conclusion (1) Faxed DHP/APS 10/12 conclusion (2) Staff from APS called 10/15- considered "invalid" it was improper transfer. A Fax Confirmation letter dated 10/11/18 indicated: Fax-To: APS/DHP From: Director of Nursing Fax numbers given: - pages 2 Date: 10/11 Re: FRI . A Scan Device Details indicated: Scanned at: Thur Oct 11 18:27:34 2018 Submitted at: Thur Oct 11 18:27:35 2018 Completed at Thur Oct 11 18:27:40 2018. During an interview on 3/15/19 at 3:15 P.M. with the Director of Nursing she stated, she had submitted the Facility Reported Incident report timely to the State Survey Agency. After review the documents as presented with the DON she stated, I did not submit the FRI to the State Survey Agency. A facility policy indicated "Policy- The Administrator will ensure the timely reporting, investigating and follow up reporting of incidents of alleged/suspected patient abuse, neglect, mistreatment, exploitation, or crime against a	F 609		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495418	A. BUILDING _____ B. WING _____	C 03/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRINCESS ANNE HEALTH & REHABILITATION CENTER	1948 LANDSTOWN CENTRE WAY VIRGINIA BEACH, VA 23456

(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 609	Continued From page 32 patient to the State Agency and any other appropriate authorities. Procedures: (1)-Immediately upon notification of any alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of unknown source and misappropriation of resident property, the Administrator will immediately report to the State Agency, but not later than 2 hours after the allegation is made, if the events that caused the allegation involves abuse or results in serious bodily injury, or not later than 24 hours if the events that caused the allegation do not involve abuse and do not result in serious bodily injury. (5). The Administrator must thoroughly investigate and file a complete written report of the investigation of the submitted FRI to the State Survey Agency within five (5) working days of the incident."	F 609		
F 625 SS=E	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;	F 625		4/29/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495418	A. BUILDING _____ B. WING _____	C 03/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRINCESS ANNE HEALTH & REHABILITATION CENTER	1948 LANDSTOWN CENTRE WAY VIRGINIA BEACH, VA 23456

(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 625	Continued From page 33 (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on staff interviews, facility documentation review and clinical record review the facility staff failed send a copy of the Bed-Hold Policy for 5 of 57 resident's (Resident #26, 40, 70, 49 and 300) after being transferred to the hospital. 1. The facility staff failed to provide the resident or resident's representative with a written copy of the bed hold policy for Resident #26 upon discharge to the hospital on 12/07/18. 2. The facility staff failed to provide the resident or resident's representative with a written copy of the bed hold policy for Resident #40 upon discharge to the hospital on 11/18/18. 3. The facility staff failed to ensure Resident #70 was issued a written notice of the bed hold policy upon transfer to the local hospital/emergency department (ED) on 12/29/18 and 2/3/19. 4. The facility staff failed to ensure that Resident #49 received a written notice of the facility	F 625	F625 1. Residents #26, 40, 70, 49, and 300 are current residents. 2. Residents discharging to the hospital or for therapeutic leave will receive a written copy of the Bed-Hold Policy. 3. Charge Nurses will be educated on: " Provision of written copy of Bed-Hold Policy to residents being discharged to the hospital or therapeutic leave " Documentation of provision of the written Bed-Hold Policy 4. Administrative staff will complete a random weekly review of residents discharged to the hospital or therapeutic leave to ensure that a written copy of the Bed-Hold Policy was given to the resident or resident□s representative. 5. Issues noted during the random weekly review will be presented to the Quality Assurance Committee for review and recommendation.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495418	A. BUILDING _____ B. WING _____	C 03/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRINCESS ANNE HEALTH & REHABILITATION CENTER	1948 LANDSTOWN CENTRE WAY VIRGINIA BEACH, VA 23456

(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 625	Continued From page 34 Bed-Hold policy upon transfer to the hospital on 1/7/19. 5. The facility staff failed to ensure that Resident #300 received a written notice of the facility Bed-Hold policy upon transfer to the hospital on 1/24/19. The findings included: 1. Resident #26 was admitted to the facility on 10/10/18. Diagnosis for Resident #26 included but not limited to Chronic Obstructive Pulmonary Disease (COPD.) The current Minimum Data Set (MDS), a 14-day assessment with an Assessment Reference Date (ARD) of 01/07/19 coded the resident with a 09 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 12/07/18-discharge return anticipated; re-admitted to the facility on 12/24/19. On 12/07/18, according to the facility's documentation, Resident #26 was transferred to the local hospital for change in mental status. An interview was conducted with the Admission Director on 03/13/19 at approximately 11:24 a.m., who stated, "I am not always here so I would not be able to send the bed hold policy with a resident that is being transferred out to the hospital." The surveyor asked, "Who is responsible for sending the bed hold policy when a resident is being discharged to the hospital" she replied, "Check with nursing."	F 625		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495418	A. BUILDING _____ B. WING _____	C 03/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRINCESS ANNE HEALTH & REHABILITATION CENTER	1948 LANDSTOWN CENTRE WAY VIRGINIA BEACH, VA 23456

(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 625	Continued From page 35 An interview was conducted with License Practical Nurse (LPN) #4 on 03/14/19 at approximately 12:20 p.m., who stated, "I am not sure what a bed hold policy is." On 03/14/19 at approximately 12:23 p.m., and interview was conducted with the Assistant Director of Nursing (ADON) who stated, "That is something I'm not really sure; I don't think we are sending the bed hold policy when a resident has been discharged out the hospital." On 03/15/19 at approximately 10:24 a.m., an interview was conducted with the Admissions Director. She stated, "The admission department does a follow up with the resident after their discharge but we do not issue a bed hold notice." The facility administration was informed of the finding during a briefing on 03/15/18 at approximately 4:45 p.m. The facility did not present any further information about the findings. 2. Resident #40 was re-admitted to the facility on 01/21/19. Diagnosis for Resident #26 included but not limited to Chronic Obstructive Pulmonary Disease (COPD.) The current Minimum Data Set (MDS), a significant change with an Assessment Reference Date (ARD) of 01/07/19 coded the resident with a 15 out of a possible score of 15 on the Brief Interview for Mental Status (BIMS) indicating no cognitive impairment. The Discharge MDS assessments was dated for 11/18/18-discharge return anticipated; re-admitted to the facility on 01/21/19.	F 625		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495418	A. BUILDING _____ B. WING _____	C 03/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRINCESS ANNE HEALTH & REHABILITATION CENTER	1948 LANDSTOWN CENTRE WAY VIRGINIA BEACH, VA 23456

(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 625	Continued From page 36 On 11/18/18, according to the facility's documentation, Resident #40 was found with shortness of breath (SOB), lethargic and respiratory rate of 22 with abnormal rise and fall of the chest. An interview was conducted with the Admission Director on 03/13/19 at approximately 11:24 a.m., who stated, "I am not always here so I would not be able to send the bed hold policy with a resident that is being transferred out to the hospital." The surveyor asked, "Who is responsible for sending the bed hold policy when a resident is being discharged to the hospital" she replied, "Check with nursing." An interview was conducted with License Practical Nurse (LPN) #4 on 03/14/19 at approximately 12:20 p.m., who stated, "I am not sure what a bed hold policy is." On 03/14/19 at approximately 12:23 p.m., and interview was conducted with the Assistant Director of Nursing (ADON) who stated, "That is something I'm not really sure; I don't think we are sending the bed hold policy when a resident has been discharged out the hospital." On 03/15/19 at approximately 10:24 a.m., an interview was conducted with the Admissions Director. She stated, "The admission department does a follow up with the resident after their discharge but we do not issue a bed hold notice." The facility administration was informed of the finding during a briefing on 03/15/18 at approximately 4:45 p.m. The facility did not present any further information about the findings.	F 625		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495418	A. BUILDING _____ B. WING _____	C 03/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRINCESS ANNE HEALTH & REHABILITATION CENTER	1948 LANDSTOWN CENTRE WAY VIRGINIA BEACH, VA 23456

(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 625	Continued From page 37 3. Resident #70 was admitted to the nursing facility on 8/15/15 with diagnoses that included osteoarthritis, Alzheimer's disease, and hemiplegia and hemiparesis post stroke. The most recent Minimum Data Set (MDS) assessment was dated 2/13/19 and coded the resident with a 4 out of a possible score of 15 on the Brief Interview for Mental Status (BIMS) which indicated the resident was severely impaired in the skills needed for daily decision making. Resident #70 was discharged to the local hospital on 12/29/18 and 2/3/19. There was no documentation in the clinical record that indicated a bed hold notice was issued to the resident at the time of this transfer. On 3/15/19 at 10:30 a.m., the Director of Admissions stated she did not issue bed hold notices at the time of discharge, but did follow-up calls after discharge to acquire bed hold needs. She stated it would be a nursing intervention to issue the bed hold notices at the time of discharge and document the action in the clinical record. On 3/15/19 at 4:00 p.m., the Administrator stated she was not able to provide documentation that the bed hold notices were sent out with the resident at discharge. She also stated she did not have a facility policy or procedure on the process of issuing bed hold notices at the time of discharge from the facility. On 3/15/19 at 4:48 p.m., a final debriefing was held with the Administrator, the Director of Nursing (DON) and the Regional Nurse	F 625		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495418	A. BUILDING _____ B. WING _____	C 03/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRINCESS ANNE HEALTH & REHABILITATION CENTER	1948 LANDSTOWN CENTRE WAY VIRGINIA BEACH, VA 23456

(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 625	Continued From page 38 Consultant (RNC). No further information was provided prior to survey exit. 4. Resident #49 was a 46 year old admitted to the facility originally on 12/28/18 and was readmitted on 1/11/19 with diagnoses to include but not limited to *Fusion of the Spine and *Acute Embolism. The most recent comprehensive Minimum Data Set (MDS) was an Admission 5 day with an Assessment Reference Date (ARD) of 1/18/19. The Brief Interview for Mental Status was coded as a 15 out of a possible 15 which indicated Resident #49 was cognitively intact and capable of daily decision making. A review of Resident #49's MDS's revealed an Unplanned Discharge Assessment-return anticipated with an ARD dated of 1/7/19 and an Entry Assessment with an ARD date of 1/11/19. On 3/12/19 during the initial facility tour Resident #49 was interviewed and stated that she had went back to the hospital in January because a blood clot had formed in her cervical area from her surgery and she was having increased numbness and tingling in her hands and arms. Resident #49's Progress Notes were reviewed and are documented in part, as follows: 1/7/19 8:55 AM: Transfer to ED (emergency department) for evaluation regarding recent C-Spine operation with Epidural hematoma-progressive (NEW) left arm weakness. 1/7/19 10:08 AM Change of Condition SBAR (Situation, Background, Assessment Recommendation)	F 625		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495418	A. BUILDING _____ B. WING _____	C 03/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRINCESS ANNE HEALTH & REHABILITATION CENTER	1948 LANDSTOWN CENTRE WAY VIRGINIA BEACH, VA 23456

(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 625	Continued From page 39 Situation: Pain uncontrolled, this started on 1/7/19 during the morning. Recommendation: transfer to ED (emergency department) for evaluation. 1/11/19 16:44 PM (4:44) Admission Summary: An Admission Assessment has been completed. The Resident arrived from hospital. Resident #49's Nursing Home to Hospital Transfer Form dated 1/7/19 was reviewed and is documented in part, as follows: Reasons for transfer: Other-Left arm numbness and weakness, On 3/13/19 at approximately 6:05 PM an interview was conducted with the Director of Nursing regarding bed-holds. The Director of Nursing was asked if the floor nurses send a copy of the bed-hold policy with the resident upon transfer to the hospital. The Director of Nursing stated, "No, the nurses don't send the bed-holds when the resident's go to the hospital they just send the care plan. Admissions call the next day and discuss the bed-holds with the resident or families." On 3/15/19 at approximately 11:30 AM a pre-exit de-briefing was held with the Administrator, the Director of Nursing and the Regional Nurse Consultant were the above information was shared. Prior to exit no further information was provided. 5. Resident #300 was an 83 year old admitted to the facility originally on 2/14/19 and re-admitted	F 625		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495418	A. BUILDING _____ B. WING _____	C 03/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRINCESS ANNE HEALTH & REHABILITATION CENTER	1948 LANDSTOWN CENTRE WAY VIRGINIA BEACH, VA 23456

(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 625	Continued From page 40 on 3/1/19 with diagnoses to include but not limited too *End Stage Renal Disease, *Dependence on Renal Dialysis and *Hypertension. The most recent comprehensive Minimum Data Set (MDS) was an Admission 5 day with an Assessment Reference Date (ARD) of 3/8/19. The Brief Interview for Mental Status was coded as a 15 out of a possible 15 which indicates Resident #300 is cognitively intact and capable of daily decision making. A review of Resident #300's MDS's revealed an Unplanned Discharge Assessment-return anticipated with an ARD dated of 2/24/19 and an Entry Assessment with an ARD date of 3/1/19. On 3/12/19 during the initial facility tour Resident #300 was interviewed and stated that she had went to the hospital at the end of February for a few days. Resident #300's Progress Notes were reviewed and are documented in part, as follows: 2/24/19 18:02 PM (6:02) Change of Condition SBAR (Situation, Background, Assessment Recommendation) Situation: Chest pain, this started on 2/24/19 during the afternoon. Recommendation: send to ER (emergency room) for evaluation. 2/25/19 6:39 AM: Pt. (patient) admitted with diagnosis of Colitis and UTI (urinary tract infection). 3/1/19 21:10 PM (9:10) Admission Summary: An Admission Assessment has been completed.	F 625		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495418	A. BUILDING _____ B. WING _____	C 03/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRINCESS ANNE HEALTH & REHABILITATION CENTER	1948 LANDSTOWN CENTRE WAY VIRGINIA BEACH, VA 23456

(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 625	Continued From page 41 The Resident arrived from hospital. The reason for the admission per the resident/POA (power of attorney) is Colitis. Resident #300's Nursing Home to Hospital Transfer Form dated 2/24/19 was reviewed and is documented in part, as follows: Reasons for transfer: Chest Pain On 3/13/19 at approximately 6:05 PM an interview was conducted with the Director of Nursing regarding bed-holds. The Director of Nursing was asked if the floor nurses send a copy of the bed-hold policy with the resident upon transfer to the hospital. The Director of Nursing stated, "No, the nurses don't send the bed-holds when the resident's go to the hospital they just send the care plan. Admissions call the next day and discuss the bed-holds with the resident or families." The facility policy titled "Bed Reserve" effective date 2/5/15 was reviewed and is documented in part, as follows: Policy: The Health and Rehabilitation Center charges the prevailing room rate for any bed reservation arrangement whenever a patient is not in the Health and Rehabilitation Center for the day or when reserving a bed for in-house transfer. Procedure: 3. Hospitalization/Observation: Medicare and Medicaid programs do not pay to hold beds in the Health and Rehabilitation Center when a patient is hospitalized overnight. Consequently, whenever any patient is transferred from the	F 625		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495418	A. BUILDING _____ B. WING _____	C 03/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRINCESS ANNE HEALTH & REHABILITATION CENTER	1948 LANDSTOWN CENTRE WAY VIRGINIA BEACH, VA 23456

(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 625	Continued From page 42 Health and Rehabilitation Center and is admitted for overnight hospitalization/observation, the patient or the responsible representative must pay to hold the bed if the patient wishes to ensure that he/she can return to the bed he/she has been occupying. To make this arrangement the patient and/or responsible representative must (1) promptly complete and sign a formal "Voluntary Bed Retention Agreement" and (2) provide private payment to the Health and Rehabilitation Center for the requested days. This arrangement can be made at the time of transfer, or by the close of the business day on which the hospitalization occurs, but no later than 10:00 a.m. on the day following the hospitalization. On 3/15/19 at approximately 11:30 AM a pre-exit de-briefing was held with the Administrator, the Director of Nursing and the Regional Nurse Consultant were the above information was shared. Prior to exit no further information was provided.	F 625		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on clinical record review and staff interview, the facility staff failed to accurately code the MDS (Minimum Data Set) for one resident (Resident #97) in the survey sample of 57 residents. The finding included:	F 641	F641 1. Resident #97□s discharge MDS was modified on 3/15/19 to reflect the correct discharge information. 2. A review of all current discharge MDS dispositions has been done. 3. MDS department will be educated on: " Entering correct discharge MDS with	4/29/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495418	A. BUILDING _____ B. WING _____	C 03/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRINCESS ANNE HEALTH & REHABILITATION CENTER	1948 LANDSTOWN CENTRE WAY VIRGINIA BEACH, VA 23456

(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 641	Continued From page 43 Resident #97 was originally admitted to the facility on 10/16/2018 and discharged from the facility on 12/12/2018. A closed record review was conducted. The diagnoses were Hypertension, Type 2 diabetes Mellitus, Muscle Weakness, Peripheral Vascular Disease and acute kidney disease. Resident #97 had a discharge MDS assessment completed with an ARD of 12/12/18. It coded the resident completing the Brief Interview For Mental Status with a score of 15. The 12/12/18 discharge assessment MDS at section "A" Identification Information was coded as follows: A2100-Resident having a discharge status as "Acute Hospital" however the resident was discharged to the community. A review of nursing notes revealed that resident #97 was discharged home with her husband on 12/12/18. A review of the activities note stated resident discharged from skilled nursing facility on 12/12/18 with return not anticipated. On 03/15/19 at approximately 3:52 PM, the MDS Coordinator was asked to review the MDS section "A" concerning resident discharge. The MDS Coordinator (Registered Nurse #3) stated the resident was sent to the hospital as coded on the MDS. She referred to the nursing notes in the clinical record which stated resident #97 was discharged from the facility to go home. The MDS Coordinator (Registered Nurse #3) verified MDS discrepancy and stated that she would do	F 641	correct disposition " Modifying an MDS if done incorrectly 4. A registered nurse will complete a random weekly review of all discharge MDSs to confirm the correct disposition. 5. Issues noted during the random weekly review will be presented to the Quality Assurance Committee for review and recommendation.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495418	A. BUILDING _____ B. WING _____	C 03/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRINCESS ANNE HEALTH & REHABILITATION CENTER	1948 LANDSTOWN CENTRE WAY VIRGINIA BEACH, VA 23456

(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 641	Continued From page 44 an MDS modification. On 03/15/19 at approximately 4:48 PM the above findings were shared with the Administrator, Nurse Consultant and The Director Of Nursing. No comments were voiced. On 03/15/19 at approximately 6:00 PM, the MDS Coordinator presented the Modified MDS to the surveyor. Section A2100 states that resident was discharged to the community.	F 641		
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan-	F 655		4/29/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495418	A. BUILDING _____ B. WING _____	C 03/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRINCESS ANNE HEALTH & REHABILITATION CENTER	1948 LANDSTOWN CENTRE WAY VIRGINIA BEACH, VA 23456

(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 655	Continued From page 45 (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on a family interview, staff interview, clinical record review, and review of the facility's policy the facility staff failed to provide the resident representative of their initial plan for delivery of care and services for 1 of 57 residents (Resident #248), in the survey sample. The facility's staff failed to provide Resident 248's resident representative with a written summary of the baseline care plan. The findings included: Resident #248 was originally admitted to the facility 3/4/19 and had never been discharged from the facility. The current diagnoses included; dementia with Lewy bodies. The admission Minimum Data Set (MDS)	F 655	F655 1. Resident #248 was discharged from the facility on 3/27/19. 2. Resident representatives will receive a copy of the resident□s initial plan of care for delivery of care and services. 3. Charge Nurses will be educated on: " Provision of copy of the resident□s initial plan of care for delivery of care and services to the resident□s representative " Documentation of provision of the initial plan of care 4. A Registered Nurse will complete a random weekly review of provision of the initial plan of care. 5. Issues noted during the random weekly review will be presented to the Quality Assurance Committee for review and recommendation.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495418	A. BUILDING _____ B. WING _____	C 03/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRINCESS ANNE HEALTH & REHABILITATION CENTER	1948 LANDSTOWN CENTRE WAY VIRGINIA BEACH, VA 23456

(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 655	Continued From page 46 assessment with an assessment reference date (ARD) of 3/11/19 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 1 out of a possible 15. This indicated Resident #248's cognitive abilities for daily decision making were severely impaired. The resident was coded in section "D" (Mood) as having trouble concentrating and being fidgety or restless nearly every day. In section "E" (Behaviors) the resident was coded to exhibit physical behaviors directed towards other which put the resident at significant risk for injury, significantly interfered with the resident's care and significantly interfered with the resident's participation in activities or social interactions. In section "G" (Physical functioning) the resident was coded as requiring extensive assistance of one person with eating, extensive assistance of two people with bed mobility, transfers, dressing, toileting, personal hygiene and total care of two people with bathing. An interview was conducted with Resident #248's responsible party on 3/12/19 at approximately 6:05 p.m. The responsible party stated she felt the facility's staff lacked knowledge in caring for resident's with dementia. She stated there are usually 3 staff providing care to the resident and it frightens him because they handle him roughly and bounce him around. She further stated the resident lacks the ability to utilize a call bell and on one occasion he attempted to walk to the bathroom which resulted in a fall with stool being smeared about the room and 6 staff members transferring him from the floor to the bed. She also stated the staff's lack of technique in caring for the dementia resident has resulted in the resident striking out and grabbing the staff related to not understanding what's occurring. The	F 655		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495418	A. BUILDING _____ B. WING _____	C 03/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRINCESS ANNE HEALTH & REHABILITATION CENTER	1948 LANDSTOWN CENTRE WAY VIRGINIA BEACH, VA 23456

(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 655	Continued From page 47 responsible party stated she had not been included in planning the resident's care, offering strategies for care for the resident or simply sharing with the staff what she had ascertained worked well with the resident therefore; she made an executive decision to hire private sitters to ensure the resident's safety. Resident #248's responsible party stated the facility staff had not provided her with a plan developed within his first 48 hours in the facility which summarized their plan for services and neither had they made any attempts to communicate with her. The responsible party stated communication was only initiated when she sought the staff out. An interview was conducted with the Assistant Director of Nursing on 3/15/18, at approximately 4:25 p.m., Assistant Director of Nursing stated he didn't attend Resident #248's "Jump Start" meeting and he had no knowledge of who represented nursing for the meeting. He recommended I speak to the MDS Coordinator. An interview was conducted with the MDS Coordinator, on 3/15/19 at approximately 4:35 p.m. The MDS Coordinator stated they don't write the baseline care plans for it is the direct care nurse's responsible. The MDS Coordinator also stated the resident's interdisciplinary care plan meeting had not been conducted at that time. An interview was conducted with the Unit Manager on 3/15/19 at approximately 4:55 p.m. The Unit Manager stated the base line care plan was developed but she wasn't aware a copy of the summary should be given to the resident and/or responsible party.	F 655		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495418	A. BUILDING _____ B. WING _____	C 03/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRINCESS ANNE HEALTH & REHABILITATION CENTER	1948 LANDSTOWN CENTRE WAY VIRGINIA BEACH, VA 23456

(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 655	Continued From page 48 A copy of the baseline care plan was not provided. On 3/15/19 at approximately 7:00 p.m., the above findings were shared with the Administrator, Director of Nursing and Corporate Consultant. An opportunity was given for the facility to present additional information but none was provided. The Corporate Consultant stated there was no regulation concerning the "Jump Start" meeting for it was a meeting specific to the corporation. The facility's staff were informed the requirement wasn't about the "Jump Start" meeting, it was if the facility provided a summary of the baseline care plan to the resident representative. The facility's policy titled Care Planning, dated 11/28/17 read; The computerized baseline care plan is initiated and activated within 48 hours. The Center will provide the patient and representative(s) with a summary of the baseline care plan that includes, but is not limited to the initial goals of the patient, a summary of the patient's medications list, the patient's dietary instructions, and any services and treatments to be administered by the Center, personnel acting on behalf of the Center and any updated information based on the details of the comprehensive care plan.	F 655		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and	F 656		4/29/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495418	A. BUILDING _____ B. WING _____	C 03/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRINCESS ANNE HEALTH & REHABILITATION CENTER	1948 LANDSTOWN CENTRE WAY VIRGINIA BEACH, VA 23456

(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 656	Continued From page 49 §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, and clinical record review, it was	F 656	F656 1. Resident #42 was discharged on	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495418	A. BUILDING _____ B. WING _____	C 03/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRINCESS ANNE HEALTH & REHABILITATION CENTER	1948 LANDSTOWN CENTRE WAY VIRGINIA BEACH, VA 23456

(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 656	Continued From page 50 determined that facility staff failed to implement/develop a comprehensive care plan for one (1) of 57 residents in the survey sample, Resident #42 and #75. 1. For Resident #42, facility staff failed to add cardiac function as a care area to the comprehensive care plan. 2. For Resident #75, facility staff failed to offer and/or provide showers per the plan of care. The findings include: 1. Resident #42 was admitted to the facility on 1/31/19 with diagnoses that included but were not limited to fracture of the left lower leg, type two diabetes, high blood pressure, atrial fibrillation, and Alzheimer's disease. Resident #42's most recent MDS (minimum data set) assessment was a 14 day scheduled assessment with an ARD (assessment reference date) of 2/14/19. Resident #42 was coded as being moderately impaired in cognitive function scoring 08 out of possible 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #42 was coded in Section I (active diagnoses) as having diagnoses of hypertension and coronary artery disease (CAD) s/p (status post) CABG (coronary artery bypass graft). Review of Resident #42's POS (Physician Order Summary) revealed that she was taking the following cardiac/antithrombotic medications: "Cardizem CD Capsule Extended Release (1) 24 Hour 120 MG (milligram) Give 1 capsule by mouth one time a day for afib (atrial fibrillation)	F 656	3/22/19 and resident #75 was discharged 3/16/19. 2. Current residents have comprehensive person-centered care plans. 3. The Interdisciplinary Team will be educated on: " Development of comprehensive care plan to form person centered care plan upon admission 4. A registered nurse will complete a random weekly review of resident comprehensive care plans to ensure that the care plan is comprehensive and centered to resident needs. 5. Issues noted during the random weekly review will be presented to the Quality Assurance Committee for review and recommendation.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495418	A. BUILDING _____ B. WING _____	C 03/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRINCESS ANNE HEALTH & REHABILITATION CENTER	1948 LANDSTOWN CENTRE WAY VIRGINIA BEACH, VA 23456

(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 656	Continued From page 51 hold for SBP (systolic blood pressure) < (less than) 110 or HR (heart rate) < (less than) 60." Metoprolol Tartrate Tablet (2) 50 MG Give 1 tablet by mouth two times a day for afib (atrial fibrillation) hold for SBP <110 or HR <60. Isosorbide Mononitrate ER (3) (extended release) Tablet 24 hour 30 MG Give 1 tablet by mouth one time a day for CAD (coronary artery disease) s/p (status post) CABG, angina prophylactic. Apixaban Tablet (4) 5 mg Give 1 tablet by mouth two times a day for PREVENT THROMBOEMBOLISM IN CHRONIC ATRIAL FIBRILLATION." Review of Resident #42's comprehensive care plan failed to evidence a cardiac care plan. On 3/14/19 at 12:29 p.m., an interview was conducted with RN (registered nurse) #2, the unit manager. When asked who was responsible for developing the comprehensive care plan, RN #2 stated that the floor nurses were expected to develop an initial care plan upon admission addressing areas of pain, ADLS (activities of daily living), falls, skin and bowel and bladder. When asked when the comprehensive care plan was developed, RN #2 stated that management was responsible for completing comprehensive care plans within 24 hours of admission. When asked the purpose of the care plan, RN #2 stated that the purpose of the care plan was to set goals and act as a guide of care for the resident. When asked if it was important for the care plan to be accurate, RN #2 stated that it was. When asked if a cardiac care plan should be developed for a resident with hypertension, atrial fibrillation and	F 656		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495418	A. BUILDING _____ B. WING _____	C 03/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRINCESS ANNE HEALTH & REHABILITATION CENTER	1948 LANDSTOWN CENTRE WAY VIRGINIA BEACH, VA 23456

(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 656	Continued From page 52 on cardiac medications, RN #2 stated that a care plan should be in place addressing those areas. When asked what interventions she would expect to see for a cardiac resident, RN #2 stated that she would expect to see interventions such as following a low sodium diet, monitoring blood pressure and heart rate daily etc. When asked if she could find a cardiac care plan for Resident #42, RN #2 looked at her comprehensive care plan and stated that she could not find one. On 3/15/19 at 1:52 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the DON (Director of Nursing), and Corporate staff member #1 were made aware of the above concerns. Facility policy titled, "Care Planning," documents in part, the following: "A licensed nurse, in coordination with the interdisciplinary team, develops and implements an individualized care plan for each patient in order to provide effective, person centered care, and the necessary health-related care and services to attain or maintain the highest level of practical physical, mental and psychosocial well-being of the patient. The computerized baseline care plan is initiated and activated within 48 hours...An electronic interdisciplinary comprehensive care plan will be completed within the 7 days of the completion of the comprehensive assessment, but no later than day 21 following admission." No further information was presented prior to exit. (1) Cardizem CD is a calcium channel blocker used to treat high blood pressure and angina (chest pain). This information was obtained from The National Institutes of Health.	F 656		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495418	A. BUILDING _____ B. WING _____	C 03/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRINCESS ANNE HEALTH & REHABILITATION CENTER	1948 LANDSTOWN CENTRE WAY VIRGINIA BEACH, VA 23456

(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 656	Continued From page 53 https://dailymed.nlm.nih.gov/dailymed/fda/fdaDrugXsl.cfm?setid=f3e7ecef-f360-4987-a4f5-933214130ab2. (2) Metoprolol Tartrate treats high blood pressure, angina, and heart failure. This information was obtained from The National Institutes of Health. https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0011186/?report=details. (3) Isosorbide Mononitrate ER (extended release) is indicated for the prevention of angina pectoris due to coronary artery disease. This information was obtained from The National Institutes of Health. https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=ef08d90f-ba26-4b68-8e3a-d0320e4b0f8e. (4) Apixaban Tablet is used to decrease the risk of venous thromboses, systemic embolization and stroke in patients with atrial fibrillation, and lower the risk of deep vein thrombosis and pulmonary embolus after knee or hip replacement surgery. This information was obtained from The National Institutes of Health. https://livertox.nlm.nih.gov/Apixaban.htm. 2. Resident #75 was originally admitted to the facility 2/4/19 had never been discharged from the facility. The current diagnoses included; generalized muscle weakness, diabetes and neuropathic. The admission Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 2/11/19, coded the resident as	F 656		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495418	A. BUILDING _____ B. WING _____	C 03/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRINCESS ANNE HEALTH & REHABILITATION CENTER	1948 LANDSTOWN CENTRE WAY VIRGINIA BEACH, VA 23456

(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 656	Continued From page 54 completing the Brief Interview for Mental Status (BIMS) and scoring 15 out of a possible 15 which indicated no cognitive impairment. In section "G" (Physical functioning) the resident was coded as requiring supervision of one person with personal hygiene, locomotion off the unit, and eating, limited assistance of one person with locomotion on the unit, limited assistance of 2 people with dressing, extensive assistance of one person with bathing, extensive assistance of two people with bed mobility, transfers, and toileting. In section "O100G2" the resident was coded as utilizing a non-invasive mechanical ventilator (Bipap). The care plan dated 2/4/19, had a problem which read; resident has an activities of daily living(ADL), self-care performance deficit related to activity intolerance and extensive mobility assist. The goal read; the resident will improve current level of function in ADL's through the review date 5/5/19. The interventions included: bathing/showering: provide sponge bath when a full bath or shower cannot be tolerated. Bathing/showering: the resident is able to with or without assistance as needed. The Unit Manager viewed the shower schedule and stated Resident #75 should receive her shower on the 3:00 p.m.-11:00 p.m. shift, Monday, Wednesday and Friday. Documentation from the ADL record indicated the resident didn't have a shower 2/13/19, a shower was not applicable on 2/18/19, the shower was refused 2/20/19, and 2/22/19-3/11/19 the report was checked "not applicable". During a follow-up interview with Resident #75 with the Unit Manager present on 3/14/19, at approximately 11:00 a.m. The resident stated she	F 656		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495418	A. BUILDING _____ B. WING _____	C 03/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRINCESS ANNE HEALTH & REHABILITATION CENTER	1948 LANDSTOWN CENTRE WAY VIRGINIA BEACH, VA 23456

(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 656	Continued From page 55 had not been offered or received a shower or full body bath since admission to the facility. She further stated she thought it was because of her weight, because staff had told her they couldn't keep lifting on her because of her size. The resident then stated she was only bathed in the bed. The Unit Manager stated to the resident she should receive three shower each week. The resident asked if it should occur in the shower in the bathroom or some place else and the United Manager stated; showers should be given in your bathroom. The resident again stated, I have not been offered nor have I received a shower since I came here. The resident stated she would have really enjoyed the showers because it had been so long since she has been able to shower. During an interview with the Rehabilitation Director on 3/15/19 at approximately 2:50 p.m., the Rehabilitation Director stated she had never aided Resident #75 with showering because it wasn't a rehabilitation goal. She stated the resident had expressed at home she was self bathing at sink level therefore; the goal was to get her back to that level. On 3/15/19 at approximately 7:00 p.m., the above findings were shared with the Administrator, Director of Nursing and Corporate Consultant. An opportunity was given for the facility to present additional information but none was provided.	F 656		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of	F 657		4/29/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495418	A. BUILDING _____ B. WING _____	C 03/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRINCESS ANNE HEALTH & REHABILITATION CENTER	1948 LANDSTOWN CENTRE WAY VIRGINIA BEACH, VA 23456

(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 657	Continued From page 56 the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on staff interviews, clinical record review and facility documentation the facility staff failed to revise, two (2) of (Resident #22 and 37) of 57 residents in the survey sample, comprehensive person centered care plan . 1. The facility staff failed to revise Resident #22's comprehensive person centered care plan to include the diagnosis of Diabetes Mellitus. 2. The facility staff failed to revise Resident #37's care plan to include medications (Refresh eye drops and Genteal eye ointment) to be left at bedside nor was the resident assessed for	F 657	F657 1. Resident #22□s care plan was revised to include the diagnosis of Diabetes Mellitus on 3/14/19. Resident #37□s care plan was revised to include medications to be left at bedside and an assessment for self-administration of medications was done on 3/15/19. 2. Resident care plans will be revised to be comprehensive and person centered. 3. Charge Nurses will be educated on: a. Development of a comprehensive person-centered care plan b. Revision of the care plan as needed	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495418	A. BUILDING _____ B. WING _____	C 03/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRINCESS ANNE HEALTH & REHABILITATION CENTER	1948 LANDSTOWN CENTRE WAY VIRGINIA BEACH, VA 23456

(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 657	Continued From page 57 self-administration of the medications. The findings included: 1. Resident #22 was originally admitted to the nursing facility on 10/18/18. Diagnosis for Resident #22 included but was not limited to *Type II Diabetes Mellitus. *Diabetes Mellitus Type II is a lifelong (chronic) disease in which there is a high level of sugar (glucose) in the blood (https://medlineplus.gov/ency/article/007365.htm). The current Minimum Data Set (MDS) a quarterly MDS with an Assessment Reference Date (ARD) of 01/04/19 coded the resident with a 00 of a total possible score of 15 on the Brief Interview for Mental Status (BIMS), which indicated severe cognitive impairment. The residents MDS was coded under section I (Active Diagnosis) was coded for Diabetes Mellitus. The section N on the MDS under medications read as follows: Indicate the number of DAYS the resident receiving the medication during the last 7 days, the MDS was coded for receiving insulin injections for 4 days. The review of the Resident #22's comprehensive care plan did not include a care plan for the diagnosis of Diabetes Mellitus. An interview was conducted with the MDS Coordinator on 03/14/19 at approximately 3:15 p.m. The surveyor asked if Resident #22 had a diagnosis of diabetes; she replied, "Yes." The surveyor asked, "Since the resident has a diagnosis of diabetes, should there be a diabetes care plan;" she replied "Yes."	F 657	4. A Registered Nurse will complete a random weekly review of resident care plans to ensure that the care plan is comprehensive and person centered. 5. Issues noted during the random weekly review will be presented to the Quality Assurance Committee for review and recommendations.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495418	A. BUILDING _____ B. WING _____	C 03/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRINCESS ANNE HEALTH & REHABILITATION CENTER	1948 LANDSTOWN CENTRE WAY VIRGINIA BEACH, VA 23456

(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 657	Continued From page 58 An interview was conducted with the Director of Nursing (DON) on 03/15/19 at approximately 10:48 a.m., who stated, "Yes, there should have been a care plan to address diabetes mellitus." On the same day at approximately 11:05 a.m., the DON presented a diabetes care plan that was created on 03/14/19 but only after it was requested from the surveyor. The care plan included the following: The resident has Diabetes Mellitus. The goal: The resident will no complications related to diabetes, will be free from and s/s of hyperglycemia (high blood sugar) and will be free from any s/s of hypoglycemia (low blood sugar.) Some of the interventions to manage goal: Monitor/document/report any s/s of hyperglycemia, increased thirst and appetite, frequent urination, weight loss, fatigue, dry skin, poor wound healing, muscle cramps, abdominal pain, acetone breath (smells fruity), stupor or coma. The facility administration was informed of the finding during a briefing on 03/15/19 at approximately 4:45 p.m. The facility did not present any further information about the findings. 2. Resident #37 was admitted to the nursing facility on 11/19/15 with diagnoses that included Chronic Obstructive Pulmonary Disease (COPD), stroke with left arm hemiplegia, and dry eye syndrome of unspecified lacrimal gland. The most recent Minimum Data Set (MDS) was a quarterly dated 12/28/18 coded the resident with a 15 out of a possible score of 15 on the Brief Interview for Mental Status (BIMS). The care plan dated 1/31/19 did not identify nor was it revised to allow Resident #37 to have	F 657		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495418	A. BUILDING _____ B. WING _____	C 03/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRINCESS ANNE HEALTH & REHABILITATION CENTER	1948 LANDSTOWN CENTRE WAY VIRGINIA BEACH, VA 23456

(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 657	Continued From page 59 medications left at the bedside. On 3/15/19 at 1:30 p.m., this surveyor and the Regional Nurse Consultant (RNC) spoke to the resident at the bedside about some of her concerns. While at the bedside the resident stated one of the licensed nurses poked her in the eye while trying to instill Genteal eye ointment that is kept at the bedside in a white basket. She stated she also kept Refresh eye drops at the bedside. The resident stated she was not able to instill any medications in her eyes with her right hand because it took both hands, and she had contractures in her left hand and arm. The resident said, "If I could get Rosie (lifted her left hand with her right hand) to work, I would be able to do a lot." On 3/15/19 at 1:45 p.m., the RNC stated Resident #37's care plan would be updated to include eye medications at the bedside and that the nurse would instill them. She stated the resident was not assessed to self administer either medication.	F 657		
F 658 SS=E	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review and clinical record review, it was determined that facility staff failed to provide care and services in accordance with professional	F 658	F658 1. Residents #82 and 21 are receiving medications as ordered. Resident #347 was discharged on 10/26/17. Resident	4/29/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495418	A. BUILDING _____ B. WING _____	C 03/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRINCESS ANNE HEALTH & REHABILITATION CENTER	1948 LANDSTOWN CENTRE WAY VIRGINIA BEACH, VA 23456

(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 658	Continued From page 60 standards of practice, and the comprehensive person-centered care plan for 5 of 57 residents in the survey sample, Resident #347, #349, #82, #21, and #75. 1. For Resident #347, facility staff failed to administer an IV antibiotic per physician's order on 10/26/17. 2. For Resident #349, facility staff failed to follow physician's orders and administer the correct dose of Lasix. 3. For Resident #82, facility staff failed to administer two doses of antibiotics per physician's orders. 4. For Resident #21, facility staff failed to administer eye drops per physician's order on 3/1/19 and 3/5/19. 5. The facility staff failed to apply Resident #75's Aquaphor Oinment as ordered. The findings include: 1. Resident #347 was admitted to the facility on 10/25/17 with diagnoses that included but were not limited to sepsis, muscle weakness and osteomyelitis of the sacral and sacrococcygeal region. Resident #347 was sent to the hospital on 10/26/17 and an MDS (minimum data set assessment) was not completed. Review of Resident #347's admission orders dated 10/25/17 documented the following order: "Vancomycin HCL (1) solution Reconstituted Use 1 gram intravenously one time a day for MRSA until 12/1/17." Review of Resident #347's October 2017 MAR (medication administration record) revealed that	F 658	#349 was discharged 3/22/19. Resident #75 was discharged 3/16/19. 2. Residents will receive care and services in accordance with professional standards of practice. 3. Charge Nurses will be educated on: " Utilizing in-house STAT box for medications not available " Notifying MD if medication cannot be obtained in a timely manner " Administration of medications as ordered 4. A Registered Nurse will complete a random weekly review of residents with medication administration to ensure that the MD was notified as indicated and appropriate care provided. 5. Issues noted during the random weekly review will be presented to the Quality Assurance Committee for review and recommendation.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495418	A. BUILDING _____ B. WING _____	C 03/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRINCESS ANNE HEALTH & REHABILITATION CENTER	1948 LANDSTOWN CENTRE WAY VIRGINIA BEACH, VA 23456

(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 658	Continued From page 61 Resident #347 missed her 0600 a.m. dose of vancomycin. A "9" was coded on the MAR indicating a nursing note was written. Review of Resident #347's nursing note documented the following: "medication unavailable." There was no evidence that the physician was notified of the missed dose of Vancomycin on 10/26/17. On 3/14/19 at 10:20 a.m., an interview was conducted with LPN (licensed practical nurse) 1, the nurse who worked the 11-7 shift on 10/25/17. When asked the process for ordering medications for new admissions, LPN #1 stated that as soon as the resident enters the building, medication orders are faxed over to the pharmacy. LPN #1 stated that nurses should also call pharmacy to follow up on medications to ensure they will be available for their next ordered dose. LPN #1 stated that nurses can also order medications STAT. LPN #1 stated that if the medication is still not available when its due to be administered, she would make the on-call physician aware so that he can order an alternative. LPN #1 stated that she was not the nurse who conducted Resident #347's admission. On 3/15/19 at 9:00 a.m., an interview was conducted with ASM (administrative staff member) #2, the DON (Director of Nursing). ASM #2 stated that some IV (intravenous) medications are in the STAT box that can be mixed. ASM #2 stated that medication should be in the building when it is due and if not, the medication should be requested from pharmacy STAT and the physician should be notified. ASM #2 stated that the physician would then reprogram the antibiotic order or extend the order. The STAT box list was	F 658		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495418	A. BUILDING _____ B. WING _____	C 03/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRINCESS ANNE HEALTH & REHABILITATION CENTER	1948 LANDSTOWN CENTRE WAY VIRGINIA BEACH, VA 23456

(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 658	Continued From page 62 requested. On 3/15/19 at 9:50 a.m., ASM #2 presented the IV STAT Box list. Vancomycin 1 gram was in the STAT box. On 3/15/19 at 9:54 a.m., further interview was conducted with LPN #1. When asked why she did not administer Resident #347's Vancomycin on 10/26/17, LPN #1 stated that she could not remember Resident #347's antibiotics. LPN #1 stated, "I know her daughter was refusing a lot of things. I am not sure. Maybe the daughter refused it?" When asked if IV Vancomycin was in the STAT box, LPN #1 stated, "Yes, usually. I don't know the dose on the top of my head. It might not of been there." LPN #1 stated there had to have been a reason why she did not administer the Vancomycin. When asked if the physician was notified that the IV Vancomycin was not administered, LPN #1 stated, "Honestly, I can't tell you." LPN #1 stated that a nursing note should have been written if the physician was notified. LPN #1 stated that there was a lot going on that shift because the daughter was going back and fourth about sending the resident to the hospital. On 3/15/19 at 1:52 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the DON (Director of Nursing), and Corporate staff member #1 were made aware of the above concerns. A policy could not be provided on medication administration. The following information is provided in Basic Nursing, Essentials for Practice, 6th edition (Potter and Perry, 2007, pages 349-360) was used as a reference for medication	F 658		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495418	A. BUILDING _____ B. WING _____	C 03/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRINCESS ANNE HEALTH & REHABILITATION CENTER	1948 LANDSTOWN CENTRE WAY VIRGINIA BEACH, VA 23456

(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 658	Continued From page 63 administration...It is essential that you verify the accuracy of every medication you give to the patient with the patient's orders. To ensure safe medication administration, be aware of the six rights of medication administration: The right medication, The right dose, The right patient, The right route, The right time, The right documentation." (1) Vancomycin HCL is a broad spectrum antibiotic that has activity against methicillin-resistant strains of Staphylococcus aureus and is generally reserved for serious drug resistant gram-positive infections. This information was obtained from The National Institutes of Health. https://livertox.nlm.nih.gov/Vancomycin.htm. COMPLAINT DEFICIENCY 2. For Resident #349, facility staff failed to follow physician's orders and administer the correct dose of Lasix. Resident #349 was admitted to the facility on 3/11/19 with diagnoses that included but were not limited to acute and chronic respiratory failure, acute diastolic congestive heart failure, COPD (chronic obstructive pulmonary disease), and high blood pressure. Resident #349 did not have a completed MDS (minimum data set) assessment but was documented as being alert and oriented x 4 (person, place, time, situation) in an admission note. Review of Resident #349's most recent physician order summary revealed the following active order:	F 658		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495418	A. BUILDING _____ B. WING _____	C 03/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRINCESS ANNE HEALTH & REHABILITATION CENTER	1948 LANDSTOWN CENTRE WAY VIRGINIA BEACH, VA 23456

(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 658	Continued From page 64 "Lasix Tablet (1) 20 MG (milligrams) Give 3 tablet by mouth one time a day for CHF (congestive heart failure)." The start date was ordered for 3/12/19. On 3/13/19 at 9:17 a.m., medication administration observation was conducted with LPN (licensed practical nurse) #12. On 3/13/19 at 9:23 a.m., LPN #12 was observed preparing only one lasix tablet instead of the ordered three. At approximately 9:30 a.m., Resident #349 was given only one lasix tablet instead of the ordered three. Resident #349 was observed to have edema to her bilateral lower extremities and was on oxygen via nasal cannula at the ordered 5 liters per minute. Review of Resident #349's medication pack documented the following on the label, "Furosemide (Lasix) 20 MG tablet EA (each) Give 3 tablets by mouth one time a day." Further review of the medication pack revealed 4 missing lasix tablets from the bubble pack indicating that three were given the day prior (3/12/18) and that one was given on 3/13/18. Further observation and review of Resident #349 during the entire survey period revealed no negative outcomes from the missed lasix dose. On 3/14/19 several attempts were made to reach LPN #12 for an interview. LPN #12 could not be reached. On 3/14/19 at 10:40 a.m., an interview was conducted with RN (registered nurse) #1, the other nurse on the 300 unit. When asked why a resident would be on Lasix, RN #1 stated a	F 658		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495418	A. BUILDING _____ B. WING _____	C 03/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRINCESS ANNE HEALTH & REHABILITATION CENTER	1948 LANDSTOWN CENTRE WAY VIRGINIA BEACH, VA 23456

(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 658	Continued From page 65 resident would be on Lasix if they had fluid build up (edema). When asked what the above Lasix order meant, RN #1 stated that three Lasix tablets should be administered to the resident. When asked if it was an error if only one tablet was administered to the resident, RN #1 stated that it was. When asked if the order was followed, RN #1 stated that the order was not followed. On 3/15/19 at 1:52 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the DON (Director of Nursing), and Corporate staff member #1 were made aware of the above concerns. (1) Lasix is used to decrease edema (excess fluid) in patients with heart failure, liver impairment or kidney disease. This information was obtained from Davis's Drug Guide for Nurses, 11th edition, p.587. 3. For Resident #82, facility staff failed to administer two doses of antibiotics per physician's orders. Resident #82 was admitted to the facility on 6/8/17 and readmitted on 2/14/19 with diagnoses that included but were not limited to ESBL (extended spectrum beta-lactamase) bacteria in urine, muscle weakness, difficulty walking, and atrial fibrillation. Resident #82's most recent MDS (minimum data set) assessment was a five day scheduled assessment with an ARD (assessment reference date) of 2/21/19. Resident #82 was coded as being cognitively intact in the ability to make daily decisions scoring 15 out of possible 15 on the BIMS (Brief Interview for Mental Status) exam.	F 658		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495418	A. BUILDING _____ B. WING _____	C 03/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRINCESS ANNE HEALTH & REHABILITATION CENTER	1948 LANDSTOWN CENTRE WAY VIRGINIA BEACH, VA 23456

(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 658	Continued From page 66 Review of Resident #82's most recent POS (physician order summary) revealed the following order: "Nitrofurantoin Macrocrystal (Macrobid) (1) 100 MG capsule Give 1 capsule by mouth every 12 hours for ESBL UTI (urinary tract infection) for 7 days." The medication was ordered on 3/1/18. Review of Resident #82's March 2019 MAR (medication administration record) revealed that Resident #82 missed her 9 am dose of Macrobid on 3/2/19 and 3/3/19. The following note was documented for 3/2/19, "medication not available." The following note was documented for 3/3/19, "med on order." Review of the facility's STAT emergency medication list revealed that Macrobid 100 MG was in the STAT box. Further review of Resident #82's clinical record failed to evidence that the physician was made aware of the two missed doses of Macrobid. On 3/14/19 at 10:46 a.m., an interview was conducted with RN (registered nurse) #1. When asked the process if she were to administer a medication that was not in the medication cart, RN #1 stated that she would first check the STAT box and if the medication is not in the STAT box, she would order the medication STAT from pharmacy. RN #1 stated that she would then reschedule the medication for a different time. When asked if Macrobid was in the STAT box, RN #1 stated, "Yes, we have that in the STAT box." When asked if anyone was notified if the resident's medication was not available resulting in the resident missing their dose of medication,	F 658		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495418	A. BUILDING _____ B. WING _____	C 03/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRINCESS ANNE HEALTH & REHABILITATION CENTER	1948 LANDSTOWN CENTRE WAY VIRGINIA BEACH, VA 23456

(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 658	Continued From page 67 RN #1 stated that the physician should be notified. RN #1 stated that the physician may give a new order. When asked if it should be documented anywhere in the clinical record that the physician was notified, RN #1 stated that it should be documented in the nursing notes if the physician was notified. RN #1 stated that it looked like Resident #82 did not receive her full dose of Macrobid. On 3/14/19 several attempts were made to reach the nurses responsible for not administering Macrobid. They could not be reached for an interview. On 3/15/19 at 1:52 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the DON (Director of Nursing), and Corporate staff member #1 were made aware of the above concerns. A policy could not be provided on medication administration. (1) Macrobid is an oral antibiotic widely used either short term to treat acute urinary tract infections or long term as chronic prophylaxis against recurrent infections. This information was obtained from The National Institutes of Health. https://livertox.nih.gov/Nitrofurantoin.htm. 4) For Resident #21, facility staff failed to administer eye drops per physician's order on 3/1/19 and 3/5/19. Resident #21 was admitted to the facility on 7/8/15 and readmitted on 6/16/17 with diagnoses that included but were not limited to high blood pressure, atrial fibrillation, macular degeneration, and osteoporosis. Resident #21's most recent MDS (minimum data set) assessment was an	F 658		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495418	A. BUILDING _____ B. WING _____	C 03/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRINCESS ANNE HEALTH & REHABILITATION CENTER	1948 LANDSTOWN CENTRE WAY VIRGINIA BEACH, VA 23456

(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 658	Continued From page 68 annual assessment with an ARD (assessment reference date) of 12/31/18. Resident #21 was coded as being cognitively intact in the ability to make daily decisions scoring 15 out of 15 on the BIMS (Brief Interview for Mental Status) exam. On 3/13/19 at 2:36 p.m., a group interview was conducted with six residents. Resident #21 had stated that sometimes she does not receive her eye drops at night. Review of Resident #21's most recent POS (physician order summary) revealed the following order: "Xalatan Solution 0.005% (percent) Instill 1 drop in right eye at bedtime for glaucoma." Review of Resident #21's March 2019 MAR (medication administration record) revealed that Resident #21 had not received her Xalatan drops on 3/1/19 and 3/5/19. A "9" was coded on the MAR indicating "Other/See nurses notes." Review of Resident #21's March 2019 nursing notes failed to evidence a note for 3/1/19. A note for 3/5/19 was found that documented the following: "...medication not on hand pharmacy notified." There was no evidence in the clinical record that the physician was made aware of the two missed doses. Further review of the clinical record failed to evidence the reason Resident #21 missed her eye drop on 3/1/19. Review of Resident #21's comprehensive care plan dated 2/10/16, documented the following:	F 658		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495418	A. BUILDING _____ B. WING _____	C 03/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRINCESS ANNE HEALTH & REHABILITATION CENTER	1948 LANDSTOWN CENTRE WAY VIRGINIA BEACH, VA 23456

(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 658	Continued From page 69 "The resident has impaired visual function r/t (related to) Macular degeneration, glaucoma per patient. Occasionally refuses eyelid cleanser...Interventions: eye drops as ordered." On 3/15/19 at 8:50 a.m., an interview was conducted with ASM (administrative staff member) #2, the DON (Director of Nursing). When asked what "9" meant on the MAR, ASM #2 stated that it looked like the eye drop wasn't given. ASM #2 agreed that she could not find a note for 3/1 but that the eye drop was not available from pharmacy on 3/5. On 3/15/19 at 9:30 a.m., an interview was conducted with LPN (licensed practical nurse) #6. When asked what "9" meant on the MAR, LPN #6 stated that the code "9" meant that the medication was not given. When asked how we would know why the 3/1/19 eye drop was not given if there is no note documenting the reason why it wasn't given, LPN #6 stated that we wouldn't know. LPN #6 stated that the reason for the missed eye drop on 3/1/19 should have been documented in the clinical record. LPN #6 stated that the physician should have also been notified for both eye drops missed and that a note should also be documented. On 3/15/19 at 1:52 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the DON (Director of Nursing), and Corporate staff member #1 were made aware of the above concerns. (1) Xalatan Solution is indicated for the reduction of elevated intraocular pressure in patients with open-angle glaucoma or ocular hypertension. This information was obtained from The National	F 658		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495418	A. BUILDING _____ B. WING _____	C 03/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRINCESS ANNE HEALTH & REHABILITATION CENTER	1948 LANDSTOWN CENTRE WAY VIRGINIA BEACH, VA 23456

(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 658	Continued From page 70	F 658		

Institutes of Health.
https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=f4e73059-5ba0-4d73-9ea1-09d8d654e844.

5. Resident #75 was originally admitted to the facility 2/4/19 had never been discharged from the facility. The current diagnoses included; generalized muscle weakness, diabetes and neuropathic.

The admission Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 2/11/19, coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 15 out of a possible 15. In section "G" (Physical functioning) the resident was coded as requiring supervision of one person with personal hygiene, locomotion off the unit, and eating, limited assistance of one person with locomotion on the unit, limited assistance of 2 people with dressing, extensive assistance of one person with bathing, extensive assistance of two people with bed mobility, transfers, and toileting. In section "O100G2" the resident was coded as utilizing a non-invasive mechanical ventilator (Bipap).

The care plan dated 2/4/19, had a problem which read; potential for skin impairment related to need for assistance with activities of daily living (ADL), incontinence and weakness. The goal read; the resident will have no evidence of skin impairment through the review date 5/5/19. The interventions included; keep skin clean and dry. Lotion to dry skin. Moisture barrier cream as needed for protection of skin.

During a follow-up interview with Resident #75

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495418	A. BUILDING _____ B. WING _____	C 03/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRINCESS ANNE HEALTH & REHABILITATION CENTER	1948 LANDSTOWN CENTRE WAY VIRGINIA BEACH, VA 23456

(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 658	Continued From page 71 with the Unit Manager present on 3/14/19, at approximately 11:00 a.m. The resident stated she had dry flaking skin to her feet and legs and she was afraid it would result in skin breakdown if it wasn't applied more often. The resident also stated she was told by the physician she should receive an ointment to her feet but she stated the ointment had only been applied twice. On 3/15/19 at approximately 11:05 a.m., the Unit Manager reviewed Resident #75's physician's orders to confirm she had an ointment ordered. The order dated 2/4/19 read; Aquaphor Ointment (Emollient) Apply to both legs topically every evening shift for dry skin. After review of the order the Unit Manager looked in the medication cart for the Aquaphor ointment; the ointment was present and had never been opened. The Unit Manager stated she had no explanation for the ointment not being opened. The label was viewed and it was the original container sent to the facility from the pharmacy, 2/5/19. On 3/15/19 at approximately 7:00 p.m., the above findings were shared with the Administrator, Director of Nursing and Corporate Consultant. An opportunity was given for the facility to present additional information but none was provided but; the Director of Nursing stated she didn't think the two times the resident received ointment to her feet and legs that it was another resident's ointment since her container had never been opened.	F 658		
F 687 SS=D	Foot Care CFR(s): 483.25(b)(2)(i)(ii) §483.25(b)(2) Foot care. To ensure that residents receive proper treatment	F 687		4/29/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495418	A. BUILDING _____ B. WING _____	C 03/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRINCESS ANNE HEALTH & REHABILITATION CENTER	1948 LANDSTOWN CENTRE WAY VIRGINIA BEACH, VA 23456

(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 687	Continued From page 72 and care to maintain mobility and good foot health, the facility must: (i) Provide foot care and treatment, in accordance with professional standards of practice, including to prevent complications from the resident's medical condition(s) and (ii) If necessary, assist the resident in making appointments with a qualified person, and arranging for transportation to and from such appointments. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews and clinical record review the facility staff failed to ensure 1 of 57 residents (Resident #64) in the survey sample received the necessary services to maintain toenail care. The facility staff failed to ensure that toenail care/podiatry services was provided to Resident #64. The findings included: Resident #64 was originally admitted to the facility on 11/06/15 with a readmission date of 07/27/18. Diagnosis for Resident #64 included but not limited to *Type II Diabetes Mellitus. *Diabetes Mellitus Type II is a lifelong (chronic) disease in which there is a high level of sugar (glucose) in the blood (https://medlineplus.gov/ency/article/007365.htm). The most recent Minimum Data Set (MDS) was a quarterly assessment with an Assessment Reference Date (ARD) of 02/16/19 coded the resident on the Brief Interview for Mental Status (BIMS) with a score of 14 out of a possible score	F 687	F687 1. Resident #64 received podiatry services on 3/14/19. 2. Residents will receive toenail care and podiatry services as needed. 3. Charge Nurses will be educated on: " Provision of toenail care " Communication of need for podiatry care 4. A Registered Nurse will complete a random weekly review of resident toenails to ensure that toenail care has been provided and podiatry services provided as needed. 5. Issues noted during the random weekly review will be presented to the Quality Assurance Committee for review and recommendation.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495418	A. BUILDING _____ B. WING _____	C 03/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRINCESS ANNE HEALTH & REHABILITATION CENTER	1948 LANDSTOWN CENTRE WAY VIRGINIA BEACH, VA 23456

(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 687	Continued From page 73	F 687		

of 15, which indicated no cognitive impairment for daily decision-making. Resident #64 was coded to require limited assistance of one staff with personal hygiene.

During the initial tour on 03/12/19 at approximately 1:41 p.m., an interview was conducted with Resident #64. The resident said her toenails needed to be cut and trimmed. The resident asked if I could look at her feet. The surveyor said yes, let me get a nurse, the resident replied, "I can remove my own shoes and socks." The resident removed her socks and shoes; the resident's toenails were long and thick and the fifth toe on the right foot was long and had curved underneath the toe coming in direct contact with her skin. The resident said she transfers herself and when she stands on her feet, "They hurt because my toenails are so long."

On 03/13/19 at approximately 9:36 a.m., License Practical Nurse (LPN) #6 and this surveyor assessed resident's toenails. Resident #64's toenails remained unchanged. The LPN stated, "Her toenails need to be cut." The surveyor asked, "What is your process for getting resident's toenails cut and trimmed?" She said the Certified Nursing Assistant (CNA) would report to the nurse, the nurse would assess the resident toenails and if they needed to be cut then their name would be placed on the podiatry list. This surveyor and LPN #6 reviewed the podiatry list for the past 5 months and Resident #64's name was never placed on the list to see the podiatrist.

An interview was conducted with the Director of Nursing (DON) on 03/14/19 at approximately 10:15 a.m. The surveyor asked, "What are your

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495418	A. BUILDING _____ B. WING _____	C 03/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRINCESS ANNE HEALTH & REHABILITATION CENTER	1948 LANDSTOWN CENTRE WAY VIRGINIA BEACH, VA 23456

(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 687	Continued From page 74	F 687		

expectations to ensure residents receive podiatry services when needed." She replied, "The nurses should be assessing toenails daily while performing care and if a resident requires their toenails to be cut and trimmed, they are to informed the nurse. The nurse should obtain a podiatry order and put them on the podiatry list to be seen. The surveyor asked when was the last time Resident #64 was seen by the podiatrist, she replied, "I reviewed Resident #64's medical record and was unable to find where the resident was ever seen by the podiatrist." The DON said someone should have noticed Resident #64's toenails needed to be cut. The DON said the podiatrist was called and he is coming in today to see Resident #64.

Review of the resident's medical record on 03/15/19 revealed that the podiatrist came in on 03/14/19 at 3:37 p.m., and provided toenail care to Resident #64. The findings included:

-Subjective: patient seen for treatment of thick, long and painful ingrown nails that the patient and staff cannot safely cut.
-Objective: the toenails are long, thick, yellow and incurved with pain on debridement.
-Plan: debride nails 1-5 b/l in thickness and in length.

On 03/15/19 at approximately 10:07 a.m., License Practical Nurse (LPN) #6 and this surveyor assessed Resident 64's toenails. Resident #64's toenails were cut and trimmed. The resident stated, "Thank you, my toes feels a lot better and my toenails are not growing over like this (making a hock shape with her forefinger)."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495418	A. BUILDING _____ B. WING _____	C 03/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRINCESS ANNE HEALTH & REHABILITATION CENTER	1948 LANDSTOWN CENTRE WAY VIRGINIA BEACH, VA 23456

(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 687	Continued From page 75 The facility administration was informed of the finding during a briefing on 03/15/19 at approximately 4:45 p.m. No additional information was provided. The facility did not have a policy related to podiatry services but follows the following: Mosby's Textbook for Long Term Care Nursing Assistant, 7th Edition. -Nail and Foot Care: Nail and foot care prevents infection, injury and odors. Hangnails, ingrown nails (nails that grow in at the side), and nails torn away from the skin cause skin breaks. The breaks are portals of entry for micorbes. -Promoting safety and comfort - Nail and Foot Care: Safety - The Registered Nurse (RN) or podiatrist cuts toenails and provides foot care for the following resident: has diabetes, has poor circulation, has very thick nails or ingrown toenails or takes medications that affect the blood clotting.	F 687		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that-	F 690		4/29/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495418	A. BUILDING _____ B. WING _____	C 03/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRINCESS ANNE HEALTH & REHABILITATION CENTER	1948 LANDSTOWN CENTRE WAY VIRGINIA BEACH, VA 23456

(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 690	Continued From page 76 (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, clinical record review and review of the facility's policy, the facility staff failed to provide the appropriate care and services to prevent indwelling catheter complications for 1 of 57 residents (Resident #67), in the survey sample. The facility staff failed to assure Resident #67's indwelling catheter was anchored to prevent tension on the catheter which could lead to urethral tears, trauma and/or dislodgement. The findings included: Resident #67 was originally admitted to the facility	F 690	F690 1. Resident #67□s indwelling catheter is anchored to prevent tension on the catheter. 2. Residents with an indwelling catheter have an anchor to prevent tension on the catheter. 3. Charge Nurses were educated on: " Use of an anchor to prevent tension on the catheter CNAs will be educated on: " Reporting an anchor for an indwelling catheter that has become dislodged 4. A Registered Nurse will complete a random weekly review of residents with	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495418	A. BUILDING _____ B. WING _____	C 03/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRINCESS ANNE HEALTH & REHABILITATION CENTER	1948 LANDSTOWN CENTRE WAY VIRGINIA BEACH, VA 23456

(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 690	Continued From page 77 2/11/19, and has never been discharged from the facility. The current diagnoses included; urinary retention. The admission Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 2/18/19 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 15 out of a possible 15. This indicated Resident #67's cognitive abilities for daily decision making were intact. In section "G" (Physical functioning) the resident was coded as requiring limited assistance with eating and locomotion, extensive assistance of one person with toileting and personal hygiene, extensive assistance of two people with bed mobility, transfers, dressing, and total care of one person with bathing. In section "H" (Bladder and Bowel), the resident was coded for requiring use of an indwelling catheter. The physician order summary revealed an order dated 2/12/19, for a Foley catheter (16 french with 30 cubic centimeter balloon), diagnosis urinary retention. Another physician's order dated 2/12/19 read; change the Foley's anchor every seven days and as needed, every night shift on Sunday. The care plan dated 2/12/19, which read; The resident has an indwelling catheter: poor fluid intake and urinary retention. The goal read; the resident will be/remain free from catheter related trauma through the review date 2/28/19 and the resident will show no signs/symptoms of a urinary infection through the review date 2/28/19. The interventions included; position the catheter bag and tubing below the level of the bladder. Monitor/document for pain/discomfort due to	F 690	indwelling catheters to ensure that an anchor is in use to prevent tension on the catheter. 5. Issues noted during the random weekly review will be presented to the Quality Assurance Committee for review and recommendation.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495418	A. BUILDING _____ B. WING _____	C 03/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRINCESS ANNE HEALTH & REHABILITATION CENTER	1948 LANDSTOWN CENTRE WAY VIRGINIA BEACH, VA 23456

(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 690	Continued From page 78 catheter. The resident was seen by the urologist 3/1/19, the progress note read; recommended keeping the Foley catheter in place until she is strong enough to use the bathroom on her own. Patient voices her understanding. Recommended monthly catheter changes at the nursing facility. Voiding Trial at nursing facility when patient is stronger and ambulatory. Resident #67 was observed in bed 3/12/19, at approximately 5:15 p.m., the resident stated she had been hospitalized for having trouble breathing and she was sent to the rehabilitation facility to regain her strength before returning home. She stated prior to admission to the hospital for difficult breathing she walked, self toileted and didn't have an indwelling catheter. During the 3/12/19, interview at approximately 5:15 p.m., the resident removed her bed linens to reveal the indwelling catheter. The catheter was unanchored and the tubing was positioned between the thighs. It drained clear tea colored urine into a fig leaf drainage bag. On 3/15/19, Resident #67 was again visited in her room at approximately 5:10 p.m. Licensed Practical Nurse (LPN) #55 entered the room to administer the resident's medications. The resident again revealed the indwelling catheter, it was still unanchored and positioned between the thighs. The resident stated she didn't recall having any type of device attached to the body to hold the indwelling catheter or prevent it from pulling away. LPN #55 told the resident she would obtain a stat-lock catheter stabilization device and apply it immediately.	F 690		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495418	A. BUILDING _____ B. WING _____	C 03/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRINCESS ANNE HEALTH & REHABILITATION CENTER	1948 LANDSTOWN CENTRE WAY VIRGINIA BEACH, VA 23456

(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 690	Continued From page 79 On 3/15/19 at approximately 7:00 p.m., the above findings were shared with the Administrator, Director of Nursing and Corporate Consultant. An opportunity was given for the facility to present additional information but none was provided. The Director of Nursing stated waiting for the resident became stronger and ambulatory wasn't an indication for use of an indwelling catheter and use of a stat-lock is the facility's protocol. The facility policy titled, "Indwelling Urinary Foley Catheter and Drainage Bag Changes" with a revision date of 2/1/15 read; to protect the closed system of urinary bladder drainage and to prevent ascending urinary tract infection, indwelling urinary Foley catheters and drainage bags are changed by the licensed nurse with specific order from the physician defining the frequency of change. Also documented in this facility policy under the heading titled, Procedure, it read; maintain the integrity of the closed system at all times and Properly secure catheter tubing."	F 690		
F 697 SS=E	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observations, clinical record review, staff and resident interviews, the facility staff failed to ensure pain management was provided that included implementation of	F 697	F697 1. Resident #197 discharged from the facility on 8/29/18. Resident #91 is currently receiving non-pharmacological	4/29/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495418	A. BUILDING _____ B. WING _____	C 03/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRINCESS ANNE HEALTH & REHABILITATION CENTER	1948 LANDSTOWN CENTRE WAY VIRGINIA BEACH, VA 23456

(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 697	Continued From page 80 non-pharmacological approaches for two (2) of 57 residents (Resident #197 and #91) in the survey sample. 1. The facility staff failed to develop and implement non-pharmacological approaches to pain management prior to administering pharmacological approaches for Resident #197. 2. The facility staff failed to develop and implement non-pharmacological approaches to pain management prior to administering pharmacological approaches for Resident #197. The findings include: 1. Resident #197 was admitted to the nursing facility on 8/22/18 with diagnoses that included Parkinson's disease, generalized muscle weakness, osteoarthritis and chronic pain syndrome. The resident was discharged on 8/29/18 and did not return to the nursing facility. The most recent Minimum Data Set (MDS) assessment prior to discharge on 8/29/18 was a 5 day and coded the resident with a score of 15 out of a possible score of 15 on the Brief Interview for Mental Status (BIMS) which indicated the resident was intact with the necessary skills for daily decision making. Resident #197's care plan dated 8/29/18 identified pain as a problem and that the goal set by the staff for the resident was that he would have no complaints of pain or at least decreased pain. Some of the approaches the staff would implement to accomplish this goal included encourage relaxation techniques and provide diversional techniques, pre-medicate in	F 697	interventions for pain management. 2. Residents receive non-pharmacological approaches to pain management prior to administration of pharmacological approaches. 3. Charge Nurses will be educated on: " Development of non-pharmacological approaches to pain management " Implementation of non-pharmacological approaches to pain management prior to administration of pharmacological approaches " Documentation of non-pharmacological approaches to pain management 4. A Registered Nurse will complete a random weekly review of implementation of non-pharmacological approaches to pain management prior to administration of pharmacological approaches. 5. Issues noted during the random weekly review will be presented to the Quality Assurance Committee for review and recommendation.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495418	A. BUILDING _____ B. WING _____	C 03/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRINCESS ANNE HEALTH & REHABILITATION CENTER	1948 LANDSTOWN CENTRE WAY VIRGINIA BEACH, VA 23456

(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 697	Continued From page 81 anticipation of painful procedures, position for comfort and notify physician if pain not relieved with medication or there are new complaints of pain. Resident #197's admission History and Physical indicated a "chronic pain disorder" as a part of his past medical history. Review of the nurse's notes and the Medication Administration Record (MAR) from 8/22/18 through 8/29/18 revealed Resident #197 was administered Norco (narcotic) tablet 7.5-325 milligram (mg) for pain. Neither the nurse's notes or the MAR documented what non-pharmacological interventions were tried prior to administering Norco. On 3/13/19 at 12:00 p.m., an interview was conducted with one of the licensed nurse's that frequently cared for the resident and administered Norco, Registered Nurse (RN) #1. She was not able to state the type of pain the resident was having nor what non-pharmacological interventions were tried prior to administering pain medication. She asked this surveyor the following: "I am not sure what you are asking." Once re-explained she stated other actions are tried for residents that take PRN (as needed) medications for anxiety, but not for pain medication and that the nurses write a follow-up note as to whether the pain medication was effective. The ADON joined the interview at 12:45 p.m. and reiterated that non-pharmacological measures are implemented prior to administering anti-anxiety medications. On 3/13/19 at 1:10 p.m.,during an interview with the DON and with the Regional Nurse Consultant	F 697		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495418	A. BUILDING _____ B. WING _____	C 03/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRINCESS ANNE HEALTH & REHABILITATION CENTER	1948 LANDSTOWN CENTRE WAY VIRGINIA BEACH, VA 23456

(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 697	Continued From page 82	F 697		

(RNC), they were not able to provide evidence through any form of documentation that specific interventions were tried before given Norco, but information is on the care plan and they expected those interventions were tried prior to administering Norco.

On 3/15/19 at 4:48 p.m., during the debriefing with the Administrator, DON and RNC, the aforementioned issue was reviewed again. They stated they were going to modify the EHR (electronic health record) that would prompt the nurses to choose interventions prior to administering pain medications as was set up for the PRN anti-anxiety medications.

The facility's policy and procedures titled Pain Management dated 2/1/15 did not specifically address non-pharmacological interventions prior to administering pain medications.

2. The facility staff failed to developing and implement non-pharmacological approaches to pain management prior to administering pharmacological interventions for Resident #91.

Resident #91 was admitted to the nursing facility on 2/3/18 with diagnoses that included cystitis, arthritis, benign prostatic hyperplasia (BPH) and generalized muscle weakness.

The Annual Minimum Data Set Assessment (MDS) dated 2/14/19 coded the resident with a score of 10 out of a possible score of 15 on the Brief Interview for Mental Status (BIMS) which indicated the resident was moderately impaired with the necessary skills needed for daily decision making. The resident was assessed to have frequent pain in the in the last five days of the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495418	A. BUILDING _____ B. WING _____	C 03/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRINCESS ANNE HEALTH & REHABILITATION CENTER	1948 LANDSTOWN CENTRE WAY VIRGINIA BEACH, VA 23456

(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 697	Continued From page 83	F 697		

current assessment with a rating of 8 (severe) on a pain scale 00-10.

The care plan dated 2/5/19 identified pain as one of the resident's problems. The goal the staff set for the resident was that he would have no pain or a decrease in his pain through the next care plan review. Some of the approaches the staff would implement to accomplish this goal included medicate as ordered, notify the physician if pain in not relieved with medication or with new complaints of pain, and pre-medicate in anticipation of painful procedures.

Review of the nurse's notes and Medication Administration Record (MAR) for month of January 2019, February 2019 and March 2019 identified that Resident #91 was administered as needed Ultram 50 (narcotic pain reliever) milligrams 14 times. There was one nurses note that indicated non-pharmacological interventions were tried before administration of the Ultram.

On 3/14/19 at 10:15 a.m., one of the licensed nurses, Licensed Practical Nurse (LPN) #2 that was assigned to the resident stated he had not received Ultram recently, but made sure after PRN pain medication was given it is recorded whether effective or not and the resident was comfortable. She stated she was not aware of any actions to take before giving PRN pain relievers.

On 3/14/19 at 11:00 a.m., Resident #91 stated, "Sometimes I ask for pain medication the nurses ask me to rate pain just before they give it and sometimes they come back to ask if it worked. I also get pain medication around the clock."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495418	A. BUILDING _____ B. WING _____	C 03/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRINCESS ANNE HEALTH & REHABILITATION CENTER	1948 LANDSTOWN CENTRE WAY VIRGINIA BEACH, VA 23456

(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 697	Continued From page 84 On 3/15/19 at 4:40 p.m.,during an interview with the Regional Nurse Consultant (RNC), she stated they were not able to provide evidence through any form of documentation of specific interventions tried On 3/15/19 at 4:48 p.m., during the debriefing with the Administrator, DON and RNC, the aforementioned issue was reviewed again. They stated they were going to modify the EHR that would prompt the nurses to choose interventions prior to administering pain medications as was set up for the PRN anti-anxiety medications.	F 697		
F 698 SS=E	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on medical record review, staff interviews and facility document review the facility staff failed to maintain ongoing communication with the dialysis facility and ensure resident assessment to include checking patency (bruit and thrill) of the dialysis access was done before and after dialysis treatments for 1 of 57 Residents in the survey sample, Resident #300. The facility staff failed to ensure that on Mondays, Wednesdays, and Fridays ongoing communication and collaboration was maintained with the dialysis center regarding care and services for Resident #300 and failed to ensure	F 698	F698 1. Ongoing communication and collaboration is maintained with the dialysis center regarding care and services for Resident #300. 2. Residents receiving dialysis have ongoing communication and collaboration with the dialysis center regarding care and services and are monitored for bruit and thrill. 3. Charge Nurses will be educated on: " Use of communication form to ensure ongoing communication and collaboration	4/29/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495418	A. BUILDING _____ B. WING _____	C 03/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRINCESS ANNE HEALTH & REHABILITATION CENTER	1948 LANDSTOWN CENTRE WAY VIRGINIA BEACH, VA 23456

(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 698	Continued From page 85 that Resident #300's dialysis access was checked for patency (bruit and thrill) before and after dialysis treatments The findings included: Resident #300, an 83 year old, was admitted to the facility originally on 9/28/18 and re-admitted on 3/1/19 with diagnoses to include but not limited too *End Stage Renal Disease, *Dependence on Renal Dialysis and *Hypertension. The most recent comprehensive Minimum Data Set (MDS) was an Admission 5 day with an Assessment Reference Date (ARD) of 3/8/19. The Brief Interview for Mental Status was coded as a 15 out of a possible 15 which indicated Resident #300 was cognitively intact and capable of daily decision making. Under Section O Special Treatments, Procedures, and Programs, Resident #300 was coded for Dialysis. Resident #300's Comprehensive Care Plan was reviewed and is documented in part, as follows: Focus: The resident need hemodialysis r/t (related to) renal failure. Hemodialysis at 1:00 PM chairtime every MONDAY, WEDNESDAY, and FRIDAY. Created on 10/1/18 Revision on: 3/1/19 Interventions: *Do not draw blood or take B/P (blood pressure) in left arm with graft. Created on 10/1/18 Revision on: 3/1/19 *Monitor RUE (right upper extremity) AV	F 698	with the dialysis center " Monitoring of bruit & thrill 4. A Registered Nurse will complete a random weekly review of documented communication and collaboration with the dialysis center and for monitoring of bruit and thrill for residents receiving dialysis. 5. Issues noted during the random weekly review will be presented to the Quality Assurance Committee for review and recommendation.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495418	A. BUILDING _____ B. WING _____	C 03/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRINCESS ANNE HEALTH & REHABILITATION CENTER	1948 LANDSTOWN CENTRE WAY VIRGINIA BEACH, VA 23456

(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 698	Continued From page 86 (ateriovenous fistula) shunt QS (every shift) for bruit and thrill. Created on 1/7/19 Revision on: 3/1/19 *Monitor/document/report PRN (as needed) any signs or symptoms of infection to left AV access site: Redness, Swelling, warmth or drainage. Created on 10/1/18 Revision on: 3/1/19 Resident #300's current Physician Orders were reviewed and are documented in part, as follows: HEMODIALYSIS QMWF (every Monday, Wednesday and Friday. Order Date: 3/1/19 CHECK BRUIT AND THRILL TO RUE every shift. Order Date: 3/1/19 Start date: 3/1/19 On 03/14/19 at 12:11 PM an interview was conducted with the Unit Manager RN (Registered Nurse) #2 regarding dialysis communication for Resident #300. RN #2 stated, "To my knowledge and according to our dialysis communication book, it looks like we have not sent or received any dialysis communication sheets. She had been here since 3/1/19 and goes to dialysis Monday, Wednesday, and Friday, her daughter takes her." RN #2 was then asked should the facility have communication with the dialysis center on the resident's dialysis days. RN #2 stated, "Yes they should be sent to help keep track of pre and post dialysis weights, vital signs and to see if there were any issues while the resident was at the dialysis center." The Director of Nursing was also at the nurse's desk and was	F 698		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495418	A. BUILDING _____ B. WING _____	C 03/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRINCESS ANNE HEALTH & REHABILITATION CENTER	1948 LANDSTOWN CENTRE WAY VIRGINIA BEACH, VA 23456

(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 698	Continued From page 87 asked what are her expectations for her staff in regards to communication with the dialysis center. The Director of Nursing stated, "I expect for each dialysis resident to have a communication notebook that goes back and forth with them to dialysis, and if they don't come back with the notebook I expect for the nurses to call the dialysis center and get a verbal report about the resident." Resident #300's Treatment Administration Record for March 2019 was reviewed and is documented in part, as follows: CHECK BRUIT AND THRILL TO RUE QS (every shift)-Order Date-3/1/19 The following dates and shifts were not signed off by the licensed the nurse to show the above order was carried out for Resident #300. 7-3 Shift: 3/3/19 and 3/12/19 3-11 Shift: 3/4/19, 3/5/19, 3/11/19, 3/12/19 No BPs (blood pressures) OR NEEDLE STICKS TO RUE every shift-Order Date-3/1/19 The following dates and shifts were not signed off by the licensed the nurse to show the above order was carried out for Resident #300. 7-3 Shift: 3/3/19 and 3/12/19 3-11 Shift: 3/2/19, 3/4/19, 3/5/19, 3/11/19, 3/12/19 On 03/14/19 at 12:30 PM an interview was conducted with the Unit Manager RN #2 regarding the missing nursing signatures for care on Resident #300's March Treatment Administration Record. RN #2 stated, ""She (Resident #300) was here so the MAR should have been signed off after the physician orders were	F 698		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495418	A. BUILDING _____ B. WING _____	C 03/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRINCESS ANNE HEALTH & REHABILITATION CENTER	1948 LANDSTOWN CENTRE WAY VIRGINIA BEACH, VA 23456

(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 698	Continued From page 88 followed." RN #2 was asked if the orders were followed. RN #2 stated, "If you don't initial it off it wasn't done" On 3/14/19 at approximately 6:00 PM an interview was conducted with the Director of Nursing regarding the missing nursing signatures for care on Resident #300's March Treatment Administration Record. The Director of Nursing stated, "That doesn't look good, I would not expect all those holes. If it was not documented it wasn't done." The facility policy titled "Hemodialysis" effective date 9/20/18 was reviewed and is documented in part, as follows: Policy: A licensed nurse will be responsible for monitoring access grafts/devices as ordered by the physician. Procedure: 4. Monitor for signs of bleeding and signs and symptoms of infection every shift. 5. Document findings daily on the Treatment Administration Record, and document any unusual findings and notification of physician/responsible party in the Nurses Note. 7. The Dialysis Communication Form will be initiated prior to sending patient for dialysis. A dialysis center's designated for may be used in place of Facility Dialysis Communication Form. 8. Patient reports received from dialysis center will be uploaded to the patient's EHR (electronic health record). On 3/15/19 at approximately 11:30 AM a pre-exit de-briefing was held with the Administrator, the Director of Nursing and the Regional Nurse	F 698		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495418	A. BUILDING _____ B. WING _____	C 03/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRINCESS ANNE HEALTH & REHABILITATION CENTER	1948 LANDSTOWN CENTRE WAY VIRGINIA BEACH, VA 23456

(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 698	Continued From page 89 Consultant were the above information was shared. Prior to exit no further information was provided.	F 698		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced	F 755		4/29/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495418	A. BUILDING _____ B. WING _____	C 03/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRINCESS ANNE HEALTH & REHABILITATION CENTER	1948 LANDSTOWN CENTRE WAY VIRGINIA BEACH, VA 23456

(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 755	Continued From page 90 by: Based on resident interview, staff interview, facility document review and clinical record review, it was determined that facility staff failed to ensure medications were available for two of 57 residents in the survey sample, Resident #21 and #75. 1. For Resident #21, facility staff failed to ensure her eye drops were available to be administered on 3/5/19. 2. The facility staff failed to ensure Resident #75's scheduled neuropathic pain medication, Lyrica was available to be administered as scheduled on 3/15/19. The findings include: 1. Resident #21 was admitted to the facility on 7/8/15 and readmitted on 6/16/17 with diagnoses that included but were not limited to high blood pressure, atrial fibrillation, macular degeneration, and osteoporosis. Resident #21's most recent MDS (minimum data set) assessment was an annual assessment with an ARD (assessment reference date) of 12/31/18. Resident #21 was coded as being cognitively intact in the ability to make daily decisions scoring 15 out of 15 on the BIMS (Brief Interview for Mental Status) exam. On 3/13/19 at 2:36 p.m., a group interview was conducted with six residents. Resident #21 had stated that sometimes she does not receive her eye drops at night. Review of Resident #21's most recent POS (physician order summary) revealed the following order:	F 755	F755 1. Resident #21 is receiving eye drops as ordered. Resident #75 discharged from the facility on 3/15/19. 2. A process is established to ensure that medications are available as ordered. If a medication is not available as ordered, the physician will be notified for a change in orders. 3. Charge Nurses will be educated on: " Pharmacy policy on re-ordering medications " Utilizing in-house STAT box " Notifying MD when medication is not available " Assigning appropriate times for new medications 4. A Registered Nurse will complete a random weekly review of medication administration to ensure that medications have been administered as ordered. 5. Issues noted during the random weekly review will be presented to the Quality Assurance Committee for review and recommendation.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495418	A. BUILDING _____ B. WING _____	C 03/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRINCESS ANNE HEALTH & REHABILITATION CENTER	1948 LANDSTOWN CENTRE WAY VIRGINIA BEACH, VA 23456

(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 755	Continued From page 91 "Xalatan Solution 0.005% (percent) Instill 1 drop in right eye at bedtime for glaucoma." Review of Resident #21's March 2019 MAR (medication administration record) revealed that Resident #21 had not received her Xalatan drops on 3/1/19 and 3/5/19. A "9" was coded on the MAR indicating "Other/See nurses notes." Review of Resident #21's March 2019 nursing notes failed to evidence a note for 3/1/19. A note for 3/5/19 was found that documented the following: "...medication not on hand pharmacy notified." Review of Resident #21's comprehensive care plan dated 2/10/16, documented the following: "The resident has impaired visual function r/t (related to) Macular degeneration, glaucoma per patient. Occasionally refuses eyelid cleanser...Interventions: eye drops as ordered." On 3/15/19 at 8:50 a.m., an interview was conducted with ASM (administrative staff member) #2, the DON (Director of Nursing). When asked what "9" meant on the MAR, ASM #2 stated that it looked like the eye drop wasn't given. ASM #2 agreed that she could not find a note for 3/1 but that the eye drop was not available from pharmacy on 3/5. On 3/15/19 at 1:36 p.m., an interview was conducted with LPN (licensed practical nurse) #8. When asked the process of reordering medications so that they are available for residents, LPN #8 stated that when the medication is low enough nurses should be re-ordering. LPN #8 stated with eye drops the nurses should be able to tell that the medication	F 755		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495418	A. BUILDING _____ B. WING _____	C 03/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRINCESS ANNE HEALTH & REHABILITATION CENTER	1948 LANDSTOWN CENTRE WAY VIRGINIA BEACH, VA 23456

(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 755	Continued From page 92 is running out and needs to be re-ordered. LPN #8 stated that nurses should re-order medications a week before they run out. When asked the process if she were to try to administer a medication and it was out, LPN #8 stated that if the medication was not in the STAT box, she would call pharmacy and have pharmacy send the medication as soon as possible. LPN #8 stated that she would then call the physician to see of he can order a hold on the medication until it arrives from pharmacy or change the order to medication that is available in the STAT box. LPN #8 stated that Xalatan eye drops were not in the STAT box. On 3/15/19 at 1:52 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the DON (Director of Nursing), and Corporate staff member #1 were made aware of the above concerns. (1) Xalatan Solution is indicated for the reduction of elevated intraocular pressure in patients with open-angle glaucoma or ocular hypertension. This information was obtained from The National Institutes of Health. https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=f4e73059-5ba0-4d73-9ea1-09d8d654e844. 2. Resident #75 was originally admitted to the facility 2/4/19 had never been discharged from the facility. The current diagnoses included; diabetes and neuropathic (pain). The admission Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 2/11/19, coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 15 out of a possible 15. In	F 755		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495418	A. BUILDING _____ B. WING _____	C 03/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRINCESS ANNE HEALTH & REHABILITATION CENTER	1948 LANDSTOWN CENTRE WAY VIRGINIA BEACH, VA 23456

(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 755	Continued From page 93 section "G" (Physical functioning) the resident was coded as requiring supervision of one person with personal hygiene, locomotion off the unit, and eating, limited assistance of one person with locomotion on the unit, limited assistance of 2 people with dressing, extensive assistance of one person with bathing, extensive assistance of two people with bed mobility, transfers, and toileting. In section "O100G2" the resident was coded as utilizing a non-invasive mechanical ventilator (Bipap). A physician's order dated 2/4/19, read Lyrica capsule 150 milligrams-Give one tablet by mouth two times a day for neuropathic (pain). The care plan had a problem dated 2/4/19, which read; Pain. The goal read: the resident will have no/decreased complaints of pain through next review 5/5/19. The interventions included: encourage relaxation techniques and provide diversional activities. Medicate as ordered. Position resident for comfort. Resident #75 was visited on 3/15/19, at approximately 11:00 a.m. The resident was seated on her bed complaining of severe pain to her feet. She stated when she received the Lyrica the pain was managed but when her medications were administered at approximately 9:00 a.m., the nurse stated they didn't have the Lyrica therefore, when the resident arrived home she should obtain the Lyrica and take it. An interview was conducted with the Assistant Director of Nursing at approximately 12:15 p.m. The Assistant Director of Nursing stated the Nurse Practitioner left a prescription at the facility 3/14/19 for the resident's Lyrica but the staff didn't	F 755		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495418	A. BUILDING _____ B. WING _____	C 03/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRINCESS ANNE HEALTH & REHABILITATION CENTER	1948 LANDSTOWN CENTRE WAY VIRGINIA BEACH, VA 23456

(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 755	Continued From page 94 know it until approximately 2:00 a.m. on 3/15/19. The Assistant Director of Nursing stated he contacted the pharmacy and they stated the prescription didn't arrive until 2:11 a.m., therefore the medication would arrive to the facility on the midday run. The Assistant Director of Nursing stated he would offer the resident some Percocet since the Lyrica wasn't available. At approximately 2:00 p.m., the Assistant Director of Nursing presented a new order for a one time dose of Lyrica to be administer to Resident #75 at 1:45 p.m. On 3/15/19 at approximately 7:00 p.m., the above findings were shared with the Administrator, Director of Nursing and Corporate Consultant. An opportunity was given for the facility to present additional information but none was provided.	F 755		
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse	F 757		4/29/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495418	A. BUILDING _____ B. WING _____	C 03/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRINCESS ANNE HEALTH & REHABILITATION CENTER	1948 LANDSTOWN CENTRE WAY VIRGINIA BEACH, VA 23456

(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 757	Continued From page 95 consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, it was determined that facility staff failed to ensure residents were free from unnecessary medications for one of 57 residents in the survey sample, Resident #42. For Resident #42, facility staff administered blood pressure medications when her blood pressure was below the ordered parameters. The findings include: Resident #42 was admitted to the facility on 1/31/19 with diagnoses that included but were not limited to fracture of the left lower leg, type two diabetes, high blood pressure, and Alzheimer's disease. Resident #42's most recent MDS (minimum data set) assessment was a 14 day scheduled assessment with an ARD (assessment reference date) of 2/14/19. Resident #42 was coded as being moderately impaired in cognitive function scoring 08 out of possible 15 on the BIMS (Brief Interview for Mental Status) exam. Review of Resident #42's POS (Physician Order Summary) revealed the following active physician orders: "Cardizem CD Capsule Extended Release (1) 24	F 757	F757 1. Resident #42 is receiving medications as ordered per parameters. 2. Residents receive medications as ordered per parameters. 3. Charge Nurses will be educated on: " Following physician orders for ordered parameters 4. A Registered Nurse will complete a random weekly review of medication administration to ensure that medications were given per physician ordered parameters. 5. Issues noted during the random weekly review will be presented to the Quality Assurance Committee for review and recommendation.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495418	A. BUILDING _____ B. WING _____	C 03/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRINCESS ANNE HEALTH & REHABILITATION CENTER	1948 LANDSTOWN CENTRE WAY VIRGINIA BEACH, VA 23456

(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 757	Continued From page 96	F 757		

Hour 120 MG (milligram) Give 1 capsule by mouth one time a day for afib (atrial fibrillation) hold for SBP (systolic blood pressure) (3) < (less than) 110 or HR (heart rate) < (less than) 60."

Metoprolol Tartrate Tablet 50 MG Give 1 tablet by mouth two times a day for afib hold for SBP <110 or HR <60."

Review of Resident #42's March 2019 MARS (medication administration record) revealed that Resident #42 received Cardizem and Metoprolol on 3/13/19 when her blood pressure was 107/49.

Review of Resident #42's current comprehensive care plan failed to evidence a cardiac care plan.

On 3/14/19 at 10:40 a.m., an interview was conducted with RN (registered nurse) #1, a nurse working the 300 unit. When asked what the above parameters meant that were attached to the blood pressure medication orders, RN #1 stated that blood pressure medications should be held if the systolic blood pressure is less than 110 and the heart rate is less than 60. When asked if blood pressure medication should be given if the systolic blood pressure is 107, RN #1 stated that the medication should be held (not administered). When asked what check marks meant on the MAR under a medication, RN #1 stated that the checks meant that the medication was administered. When asked if Resident #42 received her Cardizem and Metoprolol on 3/13/19 when her systolic blood pressure was below the ordered parameters, RN #1 stated, "It looks like it to me. I wouldn't have given it." When asked the potential outcome for a resident to receive blood pressure medications with a low blood pressure reading, RN #1 stated that the resident could

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495418	A. BUILDING _____ B. WING _____	C 03/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRINCESS ANNE HEALTH & REHABILITATION CENTER	1948 LANDSTOWN CENTRE WAY VIRGINIA BEACH, VA 23456

(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 757	Continued From page 97 become dizzy or bottom out (blood pressure drop) and that the facility might have to send the resident out to the hospital if they can't recover the resident. On 3/14/19 several attempts were made to contact the nurse who administered the above blood pressure medications to Resident #42 on 3/13/19. This nurse could not be reached for an interview. On 3/15/19 at 1:52 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the DON (Director of Nursing), and Corporate staff member #1 were made aware of the above concerns. A policy could not be provided on unnecessary medications. No further information was presented prior to exit. The following information is provided in Basic Nursing, Essentials for Practice, 6th edition (Potter and Perry, 2007, pages 349-360) was used as a reference for medication administration...It is essential that you verify the accuracy of every medication you give to the patient with the patient's orders. To ensure safe medication administration, be aware of the six rights of medication administration: The right medication, The right dose, The right patient, The right route, The right time, The right documentation." (1) Cardizem CD is a calcium channel blocker used to treat high blood pressure and angina (chest pain). This information was obtained from The National Institutes of Health. https://dailymed.nlm.nih.gov/dailymed/fda/fdaDrugXsl.cfm?setid=f3e7ecef-f360-4987-a4f5-933214	F 757		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495418	A. BUILDING _____ B. WING _____	C 03/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRINCESS ANNE HEALTH & REHABILITATION CENTER	1948 LANDSTOWN CENTRE WAY VIRGINIA BEACH, VA 23456

(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 757	Continued From page 98 130ab2. (2) Metoprolol Tartrate treats high blood pressure, angina, and heart failure. This information was obtained from The National Institutes of Health. https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0011186/?report=details. (3) Blood pressure is a measurement of the force applied to the walls of the arteries as the heart pumps blood through the body. The pressure is determined by the force and amount of blood pumped, and the size and flexibility of the arteries. Blood pressure readings are measured in millimeters of mercury (mmHg) and are given as two numbers, for example, 110 over 70 (written as 110/70). The top number is the systolic blood pressure reading. It represents the maximum pressure exerted when the heart contracts. The bottom number is the diastolic blood pressure reading. It represents the minimum pressure in the arteries when the heart is at rest. The information above was obtained from the web site: <http://www.nlm.nih.gov/medlineplus/ency/article/003398.htm>	F 757		
F 760 SS=D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, and clinical record review, it was determined that facility staff failed to ensure	F 760	F760 1. Resident #42 is receiving medication as ordered and without significant	4/29/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495418	A. BUILDING _____ B. WING _____	C 03/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRINCESS ANNE HEALTH & REHABILITATION CENTER	1948 LANDSTOWN CENTRE WAY VIRGINIA BEACH, VA 23456

(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 760	Continued From page 99 residents were free from significant medication errors for one of 57 residents in the survey sample, Resident #42. For Resident #42, facility staff administered blood pressure medications below the physician ordered parameters. The findings include: Resident #42 was admitted to the facility on 1/31/19 with diagnoses that included but were not limited to fracture of the left lower leg, type two diabetes, high blood pressure, and Alzheimer's disease. Resident #42's most recent MDS (minimum data set) assessment was a 14 day scheduled assessment with an ARD (assessment reference date) of 2/14/19. Resident #42 was coded as being moderately impaired in cognitive function scoring 08 out of possible 15 on the BIMS (Brief Interview for Mental Status) exam. Review of Resident #42's POS (Physician Order Sheet) revealed the following active physician orders: "Cardizem CD Capsule Extended Release (1) 24 Hour 120 MG (milligram) Give 1 capsule by mouth one time a day for afib (atrial fibrillation) hold for SBP (systolic blood pressure) (3) < (less than) 110 or HR (heart rate) < (less than) 60." Metoprolol Tartrate Tablet (2) 50 MG Give 1 tablet by mouth two times a day for afib hold for SBP <110 or HR <60." Review of Resident #42's March 2019 MARS (medication administration record) revealed that	F 760	medication error. 2. Residents receive medications as ordered and without significant medication error. 3. Charge Nurses will be educated on: " Following physician orders for ordered parameters 4. A Registered Nurse will complete a random weekly review of medication administration to ensure that medications were given per physician ordered parameters. 5. Issues noted during the random weekly review will be presented to the Quality Assurance Committee for review and recommendation.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495418	A. BUILDING _____ B. WING _____	C 03/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRINCESS ANNE HEALTH & REHABILITATION CENTER	1948 LANDSTOWN CENTRE WAY VIRGINIA BEACH, VA 23456

(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 760	Continued From page 100 Resident #42 received Cardizem and Metoprolol on 3/13/19 when her blood pressure was 107/49. Review of Resident #42's comprehensive care plan failed to evidence a cardiac care plan. On 3/14/19 at 10:40 a.m., an interview was conducted with RN (registered nurse) #1, a nurse working the 300 unit. When asked what the above parameters meant that were attached to the blood pressure medication orders, RN #1 stated that blood pressure medications should be held if the systolic blood pressure is less than 110 and the heart rate is less than 60. When asked if blood pressure medication should be given if the systolic blood pressure is 107, RN #1 stated that the medication should be held (not administered). When asked what check marks meant on the MAR under a medication, RN #1 stated that the checks meant that the medication was administered. When asked if Resident #42 received her Cardizem and Metoprolol on 3/13/19 when her systolic blood pressure was below the ordered parameters, RN #1 stated, "It looks like it to me. I wouldn't have given it." When asked the potential outcome for a resident to receive blood pressure medications with a low blood pressure reading, RN #1 stated that the resident could become dizzy or bottom out (blood pressure drop) and that the facility might have to send the resident out to the hospital if they can't recover the resident. When asked if she would consider this medication error to be significant, RN #1 stated that she would. On 3/14/19 several attempts were made to contact the nurse who administered the above blood pressure medications to Resident #42 on 3/13/19. This nurse could not be reached for an	F 760		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495418	A. BUILDING _____ B. WING _____	C 03/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRINCESS ANNE HEALTH & REHABILITATION CENTER	1948 LANDSTOWN CENTRE WAY VIRGINIA BEACH, VA 23456

(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 760	Continued From page 101 interview. On 3/15/19 at 1:52 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the DON (Director of Nursing), and Corporate staff member #1 were made aware of the above concerns. A policy could not be provided on medication administration. (1) Cardizem CD is a calcium channel blocker used to treat high blood pressure and angina (chest pain). This information was obtained from The National Institutes of Health. https://dailymed.nlm.nih.gov/dailymed/fda/fdaDrugXsl.cfm?setid=f3e7ecef-f360-4987-a4f5-933214130ab2. (2) Metoprolol Tartrate treats high blood pressure, angina, and heart failure. This information was obtained from The National Institutes of Health. https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0011186/?report=details. (3) Blood pressure is a measurement of the force applied to the walls of the arteries as the heart pumps blood through the body. The pressure is determined by the force and amount of blood pumped, and the size and flexibility of the arteries. Blood pressure readings are measured in millimeters of mercury (mmHg) and are given as two numbers, for example, 110 over 70 (written as 110/70). The top number is the systolic blood pressure reading. It represents the maximum pressure exerted when the heart contracts. The bottom number is the diastolic blood pressure reading. It represents the minimum pressure in the arteries when the heart is at rest. The information above was obtained	F 760		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495418	A. BUILDING _____ B. WING _____	C 03/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRINCESS ANNE HEALTH & REHABILITATION CENTER	1948 LANDSTOWN CENTRE WAY VIRGINIA BEACH, VA 23456

(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 760	Continued From page 102 from the web site: <http://www.nlm.nih.gov/medlineplus/ency/article/003398.htm>	F 760		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews the facility staff failed to discard an outdated multi-dose vial of PPD (a purified protein derivative) vaccine. The facility staff failed to ensure a Humalog (insulin) pen was labeled with	F 761	F761 1. The outdated multi-dose vial of PPD vaccine was discarded on 3/15/19. The unlabeled Humalog pen was discarded on	4/29/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495418	A. BUILDING _____ B. WING _____	C 03/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRINCESS ANNE HEALTH & REHABILITATION CENTER	1948 LANDSTOWN CENTRE WAY VIRGINIA BEACH, VA 23456

(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 761	Continued From page 103 the resident's name and failed to date a Humalog insulin pen once opened. 1. The facility staff failed to discard a multi-dose vial of PPD vaccine used for a skin test to determine tuberculosis (TB) stored inside the medication refrigerator on Unit 4. 2. The facility staff failed to ensure one (1) Humalog (insulin) pen located inside the medication cart on Unit (1) cart 1 was was labeled with the resident's name. 3. The facility staff failed to ensure one Humalog (insulin) pen located inside the medication cart on Unit 3 (cart 2) was dated once opened. The finding included: 1. On 03/15/19 at approximately 10:30 a.m., the medication refrigerator was inspected on Unit 4 with Licensed Practical Nurse (LPN) #2. Stored inside the medication refrigerator was an opened multidose vial of PPD vaccine with an open date of 02/02/19. The surveyor asked LPN #2 how long is PPD good for once opened, she replied "30 days." The surveyor asked, "Should the open vial of PPD dated 02/02/19 still be stored inside the medication refrigerator" she replied, "No ma'am." An interview was conducted with the Director of Nursing (DON) on 03/15/19 at approximately 12:43 p.m. The DON stated, "PPD solution is only good for 30 days after being open." The surveyor asked, "Should the multi-dose of PPD solution with an open date of 02/02/19 still be stored in the medication refrigerator" she relied "No."	F 761	3/15/19. The undated Humalog pen was discarded on 3/15/19. 2. Medications are properly stored with labeling and dating when opened. 3. Charge Nurses will be educated on: " Labeling of medications " Dating of medication when opened " Monitoring of labels and dating when opened 4. A Registered Nurse will complete a random weekly review of the medication storage areas to ensure that medications are labeled and dated when opened. 5. Issues noted during the random weekly review will be presented to the Quality Assurance Committee for review and recommendation.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495418	A. BUILDING _____ B. WING _____	C 03/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRINCESS ANNE HEALTH & REHABILITATION CENTER	1948 LANDSTOWN CENTRE WAY VIRGINIA BEACH, VA 23456

(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 761	Continued From page 104 Manufacture Guidelines: -Aplisol (PPD) vials should be inspected visually for both particulate matter and discoloration prior to administration and discarded if either is seen. Vials is use for more than 30 days should be discarded due to possible oxidation and degradation which may affect potency. 2. On 03/15/19 at approximately 11:35 p.m., the medication cart (cart 1) was inspected on Unit 1 with LPN #4. Stored inside the medication cart was a Humalog (insulin) pen with the resident's name removed. The surveyor asked, "Who does the insulin pen belong too, she replied, "I'm not sure because the label has been partially removed." The surveyor asked, "Who is responsible to ensure all insulin pens are properly labeled" she replied, "All the nurses are responsible." An interview was conducted with the DON on 03/15/19 at approximately 12:43 p.m. The DON stated, "The Humalog insulin pen should have been removed from the medication cart and reordered. She said the resident's name on the insulin pen should be clear to identity who that insulin pen belongs too." 3. On 03/15/19 at approximately 11:45 a.m., the medication cart (cart 2) was inspected on Unit 3 with LPN #3. Stored inside the medication cart was a Humalog (insulin) pen without an open date. The LPN was asked, "When was the Humalog pen opened" she replied, "I am not sure what happened, some made a mistake and did not date the insulin pen once they opened it." The surveyor asked, "Should the Humalog insulin pen have been dated once open she replied,	F 761		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495418	A. BUILDING _____ B. WING _____	C 03/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRINCESS ANNE HEALTH & REHABILITATION CENTER	1948 LANDSTOWN CENTRE WAY VIRGINIA BEACH, VA 23456

(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 761	Continued From page 105 "Yes." An interview was conducted with the DON on 03/15/19 at approximately 12:43 p.m. The DON stated, "The insulin pen should have been dated immediately after being open." She said by the insulin not being dated once open; there is no way to know how long the insulin pen is good for. The Administration was informed of the finding during a briefing on 03/15/19 at approximately 4:45 p.m. The facility did not present any further information about the findings. The facility's policy titled 5.3 Storage and Expirations, Biologicals, Syringes and Needles (Last revision date 01/01/13). 5. Once any medication or biological package is opened, the Facility should follow manufactures/supplier guidelines with respect to expiration dates for opened medications. Facility should record the date opened on the medications container when the medication has a shortened expiration date once opened. 6. Facility should destroy and recorder medications and biologicals with soiled, illegible, worn, makeshift, incomplete, damaged or missing labels. Definitions: *Humalog is a fast-acting insulin that starts to work about 15 minutes after injection, peaks in about 1 hour, and keeps working for 2 to 4 hours. Insulin is a hormone that works by lowering levels of glucose (sugar) in the blood (https://www.drugs.com/humalog.html). *Tuberculosis (TB) is a potentially serious	F 761		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495418	A. BUILDING _____ B. WING _____	C 03/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRINCESS ANNE HEALTH & REHABILITATION CENTER	1948 LANDSTOWN CENTRE WAY VIRGINIA BEACH, VA 23456

(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 761	Continued From page 106 infectious disease that mainly affects your lungs. The bacteria that cause tuberculosis are spread from one person to another through tiny droplets released into the air via coughs and sneezes (https://www.mayoclinic.org/diseases-conditions/tuberculosis/symptoms).	F 761		
F 803 SS=D	Menus Meet Resident Nds/Prep in Adv/Followed CFR(s): 483.60(c)(1)-(7) §483.60(c) Menus and nutritional adequacy. Menus must- §483.60(c)(1) Meet the nutritional needs of residents in accordance with established national guidelines.; §483.60(c)(2) Be prepared in advance; §483.60(c)(3) Be followed; §483.60(c)(4) Reflect, based on a facility's reasonable efforts, the religious, cultural and ethnic needs of the resident population, as well as input received from residents and resident groups; §483.60(c)(5) Be updated periodically; §483.60(c)(6) Be reviewed by the facility's dietitian or other clinically qualified nutrition professional for nutritional adequacy; and §483.60(c)(7) Nothing in this paragraph should be construed to limit the resident's right to make personal dietary choices. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff	F 803	F803	4/29/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495418	A. BUILDING _____ B. WING _____	C 03/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRINCESS ANNE HEALTH & REHABILITATION CENTER	1948 LANDSTOWN CENTRE WAY VIRGINIA BEACH, VA 23456

(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 803	Continued From page 107 interview and facility document review, it was determined that facility staff failed to ensure residents were able to make their own dietary choices for one of 57 residents in the survey sample, Resident # 94. For Resident #94, facility staff failed to follow her ordered food preferences for lunch on 3/12/19. The findings include: Resident #94 was admitted to the facility on 2/19/19 with diagnoses that included but were not limited to muscle weakness, UTI (urinary tract infection), hypothyroidism and high blood pressure. Resident #94's most recent MDS (minimum data set) assessment was a 5 day scheduled assessment with an ARD (assessment reference date) of 2/26/19. Resident #94 was coded as being intact in cognitive function scoring 15 out of possible 15 on the BIMS (Brief Interview for Mental Status) exam. On 3/12/19 at 1:00 p.m., an interview was conducted with Resident #94. Resident #94 stated that she was excited for lunch and that she had ordered the chicken cordon bleu. At the same time the activities assistant (OSM (other staff member)) #2, entered the room and presented Resident #94 her lunch. OSM #2 lifted the top of her plate and presented the resident with a Salisbury steak. Resident #94's meal ticket was checked for "Chicken Cordon Bleu." When Resident #94 asked what had happened to her original order, OSM #2 stated that the kitchen had run out of the chicken cordon bleu. OSM #2 then stated she could get the resident a sandwich instead of the steak. Resident #94 declined the sandwich and stated that the steak was fine.	F 803	1. Resident #94 is receiving foods per dietary choice. 2. Residents receive food per their dietary choice. 3. Facility staff will be educated on: " Provision of residents□ dietary choice 4. Administrative staff will complete random weekly reviews of provision of dietary choice. 5. Issues noted during the random weekly review will be presented to the Quality Assurance Committee for review and recommendation.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495418	A. BUILDING _____ B. WING _____	C 03/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRINCESS ANNE HEALTH & REHABILITATION CENTER	1948 LANDSTOWN CENTRE WAY VIRGINIA BEACH, VA 23456

(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 803	Continued From page 108 On 3/12/19 at 3:08 p.m., further interview was conducted with Resident #94. When asked how lunch went, Resident #94 stated that she was looking forward to the chicken cordon bleu and was not sure how the kitchen ran out. Resident #94 stated that she was not asked ahead of time if the steak option was okay with her. On 3/14/19 at 8:52 a.m., an interview was conducted with OSM #4, the dietary aide. When asked the process if the kitchen runs out of food, OSM #4 stated that he works in the kitchenettes on the hallways and will call to the main kitchen if he runs out of food items. OSM #4 could not recall the main kitchen ever running out of food. OSM #4 stated that he would probably offer a substitute item if that ever happened. When asked how kitchen staff ensure there is enough food for all residents, OSM #4 stated that all residents will pick their meals for the day on a meal ticket. OSM #4 stated that these sheets are passed out the day prior. OSM #4 stated that kitchen staff collect these sheets/tickets at night or in the morning. OSM #4 stated that items are counted before cooking is started. When asked who passes out trays from the kitchenettes to the residents rooms, OSM #4 stated that CNAs (certified nursing assistants) pass out trays to the residents in their rooms. On 3/14/19 at 9:10 a.m., an interview was conducted with CNA (certified nursing assistant) #1, a CNA on the 300 hall. When asked where the food comes from for the residents who eat in their rooms, CNA #1 stated that she passes out trays from the kitchenette area to the hallways. When asked the process if she were to run out of food, CNA#1 stated that she would go to the main	F 803		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495418	A. BUILDING _____ B. WING _____	C 03/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRINCESS ANNE HEALTH & REHABILITATION CENTER	1948 LANDSTOWN CENTRE WAY VIRGINIA BEACH, VA 23456

(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 803	Continued From page 109 kitchen to go get it. CNA #1 stated that she worked the 300 unit on 3/12/19 and could not recall running out of food items. On 3/14/19 at 9:22 a.m., an interview was conducted with OSM #2, the activities assistant. When asked if she helps with passing out meal trays to residents, OSM #2 stated, "For lunch time." When asked where the trays come from, OSM #2 stated that the trays come from the dining areas on the units. When asked the process if the kitchenettes/dining areas run out of food items, OSM #2 stated that she would offer other options to the residents. When asked if the main kitchen had run out of the chicken cordon bleu on 3/12/19, OSM #2 stated that she was not sure because she did not go to the main kitchen to check. When asked if she should have checked with the main kitchen for Resident #94's chicken cordon bleu, OSM #2 stated that she should have. On 3/14/19 at 9:35 a.m., an interview was conducted with OSM #3, the dietary manager. OSM #3 stated that he had more than enough food options on 3/12/19 and that they did not run out of the chicken cordon blue that day. OSM #3 stated that they never run out of food items because they count the number of meal tickets and cook extra. On 3/15/19 at 1:52 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the DON (Director of Nursing), and Corporate staff member #1 were made aware of the above concerns.	F 803		
F 842 SS=E	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5)	F 842		4/29/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495418	A. BUILDING _____ B. WING _____	C 03/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRINCESS ANNE HEALTH & REHABILITATION CENTER	1948 LANDSTOWN CENTRE WAY VIRGINIA BEACH, VA 23456

(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 842	Continued From page 110 §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted	F 842		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495418	A. BUILDING _____ B. WING _____	C 03/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRINCESS ANNE HEALTH & REHABILITATION CENTER	1948 LANDSTOWN CENTRE WAY VIRGINIA BEACH, VA 23456

(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 842	Continued From page 111 by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on medical record review, staff interviews and facility document review the facility staff failed to ensure that medical records were complete and accurate for 2 of 57 Residents in the survey sample, Resident #300 and Resident #21. 1. The facility staff failed to ensure that Resident #300's March Treatment Administration Record was complete 2. The facility staff failed to document the reason	F 842	F842 1. Resident #300 Treatment Administration Record is currently complete. Resident #21 is receiving eye drops as ordered and as documented. 2. Resident medical records are complete and accurate. 3. Charge Nurses will be educated on: " Documentation of medications and treatments	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495418	A. BUILDING _____ B. WING _____	C 03/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRINCESS ANNE HEALTH & REHABILITATION CENTER	1948 LANDSTOWN CENTRE WAY VIRGINIA BEACH, VA 23456

(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 842	Continued From page 112 Resident #21's eye drops was not administered on 3/1/19. The findings included: 1. Resident #300, an 83 year old, admitted to the facility originally on 9/28/18 and re-admitted on 3/1/19 with diagnoses to include but not limited too *End Stage Renal Disease, *Dependence on Renal Dialysis and *Hypertension. The most recent comprehensive Minimum Data Set (MDS) was an Admission 5 day with an Assessment Reference Date (ARD) of 3/8/19. The Brief Interview for Mental Status was coded as a 15 out of a possible 15 which indicates Resident #300 is cognitively intact and capable of daily decision making. Under Section O Special Treatments, Procedures, and Programs, Resident #300 was coded for Dialysis. Resident #300's Comprehensive Care Plan was reviewed and is documented in part, as follows: Focus: The resident need hemodialysis r/t (related to) renal failure. Hemodialysis at 1:00 PM chairtime every MONDAY, WEDNESDAY, and FRIDAY. Created on 10/1/18 Revision on: 3/1/19 Interventions: *Do not draw blood or take B/P (blood pressure) in left arm with graft. Created on 10/1/18 Revision on: 3/1/19 *Monitor RUE (right upper extremity) AV (ateriovenous fistula) shunt QS (every shift) for	F 842	" Documentation of reason medication is not administered as ordered 4. A Registered Nurse will complete a random weekly monitor of medical records to ensure that medications and treatments are documented as administered and that the reason is documented if a medication is not administered as ordered. 5. Issues noted during the random weekly review will be presented to the Quality Assurance Committee for review and recommendation.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495418	A. BUILDING _____ B. WING _____	C 03/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRINCESS ANNE HEALTH & REHABILITATION CENTER	1948 LANDSTOWN CENTRE WAY VIRGINIA BEACH, VA 23456

(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 842	Continued From page 113 bruit and thrill. Created on 1/7/19 Revision on: 3/1/19 *Monitor/document/report PRN (as needed) any signs or symptoms of infection to left AV access site: Redness, Swelling, warmth or drainage. Created on 10/1/18 Revision on: 3/1/19 Resident #300's current Physician Orders were reviewed and are documented in part, as follows: HEMODIALYSIS QMWF (every Monday, Wednesday and Friday. Order Date: 3/1/19 CHECK BRUIT AND THRILL TO RUE every shift. Order Date: 3/1/19 Start date: 3/1/19 Resident #300's Treatment Administration Record (TAR) for March 2019 was reviewed and is documented in part, as follows: CHECK BRUIT AND THRILL TO RUE QS (every shift) -Order Date-3/1/19 The following dates and shifts were not signed off by the licensed the nurse to show the above order was carried out for Resident #300. 7-3 Shift: 3/3/19 and 3/12/19 3-11 Shift: 3/4/19, 3/5/19, 3/11/19, 3/12/19 No BPs (blood pressures) OR NEEDLE STICKS TO RUE every shift -Order Date-3/1/19 The following dates and shifts were not signed off by the licensed the nurse to show the above order was carried out for Resident #300. 7-3 Shift: 3/3/19 and 3/12/19	F 842		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495418	A. BUILDING _____ B. WING _____	C 03/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRINCESS ANNE HEALTH & REHABILITATION CENTER	1948 LANDSTOWN CENTRE WAY VIRGINIA BEACH, VA 23456

(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 842	Continued From page 114 3-11 Shift: 3/2/19, 3/4/19, 3/5/19, 3/11/19, 3/12/19 On 03/14/19 at 12:30 PM an interview was conducted with the Unit 300 Manager RN #2 regarding the missing nursing signatures for care on Resident #300's March Treatment Administration Record. RN #2 stated, ""She (Resident #300) was here so the MAR should have been signed off after the physician orders were followed." RN #2 was asked if the orders were followed. RN #2 stated, "If you don't initial it off it wasn't done" On 3/14/19 at approximately 6:00 PM an interview was conducted with the Director of Nursing regarding the missing nursing signatures for care on Resident #300's March Treatment Administration Record. The Director of Nursing stated, "That doesn't look good, I would not expect all those holes. If it was not documented it wasn't done." The facility policy titled "Documentation Summary" effective date 2/1/15 was reviewed and is documented in part, as follows: Policy: Licensed Nurses and CNA's (Certified Nursing Assistants) will document all pertinent nursing assessments, care interventions, and follow up actions in the medical record. Procedure: 17. It is illegal to willfully falsify entries on MAR"s, TAR's, and other flow sheet records, and illegal to go back and fill in "holes." If the staff has total recall, omissions can be completed with 24 hours of the event. Note date of entry. If an omission is	F 842		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495418	A. BUILDING _____ B. WING _____	C 03/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRINCESS ANNE HEALTH & REHABILITATION CENTER	1948 LANDSTOWN CENTRE WAY VIRGINIA BEACH, VA 23456

(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 842	Continued From page 115 older than 24 hours and the staff member does have clear recollection or clear supporting documentation, a late entry is used. Self-monitoring, or an end-of-the-shift review should occur in order to assure that documentation is complete. If an omission is older than 24 hours and the staff member does not have clear recollection or clear supporting documentation, the record should be left blank. 18. Every change in the patient's condition or significant patient care issues will be noted and charted until the condition is resolved or stabilized. Documentation that provides evidence of follow-through is critical. Use summary statements to describe changes of condition, stating objective facts. On 6/15/19 at approximately 11:30 AM a pre-exit de-briefing was held with the Administrator, the Director of Nursing and the Regional Nurse Consultant were the above information was shared. Prior to exit no further information was provided. 2. Resident #21 was admitted to the facility on 7/8/15 and readmitted on 6/16/17 with diagnoses that included but were not limited to high blood pressure, atrial fibrillation, macular degeneration, and osteoporosis. Resident #21's most recent MDS (minimum data set) assessment was an annual assessment with an ARD (assessment reference date) of 12/31/18. Resident #21 was coded as being cognitively intact in the ability to make daily decisions scoring 15 out of 15 on the BIMS (Brief Interview for Mental Status) exam. On 3/13/19 at 2:36 p.m., a group interview was conducted with six residents. Resident #21 had stated that sometimes she does not receive her	F 842		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495418	A. BUILDING _____ B. WING _____	C 03/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRINCESS ANNE HEALTH & REHABILITATION CENTER	1948 LANDSTOWN CENTRE WAY VIRGINIA BEACH, VA 23456

(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 842	Continued From page 116 eye drops at night. Review of Resident #21's most recent POS (physician order summary) revealed the following order: "Xalatan Solution 0.005% (percent) Instill 1 drop in right eye at bedtime for glaucoma." Review of Resident #21's March 2019 MAR (medication administration record) revealed that Resident #21 had not received her Xalatan drops on 3/1/19 and 3/5/19. A "9" was coded on the MAR indicating "Other/See nurses notes." Review of Resident #21's March 2019 nursing notes failed to evidence a note for 3/1/19. A note for 3/5/19 was found that documented the following: "...medication not on hand pharmacy notified." There was no evidence in the clinical record that the physician was made aware of the two missed doses. Further review of the clinical record failed to evidence the reason Resident #21 missed her eye drop on 3/1/19. Review of Resident #21's comprehensive care plan dated 2/10/16, documented the following: "The resident has impaired visual function r/t (related to) Macular degeneration, glaucoma per patient. Occasionally refuses eyelid cleanser...Interventions: eye drops as ordered." On 3/15/19 at 8:50 a.m., an interview was conducted with ASM (administrative staff member) #2, the DON (Director of Nursing). When asked what "9" meant on the MAR, ASM	F 842		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495418	A. BUILDING _____ B. WING _____	C 03/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRINCESS ANNE HEALTH & REHABILITATION CENTER	1948 LANDSTOWN CENTRE WAY VIRGINIA BEACH, VA 23456

(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 842	Continued From page 117 #2 stated that it looked like the eye drop wasn't given. ASM #2 agreed that she could not find a note for 3/1 but that the eye drop was not available from pharmacy on 3/5. On 3/15/19 at 9:30 a.m., an interview was conducted with LPN (licensed practical nurse) #6. When asked what "9" meant on the MAR, LPN #6 stated that the code "9" meant that the medication was not given. When asked how we would know why the 3/1/19 eye drop was not given if there is no note documenting the reason why it wasn't given, LPN #6 stated that we wouldn't know. LPN #6 stated that the reason for the missed eye drop on 3/1/19 should have been documented in the clinical record. LPN #6 stated that the physician should have also been notified for both eye drops missed and that a note should also be documented. On 3/15/19 at 1:52 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the DON (Director of Nursing), and Corporate staff member #1 were made aware of the above concerns. Facility policy titled, "Documentation Summary," documents in part, the following: "Licensed nurses and CNAs (certified nursing assistants) will document all pertinent nursing assessments, care interventions, and follow up actions in the medical record." In Fundamentals of Nursing, 6th edition (Potter and Perry, 2005, p. 482), the following information related to documentation was provided: "The information within a recorded entry or a report needs to be complete, containing appropriate and essential information."	F 842		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495418	A. BUILDING _____ B. WING _____	C 03/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRINCESS ANNE HEALTH & REHABILITATION CENTER	1948 LANDSTOWN CENTRE WAY VIRGINIA BEACH, VA 23456

(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 842	Continued From page 118 (1) Xalatan Solution is indicated for the reduction of elevated intraocular pressure in patients with open-angle glaucoma or ocular hypertension. This information was obtained from The National Institutes of Health. https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=f4e73059-5ba0-4d73-9ea1-09d8d654e844.	F 842		