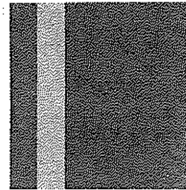


June 06, 2019

Dear Ms. Laura Veuhoff, LTC Supervisor:

Please find the enclosed corrected plan of correction for the standard survey conducted on May 14, 2019 through May 16, 2019 for your review. If you have any questions about this plan of correction, please do not hesitate to call me.

Sincerely,

Mel Epelle, LNHA, MHSA

Executive Director

757-539-8744

200 W Constance Road

Suffolk, VA 23434

Mellanby.epelle@concordiacare.net

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

May 23, 2019

Mr. Mellanby Epelle, Administrator
Concordia Transitional Care Rehab-Nansemond Pointe
200 West Constance Road
Suffolk, VA 23434

RE: Concordia Transitional Care Rehab-Nansemond Pointe
Provider Number 495247

Dear Mr. Epelle:

An unannounced standard survey, ending May 16, 2019, was conducted at your facility by staff from the Virginia Department of Health's Office of Licensure and Certification (the State Survey Agency) to determine if your facility was in compliance with Federal long term care participation requirements for the Medicare and/or Medicaid programs and, if applicable, State licensure regulations. Five complaints were investigated during the survey. Four complaints were substantiated, with no deficiencies. One complaint was unsubstantiated, with no deficiencies.

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

Survey Results

The results of this survey are reflected on the enclosed Statement of Isolated Deficiencies, "A" Form and/or the Statement of Deficiencies and Plan of Correction, 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), the current survey report must be made available for examination in a place readily accessible to residents and is disclosable to all interested parties.

This survey found that your facility was not in substantial compliance with the participation requirements. The most serious deficiency in your facility was a pattern deficiency that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy (S/S of E), as evidenced by the attached CMS-2567L, whereby 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.virginia.gov/licensure-and-certification/the-division-of-long-term-care/.

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.

Recommended Remedies

Based on the deficiencies cited during the survey, under Subpart F of 42 CFR Part 488 the following remedies may be imposed by the Centers for Medicare and Medicaid Services (CMS) Regional Office and/or the State Medicaid Agency (DMAS):

- Pursuant to §488.408(c)
    - Directed Plan of Correction (PoC) (§488.424).
    - State monitoring (§488.422).
    - Directed In-Service Training (§488.425).

- Pursuant to §488.408(d)
    - Denial of payment for new admissions - (§488.417).
    - Denial of payment for all individuals - (§488.418).
    - Civil Money Penalty, $50 - $3,000 per day (§488.430, §488.438), effective on the survey ending date,

- Civil money penalties of $1,000 - $10,000 per instance of noncompliance.

Informal dispute resolution for the cited deficiencies will not delay the imposition of the enforcement actions recommended (or revised, as appropriate). A change in the seriousness of the noncompliance may result in a change in the remedy selected. When this occurs, you will be advised of any change in remedy.

Please note: This survey cover letter does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services or the Virginia Department of Medical Assistance Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination. If you do not achieve substantial compliance within three (3) months after the last day of the survey identifying noncompliance, §488.417(b) requires the denial of payment for new Medicare or Medicaid admissions. If substantial compliance is not attained within six months from the last day of the survey, §488.412(b) provides that "CMS will and the State must terminate the facility's provider agreement."

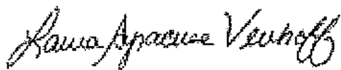
Please be advised: The facility must maintain compliance with both the Health and the Life Safety Code requirements in order to continue provider certification.

Survey Response Form

The LTC 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/content/uploads/sites/96/2019/02/LTC-facility-survey-response-form.pdf"
We will appreciate your participation.

If you have any questions concerning this letter, please contact me at (804) 367-2100.

Sincerely,



Laura S. Veuhoff, LTC Supervisor
Division of Long Term Care

Enclosure

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

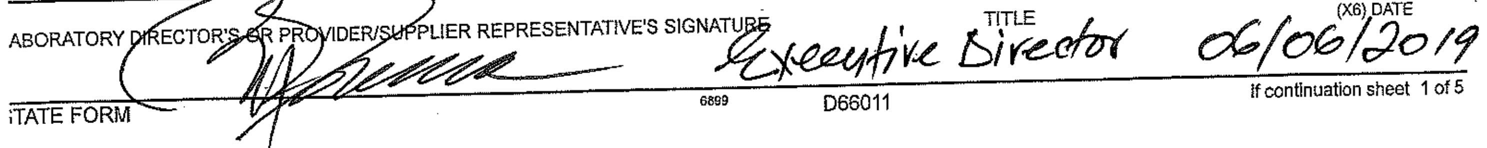
PRINTED: 05/23/2019
FORM APPROVED

State of Virginia

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	VA0169	A. BUILDING: ______ B. WING ______	C 05/16/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONCORDIA TRANSITIONAL CARE REHAB-N/	200 WEST CONSTANCE ROAD SUFFOLK, VA 23434

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
F 000	Initial Comments An unannounced biennial State licensure inspection was conducted 5/14/19 through 5/16/19. Five complaints were investigated during the survey. The facility was not in compliance with the Virginia Regulations for the Licensure of Nursing Facilities. The census in this 148 certified bed facility was 129 at the time of the survey. The survey sample consisted of 56 resident reviews: 49 current residents and 7 closed record reviews.	F 000	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*	06/20/2019
F 001	Non Compliance The facility was out of compliance with the following state licensure requirements: This RULE: is not met as evidenced by: The facility was not in compliance with the following Rules and Regulations for the Licensure of Nursing Facilities: 12 VAC 5-371-150 B1, F. Resident Rights. Cross Reference to F625. 12 VAC 5-371-180 A, C. Infection Control. Cross Reference to F881. 12 VAC 5-371-200 (A) RN/8 HRs 7 days/week. Cross reference F727. 12VAC5-371-220. Nursing Services. Cross Reference F658, F695. 12VAC5-371-240. Physician Services. Cross Reference F712. 12 VAC5-371-250 (C) (F) (G) Resident Assessment and Care Planning. Cross	F 001	F001 12 VAC 5-371-150 B1, F. 1. Please see plan of correction (POC) F625. 12 VAC 5-371-180 A, C. 2. Please see plan of correction (POC) F881. 12 VAC 5-371-200 (A) 3. Please see plan of correction (POC) F727. 12 VAC 5-371-220. 4. Please see plan of correction (POC) F658, F659. 12 VAC 5-371-240. 5. Please see plan of correction (POC) F712. 12 VAC 5-371-250 (C) (F) (G). 6. Please see plan of correction (POC) F656.	



LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Executive Director — (X6) DATE: 06/06/2019

State of Virginia

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	VA0169	A. BUILDING: ____ B. WING ____	C 05/16/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONCORDIA TRANSITIONAL CARE REHAB-N/	200 WEST CONSTANCE ROAD SUFFOLK, VA 23434

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
F 001	Continued From page 1 Reference F656. 12VAC5-371-340 (A) Garbage Disposal. Cross Reference F812. 12VAC5-371-140. Policies and Procedures. Based on staff interview and employee record review, it was determined that the facility staff failed to obtain license verification prior to employment; and failed to complete a criminal background check and sworn statement for 5 of 25 employee record reviews. The findings include: On 5/15/19 at approximately 11:00 a.m., 25 employee files were requested from OSM (other staff member) #2, human resources and ASM (administrative staff member) #1. Review of the employee files revealed the following: RN (Registered nurse) #7 was hired for employment on 5/25/18. Human Resources could not present an employee file for this staff member. CNA (certified nursing assistant) #3 was hired for employment on 2/5/19. Human Resources could not present an employee file for this staff member. CNA #4 was hired for employment on 2/28/18. Human Resources could not present an employee file for this staff member. CNA #5 was hired for employment on 2/13/18. Human Resources could not present an employee file for this staff member. LPN (licensed practical nurse) #8 was hired for	F 001	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* 12 VAC 5-371-340 (A) 7. Please see plan of correction (POC) F812. F371-140 1. Employee #7, #3, #4, #5 and #8 are not currently employed at the facility. 2. All newly hired employees have the potential to be affected. 3. The SDC/designee will perform a one-time audit of newly hired employees within the last 4 months to ensure license verifications, criminal background check and sworn statement was completed. Newly hired employee files will be reviewed by the Executive Director. 4. The SDC/designee will audit new hire personnel files weekly x 4 and monthly x 3 to ensure compliance. 5. Results of audit will be taken to the monthly Performance Improvement meeting which consist of Executive Director, Medical Director, DNS, SDC, Social Services Director, Dietitian, C.N.A & Pharmacy for review, corrective action will be initiated if appropriate.	06/20/2019

State of Virginia

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	VA0169	A. BUILDING: ______ B. WING ______	C **05/16/2019**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONCORDIA TRANSITIONAL CARE REHAB-N/	**200 WEST CONSTANCE ROAD SUFFOLK, VA 23434**

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F 001	Continued From page 2 employment on 6/19/18. Human Resources could not present an employee file for this staff member. On 5/16/19 at 6:19 p.m., OSM #2 could not present any of the above employee records. OSM #2 stated that employee records have been hard to obtain since the building was changed over to a new company. On 5/16/19 at 7:07 p.m., ASM (administrative staff member) #1, the administrator, was made aware of the above findings. 12VAC5-371-150. Resident Rights (G) Based on staff interviews and facility documentation review the facility staff failed to register with the Department of State Police to receive automatic notification from the Sex Offender Registry of the registration or reregistration of any sex offender within the same or a contiguous zip code in which the facility is registered and failed to provide each resident and perspective resident with information on how to access the Sex Offender Registry. The facility staff failed to ensure that the facility would receive automatic notification of registration or reregistration of Sex Offenders within the same or a contiguous zip code in which the facility is registered. The findings included: 1. On 05/15/2019 at 9:25 a.m., an interview was conducted with the Administrator. The Administrator was asked, "Who in the facility is registered with the Department of the State Police to receive	F 001	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* F371-150 1. The facility was registered on 05/16/2019 with the Virginia State police to receive automatic notification from the sex registry. 2. All residents have the potential to be affected. All current residents of the facility have been provided information on how to access the sex offender registry. 3. The Executive Director will Inservice the Admissions Director/designee to provide prospective residents with information on how to access the sex offender registry. 4. All new admissions will be reviewed in the morning meeting to ensure information was provided to new admissions on how to access the sex offender registry.	06/20/2019

State of Virginia

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	VA0169	A. BUILDING: ____ B. WING ____	C 05/16/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONCORDIA TRANSITIONAL CARE REHAB-N/	200 WEST CONSTANCE ROAD SUFFOLK, VA 23434

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F 001	Continued From page 3 automatic notification, updates of registration or reregistration of Sex Offenders in the facility area?" The Administrator stated, "We don't have anyone." On 05/16/2019 at 5:15 p.m., at the pre-exit meeting the Administrator was asked, "Is there anyone in the facility that is registered with the State Police to receive automatic notification from the Sex Registry?" The Administrator stated, "Just registered today." The Administrator and the Director of Nursing was informed of the findings. The facility did not present any further information about the findings. Based on staff interviews and facility documentation review the facility staff failed to provide each resident and perspective resident with information on how to access the Sex Offender Registry. 2. The facility staff failed to provide each resident and perspective resident with information on how to access the Sex Offender Registry. The findings included: On 05/15/2019 at approximately 9:30 a.m., an interview was conducted with the Administrator and the Admissions Director. The Administrator and Admissions Director was asked, " Are residents and perspective residents provided information on how to access the Sex Offender Registry?" The Administrator and Admissions Director stated, "No." The Administrator stated, "Is this new? We have never done this." On 05/16/2019 at 5:15 p.m., at the pre-exit meeting the Administrator and Director of Nursing was informed of the findings. The Administrator	F 001	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* 5. Results of audit will be taken to the monthly Performance Improvement meeting which consist of Executive Director, Medical Director, Director of Nursing, Staff Development, Social Services Director, Dietitian, C.N.A & Pharmacy for review, corrective action will be initiated if appropriate.	06/20/2019

State of Virginia

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F 001	Continued From page 4 and Director of Nursing was asked, "Would you like to add anything else?" The Director of Nursing stated, "Going to start today."	F 001		

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
	495247	A. BUILDING ______ B. WING ______	C 05/16/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONCORDIA TRANSITIONAL CARE REHAB-NANSEMOND POINTE	200 WEST CONSTANCE ROAD SUFFOLK, VA 23434

(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 5/14/19 through 5/16/19. No emergency preparedness complaints were investigated during the survey. Corrections are required for compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities.	E 000	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*	06/20/2019
E 007 SS=C	EP Program Patient Population CFR(s): 483.73(a)(3) [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following:] (3) Address patient/client population, including, but not limited to, persons at-risk; the type of services the [facility] has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession plans.** *Note: ["Persons at risk" does not apply to: ASC, hospice, PACE, HHA, CORF, CMCH, RHC, FQHC, or ESRD facilities.] This REQUIREMENT is not met as evidenced by: Based on review of the facility's emergency preparedness (EP) program and interview with the Administrator, the Director of Maintenance and Director of Human Resources, the facility was not able to identify specificity related the facility's patient populations that would be at risk in the event of an emergency. The findings included:	E 007	E007 1. The facility has reviewed and documented it's identified population at risk during an emergency. 2. All residents residing in the facility have been identified as having the potential to be affected. There is no negative outcome to residents currently residing at the facility. 3. Executive Director/SDC/designee will educate staff on identifying the facility population at risk, and on resident acuity levels identified in the Facility Tools Assessment section of Special Treatments and conditions. 4. The ED/SDC/designee will review facility emergency preparedness plan monthly x three months, and then annually to ensure compliance. 5. The findings will be reviewed in the monthly Performance Improvement which consist of Executive Director, Medical Director, Director of Nursing, Staff Development, Social Services Director, Dietitian, C.N.A & Pharmacy.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Executive Director — (X6) DATE: 06/06/2019

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.

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
	495247	A. BUILDING ______ B. WING ______	C 05/16/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONCORDIA TRANSITIONAL CARE REHAB-NANSEMOND POINTE	200 WEST CONSTANCE ROAD SUFFOLK, VA 23434

(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 007	Continued From page 1 On 5/15/19 at 11:56 a.m., an interview was conducted with the Administrator and the Director of Maintenance. The Administrator, Director of Maintenance and the Director of Human Resources were not able to present the individual resident's needs in case of an emergency. They called to ask the Director of Nursing (DON) to go to each unit and determine how many residents needed oxygen. Approximately an hour later, report sheets were brought forth that itemized the resident's on oxygen. When asked why just oxygen, the Administrator stated it is what he asked the DON to identify, but understood he needed to find a way to update the vulnerable populations in the facility and their specific needs, not just oxygen.	E 007	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*	
E 015 SS=C	Subsistence Needs for Staff and Patients CFR(s): 483.73(b)(1) [(b) Policies and procedures. [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: (1) The provision of subsistence needs for staff and patients whether they evacuate or shelter in place, include, but are not limited to the following: (i) Food, water, medical and pharmaceutical supplies (ii) Alternate sources of energy to maintain the	E 015	E015 1. All residents residing in the facility have been identified as having the potential to be affected. There is no negative outcome to residents currently residing at the facility. 2. The Executive Director updated the facility emergency preparedness plan with vendor contract agreement to provide provision for sewage and waste disposal on 05/16/2019. 3. Executive Director/SDC/designee in-serviced staff on current facility vendor contract agreement to provide provision for sewage and waste disposal. 4. The Executive Director/designee will review facility emergency preparedness plan monthly x three months, and then annually to ensure compliance.	06/20/2019

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
	495247	A. BUILDING ____ B. WING ____	C 05/16/2019

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CONCORDIA TRANSITIONAL CARE REHAB-NANSEMOND POINTE	200 WEST CONSTANCE ROAD SUFFOLK, VA 23434

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E 015	Continued From page 2 following: (A) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions. (B) Emergency lighting. (C) Fire detection, extinguishing, and alarm systems. (D) Sewage and waste disposal. *[For Inpatient Hospice at §418.113(b)(6)(iii):] Policies and procedures. (6) The following are additional requirements for hospice-operated inpatient care facilities only. The policies and procedures must address the following: (iii) The provision of subsistence needs for hospice employees and patients, whether they evacuate or shelter in place, include, but are not limited to the following: (A) Food, water, medical, and pharmaceutical supplies. (B) Alternate sources of energy to maintain the following: (1) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions. (2) Emergency lighting. (3) Fire detection, extinguishing, and alarm systems. (C) Sewage and waste disposal. This REQUIREMENT is not met as evidenced by: Based on review of the facility's emergency preparedness (EP) program and interview with the Administrator, the Director of Maintenance and Director of Human Resources, the facility staff was unable to provide a plan that included provision for sewage and waste disposal.	E 015	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* 5. The findings will be reviewed in the monthly Performance Improvement which consist of Executive Director, Medical Director, Director of Nursing, Staff Development, Social Services Director, Dietitian, C.N.A & Pharmacy.	06/20/2019

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	495247	A. BUILDING ______ B. WING ______	C 05/16/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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E 015	Continued From page 3 The findings included: On 5/15/19 at 11:56 a.m., an interview was conducted with the Administrator and the Director of Maintenance. The Administrator, Director of Maintenance and the Director of Human Resources presented a plan for port-a-potties, but stated they did not contract to have waste disposal to include disposing of soiled briefs, wipes and other disposable items. On 5/16/19 at approximately 4:45 p.m., the Administrator presented a quotation for 20, 30 and 40 cubic yard containers with a disposal plan.	E 015	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*	06/20/2019
E 023 SS=C	Policies/Procedures for Medical Documentation CFR(s): 483.73(b)(5) [(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:] (5) A system of medical documentation that preserves patient information, protects confidentiality of patient information, and secures and maintains availability of records. [(5) or (3),(4),(6)] A system of medical documentation that preserves patient information, protects confidentiality of patient information, and secures and maintains availability of records.	E 023	E023 1. All residents residing in the facility have been identified as having the potential to be affected. 2. The facility Emergency Preparedness Plan has a documented policy to ensure patient records are secure and readily available to support the continuity of care for resident during an emergency. 3. Executive Director/SDC/designee will in-service staff on protecting the confidentiality of patients, ensure records are secure and readily available to support continuity of care for residents during emergency. 4. The ED/SDC/designee will review facility Emergency Preparedness Plan to ensure patients records are readily available to support the continuity of care for residents during an emergency monthly x three months, and then annually to ensure compliance.	

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E 023	Continued From page 4 *[For RNHCIs at §403.748(b):] Policies and procedures. (5) A system of care documentation that does the following: (i) Preserves patient information. (ii) Protects confidentiality of patient information. (iii) Secures and maintains the availability of records. *[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. This REQUIREMENT is not met as evidenced by: Based on review of the facility's emergency preparedness (EP) program and interview with the Administrator, the Director of Maintenance and Director of Human Resource the facility staff was unable to verify they had developed policies and procedures that preserve patient information, protects confidentiality of patient information, and secures and maintains accessibility of records The findings include: On 5/15/19 at 11:56 a.m., an interview was conducted with the Administrator and the Director of Maintenance. The Administrator, Director of Maintenance and the Director of Human Resources stated that the resident's face sheet with diagnoses, physician orders, Medication Administrator Records (MAR), Treatment Administration Records (TAR) would be printed off from the computer and securely sent with the resident in their packets that is kept secure with the resident. They showed this writer	E 023	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* 5. The findings will be reviewed in the monthly Performance Improvement which consist of Executive Director, Medical Director, Director of Nursing, Staff Development, Social Services Director, Dietitian, C.N.A & Pharmacy.	06/20/2019

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E 023	Continued From page 5 the packets with lanyards and a slipped folder that resident the information is placed in. When asked if there was a policy and procedure in place for the designated staff to follow based on the aforementioned process, it was stated, "They know what to do, but we did not develop policy and procedures related to the process to maintain confidentiality and accessibility of records."	E 023		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 5/14/19 through 5/16/19. Five complaints were investigated during the survey. Corrections are required for compliance with the following 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. The census in this 148 certified bed facility was 129 at the time of the survey. The survey sample consisted of 56 resident reviews: 49 current residents and 7 closed record reviews.	F 000		
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, clinical record review, and review of the facility's policy the facility staff failed to create an environment to accommodate the needs for 1 of	F 558		

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F 558	Continued From page 6 56 residents (Resident #50), in the survey sample. The facility's staff failed to ensure a call bell system was in place that Resident #50 was capable of using to contact the staff. The findings included: Resident #50 was originally admitted to the facility 6/14/18, and readmitted 12/30/18, after an acute care hospital stay. The current diagnoses were quadriplegia, traumatic brain injury, hepatitis and cirrhosis. The quarterly Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 3/21/19, coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 0 out of a possible 15. This indicated Resident #50's cognitive abilities for daily decision making were severely impaired. In section "G" (Physical functioning) the resident was coded as requiring extensive assistance of 1 person with eating and personal hygiene, extensive assistance of 2 people with bed mobility and dressing, total care of 1 with locomotion and bathing and total care of 2 people with transfers and toileting. The resident's range of motion was coded for poor bilateral upper and lower extremity. Both of Resident #50's hands were severely contracted and unable to hold objects and they were with very little physical abilities. During the initial tour of the facility on 5/14/19 at approximately 3:45 p.m., the resident was observed in bed with his bed linens pulled up to his neck with his chin lying on them. The call light	F 558	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* F558 1. Resident #50 currently resides in the facility. A specialty call bell has been installed for resident #50. 2. Residents with physical limitations have been identified as having the potential to be affected. An audit was conducted on all current residents residing in the facility to ensure compliance 3. Licensed Nursing staffs and Certified Nursing Assistants have been in-serviced by Staff Development Coordinator (SDC)/designee on ensuring all residents with physical limitations are provided with specialty call bell. 4. DNS/ADNS/Unit Managers/designee will conduct audit on new admissions/re-admissions to determine their ability to use standard call light.	06/20/2019

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F 558	Continued From page 7 was observed freely hanging behind the resident's head of the bed and out of the resident's reach. Both of the double windows were opened and the room was very cool. Resident #50 didn't respond to questions asked. During the medication pass on 5/15/19 at approximately 9:57 a.m., Licensed Practical Nurse (LPN) #4 entered the resident's room and explained she had his medications, which the resident accepted without problem. Again the resident's windows were opened and the room was extremely cold. The resident's left hand was beneath the bed linen and the right hand was outside the linen. It was brought to LPN #4's attention that the windows were up, the room was extremely cold and the resident was without a call light to contact staff if needed. LPN #4 asked Resident #50 was he cold and he responded "Yes." LPN #4 closed one window and left the other open, then she looked for Resident #50's call light, which was located behind the head on the bed near the floor. LPN #4 attached the call light to the resident's gown top and left the room. An interview was conducted with Certified Nursing Assistant (CNA) #1 on 5/16/19 at approximately 1:45 p.m. CNA #1 stated Resident #50 can't do anything for himself because his hands are contracted. CNA #1 further stated the resident's right hand moved a little better than the left hand and prior to Resident #50 going to the hospital in December, he resided in a another room and in the other room a specialty call light was used but since he return from the hospital to a new room he's only had a regular call light which he was unable to activate. CNA #1 stated Resident #50's window is	F 558	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* 5. Audit tools will be presented to Performance Improvement Committee consists of Executive Director, Medical Director, Director of Nursing, Staff Development, Social Services Director, Dietitian, C.N.A & Pharmacy. monthly for three months for review, recommendation and continued need for further monitoring to sustain compliance.	06/20/2019

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F 558	Continued From page 8 frequently opened because the resident sweats a lot, and on occasion the resident has requested the air to be cut on to aid him in cooling off. CNA #1 also stated the resident has frequent smelly stools related to a medication he is administered and the window is often opened to help remove the odors. An interview was conducted with LPN #4 on 5/16/19 at approximately 1:58 p.m. LPN #4 stated she had never noticed Resident #50's window staying opened for long periods of time. LPN #4 also stated she was aware the resident required use of a specialty call light he could easily activate with his chin or hand because of limited hand movement but she had not noticed he didn't have it until it was bought to her attention. LPN #4 stated she contacted the Maintenance Director on 5/15/19, and the specialty call light was immediately installed in the resident's current room. The above findings were shared with the Administrator and Director of Nursing on 5/16/19 at approximately 6:00 p.m. The Director of Nursing stated the expectation was for Resident #50 to have a call light he could activate within reach and the staff simply needed to notify the Maintenance department to obtain the specialty call light.	F 558		
F 622 SS=D	Transfer and Discharge Requirements CFR(s): 483.15(c)(1)(i)(ii)(2)(i)-(iii) §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- (i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless-	F 622		

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F 622	Continued From page 9 (A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; (C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident; (D) The health of individuals in the facility would otherwise be endangered; (E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or (F) The facility ceases to operate. (ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose. §483.15(c)(2) Documentation. When the facility transfers or discharges a	F 622	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* F622 1. Resident #17, #121, #111, & #106 were re-admitted and currently resides in the facility. 2. All residents residing in the facility have been identified as having the potential to be affected. 3. The Director of Nursing Services (DNS)/ Staff Development Coordinator (SDC)/ designee in-serviced license staffs – Nurses to ensure that resident's care plan summary goals are being sent with resident upon discharge to the hospital. The Unit Managers/Assistant Director of Nursing (ADNS) will audit 5 residents' chart per week for one month, then monthly for 2 months and then as recommended by Performance Improvement Committee to ensure compliance.	06/20/2019

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F 622	Continued From page 10 resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (i) Documentation in the resident's medical record must include: (A) The basis for the transfer per paragraph (c)(1)(i) of this section. (B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s). (ii) The documentation required by paragraph (c)(2)(i) of this section must be made by- (A) The resident's physician when transfer or discharge is necessary under paragraph (c) (1) (A) or (B) of this section; and (B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure	F 622	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* 4. Results of audit will be taken to the monthly Performance Improvement meeting which consist of Executive Director, Medical Director, Director of Nursing, Staff Development, Social Services Director, Dietitian, C.N.A & Pharmacy for review, corrective action will be initiated if appropriate.	06/20/2019

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F 622	Continued From page 11	F 622		

Continued From page 11

a safe and effective transition of care.
This REQUIREMENT is not met as evidenced by:
Based on staff interviews and clinical record reviews the facility staff failed to send care plan summary goals for 4 residents (Resident #17, Resident #121, Resident #111, Resident #106) out of 56 residents in the survey sample when discharged to the hospital.

1. The facility staff failed to send Resident # 17's care plan summary goals when discharged to the hospital.

2. The facility staff failed to send care plan summary goals for Resident #121 when discharged to the hospital.

3. The facility staff failed to ensure that Resident #111's Plan of Care Summary to include their care plan goals was sent upon transfer/discharge to the hospital on 04/11/19.

4. The facility staff failed to include in the transfer summary indication that the facility staff conveyed to the receiving providers the resident's comprehensive care plan goals at the time of discharge to the local hospital on 2/12/19 and 3/14/19 or as soon as possible to the actual time of transfer for Resident #106.

The findings included:

1. Resident #17 was discharged to the hospital on 02/01/2019 and readmitted to the facility on 02/08/2019. Diagnoses included but were not limited to Hemiplegia and Diabetes Mellitus. Resident #17's Minimum Data Set (an assessment protocol) with an Assessment

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F 622	Continued From page 12	F 622		

Reference Date of 02/15/2019 was coded with a BIMS (Brief Interview for Mental Status) score of 14 indicating no cognitive impairment. In addition, the Minimum Data Set coded Resident #17 as requiring extensive assistance of 2 with bed mobility, transfer and toilet use, extensive assistance of 1 with dressing, eating and personal hygiene and total dependence of 1 for bathing.

On 5/15/19 at 2:08 p.m., an interview was conducted and Registered Nurse (RN) #6, Unit Manager on Butler Hall who stated when residents are discharged from the nursing facility the SBAR/Interact document is sent along with a copy of the Medication Administration Record (MAR), Treatment Administration Record (TAR), discharge summary, history and physical, Do Not Resuscitate (DNR) form and any laboratory findings. When asked if the bed hold reserve policy was issued to the resident or the Resident Representative (RR) at the time of discharge, and a copy of the comprehensive summary of care plan goals forwarded to the hospital, she stated, "I am not aware of the documents you are talking about. The ones I told you are the only ones we send."

On 5/15/19 at 2:30 p.m., an interview was conducted with the RN Unit Manager on Joyner Hall and when asked if he forwarded a copy of the comprehensive summary of care plan goals to the local hospital, he responded, "This is something I don't know about and I know we are not sending that with the resident or forwarding over to the hospital at this time."

On 5/16/19 at 11:45 a.m., an interview was conducted with the Director of Nursing (DON) and

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F 622	Continued From page 13 she said, "I can say for certain we are not sending care plan summaries with the resident upon discharge or that we fax over those summaries to the hospital. We will be training on this process as soon as possible." The Administrator and Director of Nursing was informed of the findings on 05/16/2019 at 5:15 p.m. at the pre-exit meeting. The facility did not present any further information about the findings. 2. The facility staff failed to send care plan summary goals for Resident #121 when discharged to the hospital. Resident #121 was discharged to the hospital on 04/17/2019 and readmitted to the facility on 04/28/2019. Diagnoses included but were not limited to, Anoxic Brain Damage, Tracheostomy and Dry Eye Syndrome of Unspecified Lacrimal Gland. Resident #121's Minimum Data Set (an assessment protocol) with an Assessment Reference Date of 04/29/2019 was coded with short-term memory problems, long-term memory problems and with severely impaired cognitive skills for daily decision making. In addition, the Minimum Data Set coded Resident #121 as requiring total dependence, on staff, for Activities of Daily Living. On 5/15/19 at 2:08 p.m., an interview was conducted and Registered Nurse (RN) #6, Unit Manager on Butler Hall stated when residents are discharged from the nursing facility the SBAR/Interact document is sent along with a copy of the Medication Administration Record (MAR), Treatment Administration Record (TAR), discharge summary, history and physical, Do Not Resuscitate (DNR) form and any laboratory	F 622		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495247	A. BUILDING ______ B. WING ______	C 05/16/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONCORDIA TRANSITIONAL CARE REHAB-NANSEMOND POINTE	200 WEST CONSTANCE ROAD SUFFOLK, VA 23434

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F 622	Continued From page 14 findings. When asked if a copy of the comprehensive summary of care plan goals forwarded to the hospital, she stated, "I am not aware of the documents you are talking about. The ones I told you are the only ones we send." On 5/15/19 at 2:30 p.m., an interview was conducted and when asked of the RN Unit Manager on Joyner Hall if he issued the bed hold reserve policy to the resident or the RR at the time of discharge to the hospital, he stated that he thought that might have been an admissions process, but was not given when discharged to the hospital. When asked if he forwarded a copy of the comprehensive summary of care plan goals to the local hospital, he responded, "This is something I don't know about and I know we are not sending that with the resident or forwarding over to the hospital at this time." On 5/16/19 at 11:45 a.m., an interview was conducted with the Director of Nursing (DON) and she stated "I can say for certain we are not sending care plan summaries with the resident upon discharge or that we fax over those summaries to the hospital. We will be training on this process as soon as possible." The Administrator and Director of Nursing was informed of the findings on 05/16/2019 at 5:15 p.m. at the pre-exit meeting. The facility did not present any further information about the findings. 3. The facility staff failed to ensure that Resident #111's Plan of Care Summary to include the care plan goals, was sent upon transfer/discharge to the hospital on 04/11/19. Resident #111 was originally admitted to the facility on 09/30/17. The resident was	F 622		

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F 622	Continued From page 15 re-admitted to the facility on 04/17/19. Diagnoses for Resident #111 included but were not limited to, Cerebral infarction, Acute and Chronic Respiratory Failure. Resident #111's current Minimum Data Set (MDS), a significant change with an Assessment Reference Date (ARD) of 04/24/19 coded the resident with a 10 out of a possible score of 15 on the Brief Interview for Mental Status (BIMS) indicating moderate cognitive impairment. An interview was conducted with Licensed Practical Nurse (LPN) #1 on 05/16/19 at approximately, 12:22 PM concerning Resident transfer/discharge. He was asked what paperwork is sent with the resident when they are being sent out to the hospital. LPN #1 replied that "We usually will send out a copy of the MAR (Medication Administration Record), the Face Sheet, bed hold notice, Quality Assurance, SBAR (Situation ,Background, Assessment, Recommendation) and the History and Physical." He was asked if the care plan is normally sent. He stated, "We don't send a care plan." An interview was conducted with the Administrator and Director of Nursing (DON) on 05/16/19 at approximately 5:09 PM. They were asked what should have been done concerning the above issue. The DON stated that "we will send care plan to the hospital with the resident." 4. The facility staff failed to include in the transfer summary indication that the facility staff conveyed to the receiving providers the resident's comprehensive care plan goals at the time of discharge to the local hospital on 2/12/19 and 3/14/19 or as soon as possible to the actual time	F 622		

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F 622	Continued From page 16 of transfer for Resident #106. Resident #106 was admitted to the nursing facility on 3/12/19 with diagnoses that included diabetes, end stage renal disease and left below the knee amputation. Resident #106's most recent Minimum Data Set (MDS) assessment was a quarterly assessment dated 4/4/19 and coded the resident with a score of 14 out of a possible score of 15 on the Brief Interview for Mental Status (BIMS) which indicated the resident was fully intact in the cognitive skills necessary for daily decision making. The nurse's notes dated 2/12/19 indicated Resident #106 was transported to the local hospital for surgery. Resident #106 was readmitted to the nursing facility on 2/15/19. There was no documentation in the clinical record that facility staff conveyed to the receiving providers the resident's comprehensive care plan goals at the time of discharge or soon thereafter to the local hospital. The nurse's notes dated 3/14/19 indicated the resident was transferred to the emergency department (ED) for evaluation due to dark blood in the indwelling urinary tubing and drainage bag. He was admitted to the hospital and re-admitted to the nursing facility on 3/21/19. There was no documentation in the clinical record that facility staff conveyed to the receiving provider the resident's comprehensive care plan goals at the time of discharge or soon thereafter to the local hospital. On 5/15/19 at 2:08 p.m., Registered Nurse (RN)	F 622		

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F 622	Continued From page 17 Unit Manager on Butler hall stated when residents are discharged from the nursing facility the SBAR/Interact document is sent along with a copy of the Medication Administration Record (MAR), Treatment Administration Record (TAR), discharge summary, history and physical, Do Not Resuscitate (DNR) form and any laboratory findings. When asked if a copy of the comprehensive summary of care plan goals forwarded to the hospital, she stated, "I am not aware of the documents you are talking about. The ones I told you are the only ones we send." On 5/16/19 at 11:45 a.m., the Director of Nursing (DON) stated "I can say for certain we are not sending care plan summaries with the resident upon discharge or that we fax over those summaries to the hospital. We will be training on this process as soon as possible." The facility did not have a current policy that identified issuance of the comprehensive care plan summary upon transfer or discharge. The Administrator nor the DON presented additional documentation prior to survey exit on 5/16/19 at 7:30 p.m.	F 622		
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-	F 625		

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F 625	Continued From page 18 (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on staff interviews and clinical record reviews the facility staff failed to issue written Bed Hold Notices to 3 Residents and/or Resident Representatives (Resident #17, Resident #121, Resident #106) out of 56 residents in the survey sample, when discharged to the hospital. 1. Resident #17 was discharged to the hospital on 02/01/2019 and the facility staff failed to issue the Resident and/or Resident Representative a written Bed Hold Notice. 2. For Resident #121, the facility staff failed to issue a written Bed Hold Notice to the Resident and/or Resident Representative when discharged to the hospital on 04/17/2019.	F 625	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* F625 1. Resident #17, #121, & #106 were re-admitted and currently resides in the facility. 2. All residents residing in the facility have been identified as having the potential to be affected. 3. The Director of Nursing Services (DNS)/ Staff Development Coordinator (SDC)/Designee in-serviced license staffs – Nurses to ensure that written bed hold notice are being sent with resident upon discharge to the hospital. The Unit Managers/Assistant Director of Nursing (ADNS) will audit 5 residents' chart per week x 4 weeks, then monthly x 2 months and then as recommended by the Performance Improvement Committee to ensure compliance.	06/20/2019

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F 625	Continued From page 19 3. The facility staff failed to ensure Resident #106 or Resident Representative (RR), who resided on Butler Hall, was issued a written notice of the bed hold reserve policy upon transfer to the local hospital on 2/12/19 and on 3/14/19. The findings included: 1. Resident #17 was discharged to the hospital on 02/01/2019 and readmitted to the facility on 02/08/2019. Diagnoses included but were not limited to, Hemiplegia and Diabetes Mellitus. Resident #17's Minimum Data Set (an assessment protocol) with an Assessment Reference Date of 02/15/2019 was coded with a BIMS (Brief Interview for Mental Status) score of 14 indicating no cognitive impairment. In addition, the Minimum Data Set coded Resident #17 as requiring extensive assistance of 2 with bed mobility, transfer and toilet use, extensive assistance of 1 with dressing, eating and personal hygiene and total dependence of 1 for bathing. On 5/15/19 at 2:08 p.m., an interview was conducted and Registered Nurse (RN) #6, Unit Manager on Butler Hall who stated when residents are discharged from the nursing facility the SBAR/Interact document is sent along with a copy of the Medication Administration Record (MAR), Treatment Administration Record (TAR), discharge summary, history and physical, Do Not Resuscitate (DNR) form and any laboratory findings. When asked if the bed hold reserve policy was issued to the resident or the Resident Representative (RR) at the time of discharge she stated, "I am not aware of the documents you are talking about. The ones I told you are the only ones we send."	F 625	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* 4. Results of audit will be taken to the monthly Performance Improvement meeting which consist of Executive Director, Medical Director, Director of Nursing, Staff Development, Social Services Director, Dietitian, C.N.A & Pharmacy for review, corrective action will be initiated if appropriate.	06/20/2019

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F 625	Continued From page 20 On 5/15/19 at 2:30 p.m., an interview was conducted and when asked of the RN Unit Manager on Joyner Hall if he issued the bed hold reserve policy to the resident or the RR at the time of discharge to the hospital, he stated that he thought that might have been an admissions process, but was not given when discharged to the hospital. On 5/16/19 at 11:45 a.m., an interview was conducted with the Director of Nursing (DON) and she said, "We do not have documentation in the clinical record that we are issuing the bed hold policy to the resident or family at time of discharge." "We will be training on this process as soon as possible." The Administrator and Director of Nursing was informed of the findings on 05/16/2019 at 5:15 p.m. at the pre-exit meeting. The facility did not present any further information about the findings. 2. For Resident #121, the facility staff failed to issue a written Bed Hold Notice to the Resident and/or Resident Representative (RR)when discharged to the hospital on 04/17/2019. Resident #121 was discharged to the hospital on 04/17/2019 and readmitted to the facility on 04/28/2019. Diagnosis included but were not limited to Anoxic Brain Damage, Tracheostomy and Dry Eye Syndrome of unspecified Lacrimal Gland. Resident #121's Minimum Data Set (an assessment protocol) with an Assessment Reference Date of 04/29/2019 was coded with short-term memory problems, long-term memory problems and with severely impaired cognitive	F 625		

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F 625	Continued From page 21 skills for daily decision making. In addition, the Minimum Data Set coded Resident #121 as requiring total dependence, on staff, for Activities of Daily Living. On 5/15/19 at 2:08 p.m., an interview was conducted and Registered Nurse (RN) #6, Unit Manager on Butler Hall who stated when residents are discharged from the nursing facility the SBAR/Interact document is sent along with a copy of the Medication Administration Record (MAR), Treatment Administration Record (TAR), discharge summary, history and physical, Do Not Resuscitate (DNR) form and any laboratory findings. When asked if the bed hold reserve policy was issued to the resident or the Resident Representative (RR) at the time of discharge, she stated, "I am not aware of the documents you are talking about. The ones I told you are the only ones we send." On 5/15/19 at 2:30 p.m., an interview was conducted and when asked of the RN Unit Manager on Joyner Hall if he issued the bed hold reserve policy to the resident or the RR at the time of discharge to the hospital, he stated that he thought that might have been an admissions process, but was not given when discharged to the hospital. On 5/16/19 at 11:45 a.m., an interview was conducted with the Director of Nursing (DON) and she said, "We do not have documentation in the clinical record that we are issuing the bed hold policy to the resident or family at time of discharge." "We will be training on this process as soon as possible." The Administrator and Director of Nursing was	F 625		

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F 625	Continued From page 22 informed of the findings on 05/16/2019 at 5:15 p.m. at the pre-exit meeting. The facility did not present any further information about the findings. 3. The facility staff failed to ensure Resident #106 or Resident Representative (RR), who resided on Butler Hall, was issued a written notice of the bed hold reserve policy upon transfer to the local hospital on 2/12/19 and on 3/14/19. Resident #106 was admitted to the nursing facility on 3/12/19 with diagnoses that included diabetes, end stage renal disease and left below the knee amputation. Resident #106's most recent Minimum Data Set (MDS) assessment was a quarterly dated 4/4/19 and coded the resident with a score of 14 out of a possible score of 15 on the Brief Interview for Mental Status (BIMS) which indicated the resident was fully intact in the cognitive skills necessary for daily decision making. The nurse's notes dated 2/12/19 indicated Resident #106 was transported to the local hospital for surgery. Resident #106 was readmitted to the nursing facility on 2/15/19. There was no documentation in the clinical record that facility staff issued a written notice of the bed hold reserve policy upon transfer to the local hospital to either the Resident or RR. The nurse's notes dated 3/14/19 indicated the resident was transferred to the emergency department (ED) for evaluation due to dark blood in the indwelling urinary tubing and drainage bag. He was admitted to the hospital and re-admitted to the nursing facility on 3/21/19. There was no documentation in the clinical record that facility	F 625		

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F 625	Continued From page 23 staff issued a written notice of the bed hold reserve policy upon transfer to the local hospital to either the Resident or RR. On 5/15/19 at 2:08 p.m., Registered Nurse (RN) Unit Manager on Butler hall stated when residents are discharged from the nursing facility the SBAR/Interact document is sent along with a copy of the Medication Administration Record (MAR), Treatment Administration Record (TAR), discharge summary, history and physical, Do Not Resuscitate (DNR) form and any laboratory findings. When asked if the bed hold reserve policy was issued to the resident or the Resident Representative (RR) at the time of discharge, she stated, "I am not aware of the documents you are talking about. The ones I told you are the only ones we send." On 5/16/19 at 11:45 a.m., the Director of Nursing (DON) said, "We do not have documentation in the clinical record that we are issuing the bed hold policy to the resident or family at time or discharge." "We will be training on this process as soon as possible." The facility did not have a current policy that identified issuance to the resident or RR the bed hold reserve policy upon discharge to the local hospital. No additional documentation was provided prior to survey exit on 5/16/19 at 7:30 p.m.	F 625		
F 645 SS=D	PASARR Screening for MD & ID CFR(s): 483.20(k)(1)-(3) §483.20(k) Preadmission Screening for individuals with a mental disorder and individuals	F 645		

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F 645	Continued From page 24 with intellectual disability. §483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission, (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services; or (ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission- (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability. §483.20(k)(2) Exceptions. For purposes of this section- (i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital. (ii) The State may choose not to apply the	F 645	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* F645 1. Resident # 88 currently resides in the facility and Level 1 PASRR has been completed on resident, #88. 2. All residents residing in the facility have been identified as having the potential to be affected. 3. Social Worker/designee reviewed all residents for PASSR Level I to assess for service that might be necessary based on diagnosis of a mental disorder. PASSR Level 1 assessment has been completed for all residents' currently residing in the facility as of 5/23/2019 4. The Executive Director/designee in-serviced the Director of Social Services on completing PASRR level 1 on all residents upon admission to the facility. All new admissions will be reviewed in morning meeting for PASSR level I determination to determine if appropriate recommendations and care plan addresses disability.	06/20/2019

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CONCORDIA TRANSITIONAL CARE REHAB-NANSEMOND POINTE	200 WEST CONSTANCE ROAD SUFFOLK, VA 23434

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 645	Continued From page 25 preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual- (A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital, (B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and (C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services. §483.20(k)(3) Definition. For purposes of this section- (i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1). (ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter. This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff interviews and facility documentation review, the facility staff failed to issue a Preadmission Screening and Resident Review (PASRR) for 1 out of 56 residents (Resident #88) in the survey sample. Resident #88 did not have the required Level I PASRR to assess for service that might be necessary based on diagnosis of a mental disorder. The findings included:	F 645	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* 5. Results of all Residents with PASRR I determination will be reviewed and discussed by the Executive Director, reviewed and analyzed by the interdisciplinary Team which consist of Executive Director, Medical Director, Director of Nursing, Staff Development, Social Services Director, Dietitian, C.N.A & Pharmacy at the monthly Quality Assessment and Performance Improvement meeting for three months with a subsequent plan of correction as needed.	06/20/2019

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F 645	Continued From page 26 Resident #88 was admitted to the nursing facility on 7/4/18 with diagnoses that included bipolar disorder and schizophrenia. There was no documentation in the clinical record that a Level I PASRR was completed. Resident #88's most recent Minimum Data Set (MDS) assessment dated 4/13/19 was a quarterly assessment which coded the resident with short and long term memory and severely impaired with the necessary skills for daily decision making. The resident's active diagnoses were coded in Section I: anxiety disorder, depression, manic depression (bipolar) and psychotic disorder, schizophrenia. On 5/16/19 at 3:15 p.m., an interview was conducted with the Social Services Coordinator who stated, "Everyone in the facility will have a Level I PASRR either upon admission or one completed after their admission to determine if specialized services are needed, then coordination of a Level II assessment will be completed by (name of the assessment service)." The facility's policy and procedures dated 11/28/17 indicated PASRR screenings are required for nursing centers having State Medicaid Certification. No additional information was presented prior to survey exit on 5/16/19 at 7:30 p.m.	F 645		
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	F 656		

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F 656	Continued From page 27 care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §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:	F 656	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* F656 1. Residents, #44 and #50 currently resides in the facility. Comprehensive care plan has been completed and updated for residents #44 and #50. 2. All residents residing in the facility have been identified as having the potential to be affected. 3. The DNS/Staff Development Coordinator (SDC)/designee in-serviced Licensed Dietitian, License Nurses & MDS Coordinators and on-going to ensure the resident's care plans are updated to reflects residents' needs. DNS/ADNS/UM/designee will perform random audit 3X weekly for 1 month and then monthly x 2 months to validate that resident care plans are updated to maintain compliance.	06/20/2019

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F 656	Continued From page 28 Based on staff interview, facility document review, and clinical record review, it was determined that facility staff failed to develop the comprehensive care plan for two of 56 residents in the survey sample, Resident #44 and #50. 1. For Resident #44, facility staff failed to develop a nutritional care plan to her comprehensive care plan dated 12/27/17. 2. The facility staff failed to develop a care plan to address Resident #50's inability to utilize a regular call light due to decreased range of motion of bilateral hands related to quadriplegia and traumatic brain injury. The findings include: 1. Resident #44 was admitted to the facility on 12/27/17 with diagnoses that included but were not limited to Bipolar disorder, anxiety disorder, and mild cognitive impairment. Resident #44's most recent MDS (minimum data set) assessment was a quarterly assessment with an ARD (assessment reference date) of 3/3/19. Resident #44 was coded as being intact in cognitive function scoring 12 out of possible 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #44 was coded in Section K (Nutritional Status) as having a significant weight loss. Review of Resident #44's annual MDS assessment with an ARD of 12/11/18 revealed in Section V, "Care Area Assessment (CAA) Summary," that Nutritional status was an area triggered on the CAA. It was also documented in Section V that Nutritional status would be care	F 656	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* 4. Results of audit will be taken to the monthly Performance Improvement meeting which consist of Executive Director, Medical Director, Director of Nursing, Staff Development, Social Services Director, Dietitian, C.N.A & Pharmacy for review, corrective action will be initiated if appropriate.	06/20/2019

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F 656	Continued From page 29 planned. The CAA worksheets dated 12/24/18 documented the following under the area of Nutritional Status: "Functional problems that affect ability to eat: Functional limitation in range of motion. Inability to perform ADLs (activities of daily living) without significant physical assistance. Cognitive, mental status and behavior problem that can interfere with eating: Anxiety problems...Other diseases and condition that can affect appetite or nutritional status: Delirium...Medications: Antipsychotics...Is a referral to another discipline warranted? Yes, nursing, dietician to monitor for unmet needs." Review of Resident #44's clinical record revealed that she had a ten percent weight loss from 9/13/18 through 3/12/19. The following weights were recorded: "9/13/18: 161.6 3/12/19: 140.0" The following note was written by the dietitian on 3/21/19: "Resident reports good appetite. Per nursing she consumes 75-100 percent of most meals. She is edentulous (without teeth) but denies problems chewing or swallowing the regular texture diet. Discussed food preferences, likes/dislikes. Weight stable this month. Significant weight loss noted this quarter...Recommended: Added Ensure plus...Continue current diet regimen w/ (with)snacks between meals. Will continue to monitor." Review of Resident #44's clinical record revealed	F 656		

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F 656	Continued From page 30	F 656		

that staff were assisting with meals and putting interventions in place to promote weight gain.

Review of Resident #44's comprehensive care plan dated 12/27/17 and revised 5/7/19, failed to evidence a nutritional care plan.

On 5/14/19 at approximately 4 p.m., a copy of Resident #44's comprehensive care plan was requested from administration.

On 5/15/19 at approximately 10:00 a.m., administration presented Resident #44's care plan. Nutritional Status was added to her care plan on 5/15/19 (during survey). The following was documented: "Resident has unplanned/unexpected weight loss r/t (related to) poor food intake. Goal: Will consume 50 percent two of three meals/day through next review date. Interventions: Alert dietician if consumption is poor for more than 48 hours. Give Ensure Plus supplements bid (two times a day) as ordered. Alert nurse/dietician if not consuming in a routine basis. Monitor/Evaluate meal percentage intake via meal intake records and observation. Monitor and evaluate any weight loss. Determine percentage lost and follow facility protocol for weight loss."

On 5/16/19 at 11:14 a.m., an interview was conducted with LPN (licensed practical nurse) #1, the unit manager. When asked the purpose of the care plan, LPN #1 stated that the care plan was a guide on how to care for the resident. LPN #1 stated that all staff can look at the care plan if they have a question regarding care. LPN #1 stated that it was important for the care plan to be accurate. LPN #1 stated that nurses and MDS can update the care plan with any new changes

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F 656	Continued From page 31 in the condition of the resident. When asked who was responsible for developing the comprehensive care plan, LPN #1 stated that MDS develops the baseline care plan and the comprehensive care plan. What asked what type of care areas he would expect to see on a baseline care plan, LPN #1 stated that he would expect to see the following care areas: skin, falls, ADLs (activities of daily living). When asked if he would expect to see nutrition on a baseline care plan, LPN #1 stated that he would expect to see care area "nutrition" on the comprehensive care plan. LPN #1 stated that even if a resident has no current nutritional issues, he would expect to see a care plan addressing diet, food preferences etc. LPN #1 looked at Resident #44's care plan and stated that he was not sure why she did not have a care plan in place until 5/15/19. When asked if there was any concern with Resident #44's weight, LPN #1 stated that he didn't have concerns with Resident #44's weight because her meal intake was good when encouraged by staff. LPN #1 stated that on occasion she will refuse meals and get upset. LPN #1 stated that sometimes Resident #44 would rather smoke than eat. On 5/16/19 at 12:19 p.m., an interview was conducted with RN (registered nurse) #4, the MDS coordinator. When asked who was responsible for developing the comprehensive care plan, RN #4 stated that her department (MDS) was responsible for developing the comprehensive care plan within the first few days of admission. When asked what type of care areas are addressed on the comprehensive care plan, RN #4 stated that she would add the following care areas: ADLS, pain management, skin issues, any infections, diagnoses etc. When	F 656		

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F 656	Continued From page 32 asked if she would expect to see nutritional status on the comprehensive care plan, RN #4 stated that she would. When asked why nutrition was not on Resident #44's comprehensive care plan especially after it triggered on her annual MDS assessment, RN #4 stated that MDS was not responsible for developing the nutrition care plan, that the dietician initiates the nutrition care plan. RN #4 confirmed that it was her staff's signature on the 12/11/18 MDS under section V documenting that nutrition was an area to be care planned. RN #4 stated again that the dietician would be responsible for developing a nutrition care plan. On 5/16/19 at 12:20 p.m., an interview was conducted with OSM (other staff member) #4, the Dietician. When asked if nutrition was a care area that she would expect to see on a resident's comprehensive care plan, OSM #4 stated that most residents had a nutrition care plan. OSM #4 stated that she would do a nutritional assessment within seven days of admission and develop a care plan. When asked if Resident #44 had a nutrition care plan, OSM #4 stated that she had just added one yesterday (5/15/19). When asked if there was one in place prior to 5/15/19, OSM #4 stated, "Seems like there should have been one before that." OSM #4 stated that Resident #44 was having weight loss and that she added her on supplements. OSM #4 stated that there should have been a nutritional care plan because she would have added supplements to the care plan. When asked why she created a care plan yesterday 5/15/19, OSM #4 stated that she was alerted that Resident #44 did not have a nutrition care plan and that she needed one. OSM #4 could not present a nutrition care plan	F 656		

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F 656	Continued From page 33 prior to 5/15/19. On 5/16/19 at 5:30 p.m., ASM (administrative staff member) #1, the administrator and ASM #2, the DON (Director of Nursing) were made aware of the above concerns. 2. Resident #50 was originally admitted to the facility 6/14/18, and readmitted 12/30/18, after an acute care hospital stay. The current diagnoses are quadriplegia, traumatic brain injury, hepatitis and cirrhosis. The quarterly Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 3/21/19, coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 0 out of a possible 15. This indicated Resident #50's cognitive abilities for daily decision making were severely impaired. In section "G" (Physical functioning) the resident was coded as requiring extensive assistance of 1 person with eating and personal hygiene, extensive assistance of 2 people with bed mobility and dressing, total care of 1 with locomotion and bathing and total care of 2 people with transfers and toileting. The resident's range of motion was coded for poor bilateral upper and lower extremity. Both of Resident #50's hands were severely contracted and unable to hold objects and they were with very little physical abilities. During the initial tour with Resident #50 on 5/14/19 at approximately 3:45 p.m., the resident was observed in bed with his bed linens pulled up to his neck with his chin lying on them. The call light was observed freely hanging behind the resident's head of the bed and out of the	F 656		

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F 656	Continued From page 34 resident's reach. Both of the double windows were opened and the room was very cool. Resident #50 didn't respond to questions asked. During the medication pass on 5/15/19 at approximately 9:57 a.m., Licensed Practical Nurse (LPN) #4 entered the resident's room and explained she had his medications, which the resident accepted without problem. Again the resident's windows were opened and the room was extremely cold. The resident's left hand was beneath the bed linen and the right hand was outside the linen. It was brought to LPN #4's attention that the windows were up, the room was extremely cold and the resident was without a call light to contact staff if needed. LPN #4 asked Resident #50 was he cold and he responded "Yes." LPN #4 closed one window and left the other open, then she looked for Resident #50's call light, which was located behind the head on the bed near the floor. LPN #4 attached the call light to the resident's gown top and left the room. Review of Resident #50's care plan didn't reveal a care plan related to decreased range of motion of his hands and the need for a specialty call light. An interview was conducted with Certified Nursing Assistant (CNA) #1 on 5/16/19 at approximately 1:45 p.m. CNA #1 stated Resident #50 can't do anything for himself because his hands are contracted. CNA #1 further stated the resident's right hand moved a little better than the left hand and prior to Resident #50 going to the hospital in December, he resided in a another room and in the other room a specialty call light was used but; since he return from the hospital to a new room he's only had a regular call light which he was unable to activate.	F 656		

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CNA #1 stated Resident #50's window is frequently opened because the resident sweats a lot, and on occasion the resident has requested the air to be cut on to aid him in cooling off. CNA #1 also stated the resident has frequent smelly stools related to a medication he is administered and the window is often opened to help remove the odors.

An interview was conducted with LPN #4 on 5/16/19 at approximately 1:58 p.m. LPN #4 stated she had never noticed Resident #50's window staying opened for long periods of time. LPN #4 also stated she was aware the resident required use of a specialty call light he could easily activate with his chin or hand because of limited hand movement but; she had not noticed he didn't have it until it was bought to her attention. LPN #4 stated she contacted the Maintenance Director on 5/15/19, and the specialty call light was immediately installed in the resident's current room.

An interview was conducted with the MDS Coordinators on 5/16/19, at approximately 2:45 p.m. The MDS Coordinators stated a care plan was developed to address the resident's musculoskeletal status related to pain and activities of daily living but not the resident's inability to use a regular call light. MDS Coordinator #4 stated she had heard Resident #50 call out for assistance. MDS Coordinator #4 stated the resident calling out for assistance wasn't the optimal means for the resident to contact staff; a touch pad call light would be appropriate device.

On 5/16/19 at approximately 5:00 p.m., the MDS

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F 656	Continued From page 36 Coordinators provided a revised care plan which had a problem dated 12/30/18, which read (name of resident) has impaired communication related to a cognitive decline, head injury. The goal read; (name of resident) will be able to make basic needs known on a daily basis through the review date 6/26/19. The interventions included a new intervention dated 5/16/19, for a touch pad call bell. The above findings were shared with the Administrator and Director of Nursing on 5/16/19 at approximately 6:00 p.m. The Director of Nursing stated the expectation was for Resident #50 to have a call light he could activate and a care plan which alerted the staff to ensure it was available for the resident's use.	F 656	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*	06/20/2019
F 658 SS=D	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 resident interview, staff interview and facility document review, it was determined that facility staff failed to follow professional standards of practice for one of 56 residents in the surveys sample, Resident #7. For Resident #7, facility staff failed to obtain daily weights per physician's order and the comprehensive care plan. The findings include:	F 658	F658 1. Resident #7 currently resides in the facility and receiving daily weights per physician order. 2. Residents with physician order for daily weights have been identified as having the potential to be affected. 3. The Staff Development Coordinator (SDC)/designee in-serviced License Nurses to ensure that residents on daily weights are being obtained and documented accurately on their medical records and inform MD as ordered. 4. DNS/ADNS/UM/designee will audit all residents on daily weights for appropriate documentation 3X weekly X 4 weeks, then weekly X 4, then monthly X 3 to maintain compliance.	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495247	A. BUILDING ______ B. WING ______	C 05/16/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONCORDIA TRANSITIONAL CARE REHAB-NANSEMOND POINTE	200 WEST CONSTANCE ROAD SUFFOLK, VA 23434

(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 37 Resident #7 was admitted to the facility on 5/22/18 and readmitted on 7/27/18 with diagnoses that included but were not limited to, atrial fibrillation, chronic kidney disease stage 3, high blood pressure, and type two diabetes. Resident #7's most recent MDS (minimum data set) assessment was a quarterly assessment with an ARD (assessment reference date) of 2/12/19. Resident #7 was coded as being cognitively intact in the ability to make daily decisions scoring 12 out of possible 15 on the BIMS (brief interview for mental status) exam. Review of Resident #7's clinical record revealed the following order: "weight daily every day shift for heart failure, Monitoring Alert MD (medical doctor) for weight gain of 3 lbs (pounds) in one day, 5 pounds in one week." This order was initiated on 7/30/18 Review of Resident #7's April and May 2019 MARs (medication administration records) revealed that facility staff were documenting daily weights on the MAR along with a nurse signature. There were no concerns with the May 2019 MARs. Further review of Resident #7's April 2019 MARs (medication administration records) revealed hole or blanks for the following dates: 4/6/19 4/7/19 4/8/19 4/21/19 Review of Resident #7's April 2019 nursing notes failed to evidence weights for these dates.	F 658	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* 5. Results of audit will be taken to the monthly Performance Improvement meeting which consist of Executive Director, Medical Director, Director of Nursing, Staff Development, Social Services Director, Dietitian, C.N.A & Pharmacy for review, corrective action will be initiated if appropriate.	06/20/2019

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F 658	Continued From page 38	F 658		

Review of Resident #7's April 2019 weight log on PCC (point click care) (electronic health record) failed to evidence weights for these dates.

Further review of Resident #7's April 2019 MARs revealed that on 4/23/19 through 4/28/19 (6 consecutive days) staff were documenting that Resident #7 weighed "191.4".

Review of Resident #7's comprehensive care plan dated 7/27/18 and revised 8/6/18 documented the following: "Altered Cardiac Output r/t (related to) history of MI (myocardial infarction) (heart attack), CHF (congestive heart failure) CAD (coronary artery disease, HTN (high blood pressure)...Weigh per facility policy and/or physician order and record."

On 5/16/19 at 11:14 a.m. an interview was conducted with LPN #1, the unit manager. When asked why a resident would need daily weights, LPN #1 stated that a resident would need daily weights if they had a diagnosis of heart failure and fluid retention had to be monitored. LPN #1 stated that a resident receiving dialysis may also need to be put on daily weight to monitor fluid balance. When asked who weighed residents, LPN #1 stated that the CNA (certified nursing assistant) weighed residents and then they put the weights on their assignment sheet to give to the nurse. LPN #1 stated that the nurses will then mark this weight into the MAR. When asked what blanks (no signatures) meant on the MAR, LPN #1 stated that blanks meant the nurse either forgot to enter in the weight or that the weight was not obtained. When asked why Resident #7 was on daily weights, LPN #1 stated that she was on weights due to her heart failure and had a

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F 658	Continued From page 39 problem with retaining fluid. This writer showed LPN #1 Resident #7's MAR. LPN #1 stated that he couldn't say what had happened with her weights. On 5/16/19 at 2:35 p.m., an interview was conducted with Resident #7. When asked if staff weighed her daily, Resident #7 stated that she was weighed maybe once a week but not daily. Resident #7 stated that she was weighed that day. Resident #7 then stated that she had a hard time getting her socks on that day. An observation was made of Resident #7's legs at this time. Edema was noted to her bilateral legs. On 5/16/19 at 3:01 p.m., an interview was conducted with LPN #5, Resident #7's nurse. When asked the process of obtaining daily weights, LPN #5 stated that the CNAs obtain daily weights and the nurse will record the weights in the clinical record. When asked if CNAs ever say or document that they obtained a weight when it really was not done, LPN #5 stated, "I have had that happen to me before." LPN #5 could not remember the last time that the aides stated that a weight was obtained when it was not completed. When asked if it was easy to weigh Resident #7, LPN #5 stated that they usually weigh Resident #7 in her wheelchair and then subtract the weight of the wheelchair. When asked if it was believable that Resident #7's weight was exactly the same "191.4" for six consecutive days in April, LPN #5 stated, "Her weights are about the same all the time." When asked if she had seen Resident #7 that shift, LPN #5 stated that she had. When asked if she had seen Resident #7's legs, LPN #7 stated that her edema was at her usual baseline. When asked if she had	F 658		

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F 658	Continued From page 40 obtained Resident #7's weight that day, LPN #5 stated that she couldn't remember. This writer pulled up Resident #7's May 2019 MAR. Her weight recorded for 5/16/19 was a little over 200 pounds. Her weight recorded for 5/15/19 (the day) prior was at 192.0 pounds. LPN #5 then stated that she would notify the physician with the weight gain of more than 5 pounds. On 5/16/19 at 5:30 p.m., ASM (administrative staff member) #1, the administrator and ASM #2, the DON (Director of Nursing) were made aware of the above concerns. No further information was presented prior to exit. Facility policy titled, "Physician's Orders," did not address the above concerns. No further information was presented prior to exit.	F 658	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*	06/20/2019
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, resident interview, clinical record review, it was determined that facility staff failed to provide respiratory treatment and services for one of 56 residents in the survey sample, Resident #13.	F 695	F695 1. Resident #13 is currently residing in the facility and receiving oxygen per physician order. 2. All current Residents with physician orders for oxygen have been identified as having the potential to be affected. Facility conducted audit of all residents with order for oxygen and no further occurrences were identified. 3. The SDC/Designee will in-service the licensed staff on implementing and monitoring MD orders for oxygen administration. 4. ADNS/Unit managers/designee will audit 10 residents weekly x 4 weeks, then monthly x 2 months and then as recommended by the Performance Improvement to ensure oxygen is administered per MD order.	

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F 695	Continued From page 41 For Resident #13 facility staff failed to administer oxygen per physician's order and comprehensive care plan. The findings include: Resident #13 was admitted to the facility on 7/26/17 and 1/11/18 with diagnoses that included but were not limited to heart failure, COPD (chronic obstructive pulmonary disease) and high blood pressure. Resident #13's most recent MDS (minimum data set) assessment was a quarterly assessment with an ARD (assessment reference date) of 4/23/19. Resident #13 was coded as being mildly impaired in cognitive function scoring 09 out of 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #13 was coded in Section O "Special treatments, Procedures, and Programs" as receiving oxygen therapy. Review of Resident #13's clinical record revealed the following order dated 2/28/19, "Oxygen at 2 liters/min (minute) via Nasal Cannula every shift." On 5/14/19 at 12:42 p.m., and 5/15/19 at 12:38 p.m., observations were made of Resident #13's oxygen concentrator with nasal cannula in use. Her oxygen concentrator was set to 1 liter per minute. Resident #13 was in bed for both observations and could not reach the concentrator from her bed. Resident #13 did not appear to be in any respiratory distress. On 5/15/19 at 12:43 p.m., an interview was conducted with LPN (licensed practical nurse) #3, Resident #13's nurse. When asked how many liters of oxygen Resident #13 should be on, LPN #3 looked at Resident #13's physician orders and stated that her oxygen should be set to 2 liters.	F 695	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* 5. Results of audit will be taken to the monthly Performance Improvement meeting which consist of Executive Director, Medical Director, Director of Nursing, Staff Development, Social Services Director, Dietitian, C.N.A & Pharmacy for review, corrective action will be initiated if appropriate.	06/20/2019

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F 695	Continued From page 42 LPN #3 then followed this writer to Resident #13's room. When asked how many liters Resident #13 was on, LPN #3 looked at the concentrator and stated, "It says one, but it gets turned easy." LPN #3 stated that the knob on the concentrator easily turns if someone bumps into it or if it brushes up against the curtain. When asked what should be done if the knob is easily turned, LPN #3 stated that she tries to check the oxygen concentrator at least twice a shift. LPN #3 also stated that she was always in Resident #13's room and that she tries to check every time she is in her room. When asked if Resident #13 turns the knob on her oxygen concentrator, LPN #3 stated that she wouldn't do that. Review of Resident #13's comprehensive care plan dated 1/11/18 and revised 5/8/18 documented the following: "(Name of Resident #13) has an alteration of Gas Exchange r/t (related to) chronic pulmonary embolism, left pleural effusion, COPD, CHF (congestive heart failure) and seasonal allergies and congestion...administer oxygen per physician's order." On 5/16/19 at 11:14 a.m., an interview was conducted with LPN #1, another nurse familiar with Resident #13. When asked if it was important to follow physician's orders for oxygen rate, LPN #1 stated it was important because oxygen was considered a medication. LPN #1 stated that the oxygen flow rate will be therapeutic at different levels for different residents. When asked why Resident #13 needed oxygen, LPN #1 stated that he believed she had heart failure and COPD. When asked how many liters of oxygen Resident #13 was supposed to be on, LPN #1 stated 2 liters. When asked if	F 695		

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F 695	Continued From page 43 Resident #13 could turn her the knob on the oxygen concentrator, LPN #1 stated, "Not that I know of." When asked if the knobs on the concentrator easily turned, LPN #1 stated that the knobs were very easy to turn if bumped into. When asked how often nurses check to see if a Resident is on the correct amount of liters, LPN #1 stated that nurses should check every time they go into a resident's room. When asked the purpose of the care plan, LPN #1 stated that the purpose of the care plan was a guide on how to care for the resident. LPN #1 stated that all staff can look at the care plan if they have a question regarding care. LPN #1 stated that it was important for the care plan to be accurate. This writer told LPN #1 about the above observations. LPN #1 was also shown Resident #13's care plan. When asked if her care plan was followed if her oxygen concentrator was set to the incorrect flow rate, LPN #1 stated that if her oxygen flow rate was set to 1 liter per minute then the care plan was not followed. On 5/16/19 at 5:30 p.m., ASM (administrative staff member) #1, the administrator and ASM #2, the DON (Director of Nursing) were made aware of the above concerns. Facility policy titled, "Respiratory Evaluation" and "Respiratory Equipment Care and Handling," did not address the above concerns. No further information was presented prior to exit.	F 695		
F 712 SS=D	Physician Visits-Frequency/Timeliness/Alt NPP CFR(s): 483.30(c)(1)-(4) §483.30(c) Frequency of physician visits §483.30(c)(1) The residents must be seen by a	F 712		

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F 712	Continued From page 44 physician at least once every 30 days for the first 90 days after admission, and at least once every 60 thereafter. §483.30(c)(2) A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required. §483.30(c)(3) Except as provided in paragraphs (c)(4) and (f) of this section, all required physician visits must be made by the physician personally. §483.30(c)(4) At the option of the physician, required visits in SNFs, after the initial visit, may alternate between personal visits by the physician and visits by a physician assistant, nurse practitioner or clinical nurse specialist in accordance with paragraph (e) 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 timely physician visits for one of 56 residents in the survey sample, Resident #44. For Resident #44, facility staff failed to ensure physician visits between the dates of: 5/25/18 through 9/19/18 (over 4 months) and 9/19/18 through 3/23/19 (6 months). The findings include: Resident #44 was admitted to the facility on 12/27/17 with diagnoses that included but were not limited to Bipolar disorder, anxiety disorder, and mild cognitive impairment. Resident #44's most recent MDS (minimum data set) assessment was a quarterly assessment with an	F 712	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* F712 1. Resident, #44 currently resides in the facility. Resident #44 was seen by the physician on 5/17/2019. 2. All residents in the facility have been identified as having the potential to be affected. 3. Medical Record Clerk/designee will audit all current residents to ensure timely physicians visits. 4. Medical Records Clerk/designee will audit all current residents' charts monthly to ensure compliance with physician visit schedule and update physician visit log. 5. Physicians will be educated on the facility policy and procedures regarding frequency and timeliness of physician visit. Medical record clerk/designee will notify Executive Director of Physician(s) not in compliance.	06/20/2019

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F 712	Continued From page 45 ARD (assessment reference date) of 3/3/19. Resident #44 was coded as 12 out of possible 15 on the BIMS (Brief Interview for Mental Status) exam which indicated moderate cognitive impairment. Review of Resident #44's clinical record revealed that the nurse practitioner (NP) had visited Resident #44 on the following dates: 5/25/18 9/19/18 3/23/19 3/30/19 4/29/19 There was no evidence of a physician and/or NP visit in between 5/25/18 and 9/19/18 (4 months); and 9/19/18 and 3/23/19 (6 months). On 5/15/19 through 5/16/19 several requests were made to to see evidence of all physician visits from the past year. On 5/16/19 at 12:50 p.m., an interview was conducted with OSM (other staff member) #3, medical records. When asked if she was responsible for ensuring that the physician and/or nurse practitioner made their required visits, OSM #3 stated that she was. When asked how often residents needed to be seen by the physician and/or NP, OSM #3 stated that the physician and/or NP had to see any new resident once every 30 days for 90 days and every 60 days after that. When asked if the physician/NP had to see long term care residents every 60 days as well, OSM #3 stated yes. When asked how the physician/NP are made aware of residents that need to be seen, OSM #3 stated that she had a	F 712	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* 6. Results of audit will be taken to the monthly Performance Improvement meeting which consist of Executive Director, Medical Director, Director of Nursing, Staff Development, Social Services Director, Dietitian, C.N.A & Pharmacy for review, corrective action will be initiated if appropriate.	06/20/2019

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log that she gave to the physician/NP alerting them to see the resident. OSM #3 stated that once the physician/NP sees the resident, they send over the visit summary that is then filed into the resident's clinical record. OSM #3 was asked to present any physician visits in between dates 5/25/18 through 9/19/18; and 9/19/18 through 3/23/19.

On 5/16/19 at approximately 1:30 p.m., OSM #3 presented the same progress summaries from the above physician visits that this writer already had. A physician audit was also presented documenting that Resident #44 was seen by the physician on 12/3/18. A progress note from this physician visit could not be presented. OSM #3 could not present any additional information.

On 5/16/19 at 5:30 p.m., ASM (administrative staff member) #1, the administrator and ASM #2, the DON (Director of Nursing) were made aware of the above concerns. ASM #2 stated that should would try to find the missing physician visits. These visits could not be found.

Facility policy titled, "Monitoring Physician Visits," documents in part, the following: "The physician (or physician extender, where states allow their use) personally visits the resident at least once every 30 days for the first 90 days after admission, and at least once every 60 days thereafter...Procedure: Enter the physician visit information into the PCC (point click care) system as follows: Review list of physician visits due from the PCC system. Notify physicians with visits due at the beginning of the month, or at least one (1) week prior to the date his/her first visit due. Gather and organize the resident's information (chart, physician orders, care plan, etc.) for

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F 712	Continued From page 47 physician's visit. During a physician's visit, the physician: a. Review the resident's total program of care at each required visit that includes: 1) Medical Services, 2) Medication Management 3) Physical, occupational, and speech/language therapy, 4) Nursing Care 5) Nutritional interventions, and 6) Social work and activity services that maintain or improve psychosocial functioning. b. Write, sign and date progress notes at each visit that include the resident's progress and problems in maintaining or improving their mental and physical functional status; and c. sign and date all orders. 5. Document in resident's progress notes the physician's visit. 6. Monitor the records to be sure the physician visits the residents/residents by the date the visits are due. 7. When the visits are made, enter the dates of the visits in PCC system. 8. Call/notify the physician if the resident/resident has not been seen by the due date. 9. Notify the Executive Director if the physician has not seen the resident/resident five (5) days following the date due."	F 712		
F 727 SS=D	RN 8 Hrs/7 days/Wk, Full Time DON CFR(s): 483.35(b)(1)-(3) §483.35(b) Registered nurse §483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(b)(3) The director of nursing may serve	F 727		

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F 727	Continued From page 48 as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility document review, the facility staff failed to ensure Registered Nurse (RN) coverage for 8 hours, 7 days a week. The facility staff failed to ensure RN coverage for 8 hours on three days 11/10/18, 12/09/18 and 01/20/19. The findings included: On 05/14/19 at approximately 11:00 AM, the facility's actual worked schedule was reviewed with Other Staff #7 (Nursing Scheduler) and revealed there was no RN coverage for the following days: 11/10/18, 12/09/18 and 01/20/19. On 05/16/19 at approximately 9:45 AM, Other Staff #7 asked surveyor if she could re-check the above RN (Registered Nurse) non- coverage dates and staffing. Other Staff #7 later confirmed that there was no RN coverage for the above dates. She was asked what should have been done to ensure RN coverage? She stated that usually she would know ahead of time if an RN wouldn't be able to work. She also stated that if an RN staff member was calling out after hours they would call to the unit to inform the nurse supervisor that they wouldn't be coming in. The Nurse Supervisor, would contact the DON (Director of Nursing) or the ADON (Assistant Director of Nursing) concerning staffing. On 5/16/19 at approximately 5:09 PM an interview was conducted with the Director of	F 727	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* F727 1. Facility has Registered Nurse (RN) coverage for 8 hours, 7 days a week. 2. All residents residing in the facility have been identified as having the potential to be affected. 3. Executive Director/Director of Nursing (DNS) will ensure that facility is staffed with at least 8 hours/day RN coverage to ensure compliance. 4. DNS/designee educated staff scheduler on 5/24/2019 to ensure that facility is staffed with at least 8 hours/day RN coverage to ensure compliance. 5. DNS/designee will audit the facility schedule 5 times weekly to ensure compliance.	06/20/2019

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	495247	A. BUILDING ______ B. WING ______	C 05/16/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONCORDIA TRANSITIONAL CARE REHAB-NANSEMOND POINTE	200 WEST CONSTANCE ROAD SUFFOLK, VA 23434

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F 727	Continued From page 49 Nursing (DON) and the facility Administrator concerning the above issue. The DON was asked what should have been done concerning the above issue. The DON stated "I will hire an RN supervisor for weekend coverage."	F 727		06/20/2019
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and facility record review, it was determined that facility staff failed to dispose of trash in a sanitary manner for one of one trash compactor and one of one recycle compactor. Facility staff failed to ensure one of one trash compactor and one of one recycle compactor were free from surrounding debris.	F 812	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* 6. Results of audit will be taken to the monthly Performance Improvement meeting which consist of Executive Director, Medical Director, Director of Nursing, Staff Development, Social Services Director, Dietitian, C.N.A & Pharmacy for review, corrective action will be initiated if appropriate.	

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F 812	Continued From page 50 The findings include: On 5/14/19 at 12:30 p.m., observation of the facility dumpster area was conducted with OSM (other staff member) #5, dietary aide and stock. It was observed that that facility had one trash and one recycle compacter. The trash compactor was observed to have the following debris on the ground around it: three gloves, plastic spoon and a plastic cup. The recycle compactor was observed to have the following debris on the ground around it: plastic bag, cookie wrapper, and a flattened box. At that time an interview was conducted with OSM #5 When asked who was responsible for maintaining the compactors in a sanitary manner, OSM #5 stated that it was his responsibility to check the compactors at least once a day. When asked if the observed trash was all from one day (the previous Monday), OSM #5 stated that the surrounding trash was probably from the weekend storms. OSM #5 stated that he had not been able to clean up the area. On 5/16/19 at 5:30 p.m., ASM (administrative staff member) #1, the Administrator and ASM #2, the Director of Nursing were made aware of the above concerns. Facility policy titled, "Waste Management," did not address the outside facility compactors. No further information was presented prior to exit.	F 812	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* F812 1. Facility remove and disposed of the trash in a sanitary manner at the trash compactor and remain debris free. 2. All residents residing in the facility have been identified as having the potential to be affected. 3. Executive Director/Environmental services supervisor/designee will in-service Environmental Services and Culinary staffs on proper disposal of trash in a sanitary manner. 4. Executive Director/Culinary Manger/Environmental services supervisor/Designee will conduct observational rounds of trash/recycle compactor weekly x5, then monthly x 2 and then as recommended by the PI committee.	06/20/2019
F 881 SS=D	Antibiotic Stewardship Program CFR(s): 483.80(a)(3) §483.80(a) Infection prevention and control	F 881		

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F 881	Continued From page 51 program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(3) An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, and review of the facility's Infection Control policy, the facility staff failed to have an Infection Control and Prevention program which monitored all antibiotics administered by the facility staff. The facility's staff failed to have an antibiotic stewardship program which monitored newly and readmitted residents who were prescribed antibiotics in the hospital, to ensure indication of use was validated and the resident was prescribed an appropriate antibiotic. The findings included: The facility's infection control records for March 2019 were reviewed with the Assistant Director of Nursing (ADON) for three residents who were admitted to the facility receiving antibiotic therapy for urinary tract infections (UTI). The infection control records indicated one resident's laboratory data included a clean catch urinalysis with microscopic reflex culture and two residents laboratory data included a urinalysis only. The resident who had the clean catch urinalysis with microscopic reflex culture on 3/3/19 revealed a laboratory report indicating a large amount of blood, leukocytes, red blood cells and white blood	F 881	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* 5. Observation rounds will be presented to Performance Improvement Committee consists of Executive Director, Medical Director, Director of Nursing, Staff Development, Social Services Director, Dietitian, C.N.A & Pharmacy monthly for three months for review, recommendation and continued need for further monitoring to sustain compliance.	06/20/2019

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F 881	Continued From page 52 cells were identified in the resident's urine specimen. The hospital started the resident on an antibiotic and discharged the resident to the nursing facility 3/5/19 on the antibiotic Ceftin 500 milligram every 12 hours for 5 days. The ADON stated the hospital didn't provide the facility with the culture and sensitivity results therefore they had no laboratory data to indicate specific bacteria's and the appropriate treatment, including if the bacteria in the resident's urine was susceptible to the antibiotic, Ceftin. Two resident's received clean catch urinalysis at the hospital. The residents were admitted to the nursing facility on antibiotic therapy with diagnoses of UTIs but no laboratory of the bacteria's being treated. During an interview with the ADON on 5/16/19 at approximately 9:45 a.m., she stated often the hospital doesn't send the culture and sensitivity to the facility and the facility had no protocol for obtaining the culture and sensitivity when it wasn't included in the admission documents. The ADON also stated without laboratory reports to review they had been unable to determine if the antibiotic is appropriate or if there is a need to adjusts the antibiotic. The ADON further stated she tracked in-house acquired infections by addressing antibiotic prescribing practices, documentation of the indication, dose, and duration of the antibiotic and review of laboratory reports to determine if the antibiotic is indicated or needs to be adjusted. The facility's policy titled "Infection Prevention and Control Program with a revision date of 11/28/17 read: An infection Prevention and Control Program is designed and implemented to identify and reduce the risk of acquiring and transmitting	F 881	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* F881 1. Facility has updated the antibiotics stewardship plan to include monitoring. 2. All residents on antibiotics have the potential to be affected. 3. DNS/ADNS/designee will review all residents with order for antibiotics to ensure appropriate documentation/labs in place/MD follow up. 4. SDC/Designee will Inservice staff on antibiotics stewardship program to ensure residents on antibiotics have appropriate diagnosis, monitoring and supporting documentation. 5. ADNS/Unit managers/designee will audit 5 residents' chart weekly x 4 and then monthly x 2 and as needed per recommendation of performance improvement committee to ensure compliance.	06/20/2019

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F 881	Continued From page 53 infections among residents, staff, physicians, licensed independent practitioners, volunteers, students, and visitors. It is maintained to promote a safe, sanitary and comfortable environment that involves each department. The above findings were shared with the Administrator and Director of Nursing on 5/16/19 at approximately 6:00 p.m. The Director of Nursing stated they have monthly pharmacy reviews but a review of bacteria's and the prescribed antibiotic wasn't addressed in the monthly pharmacy reviews related to antibiotic stewardship. The Director of Nursing further stated neither was the inability to obtain laboratory data from the hospital addressed in the Quality Assurance committee meetings. The Director of Nursing stated she will contact the Medical Director to develop a plan of how they can obtain laboratory reports from the transferring hospital and it they were not obtained at the hospital determine what is the next best strategies.	F 881	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* 6. Audit tools will be presented to Performance Improvement Committee consists of Executive Director, Medical Director, Director of Nursing, Staff Development, Social Services Director, Dietitian, C.N.A & Pharmacy. monthly for three months for review, recommendation and continued need for further monitoring to sustain compliance.	06/20/2019