COMMONWEALTH of VIRGINIA

Department of Health

Office of Licensure and Certification

M. Norman Oliver, MD, MA
State Health Commissioner

TYY 7-1-1 OR
1-800-828-1120
9960 Mayland Drive, Suite 401
Henrico, Virginia 23233-1485
Fax (804) 527-4502

November 28, 2018

Ms. Tenille Taylor, Administrator
Bayside Of Poquoson Health And Rehab
1 Vantage Drive
Poquoson, VA 23662

RE: Bayside Of Poquoson Health And Rehab
Provider Number 495264

Dear Ms. Taylor:

Based on deficiencies cited during the survey ending September 21, 2018, your facility was found not to be in compliance with Federal participation requirements for the long term care Medicare and/or Medicaid programs. On November 14, 2018 through November 15, 2018, surveyors from the Virginia Department of Health's Office of Licensure and Certification conducted an unannounced revisit to verify that your facility had achieved and maintained compliance for deficiencies cited during the previous survey. No complaints were investigated during the survey.

All references to regulatory requirements contained in this letter are found in Title 42, Code of Federal Regulations.

Survey Results

The survey findings are reflected on the enclosed Statement of Isolated Deficiencies ("A" Form) and/or the Statement of Deficiencies and Plan of Correction (CMS-2567) and/or the Post-Certification Revisit Report (CMS-2567). All survey findings generated on these forms (including the most recent standard survey and any subsequent revisits or complaint investigations) constitute the facility's current survey report. In accordance with §483.10(g) of the Federal requirements, the current survey report must be made available for examination in a place readily accessible to residents and is disclosable to all interested parties.

We had presumed, based on your allegation of compliance, that your facility was in substantial compliance. The November 15, 2018 revisit established the facility continues noncompliance with program requirements, including an isolated deficiency that constitutes actual harm that is not immediate jeopardy (S/S of G), as evidenced by the attached CMS-2567L, whereby significant corrections are required.

Plan of Correction (PoC)

A PoC is not required for deficiencies cited on the Statement of Isolated Deficiencies, "A" Form. Nevertheless, the facility is expected to address and correct all areas of concern noted on this form.

Unless specifically otherwise indicated, a PoC for all certification and licensure deficiencies cited on the Statement of Deficiencies and Plan of Correction (CMS-2567) must be submitted within ten (10) calendar days of receipt of these survey findings to Laura Veuhoff, LTC Supervisor, at: Office of Licensure and Certification, Division of Long Term Care Services, 9960 Mayland Drive, Suite 401, Richmond, Virginia 23233. **If you are participating in ePOC, please submit your Plan of Correction through the ePOC website.**

To be considered acceptable, the PoC must:

1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;
2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice;
3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;
4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; and
5. Include dates when the corrective action will be completed. (The "outside" date by which all corrections must be made is the 45th calendar day after the survey ended.)

The PoC will serve as the facility's allegation of compliance. If an acceptable plan is not submitted, the State Survey Agency may propose to the Center for Medicare and Medicaid Services (CMS) Regional Office and/or the State Medicaid agency that remedies be imposed immediately within applicable notice requirements.

Informal Dispute Resolution

Following the receipt and review of your survey report, please contact the assigned supervisor to attempt to resolve any problems or concerns you may have about the citations. If those concerns are not resolved, in accordance with §488.331, you have one opportunity to question cited federal certification deficiencies through the Office's Informal Dispute Resolution Process, which may be accessed at http://www.vdh.state.va.us/OLC/longtermcare/

To be given such an opportunity, you are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to: Director, Division of Long Term Care, Office of Licensure and Certification, 9960 Mayland Drive, Suite 401, Richmond, Virginia 23233. To be considered, the IDR request must follow the IDR guidelines and be received at the Office within 10 calendar days of your receipt of the enclosed survey findings. **An incomplete informal dispute resolution process will not delay the effective date of the imposition of any enforcement actions.**

In regards to previously listed potential remedies, by copy of this letter we are notifying the Centers for Medicare and Medicaid Services (CMS) Regional Office and the State Medicaid Agency (DMAS) that this revisit found your facility was not in in substantial compliance with the participation requirements.

Recommended Remedies

The results of the September 21, 2018 survey were forwarded to you under the October 4, 2018 initial letter. At that time, we indicated several remedies could be imposed by the Centers for Medicare and Medicaid Services (CMS) Regional Office and the State Medicaid Agency (Virginia Department of Medical Assistance Services) if compliance was not achieved. We are, by copy of this letter, notifying the CMS Regional Office and Virginia DMAS that the facility had not achieved compliance with program requirements at the time of the November 15, 2018 revisit. Those agencies will notify you about any remedy they intend to impose.

Please be advised: The facility must maintain compliance with both the Health and the Life Safety Code requirements in order to continue provider certification.

Notification

Based on the outcome of this revisit, you must notify the facility residents, responsible parties, interested family members, staff, attending physicians, and the appropriate governing body of the current compliance status of the facility. Specifically, if a second revisit determines that the facility is still not in substantial compliance with the program requirements, it is highly probable that procedures for transferring Medicare and Medicaid recipients will be initiated. Please forward, to my attention, your plan for implementing this notification and a sample of the correspondence you will be using.

We will notify the General Assembly representatives from your District so they will also be aware of the facility's current compliance status and possible outcomes.

Survey Response Form

The Survey Response Form is offered as a method to share your review of the onsite survey process. Please take a moment to complete this evaluation, which is available at: http://www.vdh.virginia.gov/OLC/Downloadables/documents/2011/pdf/LTC%20facility%20survey%20response%20form.pdf We will appreciate your participation.

If you have any questions concerning the content of this letter, please contact me at 804-367-2100.

Sincerely,

Robert Payne, Director
Office of Licensure and Certification

Enclosures

cc: Joani Latimer, State Ombudsman
Bertha Ventura, Dmas (Sent Electronically)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495264	A. BUILDING _____ B. WING _____	R 11/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAYSIDE OF POQUOSON HEALTH AND REHAB	1 VANTAGE DRIVE POQUOSON, VA 23662

(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 revisit to the standard survey conducted 09/18/18 through 09/21/18, was conducted 11/14/18 through 11/15/18. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities.	{E 000}		
{F 000}	INITIAL COMMENTS An unannounced Medicare/Medicaid revisit to the standard survey conducted 09/18/18 through 09/21/18, was conducted 11/14/18 through 11/15/18. Significant corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care Requirements. No complaints were investigated during the survey. The census in this 60 certified bed facility was 50 at the time of the survey. The survey sample consisted of 10 Current Resident reviews (Residents #101 through #109 and #111) and 1 closed record review (Resident #110).	{F 000}		
{F 583} SS=D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the	{F 583}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Jemelle Taylor | TITLE: Administrator | (X6) DATE: 12/5/18

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495264	A. BUILDING _____ B. WING _____	R 11/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAYSIDE OF POQUOSON HEALTH AND REHAB	1 VANTAGE DRIVE POQUOSON, VA 23662

(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 583}	Continued From page 1 residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and facility document review the facility staff failed to ensure personal privacy and confidentiality for 2 of 11 residents in the survey sample, Resident #111 and Resident #102. 1. The facility staff failed to ensure the privacy and confidentiality of Resident #111's medical record after a wound care observation. 2. The facility staff failed to ensure Resident #102's privacy was maintained during wound care dressing change. The findings included:	{F 583}	**F583** **Action Taken:** **1. Resident #102 medical record removed from biohazard box and shred. Resident #111 is provided privacy during delivery of care.** **2. An audit of privacy curtains was assessed to ensure all resident rooms have privacy curtains to identify any residents at risk for privacy issues.** **All resident could be potential for data breach.** **3. The DON/designee re-educate wound care physician and nursing staff on providing privacy during delivery of care. Regional Director of Clinical Service/designee educated staff on protecting patients' medical information and proper disposal.** **4. DON/designee will complete audits 3 x week x 2 months to ensure the residents privacy and monitor the destruction of medical records during wound care observation rounds.** **5. Audits will be reviewed in monthly and quarterly QAPI Meetings** **11/30/2018**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495264	A. BUILDING _____ B. WING _____	R 11/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAYSIDE OF POQUOSON HEALTH AND REHAB	1 VANTAGE DRIVE POQUOSON, VA 23662

(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 583}	Continued From page 2	{F 583}		

1. Resident #111 was a 84 year old admitted to the facility originally on 8/6/18 and readmitted on 9/28/18 with diagnoses to include Diabetes Mellitus and Dementia.

The most recent comprehensive Minimum Data Set (MDS) assessment was an Admission assessment with an Assessment Reference Date (ARD) of 10/5/18. The Brief Interview for Mental Status (BIMS) was a 4 out of a possible 15 which indicated that Resident #11 was cognitively impaired and not capable of daily decision making. Under Section G Functional Status Resident #111 was coded as requiring extensive one person physical assist for bed mobility. Under Section M Skin Conditions Resident #111 was coded at risk for developing pressure ulcers and pressure reducing device for bed and chair.

On 11/15/18 at approximately 10:30 A.M. a wound care observation was conducted with LPN (Licensed Practical Nurse) #1. Prior to doing Resident #111's wound care LPN #1 printed the residents wound care orders and carried them into the resident's room. After the completion of the wound care LPN #1 ripped Resident #111's wound care orders in strips and placed them in a red biohazard bag. LPN #1 carried the red biohazard bag out of the room, took it to the soiled utility room and placed it into the biohazard trash container. The surveyor asked LPN #1 how she disposed of Resident #111's wound care orders after completing the wound care. LPN #1 stated, "I shredded them up and put then in the red biohazard bag. I didn't want to put them in the shredder since she was on isolation."

The facility policy titled "Resident Rights" effective 1/2017 was reviewed and is documented in part,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495264	A. BUILDING _____ B. WING _____	R 11/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAYSIDE OF POQUOSON HEALTH AND REHAB	1 VANTAGE DRIVE POQUOSON, VA 23662

(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 583}	Continued From page 3	{F 583}		

as follows"

The Resident has the right to personal privacy and confidentiality of his or her personal and clinical records.

On 11/15/18 at approximately 5:20 P.M. the above observation was discussed with the Administrator. The Administrator was asked what she would have expected of LPN #1 in regards to Resident #111's clinical record. The Administrator stated, "I would have expected her to not have taken them into the room and if she did to bag them up and place them in the shredder. Because those documents have the residents information on it and its a HIPAA(Health Insurance Portability and Accountability Act) violation."

Prior to exit the Administrator stated she spoke to LPN #1 and Resident #111's medical record documents had been removed from the biohazard box. No further information was shared.

2. Resident #102 was admitted to the facility on 07/18/17. Diagnosis for Resident #102 included, but not limited to, *Down syndrome, *Autistic disorder and *Muscle weakness. Resident #102's Minimum Data Set (MDS-an assessment protocol) with an Assessment Reference Date of 10/26/18 coded Resident #102 with short and long-term memory problems and cognitive skills severely impaired-never/rarely made decisions. In addition, the MDS coded Resident #102 requiring total dependence of two with transfer, total dependence of one with bathing, personal hygiene, toilet use, dressing and extensive

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495264	A. BUILDING _____ B. WING _____	R 11/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAYSIDE OF POQUOSON HEALTH AND REHAB	1 VANTAGE DRIVE POQUOSON, VA 23662

(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 583}	Continued From page 4 assistance of two with bed mobility. During a wound dressing observation on 11/15/18 at approximately 09:20 a.m., with the wound care specialist (a physician) assisted by License Practical Nurse (LPN) #5, they failed to close the pull curtain to bed B and/or close the window curtain for Resident #102's privacy. Resident #102 was not properly draped and anyone passing by Resident #102's window could visible see the resident from the waist down. Resident #102 had a pressure ulcer to her right foot and her sacral/buttocks area. The resident's sacrum was exposed when wound care was performed. An interview was conducted with the wound specialist who stated, "The resident's curtain or window curtain should have been drawn or closed doing wound care." The facility administration was informed of the finding during a briefing on 11/15/18 at approximately 6:07 p.m. The facility did not present any further information about the findings. The facility's policy on privacy doing wound care was requested but not received.	{F 583}		
{F 657} SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the	{F 657}		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495264	A. BUILDING _____ B. WING _____	R 11/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAYSIDE OF POQUOSON HEALTH AND REHAB	1 VANTAGE DRIVE POQUOSON, VA 23662

(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 5 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 review, the facility staff failed to revise the comprehensive personal centered care plan for one (1) of 11 residents in the survey sample, (Resident #101). The facility staff failed to revise Resident #101's comprehensive person centered care plan to include a *stage IV left foot *pressure ulcer. The findings included: Resident #101 was admitted to the facility 08/06/18. Diagnosis for Resident #101 included but not limited to *Muscle weakness. Resident #101's Minimum Data Set (MDS-an assessment protocol) with an Assessment Reference Date of 10/01/18 coded Resident #101 indicating short and long-term memory problems and cognitive	{F 657}	**F657** **1. Care Plan for Resident #101 was modified with the Stage IV to left heel on care plan on 11/14/2018.** **2. Care Plan revision affect all residents.** **3. Regional Director of Clinical Services reeducated DON and license nursing staff on care plan updates.** **4. DON/Designee to review and update care plan during morning meeting with 24 hour report for wound and weekly during wound meeting for 8 weeks.** **5. Audits will be reviewed in monthly and quarterly QAPI Meetings.** **11/30/2018**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495264	A. BUILDING _____ B. WING _____	R 11/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAYSIDE OF POQUOSON HEALTH AND REHAB	1 VANTAGE DRIVE POQUOSON, VA 23662

(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 6	{F 657}		

skills severely impaired-never/rarely made decisions. In addition, the MDS coded Resident requiring total dependence of one with bathing, extensive assistance of one with bed mobility, dressing toilet use and personal hygiene.

The review of Resident #101's comprehensive person care plan did not include a stage IV left foot pressure ulcer.

The review of Resident #101's pressure ulcer weekly measurement documented the following:
-On 11/08/18 - Stage IV to left heel, 1.5 cm x 1.2 cm x 0.5 cm with 30% necrotic, 10% slough and 60% granulation tissue with moderate amount serosanquineous drainage.

The wound care specialist documented the following:
On 11/15/18 - *Stage IV to left heel, 1.5 cm x 1.2 cm x 0.4 cm with 15% necrotic tissue and 85% granulation with moderate amount of serosanquineous drainage.

An interview was conducted with the MDS Coordinator on 11/14/18 at 3:25 p.m., who stated, "I only update the resident care plans doing their quarterly assessment." She proceeded to say the floor nurses and the Director of Nursing (DON) are responsible for updating the resident's care plans on a regular basis.

An interview was conducted with the DON on 11/15/18 at approximately 3:35 p.m., who stated, "As of right now I am in the process of educating the nurses on how to care plan; but right now I am responsible for updating the care plans." The surveyor asked, "Should Resident #101's left heel stage IV ulcer be on the care plan" she replied,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495264	A. BUILDING _____ B. WING _____	R 11/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAYSIDE OF POQUOSON HEALTH AND REHAB	1 VANTAGE DRIVE POQUOSON, VA 23662

(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 7 "Yes, the heel ulcer should have been care planned." The facility administration was informed of the finding during a briefing on 11/15/18 at approximately 6:07 p.m. The facility did not present any further information about the findings. The facility does not have a care plan revision policy but does uses Lippincott's Nursing Procedures Sixth edition as their guide. -Care Plan Preparation Nurses update and revise the plan throughout the patients' stay, and the document becomes part of the permanent patient record.	{F 657}		
{F 686} SS=G	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on staff interviews, clinical record review and facility document review the facility staff failed to ensure a 2 out of 11 residents (Resident #102	{F 686}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495264	A. BUILDING _____ B. WING _____	R 11/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAYSIDE OF POQUOSON HEALTH AND REHAB	1 VANTAGE DRIVE POQUOSON, VA 23662

(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 686}	Continued From page 8 and #111) in the survey sample received care, consistent with professional standards of practice, to prevent *pressure ulcers which resulted in harm. 1. For Resident #102, the facility staff failed to prevent, identify and assess facility acquired pressure ulcers, which were first identified at an advanced stage. On 11/15/18, six (6) new pressure ulcers to the following areas: left distal buttock, left inner buttock, right lower buttock, right buttock and two areas to the left outer buttock were identified. 2. The facility staff failed to ensure that Resident #111 received care to prevent the development of an unstageable pressure area to the left heel that was first identified on 11/2/18 which constitutes harm. The findings included: 1. Resident #102 was admitted to the facility on 07/18/17. Diagnosis for Resident #102 included but not limited to, *Down syndrome, *Autistic disorder and *Muscle weakness. Resident #102's Minimum Data Set (MDS-an assessment protocol) with an Assessment Reference Date of 10/26/18 coded Resident #102 with short and long-term memory problems and cognitive skills severely impaired-never/rarely made decisions. In addition, the MDS coded Resident requiring total dependence of two with transfers, total dependence of one with bathing and personal hygiene and extensive assistance of two with bed mobility. Resident #102 was also coded always being incontinent of bowel and bladder. The MDS with an ARD of 10/28/18 under section	{F 686}	**F686** **1. Resident #102 new areas was assessed and treated by wound physician on 11/15/2018. Resident #102 wound care physician will assess wound weekly to ensure any new area are identified timely. Resident # 102 received a Foley catheter and weekly skins checks for preventative care.** **Resident #111 new area was assessed and treated by wound physician on 11/15/18. Resident #111 wound care will be assessed by wound physician and nurse weekly to ensure any new areas are identified timely. Resident #111 has air mattress in place, dietitian review chart, and heel float in place for preventative care.** **2. Head to toe assessment was completed on 11/15-16/2018 to identify any new area on current residents residing in the facility.** **3. License nursing staff was re-educated on completing weekly skin assessment and completing the appropriate documentation and notification. Licensed nursing educated on using the weekly skin documentation in PCC. CNA staff re-educated on skin observation sheet completed during ADL care and proper documentation and notification process.** **4. An audit will be completed daily at morning meeting on skin documentation 5 x week x 8 weeks by DON/designee to ensure assessments are being completed** **5. Audits will be reviewed during the monthly and quarterly QAPI Meetings.** **11/30/2018**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495264	A. BUILDING _____ B. WING _____	R 11/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAYSIDE OF POQUOSON HEALTH AND REHAB	1 VANTAGE DRIVE POQUOSON, VA 23662

(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 686}	Continued From page 9 "M" (Skin Condition - M0100) was coded: Resident has a pressure ulcer/injury, a scar over bony prominence, or a non-removable dressing/device. Under section (M0150) at risk for developing pressure ulcers was coded yes, under section (M0210) for unhealed pressure ulcers was coded yes and under section (M0300) for having two stage 3-pressure ulcers. Under section (M1200) for skin and treatments was coded for having pressure reducing device for chair and bed, nutrition or hydration intervention to manage skin problems, pressure ulcer care, application of nonsurgical dressings and applications of ointments/medications other than feet and application of dressings to feet (with or without tropical medication). Resident #102's person-centered comprehensive care plan revised on 07/20/18 documented Resident #102 with actual skin breakdown to left buttocks (*pressure ulcer-stage 3) due to assistance required with bed mobility. The goal: pressure ulcer will heal without complication. Some of the intervention/approaches to manage goal included to provide *pressure air loss mattress, conduct weekly skin inspection, moisture skin with lotion as needed, skin care after incontinent episodes and apply barrier cream and to provide treatment as ordered. A Braden Risk Assessment Report was completed on 07/27/18; resident scored a nine indicating high risk for the development of pressure ulcers. Mobility (ability to change and control body position) coded very limited - does not make even slight changes in body or extremity position without assistance and moisture degree to which skin is exposed to moisture coded very moist.	{F 686}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495264	A. BUILDING _____ B. WING _____	R 11/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAYSIDE OF POQUOSON HEALTH AND REHAB	1 VANTAGE DRIVE POQUOSON, VA 23662

(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 686}	Continued From page 10	{F 686}		

On 11/15/18 at approximately 9:20 a.m., Resident #102 was lying in bed, positioned in a supine position on an alternating low air loss mattress. Wound care observation was conducted with the wound care specialist (a physician) with the assistance of License Practical Nurse (LPN) #5. Prior to starting wound care to Resident #102's sacral area, the physician used hand sanitizer then donned a new pair of gloves. The resident was positioned on her left side with the assistance of LPN #5. The physician removed the foam dressing that covered the left buttock wound. The surveyor observed a very large sacral/left buttocks wound and six other wounds to Resident #102's left and right buttocks. The surveyor asked the physician, "Are there treatments for all the wounds observed to the resident's left and right buttocks?" the physician replied, "I had no idea all of these wounds were here; last week there were only three wounds and now there are seven." The physician said "there are no current treatment that I am aware of." The surveyor asked, "When did you know about the wounds?" She replied, "Now, after removing the wound dressing covering the left buttock."

Review of Resident #102's Pressure Injury Weekly Measurement for 11/08/18 documented the following: stage three to left buttock measuring 7 cm x 7 cm x 0.2 cm with moderate amount of serosanquineous drainage.

The wound care specialist documented the following:
1. On 11/08/18 - *Stage III to left buttocks, 7.0 cm x 7.0 cm x 0.2 cm with a surface area of 49.00 cm2 (cluster wound), with 20% thick adherent devitalized necrotic tissue, 60% granulation tissue

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495264	A. BUILDING _____ B. WING _____	R 11/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAYSIDE OF POQUOSON HEALTH AND REHAB	1 VANTAGE DRIVE POQUOSON, VA 23662

(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 686}	Continued From page 11	{F 686}		

and skin 20% with moderate amount of sero-sanguinous exudate. Additional wound detail: Would recommend *Foley catheter for wound healing due to patient with worsening wound x 2 weeks. Dressing treatment plan: Alginate calcium apply once daily x 17 days; Santyl apply once daily for 30 days and secondary dressing; Foam with silicone border, apply once daily for 17 days.; Recommendation: Off-load wound, reposition per facility protocol, Zinc sulfate 220 mg daily by mouth for 14 days.

2. On 11/15/18 - *Unstageable (due to necrosis) of the left buttock, 7.0 cm x 9.0 cm x not measurable cm with a surface area of 63.00 cm2, with 30% thick adherent black necrotic tissue (eschar), 20% thick adherent devitalized necrotic tissue, 30% granulation tissue and 20% skin with moderate serous exudate. Additional wound detail: cluster of seven wounds, could not tolerate cleaning of wound due to pain. Foley not placed, but still recommend placement of Foley catheter for wound healing. Dressing treatment plan: Apply Santyl ointment daily x 23 days; Dakin's solution apply once daily x 30 days and secondary dressing; Foam with silicone border, apply once daily for 10 days.

The treatment administration record (TAR) was reviewed and signed by the nurses on a daily bases (the treatment was being performed on the night shift) as being completed.

An interview was conducted with the wound specialist on 11/15/18 at approximately 12:05 p.m. The physician said Resident #102 had three wounds on my last visit which was on 11/08/18 to her left buttocks/sacral area; not seven and nothing like this. The physician stated, "I

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495264	A. BUILDING _____ B. WING _____	R 11/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAYSIDE OF POQUOSON HEALTH AND REHAB	1 VANTAGE DRIVE POQUOSON, VA 23662

(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 686}	Continued From page 12	{F 686}		

expected to see a change in Resident #102's left buttock pressure ulcer but I did not expect to see a giant hole." The physician stated, "Those wounds to the left and right buttocks should have come with a warning." The surveyor asked, "Which wounds were there last week" she replied, "I measured everything as one (cluster) and not as individual wounds." The surveyor asked, "Should each wound be measured as a separate wound and not as cluster wounds, she replied, "Yes, each wound should have been measured separately." The surveyor asked the physician, "Should each wound have a separate treatment" she replied, "Yes." The physician said most of these new wounds will require *Santyl ointment for debridement and *Dakin's solution.

During the review of the wound specialist note on 11/08/18 the recommendation for a Foley catheter was documented. The surveyor asked the wound specialist on 11/15/18 at approximately 12:05 p.m., "What was the purpose for ordering a Foley catheter" she replied, "Resident #102 is a big wetter, the Foley would have kept her dry." She said the catheter would have prevented the wounds from worsening. She said the Foley was recommended last week and it was not done. The physician said "I can only recommend and as you see the Foley was never placed and that is why we are in this mess." The wound specialist said the wound started to deteriorate a couple of weeks ago and that was why the Foley was recommended. The surveyor asked, "Was the new found areas to Resident #102 to left and right buttocks avoidable or unavoidable, she replied, "Absolutely avoidable."

An interview was conducted with the DON on 11/15/18 at approximately 1:05 p.m., who stated,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495264	A. BUILDING _____ B. WING _____	R 11/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAYSIDE OF POQUOSON HEALTH AND REHAB	1 VANTAGE DRIVE POQUOSON, VA 23662

(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 686}	Continued From page 13 "The recommendation for the Foley was missed." An interview was conducted with the Regional Director of Clinical Services on 11/15/18 at approximately 1:10 p.m., who stated, "We just found out today that Resident #102 had multiple wounds to her left and right buttocks." The surveyor requested a copy of the wound report form that identities the type of wound, the location of wound and the onset of the wounds that were first identified today on Resident #102. On 11/15/18 at approximately 2:05 p.m., a message was left for LPN #3 who performed wound care to Resident #102 on 11/14/18 (11-7 shift). A message was left with no return call. On 11/15/18 approximately 5:43 p.m., the Regional Director of Clinical Services presented the following documents: The initial Pressure Injury Report documentation revealed Resident #102 was first identified with the following pressure ulcers on 11/15/18. On the left distal buttock was a (*stage 2) measuring 1.9 cm x 1.1 cm x 0.1 cm, left distal buttock (*unstageable - greater than 50% slough present) measuring 1.1 cm x 1.1 cm x 0.1 cm, right buttock (stage 2) measuring 3.5 cm x 2.3 cm x 0.1 cm, right buttock (*stage 3 - 30% slough present) measuring 1.0 cm x 1.1 cm x 0.1 cm, left outer buttock #1 (*stage 1) measuring 1.6 cm x 0.5 cm and left outer buttocks #2 (unstageable - 50% slough) measuring 2.5 cm x 1.8 cm x 0.1 cm. On 11/15/18 at approximately 5:55 p.m., the Regional Director of Clinical Services presented an order for the placement of Foley catheter.	{F 686}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495264	A. BUILDING _____ B. WING _____	R 11/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAYSIDE OF POQUOSON HEALTH AND REHAB	1 VANTAGE DRIVE POQUOSON, VA 23662

(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 686}	Continued From page 14 A phone interview was conducted with wound specialist on 11/15/18 at approximately at 5:10 p.m., the surveyor asked, "What type of wounds was observed to Resident #102's right and left buttocks doing wound observation, she replied "All pressure." During pre-exit meeting on 11/15/18 at approximately 6:07 p.m., with 4 other surveyors and the facility's administration, the surveyor asked, "What stage do you expect for your staff to find a pressure ulcer" the Director of Nursing (DON) replied, "When the skin in red; at a stage 1." She said I expect the nurses to do skin checks on a regular basis along with body checks with ADL's care." The DON stated she expect for the nurses to monitor the resident's wounds for change in condition and to notify the physician of those changes with a description of the wound and to also update the DON. The facility's policy titled Pressure Sore Prevention-Quick Look (Revision-1/2017). -Assess skin daily (every shift and prn). Prevention (High Risk) -Interventions for Minimal and Moderate Risk -Place on pressure reducing chair device -Appropriate disciplines to screen - OT/PT -Care Plan to identify interventions -Increase turning and reposition Definitions: 1. Down syndrome is a chromosomal condition that is associated with intellectual disability, a characteristic facial appearance, and weak muscle tone (hypotonia) in infancy. All affected individuals experience cognitive delays, but the	{F 686}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495264	A. BUILDING _____ B. WING _____	R 11/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAYSIDE OF POQUOSON HEALTH AND REHAB	1 VANTAGE DRIVE POQUOSON, VA 23662

(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 686}	Continued From page 15 intellectual disability is usually mild to moderate (https://ghr.nlm.nih.gov/condition/down-syndrome). 2. Autistic disorder is a complex neurobehavioral condition that includes impairments in social interaction and developmental language and communication skills combined with rigid, repetitive behaviors (https://www.webmd.com/brain/autism/understanding-autism-basics). 3. Muscle weakness is reduced strength in one or more muscles (https://medlineplus.gov/ency/article/007365.htm). 4. Pressure Injury: A pressure injury is localized damage to the skin and underlying soft tissue usually over a bony prominence or related to a medical or other device. The injury can present as intact skin or an open ulcer and may be painful. The injury occurs as a result of intense and/or prolonged pressure or pressure in combination with shear. The tolerance of soft tissue for pressure and shear may also be affected by microclimate, nutrition, perfusion, co-morbidities and condition of the soft tissue (http://www.npuap.org/resources/educational-and-clinical-resources/npuap-pressure-injury-stages/) . 5. Pressure Injury-Stage 1 (Non-blanchable erythema of intact skin) Intact skin with a localized area of non-blanchable erythema, which may appear differently in darkly pigmented skin. Presence of blanchable erythema or changes in sensation, temperature, or firmness may precede visual changes. Color	{F 686}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495264	A. BUILDING _____ B. WING _____	R 11/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAYSIDE OF POQUOSON HEALTH AND REHAB	1 VANTAGE DRIVE POQUOSON, VA 23662

(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 686}	Continued From page 16 changes do not include purple or maroon discoloration; these may indicate deep tissue pressure injury (http://www.npuap.org/resources/educational-and-clinical-resources/npuap-pressure-injury-stages). 6. Pressure Injury-Stage 2 (Partial-thickness skin loss with exposed dermis_ Partial-thickness loss of skin with exposed dermis. The wound bed is viable, pink or red, moist, and may also present as an intact or ruptured serum-filled blister. Adipose (fat) is not visible and deeper tissues are not visible. Granulation tissue, slough and eschar are not present. These injuries commonly result from adverse microclimate and shear in the skin over the pelvis and shear in the heel. This stage should not be used to describe moisture associated skin damage (MASD) including incontinence associated dermatitis (IAD), intertriginous dermatitis (ITD), medical adhesive related skin injury (MARSI), or traumatic wounds (skin tears, burns, abrasions (http://www.npuap.org/resources/educational-and-clinical-resources/npuap-pressure-injury-stages). 7. Pressure Injury-Stage 3 (Full-thickness skin loss) Full-thickness loss of skin, in which adipose (fat) is visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present. Slough and/or eschar may be visible. The depth of tissue damage varies by anatomical location; areas of significant adiposity can develop deep wounds. Undermining and tunneling may occur. Fascia, muscle, tendon, ligament, cartilage and/or bone are not exposed. If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Injury	{F 686}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495264	A. BUILDING _____ B. WING _____	R 11/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAYSIDE OF POQUOSON HEALTH AND REHAB	1 VANTAGE DRIVE POQUOSON, VA 23662

(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 686}	Continued From page 17 (http://www.npuap.org/resources/educational-and-clinical-resources/npuap-pressure-injury-stages). 8. Unstageable Pressure Injury: Obscured full-thickness skin and tissue loss. Full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar. If slough or eschar is removed, a Stage 3 or Stage 4 pressure injury will be revealed. Stable eschar (i.e. dry, adherent, intact without erythema or fluctuance) on the heel or ischemic limb should not be softened or removed (http://www.npuap.org/resources/educational-and-clinical-resources/npuap-pressure-injury-stages/). 9. Foley catheter is a tube placed in the body to drain and collect urine from the bladder (https://medlineplus.gov/druginfo/meds/a682514.html). 10. Santyl is used to help the healing of burns and ulcers. Collagenase is an enzyme. It works by helping to break up and remove dead skin and tissue. This effect may also help to work better and speed up your body's natural healing process (antibiotics <http://www.webmd.com/cold-and-flu/rm-quiz-antibiotics-myths-facts). 11. Dakin's solution is a type of hypochlorite solution. It is made from bleach that has been diluted and treated to decrease irritation. Chlorine, the active ingredient in Dakin's solution, is a strong antiseptic that kills most forms of bacteria and viruses (http://www.webmd.com/drugs/2/drug-62261/dakin's-misc/details).	{F 686}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495264	A. BUILDING _____ B. WING _____	R 11/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAYSIDE OF POQUOSON HEALTH AND REHAB	1 VANTAGE DRIVE POQUOSON, VA 23662

(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 686}	Continued From page 18 2. Resident #111 is a 84 year old admitted to the facility originally on 8/6/18 and readmitted on 9/28/18 with diagnoses to include Diabetes Mellitus and Dementia. The most recent comprehensive Minimum Data Set (MDS) assessment was an Admission assessment with an Assessment Reference Date (ARD) of 10/5/18. The Brief Interview for Mental Status (BIMS) was a 4 out of a possible 15 which indicated that Resident #111 was cognitively impaired and not capable of daily decision making. Under Section G Functional Status Resident #111 was coded as requiring extensive one person physical assist for bed mobility. Under Section M Skin Conditions Resident #111 was coded at risk for developing pressure ulcers and pressure reducing device for bed and chair. Resident #111's Comprehensive Plan Of Care last revised 11/15/18 was reviewed and is documented in part, as follows: Focus: Pressure ulcer actual or at risk due to: Assistance required in bed mobility, Bowel incontinence, Diagnosis of diabetes, Actual unstageable DTI (Deep Tissue Injury) to left heel. Date Initiated: 10/12/18 Revision on: 11/10/18 Interventions: *Conduct weekly skin inspection Date Initiated: 10/12/18 Revision on: 10/12/18 *Moisturize skin with lotion as needed. Date Initiated: 10/12/18 Revision on: 10/12/18	{F 686}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495264	A. BUILDING _____ B. WING _____	R 11/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAYSIDE OF POQUOSON HEALTH AND REHAB	1 VANTAGE DRIVE POQUOSON, VA 23662

(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 686}	Continued From page 19 *Provide pressure reduction/relieving mattress Date Initiated: 10/12/18 Revision on: 10/12/18 * Skin assessment to be completed per Policy. Date Initiated: 10/12/18 Revision on: 10/12/18 *Treatments as ordered Date Initiated: 10/12/18 Revision on: 10/12/18 *Float heels as tolerated in bed and up in chair. Date Initiated: 11/9/18 Resident #111's Braden Scale dated 9/28/18 was a score of 17 indicating the resident was AT Risk for developing pressure areas. Resident #111's Physician Orders were reviewed and are documented in part, as follows: 10/03/18: Weekly Skin assessment every Tuesday, day shift. To be documented in PCC (Point Click Care). Resident #111's Treatment Administration Records (TAR) for October and November 2018 were reviewed for the above Physician Order. Tuesday October 9th, 16th, and November 13th were signed off as being completed by nursing staff. There was no signature for Tuesday October 30th or November 6th. The Director of Nursing (DON) was asked for the Skin Assessments that were signed off as being completed for Resident #111 in October and November 2018. On 11/14/18 at approximately 2:30 P.M. the DON provided the surveyor with Resident #111's Weekly Skin Integrity Check	{F 686}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495264	A. BUILDING _____ B. WING _____	R 11/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAYSIDE OF POQUOSON HEALTH AND REHAB	1 VANTAGE DRIVE POQUOSON, VA 23662

(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 686}	Continued From page 20 dated 11/2/18 which was reviewed and is documented in part, as follows: Weekly Skin Integrity Check: 2. New wound/change of condition noted. See Skin/Condition Assessment Form. 2a. Type of Skin Issue Noted: 1. Pressure Injury After reviewing the above document the DON stated that she had completed the above Weekly Skin Integrity Check in the computer. The DON was asked where the pressure ulcer was located, what stage it was and the size of the pressure area. The DON stated, "It was on his left heel, it was unstageable and it was not measured. There is no other documentation or measurement on the wound." The facility was unable to produce any other Weekly Skin Integrity Checks for October and November in PCC. Resident #111's Physician Orders were reviewed and are documented in part, as follows: 11/1/18: Float heels as tolerated while in bed and up in chair. The TAR for 11/1/18 through 11/9/18 revealed 8 shifts where this order was not signed off for as being completed. 11/1/18: Skin prep Bilateral heels every shift. The TAR for 11/1/18 through 11/9/18 revealed 7 shifts where this order was not signed off for as being completed. 11/5/18: low air loss mattress every shift for wound care. The TAR for 11/5/18 through 11/9/18 revealed 7 shifts where this order was not signed off for as being completed.	{F 686}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495264	A. BUILDING _____ B. WING _____	R 11/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAYSIDE OF POQUOSON HEALTH AND REHAB	1 VANTAGE DRIVE POQUOSON, VA 23662

(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 686}	Continued From page 21 Resident #111's medical record was reviewed for further documentation regarding the left heel. On 11/8/18 an Initial Wound Evaluation and Management Summary by the Wound Physician was reviewed and is documented in part, as follows: History of Present Illness: At the request of the referring provider, a thorough wound care assessment and evaluation was performed today. He has an unstageable DTI (Deep Tissue Injury) of the left heel of at least 1 day duration. There is no exudate. The patient appears to have associated pain evidenced by grimacing. Focused Wound Exam (Site 1) UNSTAGEABLE DTI OF THE LEFT HEEL Etiology-Pressure MDS 3.0 Stage-Unstageable DTI with intact skin Wound Size (Length X Width X Depth)-4.0 X 4.5 X Not Measurable cm (centimeters) Surface Area-18.00 cm Exudate- none DRESSING TREATMENT PLAN: Skin prep every shift for 30 days. On 11/15/18 at approximately 10:30 A.M. a wound care observation was conducted with LPN (Licensed Practical Nurse) #1. The Wound Physician evaluated the left heel wound and documented as: Wound Evaluation and Management Summary on Resident #11 to include his left heel that was reviewed and is documented in part, as follows: Focused Wound Exam (Site 1) UNSTAGEABLE (DUE TO Necrosis) OF THE LEFT HEEL Etiology-Pressure	{F 686}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495264	A. BUILDING _____ B. WING _____	R 11/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAYSIDE OF POQUOSON HEALTH AND REHAB	1 VANTAGE DRIVE POQUOSON, VA 23662

(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 686}	Continued From page 22 MDS 3.0 Stage-Unstageable Necrosis Wound Size (Length X Width X Depth)-7.0 X 9.0 X Not Measurable cm (centimeters) Surface Area-63.00 cm Exudate- none Thick adherent black necrotic tissue (eschar)-40% Other viable tissues-60% (Dermis) Blister-Fluid Filled Wound Progress-Deteriorated ADDITIONAL WOUND DETAIL-11/15: Component of blister with fluid filled area, component of DTI and component of eschar. DRESSING TREATMENT PLAN: Skin prep every shift for 30 days. On 11/15/18 at approximately 4:40 P.M. the Regional Director of Clinical Services provided the surveyor with a GUIDELINES FOR UNAVOIDABLE DECUBITUS for Resident #111 that was signed by a physician on 11/15/18 which was reviewed and is documented in part, as follows: A determination that development of a pressure sore was unavoidable may be made only if routine preventative and daily care was provided consistently If a pressure ulcer is deemed unavoidable, the resident's attending physician will write a progress note attesting that the pressure ulcer was unavoidable due to the resident's medical status. Diagnosis must support decision. Attachments: A-Guidelines for Unavoidable Decubitus (Signed by Physician on 11/15/18)	{F 686}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495264	A. BUILDING _____ B. WING _____	R 11/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAYSIDE OF POQUOSON HEALTH AND REHAB	1 VANTAGE DRIVE POQUOSON, VA 23662

(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 686}	Continued From page 23 B-Unavoidable Pressure Sore Physician Progress Note (Signed by Physician on 11/15/18) The Unavoidable Pressure Sore Physician Progress Note (Signed by Physician on 11/15/18) had the following typed template that is duplicated on the form: (Blank line) I, Dr., the attending physician for (blank line) Have evaluated my patient and determined that he/she has an unavoidable wound as determined by their clinical condition. The Results are: (blank lines) Attending Physician Date The only area on the form that was completed was the Physician signature and date. The surveyor asked if the physician who signed the document was in the building and the DON stated that he was and escorted the surveyor to the Physician who was sitting in the activity room charting. On 11/15/18 at 4:45 P.M. an interview was conducted with the Physician who signed Resident #111's Unavoidable Pressure Sore Physician Progress Note. The surveyor asked the Physician which wound of Resident #111's was unavoidable. The Physician stated, "I don't know, I was just asked to sign it." The surveyor then asked if he had assessed Resident #111's pressure area and if he did a progress note. The Physician stated, "No, he is not mine. I'm not the attending they just asked me to sign it because I was here." During this interview with the Physician the DON was in attendance the entire time. The facility policy titled "Unavoidable Pressure Sores" effective 1/2017 was reviewed and is	{F 686}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495264	A. BUILDING _____ B. WING _____	R 11/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAYSIDE OF POQUOSON HEALTH AND REHAB	1 VANTAGE DRIVE POQUOSON, VA 23662

(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 686}	Continued From page 24	{F 686}		

documented in part, as follows:

POLICY: It is the policy of the Facility that any resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable.

If a pressure ulcer is deemed unavoidable, the resident's attending physician will write a progress note attesting that the pressure ulcer was unavoidable due to resident's medical status. Diagnosis must support decision

The facility policy titled "Skin Assessment-Weekly" effective 1/2017 was reviewed and is documented in part, as follows:

POLICY: A Licensed Nurse will complete a total body assessment on each resident weekly, paying particular attention to any skin tears, bruises, stasis ulcers, rashes, pressure ulcers, lesions, abrasions, reddened areas and skin turgor problems. The purpose of the Skin Assessment is to evaluate the condition of the resident's skin on a regular basis.

Procedure:

1. A Licensed Nurse will complete a total body assessment on each resident weekly and document the assessment on the "Weekly Skin Integrity Checks" form.

2. The evaluating nurse must date and sign each assessment.

3. If a resident is assessed as having a skin problem, the evaluating nurse will initiate the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495264	A. BUILDING _____ B. WING _____	R 11/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAYSIDE OF POQUOSON HEALTH AND REHAB	1 VANTAGE DRIVE POQUOSON, VA 23662

(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 686}	Continued From page 25	{F 686}		

appropriate form. For pressure areas complete the "Decubitus/Pressure Ulcer Risk Assessment and Record".

The facility policy titled "Wound Prevention Program" no date was reviewed and is documented in part, as follows:

PRESSURE SORE PREVENTION-QUICK LOOK:
*Assess skin daily(every shift and prn(as needed))
*Weekly Skin Integrity Checks by a Nurse(document)
*Keep all skin areas(including skin folds) clean/dry/moisturize

PRESSURE RELIEVING:
*Protect skin against friction and shearing forces
*Avoid massage over bony prominences
*For residents who are ambulatory, encourage activity as tolerated
*Turn and reposition at least every 2 hours in bed
*Evaluate for pressure relieving mattress
*Active or Passive Range of Motion for bed ridden residents to optimize the perfusion of peripheral capillary vessels
*Turn and reposition every hour in chair
*Elevate Head of Bed no more than 30 degrees unless otherwise indicated
*Use pressure redistribution device/positioning device
*Relieve heel pressure
*Use heel/elbow protectors as appropriate
*Use protective clothing for fragile skin

On 11/15/18 at 6:07 P.M. a pre-exit debriefing was conducted with the Administrator, the Director of Nursing and the Director of Clinical

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495264	A. BUILDING _____ B. WING _____	R 11/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAYSIDE OF POQUOSON HEALTH AND REHAB	1 VANTAGE DRIVE POQUOSON, VA 23662

(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 686}	Continued From page 26 Services where the above information was shared. The Director of Nursing was asked what were her expectations regarding facility acquired pressure ulcers. The Director of Nursing stated, "A pressure ulcer should be identified as soon as you see redness, during a body check or during ADL (activities of daily living) care at a Stage I. If a weekly skin assessment shows a change or a new pressure ulcer there should be a note and a Pressure Ulcer Report should be completed it was not done. We need to do some education." Prior to exit no further information was shared.	{F 686}		
{F 842} SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §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	{F 842}	**F842** **1. Resident #106 TAR was reviewed and the order was updated per physician order.** **Resident #111 TAR was reviewed by Regional Director of Clinical Service and notification to MD and received new orders.** **2. An Audit of the TAR for the current residents completed.** **3. Nursing staff were re-educated by Regional Director of Clinical Services on following physician orders and completing the task prior to signing the TAR.** **4. The DON/designee will complete random audits 5 x week x 2 months.** **5. Audits will be reviewed during the monthly/quarterly QAPI meetings.** **11/30/2018**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495264	A. BUILDING _____ B. WING _____	R 11/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAYSIDE OF POQUOSON HEALTH AND REHAB	1 VANTAGE DRIVE POQUOSON, VA 23662

(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 27	{F 842}		

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 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495264	A. BUILDING _____ B. WING _____	R 11/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAYSIDE OF POQUOSON HEALTH AND REHAB	1 VANTAGE DRIVE POQUOSON, VA 23662

(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 28 (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview and facility documentation review, the facility staff failed to ensure a complete and accurate clinical record for 2 of 11 residents (Resident #106 and #111) in the survey sample. 1. The facility staff failed to ensure Resident #106 Treatment Administration Record (TAR) was accurate for timeliness of application of hearing aids. 2. The facility staff failed to maintain a complete medical record for Resident #111 as evidenced by missing signatures on the October and November 2018 Treatment Administration Record. The findings included: Resident #106 was admitted to the facility on 12/29/17. Diagnosis for Resident #106 included but not limited to Chronic Obstructive Pulmonary Disease, Dementia and Anxiety. Resident #106 Minimum Data Set (MDS) with an Assessment Reference Date of 10/6/18 coded Resident #106 Brief Interview for Mental Status (BIMS) score of 5 out of a possible score of 15 indicating moderate cognitive impairment. In addition, the MDS coded Resident #106 extensive assistance of two with bed mobility, transfer, toilet use and personal hygiene. Under section B (Hearing, Speech, and Vision) was coded for hearing aid or other hearing appliance used.	{F 842}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495264	A. BUILDING _____ B. WING _____	R 11/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAYSIDE OF POQUOSON HEALTH AND REHAB	1 VANTAGE DRIVE POQUOSON, VA 23662

(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 29	{F 842}		

During the initial tour on 11/14/18 at approximately 1:30 p.m., Resident #106 was observed in her wheelchair in the hallway at the medication cart accompanied by her daughter. It was noted that daughter was asking medication nurse where her mother's hearing aids were located and why the hearing aids were not placed in resident's ears yet for the day. Resident's ears were observed to be without hearing aids in place. Medication nurse was able to retrieve hearing aids from medication cart and install in resident's ears at this time.

Review of the clinical record evidenced a scheduled nursing treatment, ordered on 3/7/18 for ensure hearing aids are in place every morning. This scheduled nursing treatment was noted on the Treatment Administration Record (TAR) for 0900 daily. Review of Resident #106 Medication Admin Audit Report for 11/14/18 revealed the nurse had signed off on 11/14/18 that residents hearing aids were placed at 13:49.

A telephone interview was conducted with LPN #2 on 11/15/18 at 2:04 p.m., LPN #2 stated, "yesterday afternoon (11/14/18 at 1:30pm) was the first time for the day that Resident had her hearing aids put in." This information was shared with the Director of Nursing (DON) during a pre-exit meeting on 11/15/18 at 3:00pm. The surveyor asked the DON, "What are the expectations for timeliness of TAR interventions" she stated, "all interventions on the TAR should be implemented either 1 hour prior, 1 hour after or at time stated on TAR."

On 11/15/18 at approximately 6:15pm the above findings were shared with the Administrator and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495264	A. BUILDING _____ B. WING _____	R 11/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAYSIDE OF POQUOSON HEALTH AND REHAB	1 VANTAGE DRIVE POQUOSON, VA 23662

(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 30	{F 842}		

the Regional Director of Clinical Services during a pre-exit conference. No additional information was shared.

2. Resident #111 a 84 year old admitted to the facility originally on 8/6/18 and readmitted on 9/28/18 with diagnoses to include Diabetes Mellitus and Dementia.

The most recent comprehensive Minimum Data Set (MDS) assessment was an Admission assessment with an Assessment Reference Date (ARD) of 10/5/18. The Brief Interview for Mental Status (BIMS) was a 4 out of a possible 15 which indicated that Resident #11 was cognitively impaired and not capable of daily decision making. Under Section G Functional Status Resident #111 was coded as requiring extensive one person physical assist for bed mobility. Under Section M Skin Conditions Resident #111 was coded at risk for developing pressure ulcers and pressure reducing device for bed and chair.

Resident #111's Physician Orders were reviewed and are documented in part, as follows:

10/03/18: Weekly Skin assessment every Tuesday, day shift. To be documented in PCC (Point Click Care).

Resident #111's Treatment Administration Records (TAR) for October and November 2018 were reviewed for the above Physician Order. Tuesday October 9th, 16th, and November 13th were signed off as being completed by nursing staff. There was no signature for Tuesday October 30th or November 6th. The Director of Nursing (DON) was asked for the Skin Assessments that were signed off as being

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495264	A. BUILDING _____ B. WING _____	R 11/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAYSIDE OF POQUOSON HEALTH AND REHAB	1 VANTAGE DRIVE POQUOSON, VA 23662

(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 31 completed for Resident #11 in October and November 2018. The facility was unable to produce any other Weekly Skin Integrity Checks for October and November in PCC. Resident #111's Physician Orders were reviewed and are documented in part, as follows: 11/1/18: Float heels as tolerated while in bed and up in chair. The TAR for 11/1/18 through 11/9/18 revealed 8 shifts where this order was not signed off for as being completed. 11/1/18: Skin prep Bilateral heels every shift. The TAR for 11/1/18 through 11/9/18 revealed 7 shifts where this order was not signed off for as being completed. 11/5/18: low air loss mattress every shift for wound care. The TAR for 11/5/18 through 11/9/18 revealed 7 shifts where this order was not signed off for as being completed. On 11/15/18 at approximately 4:40 P.M. the Regional Director of Clinical Services provided the surveyor with a GUIDELINES FOR UNAVOIDABLE DECUBITUS for Resident #111 that was signed by the physician on 11/15/18 which was reviewed and is documented in part, as follows: A determination that development of a pressure sore was unavoidable may be made only if routine preventative and daily care was provided consistently If a pressure ulcer is deemed unavoidable, the resident's attending physician will write a progress note attesting that the pressure ulcer was	{F 842}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495264	A. BUILDING _____ B. WING _____	R 11/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAYSIDE OF POQUOSON HEALTH AND REHAB	1 VANTAGE DRIVE POQUOSON, VA 23662

(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 32 unavoidable due to the resident's medical status. Diagnosis must support decision. Attachments: A-Guidelines for Unavoidable Decubitus (Signed by Physician on 11/15/18) B-Unavoidable Pressure Sore Physician Progress Note (Signed by Physician on 11/15/18) The Unavoidable Pressure Sore Physician Progress Note (Signed by Physician on 11/15/18) has the following typed template that is duplicated on the form:_I, Dr., the attending physician for Have evaluated my patient and determined that he/she has an unavoidable wound as determined by their clinical condition. The Results are: Attending Physician Date The only area on the form that was completed was the Physician signature and date. The surveyor asked if the physician who signed the document was in the building and the DON stated that he was and escorted this surveyor to the Physician who was sitting in the activity room charting. On 11/15/18 at 4:45 P.M. an interview was conducted with the Physician who signed Resident #111's Unavoidable Pressure Sore Physician Progress Note. The surveyor asked the Physician which wound of Resident #111's was unavoidable. The Physician stated, "I don't know, I was just asked to sign it." The surveyor then asked if he had assessed Resident #111's pressure area and if he did a progress note. The Physician stated, "No, he is not mine. I'm not the attending they just asked me to sign it because I was here." During this interview with the Physician the DON was in attendance the entire time.	{F 842}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495264	A. BUILDING _____ B. WING _____	R 11/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAYSIDE OF POQUOSON HEALTH AND REHAB	1 VANTAGE DRIVE POQUOSON, VA 23662

(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 33 The facility policy titled "Chart Audit" effective 2/2017 was reviewed and is documented in part, as follows: POLICY: The Medical Record Department or the designee will conduct ongoing audits within the department to assure the integrity of all aspects of the medical record-the medical record numbering system, filing system, assembly, analysis, and completion of the medical record. PROCEDURE: 3h. Physician Progress Notes: Check for the presence of a doctor's progress note, signed and dated as required for each physician visit. 3j. Medication and Treatment Sheets: Check for presence and completion of the medication/treatment record for each month of the resident's admission. Be sure that all initials entered on the sheet have been identified with a full signature and title. On 11/15/18 at 6:07 P.M. a pre-exit debriefing was conducted with the Administrator, the Director of Nursing and the Director of Clinical Services where the above information was shared. The Director of Nursing was asked what were her expectations regarding a resident's medical record. The Director of Nursing stated, "I expect for the staff to document properly and timely and for there to be no holes in the clinical record." Prior to exit no further information was shared.	{F 842}		
F 867 SS=D	QAPI/QAA Improvement Activities CFR(s): 483.75(g)(2)(ii) §483.75(g) Quality assessment and assurance.	F 867		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495264	A. BUILDING _____ B. WING _____	R 11/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAYSIDE OF POQUOSON HEALTH AND REHAB	1 VANTAGE DRIVE POQUOSON, VA 23662

(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 867	Continued From page 34 §483.75(g)(2) The quality assessment and assurance committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, staff interviews and review of the facility's plan of correction dated 10/31/2018, the facility staff failed to implement and correct identified deficiencies. The findings include: The facility staff failed to implement Corrective Action Plans in accordance to the accepted Plan of Correction with an AOC (Allegation of Compliance) date of 10/31/18. Uncorrected Deficiencies were identified during the Revisit #1 survey conducted 11/14/18 through 11/15/18. During the Revisit #1 survey conducted 11/14/18 through 11/15/18, uncorrected deficiencies were identified at F-583, F-657, F-842. Uncorrected deficiencies were identified at F-686 which resulted in harm. The facility policy titled "Quality Assurance" effective date 2/2017 was reviewed and is documented in part, as follows: POLICY: The Quality Assurance Committee will meet monthly to review, recommend and act upon activities of the facility, performance action teams and/or departmental activities. The committee shall direct all activities including approving proposed monitoring, evaluating and review of services.	F 867	**F867** **1. Facility and Administrative staff will follow the plan of correction.** **2. IDT team will review the QAPI Worksheet daily in morning meeting.** **3. Administrator/designee will re-educate the IDT team on POC for new survey findings to ensure the QAPI process is being followed.** **4. A weekly PI review will be completed on each outstanding deficiency to ensure compliance.** **5. Audits will be reviewed during the monthly/quarterly QAPI meetings.** **11/30/2018**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495264	A. BUILDING _____ B. WING _____	R 11/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAYSIDE OF POQUOSON HEALTH AND REHAB	1 VANTAGE DRIVE POQUOSON, VA 23662

(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 867	Continued From page 35 The committee will assure activities have written indicators and standards/thresholds for evaluation, that appropriate actions are implemented, and that such correction has been evaluated by subsequent monitoring. An interview was conducted on 11/15/18 at 12:30 P.M. with the Administrator. The Administrator was asked if the facility had implemented appropriate plans of action to correct identified quality deficiencies. The Administrator stated, "The Quality Assurance Committee had met once since the standard survey. No we haven't, next time we need to go to the book (Plan of Correction) and make sure everything that is in the plan is being audited, like the skin checks." Prior to exit no further information was shared. The facility staff failed to implement appropriate Plans of action to correct identified deficiencies.	F 867		