STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495287	A. BUILDING _____ B. WING _____	C 03/28/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SENTARA NURSING CENTER HAMPTON	2230 EXECUTIVE DRIVE HAMPTON, VA 23666

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 03/26/2019 through 03/28/2019. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities. Complaint(s) were investigated during the survey.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid Standard Survey was conducted 03/26/19 through 03/28/19. Three complaints were investigated during the survey. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. The census in this 86 bed facility was 70 at the time of the survey. The survey sample consisted of 18 current Resident reviews and 6 closed record reviews.	F 000		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to ensure accurate MDS (minimum data set) assessments for 2 of 24 Residents, Resident #22 and #62. The findings included: 1. For Resident #22, the facility staff failed to code the Residents hospice status on the	F 641	1. What corrective action will be accomplished for those residents found to be affected by the deficient practice? "For Resident #22, an immediate modification of an incorrect assessment was completed on 3/27/19. "For Resident #62, an immediate modification of an incorrect assessment was completed on 3/27/19.	5/24/19

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

Electronically Signed | 05/01/2019

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

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F 641	Continued From page 1 Residents significant change in status MDS assessment. The clinical record review revealed that Resident #22 had been admitted to the facility 08/22/18. Diagnoses included, but were not limited to, hypertension, dementia, Parkinson's disease, and malignant neoplasm of prostate. Section C (cognitive patterns) of the Resident significant change in status MDS assessment with an ARD (assessment reference date) of 02/08/19 included a BIMS (brief interview for mental status) summary score of 7 out of a possible 15 points. Section O (special treatments, procedures, programs) had NOT been coded to indicate the Resident was receiving hospice care. The clinical record included a care plan that indicated the Resident was receiving hospice care effective 02/01/19. On 03/27/19 at 10:13 a.m., MDS coordinator #1 reviewed this MDS with the surveyor. After reviewing the MDS, the coordinator stated that the Residents hospice was not coded and they would complete a correction. The administrator and DON (director of nursing) were notified of the inaccurate MDS assessment during a meeting with the survey team on 03/27/19 at 3:11 p.m. Prior to the exit conference the facility provided the surveyor with a "corrected" copy of this MDS assessment that indicated the Resident was receiving hospice care. No further information regarding this issue was	F 641	2. How will other residents having the potential to be affected by the same deficient practice be identified? "An immediate 100% audit was performed of all hospice residents currently admitted to the facility by the MDS Coordinators. 3. What measures will be put in place or what systemic changes will be made to ensure that the deficient practice does not reoccur? "MDS Coordinators will receive education focusing on proper coding of hospice residents. "Auditing will be conducted monthly by MDS Team to ensure that proper coding of hospice residents is consistent. "Weekly MDS assessments will be audited by the MDS team to ensure proper coding takes place for discharged residents 4. How will the corrective action be monitored to ensure the continued effectiveness of the system changes? "MDS, in conjunction with the IDT, will discuss discharge plans in daily team meetings and weekly SOC meetings to ensure that MDS coding reflects resident□s disposition upon leaving the facility. "Results will be shared with QAPI team and action plans will be revised as needed to address any continued concerns with accuracy of MDS assessments. People Responsible □ MDS Coordinators, DON, Clinical Manager	

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F 641	Continued From page 2 provided to the survey team prior to the exit conference. 2. For Resident #62, the facility coded the Residents discharge MDS (minimum data set) assessment as the Resident was discharged to an acute care hospital when in fact they had been discharged home. The clinical record review revealed that Resident #62 had been admitted to the facility 01/21/19. Diagnoses included, but were not limited to, sepsis, hypertension, chronic atrial fibrillation, and benign prostatic hyperplasia. Section C (cognitive patterns) of the Residents discharge MDS assessment with an ARD (assessment reference date) of 01/22/19 included a BIMS (brief interview for mental status) summary score of 13 out of a possible 15 points. Section A (identification information) had been coded to indicate the Resident had been discharged on 01/22/19 to an acute care hospital. A review of the nursing notes revealed that nursing staff had documented on 01/22/19 that the Resident was discharged home with a family member at 5:30 p.m. 03/27/19 at 3:21 p.m., the surveyor reviewed the EHR (electronic health record) with the MDS staff. After reviewing the EHR the MDS staff verbalized that the MDS was coded incorrectly. The administrator and DON (director of nursing) were notified of the inaccurate MDS during a meeting with the survey team on 03.28.19 at 12:10 p.m.	F 641		

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F 641	Continued From page 3 No further information regarding this issue was provided to the survey team prior to the exit conference.	F 641		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §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	F 656		5/17/19

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F 656	Continued From page 4 whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and clinical record review the facility staff failed to implement the CCP (comprehensive care plan) for 1 of 24 Residents, Resident #53. The findings included: For Resident #53 the facility staff failed to implement a care plan for the use of bed rails. Resident #53 was admitted to the facility on 03/05/19. Diagnoses included but not limited to atrial fibrillation, end stage renal disease, hyperlipidemia, arthritis, osteoporosis, pelvic fracture, Alzheimer's disease, seizure disorder, malnutrition, and dementia. The most recent MDS (minimum data set) with an ARD (assessment reference date) of 03/12/19 coded the Resident as 10 out of 15 is section C, cognitive patterns. Section G, functional status coded the Resident as 3/3 in the areas of bed mobility and transfer, which is the equivalent of "extensive assistance/ two person physical assist". This is an admission MDS. Resident #53's CCP (comprehensive care plan) was reviewed and contained a care plan for "Bed Rails are used to enhance the quality of life due	F 656	1. What corrective action will be accomplished for those residents found to be affected by the deficient practice? "Maintenance made aware of the need to have rails applied. Bed rails were placed on the bed for Resident #53 on 3/28/19. 2. How will other residents having the potential to be affected by the same deficient practice be identified? "All residents with orders for bed rails have the potential to be affected by the same deficient practice. Clinical Manager or designees will conduct 100% audit of all residents with orders and consents for bed rails to assess for potential deficient practice. 3. What measures will be put in place or what systemic changes will be made to ensure that the deficient practice does not reoccur? "All new admissions and resident with changes in condition will be reviewed daily by Clinical Manager or designee to audit if bed rails requested and consent signed. If request made, this will be reported in	

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F 656	Continued From page 5 to: impaired physical mobility R/T (related to): pelvic fracture and L (left) shoulder fracture". Goals for this care plan included "With the use of the bed rail, the Resident will have an enhanced quality of life as evidenced by: Able to turn and position self in the bed with the use of bed rails" and "With the use of bed rail, the Resident will be able to have an enhanced quality of life as evidenced by: Able to transfer from bed to a chair/wheelchair with the use of bed rails and with 1 person assistance". Interventions for this care plan are listed as "assist Resident with transfers and mobility; ensure caretaker remains at bedside". Resident #53's clinical record was reviewed on 03/27/18. It contained a "Bedrail Consent Form" dated 03/07/19, which read in part "Assessment: The facility has conducted a comprehensive assessment and has determined that ... (Resident name omitted) would benefit from the use of bedrails. The use of alternative devices and/or approaches has been considered by the interdisciplinary team. The physician has recommended: ¼ side rails both sides. Benefit: The bedrail(s) is/are being used to: Promote safety while Resident is receiving care in bed". The Resident's representative and a facility representative signed this consent form. The surveyor observed the Resident on 03/27/19 at approximately 1115. The Resident was up in wheelchair with sitter in attendance. Surveyor did not observe ¼ side rails on the Resident's bed. Surveyor spoke with the Resident's daughter via telephone on 03/27/19 at approximately 1230. Resident's daughter stated that she had requested bed rails be placed on the Resident's	F 656	daily IDT meeting and communication will be sent to maintenance by the nursing team. "If request for bed rails made after admission, nursing staff will obtain consent and place work order for maintenance to place bed rails. "All maintenance work orders for bed rails will be copied to Administrator and DON to ensure appropriate follow up has taken place. "Review of any residents who have current bed rail orders will occur in daily IDT meetings. "Staff will be educated on the process for obtaining bed rail consents with admissions and change of condition, if warranted, and placing work orders for bed rail placement. 4. How will the corrective action be monitored to ensure the continued effectiveness of the system changes? "Daily audits will be completed by the DON, or designee for two weeks on all admissions and resident changes of condition for two weeks, then weekly thereafter, to ensure consents for bed rails signed, bed rails are in place, and work orders are completed. "Maintenance will audit work orders daily regarding bed rails to ensure completion. If any concerns with work orders, DON will be notified immediately for corrective action. "Maintenance will maintain a spreadsheet of all residents that have bed rails and will follow up with all admissions	

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F 656	Continued From page 6 bed upon admission, due to her confusion. Resident's daughter stated that Resident would try to get up on her own, not realizing that she has a broken pelvis. Resident's daughter also stated that on the day of admission, she was concerned about leaving the Resident at the facility without a sitter, but was assured that the staff would be frequently observing the Resident. The Resident's daughter stated that within 30 minutes of her departure from the facility, she received a call from the facility stating that the Resident had fallen out of bed. The concern of no ¼ side rails on the Resident's bed was discussed with the administrative staff during a meeting on 03/27/19 at approximately 1510. DON (director of nursing) stated that Resident's daughter had requested full side rails on the bed. DON also stated facility staff had explained to daughter that full side rails could not be used. DON offered no explanation why the ¼ side rails were not implemented per the physician's order. Surveyor observed Resident #52 on 03/27/19 at approximately 1545. Resident #53 was sitting up in bed with sitter in attendance. Surveyor did not observe ¼ side rails on the bed. Surveyor observed Resident #53 on 03/28/19 at approximately 0930. Surveyor observed ¼ side rails on the bed at this time. No further information was provided prior to exit.	F 656	and discharges for removal of bed rails after the resident is discharged. "Maintenance will provide Administrator and DON with spreadsheet weekly and update spreadsheet as needed. "Results will be shared with QAPI team and action plans will be revised as needed to address any continued concerns with timely application of bed rails. People Responsible □ DON, Clinical Manager, Maintenance, Staff Educator	
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry	F 677		5/17/19

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F 677	Continued From page 7 out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: The facility staff failed to provide adequate ADL (activities of daily living) services to 1 of 18 residents at the facility (Resident #113). Findings: The facility staff failed to provide adequate ADL (activities of daily living) services for Resident #113. The resident's clinical record was reviewed. Resident #113 was admitted to the facility for skilled care on 3/19/19. Her diagnoses included diverticulitis, arthritis, hypertension, and gastrointestinal hemorrhage (due to diverticulitis). The latest MDS assessment dated 3/26/19 coded the resident as cognitively unimpaired. Her ADL status was incomplete at the time of the survey. The resident 's initial CP (care plan), effective 3/20/19 coded the resident with significant ADL requirements. Due to weakness related to acute diverticulitis and post hemorrhagic anemia the resident required assistance with all self-care ADLs, bed mobility, transfers from bed to chair, and ambulation. The CP included interventions for staff assistance from physical and occupational therapy staff members, but none were listed for nursing staff (nurses or CNAs). Resident #113 was interviewed on 3/27/19 at 11:06 AM. The resident said she required help to get out of the bed but no one would answer the call light when she needed to get up and use the	F 677	1. What corrective action will be accomplished for those residents found to be affected by the deficient practice? "CNAs will be educated to offer and provide showers per schedule and resident preference to Resident #113 and to all residents. "Immediate staff education was provided on 3/27/2019 regarding the responsibility of all staff in call bell response time for Resident #113 and all residents in the facility. This education was also given to all leaders. 2. How will other residents having the potential to be affected by the same deficient practice be identified? "All residents have the potential to be affected by the same deficient practice. 100% of all shower schedules will be audited by the Clinical Manager, or designee, daily to assess CNA compliance. "All residents have the potential to be affected by the same deficient practice. Call bell reports will be audited from the last 72 hours by the Clinical Manager to identify trends in deficient practice. 3. What measures will be put in place or what systemic changes will be made to ensure that the deficient practice does not reoccur? "Supervisors will be notified by the	

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F 677	Continued From page 8 toilet. The resident stated, "I know when I need to go, but they won't come help me and I'm not supposed to get up out of the bed because I fell at home." The resident said she could walk with assistance but was afraid to walk without help because she didn't want to fall again. The resident said at three AM the night previous she had called for help and someone answered the light and told her she didn't need to go to the bathroom, that she had just had a bad dream. The resident was said she was adamant that she knew when she needed to go and finally persuaded the staff member to get her up so she could use the bathroom. "Then when they left the room they left my call light over there in the other chair where I could not reach it." This information was relayed to the administrator on 11:15 AM as she was entering Resident's room to inquire about a complaint the resident made about her treatment the previous night. She assured the resident she would inform the staff and they would be inserviced on answering the call lights and toileting care. On 3/28/19 at 10:24 AM the resident was interviewed again about her care at the facility. The resident said she was itching and asked the surveyor why she could get a shower while she was the the facility. The resident stated, "They won't take me to the shower for a bath or shower and I haven't had one since I've been here. Why do you think that is?" The resident said a couple of a times she had been assisted to take a "bird bath" at her sink in the room while she was in a wheelchair, but had never been out for a shower. The resident	F 677	primary nurse of any for follow up needed if resident did not receive a shower for any reason. "Primary nurses will document follow up with the resident in the medical record. "Primary nurses will escalate any deficient practice in administration of showers and any resident preferences to their shower schedules to the Supervisors/Clinical Managers who will follow up with the resident. "Clinical Managers and Supervisors will round during their shifts to ensure that call bells are being answered in a timely manner and check rooms to ensure call bells are in reach for the resident. "Staff Educator will educate facility staff on call bell response being everyone□s responsibility to ensure that all members of the team, regardless of the department, are responding to call bells. 4. How will the corrective action be monitored to ensure the continued effectiveness of the system changes? "Corrective action will be monitored with daily nursing/CNA handoff. Residents that received showers will be reported shift to shift. "Clinical Managers will round daily to ensure resident care needs are being addressed. "DON will follow up on any escalated concerns with showers as needed. "Clinical Manager, or designee, will audit call bell reports daily for two weeks, and then weekly for any trends in deficient practice. Any deficiencies will be escalated to DON.	

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F 677	Continued From page 9 scratched her head and stated, "I've asked them when I could get a real bath but they never get around to it. I sure could use a good soaking too." The surveyor could not find any evidence in the clinical record that the resident had any showers or any assistance with her personal hygiene needs. The physician's orders, signed and dated on 3/19/19, did not include any orders that would preclude the resident from getting out of the bed for shower/baths or toileting. At 10:30 AM staff member #1 was asked what the shower schedule was for Resident #113. She pulled a book off the shelf at the nursing desk and said, "She's scheduled for showers on Tuesday and Friday." The staff member was asked to look into the clinical record to determine if there was any documentation the resident had received any assistance to bathe or perform other hygiene tasks ny the nursing staff. Staff member #1 produced copies of the OT's (occupational therapist) notes that indicated the the resident was getting therapy to improve her strength and ability to perform these tasks for herself when she returned home. The OT notes indicated the staff assisted the resident to bath at the sink in her wheelchair and in the bed for partial baths. The resident had not received a full bath or shower as she had requested. On 3/28/19 at 10:27 AM the DON was asked why the resident had not received her requested baths/showers and was asked to provide the ADL documentation from the clinical record since the resident's stay. The DON said she was unable to find any ADL record on Resident #113 and could not say why she had not been receiving ADL	F 677	"Results will be shared with QAPI team and action plans will be revised as needed to address any continued concerns with call bell response and showers. People Responsible □ DON, Clinical Manager, RN Supervisors, CNAs, Staff Nurses, Staff Educator	

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F 677	Continued From page 10 assistance or showers. The DON stated, "I know if (name of Resident #113) says she hasn't had a bath, it hasn't been done. The CNA's have not documented any activity on her since her admission. I'm going to find out why." The DON did find some partial documented ADL records for 3/19-3/21/9. She copied them for the surveyor and said she had no other answers as to why the CNAs were not documenting assistance for bathing, hygiene ot toileting for the resident. No other information was provided prior to the survey team exit.	F 677		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on Resident interview, staff interview, and clinical record review, the facility staff failed to ensure the highest practicable well-being for 3 of 24 Residents, Resident #6, #23, and #64. The findings included: 1. For Resident #6, the facility staff failed to ensure the Residents physician ordered pain	F 684	1.What corrective action will be accomplished for those residents found to be affected by the deficient practice? "Pain management physician notified of the need for the hard prescription for Resident #6 by the nurse upon immediate identification during the survey. "Resident #64 □ This resident was discharged at the time of this survey.	5/30/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495287	A. BUILDING _____ B. WING _____	C 03/28/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SENTARA NURSING CENTER HAMPTON	2230 EXECUTIVE DRIVE HAMPTON, VA 23666

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F 684	Continued From page 11 medication was available and administered per the physicians order. The clinical record review revealed that Resident #6 had been admitted to the facility 02/15/15. Diagnoses included, but were not limited to, complex regional pain syndrome I, depressive disorder, sleep apnea, and deep vein thrombosis. Section C (cognitive patterns) of the Residents significant change in status MDS (minimum data set) assessment with an ARD (assessment reference date) of 12/31/18 included a BIMS (brief interview for mental status) summary score of 15 out of a possible 15 points. During an interview with Resident #6 on 03/28/19 at 10:40 a.m., the Resident verbalized to the surveyor that the facility had not applied her pain patch. Immediately after this interview, the surveyor approached LPN (licensed practical nurse) #1 and asked them about the Residents pain patch. LPN #1 reviewed the Residents EHR (electronic health record) and identified this medication as being buprenophine 20 mcg/hour transdermal patch. The instructions for this medication was for the transdermal patch to be applied one time weekly starting on 03/20/19. Further review of the clinical record revealed that the nursing staff had documented that this medication was not available for administration on 03/20 and 03/27/19. LPN #1 stated she would call the physician and obtain a script for the medication. On 03/28/19 at 10:46 a.m., the DON (director of	F 684	Discharge date of 7/9/18. "Nurses will receive education on the importance of administering medications for all residents as ordered by the physician and documenting medication administration appropriately. "Resident #23 □ NP on site during the survey and orders given to restart the medications ordered. (Vitamin C and Zinc Sulphate.) "Wound Care education will be given to all nursing staff by Staff Educator. 2. How will other residents having the potential to be affected by the same deficient practice be identified? "All residents with orders for pain medication have the potential to be affected by the same deficient practice. 100% audit of residents with orders for pain medication that require a hard prescription will be completed by the RN Supervisors. (Verification of prescription to medication on the cart). "All residents admitted to the facility with physicians□ orders have been identified as having the potential to be affected by the same deficient practice. "All residents have the potential to be affected by the same deficient practice. 100% of all residents being followed by the wound MD will be completed by the Clinical Manager, or designee, to include verification of their orders. 3.What measures will be put in place or what systemic changes will be made to ensure that the deficient practice does not reoccur?	

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	495287	A. BUILDING _____ B. WING _____	C 03/28/2019

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F 684	Continued From page 12 nursing) and administrator were notified that Resident #6 did not have her physician ordered pain patch available for administration on 03/20 and again on 03/27/19. Resident #6 did have other scheduled pain medications ordered and these medications were given per the physicians orders. The Residents comprehensive care plan included the problem area requires pain management. Interventions included, but were not limited to, institute associated medical orders and administer analgesic and/or adjuvant analgesics. Prior to the exit conference LPN #1 verbalized to the survey team that she had obtained the medication. No further information regarding this issue was provided to the survey team prior to the exit conference. 2. For Resident #23, the facility staff failed to follow up on a recommendation from the wound clinic for the medications zinc and vitamin c. The clinical record review revealed that Resident #23 had been admitted to the facility 07/18/18. Diagnoses included, but were not limited to, stage III pressure ulcer to sacrum, dementia, degenerative disease of nervous system, essential tremor, spondylosis, and cerebrovascular disease. Section C (cognitive patterns) of the Residents significant change in status MDS (minimum data set) assessment with an ARD (assessment reference date) of 02/12/19 had been coded 1/1/2	F 684	"Nurses will communicate any concerns with obtaining hard prescriptions with the resident and/or the RP. "Any concerns will be communicated in shift to shift handoff. "Primary nurse should contact specialist office prior to script running out to avoid any lapses in medication administration to the resident. "If nurse is unable to obtain script from outside physicians within 24-hour period, this will be escalated to DON and/or Medical Director for follow up. "DON, or designee, will obtain Medication Administration Record (MAR) reports from the EMR daily from the EMR system to verify what medications were administered for each per nurse signature. "Clinical Manager, or designee, will conduct random MAR to cart audits to verify that ordered medications are being administered per physician orders by conducting an actual pill count. This will occur weekly for three weeks, then monthly. "Staff will be educated on the escalation process for obtaining hard prescriptions and for ensuring medications are administered per ordered. "Designated RN Supervisor will be assigned to make rounds with wound MD weekly and update orders to ensure appropriate follow up takes place. "Ensure that all residents receiving wound care have the appropriate medications and supplies to carry out the current orders.	

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	495287	A. BUILDING _____ B. WING _____	C 03/28/2019

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SENTARA NURSING CENTER HAMPTON	2230 EXECUTIVE DRIVE HAMPTON, VA 23666

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F 684	Continued From page 13 to indicate the Resident had problems with long and short term memory and was moderately impaired in cognitive skills for daily decision making. Section M (skin conditions) had been coded to indicate the Resident had a stage III pressure ulcer. The clinical record included a "WOUND EVALUATION & MANAGEMENT SUMMARY" report dated 03/07/19. Page 2 and 3 of this document included a recommendation for "Vitamin C 500mg twice daily PO (by mouth); Zinc sulphate 220mg once daily PO for 14 days." The surveyor was unable to locate any further information regarding this recommendation in the Residents EHR (electronic health record). The administrator was asked about the recommendation on 03/27/19 at 11:46 a.m. During a meeting with the DON (director of nursing) and administrator on 03/27/19 at 3:11 p.m., the DON verbalized that this recommendation had been missed. No further information regarding this issue was provided to the survey team prior to the exit conference. 3. For Resident #64, the facility staff failed to administer the resident's caltrate as ordered by the physician. The clinical record review revealed that Resident #64 had been admitted to the facility 06/15/18. Diagnoses included, but were no limited to, fracture of right femur, pain, constipation, Alzheimer's disease, hypertension, cerebral	F 684	4.How will the corrective action be monitored to ensure the continued effectiveness of the system? "RN Supervisors will conduct weekly audits on all orders for pain medications to ensure that orders for refills have been initiated. "Any deficiencies will be corrected immediately and reported to the Clinical Manager for follow up. "Clinical Manager, or designee, in conjunction with Pharmacy, will conduct monthly and as needed audits on all medication carts to verify medications on the cart for each resident against the physician orders to ensure medications are being administered appropriately. Deficiencies will be reported to the DON for immediate follow up and corrective action, to include re-education if needed. "Clinical Manager will audit wound physician notes after each visit indefinitely to ensure that all orders have been updated in the EMR. "All results will be shared with QAPI team and action plans will be revised as needed to address any continued deficiencies with obtaining hard scripts in a timely manner, administration of medications per physician orders, and appropriate follow up of wound care orders. People Responsible □ DON, Clinical Manager, RN Supervisors, Medical Director, Wound Care MD	

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	495287	A. BUILDING _____ B. WING _____	C 03/28/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 684	Continued From page 14 infarction, chest pain, and depression. Section C (cognitive patterns) of the Residents admission MDS (minimum data set) assessment with an ARD (assessment reference date) of 06/22/18 included a BIMS (brief interview for mental status) summary score of 3 out of a possible 15 points. The clinical record included an order for caltrate 600+D three times daily. The nursing staff had documented on the eMARs (electronic medication administration records) for 06/22/18 at 9:00 a.m. that this medication was not administered as the medication was not available. No further information regarding this issue was provided to the survey team prior to the exit conference.	F 684		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, family interview and clinical record review the facility staff failed to ensure an accident free environment for 1 of 24 Residents, Resident #53.	F 689	1.What corrective action will be accomplished for those residents found to be affected by the deficient practice? "Maintenance made aware of the need to have rails applied. Bed rails were	5/17/19

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	495287	A. BUILDING _____ B. WING _____	C 03/28/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SENTARA NURSING CENTER HAMPTON	2230 EXECUTIVE DRIVE HAMPTON, VA 23666

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F 689	Continued From page 15 The findings included: For Resident #53 the facility staff failed to follow physician's orders for fall mats at the bedside and failed to provide ¼ side rails per the physician's recommendation. Resident #53 was admitted to the facility on 03/05/19. Diagnoses included but not limited to atrial fibrillation, end stage renal disease, hyperlipidemia, arthritis, osteoporosis, pelvic fracture, Alzheimer's disease, seizure disorder, malnutrition, and dementia. The most recent MDS (minimum data set) with an ARD (assessment reference date) of 03/12/19 coded the Resident as 10 out of 15 is section C, cognitive patterns. Section G, functional status coded the Resident as 3/3 in the areas of bed mobility and transfer, which is the equivalent of "extensive assistance/ two person physical assist". This is an admission MDS. Resident #53's CCP (comprehensive care plan) was reviewed and contained a care plan for "Bed Rails are used to enhance the quality of life due to: impaired physical mobility R/T (related to): pelvic fracture and L (left) shoulder fracture". Goals for this care plan included "With the use of the bed rail, the Resident will have an enhanced quality of life as evidenced by: Able to turn and positon self in the bed with the use of bed rails" and "With the use of bed rail, the Resident will be able to have an enhanced quality of life as evidenced by: Able to transfer from bed to a chair/wheelchair with the use of bed rails and with 1 person assistance". Interventions for this care plan are listed as "assist Resident with transfers and mobility; ensure caretaker remains at	F 689	placed on the bed for Resident #53 on 3/28/19. "Supply Chain Coordinator made aware of the need to have fall mats for Resident #53. Fall mats were place in the room for Resident #53 on 3/28/19. 2. How will other residents having the potential to be affected by the same deficient practice be identified? "All residents with orders for bed rails have the potential to be affected by the same deficient practice. Clinical Manager or designees will conduct 100% audit of all residents with orders and consents for bed rails to assess for potential deficient practice. "All residents with orders for fall mats have the potential to be affected by the same deficient practice. Clinical Manager, or designee, will conduct 100% of all residents with orders for fall mats to assess for potential deficient practice. 3. What measures will be put in place or what systemic changes will be made to ensure that the deficient practice does not reoccur? "All new admissions will be reviewed daily by Clinical Manager or designee to audit if bed rails requested and consent signed. If request made, this will be reported in daily IDT meeting and communication will be sent to maintenance by nursing team. "If request for bed rails made after admission, nursing staff will obtain consent and place work order for maintenance to place bed rails.	

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	495287	A. BUILDING _____ B. WING _____	C 03/28/2019

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F 689	Continued From page 16 bedside". Resident #53's CCP also contained a care plan for "Actual fall on 03/05/19". Goals for this care plan included "Will be without further falls with injury over the next 90 days". Interventions for this care plan included "Initiate fall prevention protocol interventions as indicated (Fall mats at bedside when in bed)". Resident #53's clinical record was reviewed on 03/27/18. It contained a signed physician's order summary, which read in part, "Fall mats continuous". This order was dated 03/06/19. The Resident's clinical record also contained a "Bedrail Consent Form" dated 03/07/19, which read in part "Assessment: The facility has conducted a comprehensive assessment and has determined that ... (Resident name omitted) would benefit from the use of bedrails. The use of alternative devices and/or approaches has been considered by the interdisciplinary team. The physician has recommended: ¼ side rails both sides. Benefit: The bedrail(s) is/are being used to: Promote safety while Resident is receiving care in bed". The Resident's representative and a facility representative signed this consent form. The surveyor observed the Resident on 03/27/19 at approximately 1115. The Resident was up in wheelchair with sitter in attendance. Surveyor did not observe fall mats in the Resident's room, not did the surveyor observe ¼ side rails on the Resident's bed. Surveyor spoke with the Resident's daughter via telephone on 03/27/19 at approximately 1230. Resident's daughter stated that she had requested bed rails be placed on the Resident's	F 689	"All maintenance work orders for bed rails will be copied to Administrator and DON to ensure appropriate follow up has taken place. "All new admissions and resident with changes in condition will be reviewed for the need for fall mats daily for two weeks, then weekly thereafter by Clinical Manager, or designee. If fall mats required, Supply Chain Coordinator will be notified for placement of fall mats. 4. How will the corrective action be monitored to ensure the continued effectiveness of the system changes? "Weekly audits will be completed by the DON, or designee to ensure consents for bed rails signed, bed rails are in place, and work orders are completed. "Maintenance will audit work orders daily regarding bed rails to ensure completion. If any concerns with work orders, DON will be notified immediately for corrective action. "Maintenance will maintain a spreadsheet of all residents that have bed rails and will follow up with all admissions and discharges for removal of bed rails after the resident is discharged. Maintenance will provide Administrator and DON with spreadsheet weekly. "Supply Chain Coordinator will conduct 100% audit of all residents weekly indefinitely who have orders for fall mats to ensure mats are in place for each resident with orders. "Supply Chain Coordinator will maintain a spreadsheet of all residents that have fall mats and report these residents to the	

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	495287	A. BUILDING _____ B. WING _____	C 03/28/2019

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F 689	Continued From page 17 bed upon admission, due to her confusion. Resident's daughter stated that Resident would try to get up on her own, not realizing that she has a broken pelvis. Resident's daughter also stated that on the day of admission, she was concerned about leaving the Resident at the facility without a sitter, but was assured that the staff would be frequently observing the Resident. The Resident's daughter stated that within 30 minutes of her departure from the facility, she received a call from the facility stating that the Resident had fallen out of bed. Surveyor spoke with unit manager on 03/27/19 at approximately 1400. Surveyor asked unit manager if Resident #53 has an order for fall mats and unit manager stated that she would have to check and see. Unit manager then stated to surveyor that Resident #53 does have an order for fall mats. Surveyor then asked unit manager where the fall mats were located and unit manager stated they were in the Resident's room. Unit manager also stated that mats did not need to be at bedside unless Resident is in bed, and can be propped against the wall when not in use. Surveyor then asked unit manager to accompany her to the Resident's room to observe the mats. Unit manager and surveyor observed Resident #53 on 03/27/19 at approximately 1415. Resident was resting in bed with sitter in attendance. Surveyor and unit manager observed no mats at the bedside or in the room. Unit manager stated that she would have the mats placed at bedside. Surveyor asked unit manager if the use of fall mats should be documented on the Resident's TAR (treatment administration record) and the unit manager stated that the order was entered as a standing order. The unit manager stated the order was not showing by shift, so that each shift	F 689	Clinical Manager. "Results of audits will be shared with QAPI team and action plans will be revised as needed to address any concerns with monitoring use of fall mats and bed rails. People Responsible □ DON, Clinical Manager, Maintenance, Staff Educator, Supply Chain Coordinator	

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	495287	A. BUILDING _____ B. WING _____	C 03/28/2019

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F 689	Continued From page 18 knew to check for the mats. Unit manager stated that she would correct the order in the computer. The concern of no fall mats and no ¼ side rails on the Resident's bed was discussed with the administrative staff during a meeting on 03/27/19 at approximately 1510. DON (director of nursing) stated that Resident's daughter had requested full side rails on the bed. DON also stated facility staff had explained to daughter that full side rails could not be used. DON offered no explanation why the ¼ side rails were not implemented per the physician's order. Surveyor observed Resident #52 on 03/27/19 at approximately 1545. Resident #53 was sitting up in bed with sitter in attendance. The surveyor observed fall mats at the Resident's bedsides at this time. Surveyor did not observe ¼ side rails on the bed. Surveyor observed Resident #53 on 03/28/19 at approximately 0930. Surveyor observed fall mats at the bedsides and ¼ side rails on the bed at this time. No further information was provided prior to exit.	F 689		
F 698 SS=E	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by:	F 698		5/24/19

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	495287	A. BUILDING _____ B. WING _____	C 03/28/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 698	Continued From page 19 Based on staff interview, clinical record review, and facility document review, facility staff failed to ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan for 1 of 21 residents in the survey sample (Resident #45). Resident #45 was admitted to the facility on 2/16/19. Diagnoses included end stage renal disease with hemodialysis, diabetes mellitus, cardiopulmonary disease with oxygen dependence, hypertension, enteritis as a result of clostridium difficile infection, and chronic pain. On the admission minimum data set assessment with assessment reference date 2/23/19, the resident scored 15/15 on the brief interview for mental status and was assessed as without signs of delirium, psychosis, or behaviors affecting care. During an interview, the resident reported receiving hemodialysis treatments 3 days per week., Clinical record review revealed a physician order fro hemodialysis treatments on Tuesday, Thursday, and Saturday. On 3/26/19, the surveyor asked the nurse where to find the resident's hemodialysis documentation and was told that it would be in a dialysis binder which traveled with the resident to and from dialysis. The electronic clinical record contained a copy of a dialysis communication sheet dated 2/23/19. On 3/28, the surveyor spoke with the medical records department head, who said the department received the completed sheets and scanned them into the clinical record. On 3/28/19, the surveyor received printed documents faxed from the dialysis center on 3/27/19 containing the	F 698	1.What corrective action will be accomplished for those residents found to be affected by the deficient practice? "Dialysis information requested for Resident #45. Will need to implement dialysis communication record. "Staff will be educated on the implementation of the dialysis communication record and its policy and procedure. 2. How will other residents having the potential to be affected by the same deficient practice be identified? "All residents with orders for dialysis have the potential to be affected by the deficient practice. 3. What measures will be put in place or what systemic changes will be made to ensure that the deficient practice does not reoccur? "Facility will start using dialysis communication form which will provide the following communication pre and post dialysis. This form will be placed in the dialysis binder which will be transported between the facility and the dialysis unit on the resident□s dialysis days. "Medical Records Clerk will ensure communication form is scanned into the resident□s medical record upon completion of the form and at discharge. 4. How will the corrective action be monitored to ensure the continued effectiveness of the system changes? "Clinical Manager, or designee, will ensure that the dialysis communication	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495287	A. BUILDING _____ B. WING _____	C 03/28/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SENTARA NURSING CENTER HAMPTON	2230 EXECUTIVE DRIVE HAMPTON, VA 23666

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F 698	Continued From page 20 dialysis center Kardex (orders) and lab results from 2/19, 2/21, 2/26, 3/5, 3/12, and 3/26. The paperwork from the dialysis center did not include assessmens of the resident's vital signs, weight, or dialysis site. There were no nursing notes concerning pre- and post- dialysis condition of the resident. There were no recorded vital signs on dialysis dates 2/19, 2/21, 2/26, or 3/23. Blood pressures were documented taken in both the right and left arms. Weights were recorded for 2/21/19 and 3/19/19. No documentation of dialysis site condition was recorded. The resident's comprehensive care plan included the problem potential weight fluctuations due to ESRD and need for dialysis with interventions including "weigh resident pre and post dialysis. DOCUMENT IN MEDICAL RECORD". Under the problem altered health maintenance R/T end stage renal disease (ESRD) AEB hemodialysis, interventions included "Monitor access site for s/s (signs and symptoms) of infection, do not take B/P in ext. (extremity) of access site, report abnormal findings to MD". The surveyor reported the concern with lack of monitoring during summary meetings on 3/27 and 3/28/19.	F 698	form sent with the resident on their dialysis days is completed with the appropriate information. "Medical Records Clerk will audit dialysis records weekly, while resident is admitted to the facility, to ensure binder is in compliance. Medical Records Clerk will ensure a Release of information is signed by the resident or RP in order to ensure facility can request any additional information from the dialysis medical record if needed. "Results of audits will be shared with QAPI team and will be revised as needed to address any continued concerns with dialysis communication. People Responsible □ DON, Clinical Manager, Medical Records Clerk, Staff Educator	
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart.	F 756		5/24/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495287	A. BUILDING _____ B. WING _____	C 03/28/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SENTARA NURSING CENTER HAMPTON	2230 EXECUTIVE DRIVE HAMPTON, VA 23666

(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 756	Continued From page 21 §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to follow up on pharmacy recommendations for 2 of 24 Residents, Residents #8 and #23. The findings included:	F 756	1. What corrective action will be accomplished for those residents found to be affected by the deficient practice? "Resident #8 □ Pharmacy recommendation for the resident identified was not obtained from the pharmacy. Seroquel and Hydrocodone APAP were	

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	495287	A. BUILDING _____ B. WING _____	C 03/28/2019

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SENTARA NURSING CENTER HAMPTON	2230 EXECUTIVE DRIVE HAMPTON, VA 23666

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F 756	Continued From page 22 1. For Resident #8, the facility staff failed to follow up on a pharmacy recommendation from April 2018 in regards to the Residents prn (as needed) tramadol. The clinical record review revealed that Resident #8 had been admitted to the facility 11/09/17. Diagnoses included, but were not limited to, heart failure, cardiomyopathy, difficulty in walking, chronic atrial fibrillation, dementia, and chronic obstructive pulmonary disease. Section C (cognitive patterns) of the Residents annual MDS (minimum data set) assessment with an ARD (assessment reference date) of 01/17/19 included a BIMS (brief interview for mental status) summary score of 12 out of a possible 15 points. The clinical record included a pharmacy recommendation dated 04/13/18 that read "Recommendation: Seroquel, Tramadol, and Hydrocodone APAP have not be used in the last 45 days. Please consider discontinuing." A review of the March 2019 eMAR (electronic administration record) revealed that the order for the tramadol was a current order and had been administered on 03/01/19. On 03/28/19 at 8:19 a.m., the administrative staff were asked to provide the surveyor with documentation that the pharmacy recommendation from April 2018 had been reviewed by the physician. This information was not provided to the surveyor prior to the exit conference on 03/28/19. 2. For Resident #23, the facility staff failed to	F 756	discontinued on 4/17/18. Tramadol orders continue. "No signed pharmacy recommendation is on the chart, however per Pharmacist statement, a verbal order was obtained from the Nurse Practitioner by the Pharmacist to discontinue the medications. The Pharmacist stated she did not write a formal recommendation, however, she documented the verbal recommendation in her report. Documentation obtained. "Resident #23 □ Pharmacy recommendation obtained from the pharmacy on 3/28/19 and scanned into the resident□s medical record. No further orders given by NP or MD regarding the ordered labs from 8/2018. 2.How will other residents having the potential to be affected by the same deficient practice be identified? "All residents who have the potential for a pharmacy review and subsequent recommendations from the pharmacy, have the potential to be affected by the deficient practice. 3. What measures will be put in place or what systemic changes will be made to ensure that the deficient practice does not reoccur? "DON, or designee will ensure that pharmacy recommendations are received from the Consulting Pharmacist after monthly reviews completed. "DON, or designee, will ensure pharmacy recommendations are signed, orders transcribed, and recommendations	

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	495287	A. BUILDING _____ B. WING _____	C 03/28/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SENTARA NURSING CENTER HAMPTON	2230 EXECUTIVE DRIVE HAMPTON, VA 23666

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F 756	Continued From page 23 follow up on a pharmacy review from 08/16/18 in regards to lab tests. The clinical record review revealed that Resident #23 had been admitted to the facility 07/18/18. Diagnoses included, but were not limited to, stage III pressure ulcer to sacrum, dementia, degenerative disease of nervous system, essential tremor, spondylosis, and cerebrovascular disease. Section C (cognitive patterns) of the Residents significant change in status MDS (minimum data set) assessment with an ARD (assessment reference date) of 02/12/19 had been coded 1/1/2 to indicate the Resident had problems with long and short term memory and was moderately impaired in cognitive skills for daily decision making. The clinical record included a pharmacy recommendation for August 2018 for the laboratory test lipid and vitamin D. The surveyor was unable to find any results for these lab tests in the clinical record. On 03/28/19 at 12:11 p.m., the administrator and DON (director of nursing) were asked to provide the surveyor with documentation that the pharmacy recommendation for April 2018 had been reviewed by the physician. This information was not provided to the surveyor prior to the exit conference on 03/28/19.	F 756	are scanned into the medical record. "Education will be given to the Pharmacy team on the importance of ensuring that all pharmacy recommendations have been received by the facility. 4. How will the corrective action be monitored to ensure the continued effectiveness of the system changes? "Medical Records Clerk will conduct monthly audits to ensure all pharmacy recommendations are scanned in the medical record. Any deficiencies will be reported immediately to the DON, or designee, for follow up. "Monthly audit results will be reported to Pharmacy Manager to follow up on any continued deficiencies. Results will also be shared with QAPI team and action plans will be revised as needed to address any continued concerns with pharmacy recommendations. People Responsible □ DON, Clinical Manager, Pharmacy team, Staff Educator, Medical Records Clerk	
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs.	F 758		5/24/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495287	A. BUILDING _____ B. WING _____	C 03/28/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SENTARA NURSING CENTER HAMPTON	2230 EXECUTIVE DRIVE HAMPTON, VA 23666

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F 758	Continued From page 24 §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and	F 758		

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	495287	A. BUILDING _____ B. WING _____	C 03/28/2019

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SENTARA NURSING CENTER HAMPTON	2230 EXECUTIVE DRIVE HAMPTON, VA 23666

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F 758	Continued From page 25 indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to ensure 1 of 24 Residents were free of unnecessary medications, Resident #22. The findings included: The Residents clinical record included a prn (as needed) order for the antipsychotic medication haldol. The clinical record did not include any information to indicate the physician had reviewed this order and/or provided a rationale for the continued use of this medication. The clinical record review revealed that Resident #22 had been admitted to the facility 08/22/18. Diagnoses included, but were not limited to, hypertension, dementia, Parkinson's disease, and malignant neoplasm of prostate. Section C (cognitive patterns) of the Resident significant change in status MDS assessment with an ARD (assessment reference date) of 02/08/19 included a BIMS (brief interview for mental status) summary score of 7 out of a possible 15 points. The Residents clinical record included orders for haldol oral concentrate as needed every 4 hours starting 02/05/19. The diagnosis was documented	F 758	1.What corrective action will be accomplished for those residents found to be affected by the deficient practice? "For Resident #22 □ Haldol discontinued on 3/27/2019. "All Haldol orders received that were transcribed on 2/15/19, 3/1/19, 3/15/19, and 3/27/19 have been signed by the physician and have been scanned into the medical record. "Discontinued medication has been removed from the medication cart for Resident #22. 2. How will other residents having the potential to be affected by the same deficient practice be identified? "100% of residents having orders for PRN antipsychotics will be audited by the Clinical Manager, or designee, to ensure the orders are in compliance with the current 14-day regulatory requirement. 3. What measures will be put in place or what systemic changes will be made to ensure that the deficient practice does not reoccur? "Any hospice agency identified that provides care to the residents in the facility will be educated on the regulatory	

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	495287	A. BUILDING _____ B. WING _____	C 03/28/2019

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F 758	Continued From page 26 as restlessness and agitation. On 03/27/19 at 3:11 p.m., the administrator and DON (director of nursing) were notified that Resident #22 had a PRN order for the antipsychotic medication haldol for greater than 14 days. The DON stated the order was obtained by hospice. On 03/28/19 at 8:51 a.m., the DON stated she had spoken with the hospice nurse via phone and that hospice was managing the haldol. The DON added "I can't say the physician laid eyes on the Resident we have no documentation." The DON then stated the process was broken. The administrative staff provided the surveyor with copies of haldol orders transcribed on 02/15/19, 03/01/19, and 03/15/19. The facility also provided the surveyor with a copy of an order to discontinue the haldol effective 03/27/19. These order had been signed by an RN (registered nurse). The physician had not signed any of these orders. On 03/28/19 at 11:04 a.m., the surveyor and LPN (licensed practical nurse) #1 checked the medication cart for the Residents haldol. LPN #1 provided the surveyor with 1 bottle of haldol with the Residents name. There was 20 ml's present in bottle LPN #1 confirmed this bottle was a 25 ml bottle indicating 5 ml's had been administered. No further information regarding this issue was provided to the survey team regarding the haldol prior to the exit conference.	F 758	requirement of limiting PRN orders for anti-psychotic medication to 14 days. "Nursing staff will be re-educated on this requirement to ensure that they are notifying the physician of a resident□s need for re-assessment, when applicable. "DON, or designee, will audit residents with orders for anti-psychotics to ensure they have the appropriate documentation and signed orders in place. This audit will take place weekly, and as needed based on census changes. "Clinical Manager, or designee, will conduct weekly cart audits to ensure that any discontinued medications have been removed from the medication cart. 4. How will the corrective action be monitored to ensure the continued effectiveness of the system changes? "Consulting Pharmacist will conduct a Drug Regimen Review weekly for two weeks, then monthly thereafter, and inform NP and/or MD of any orders not meeting criteria. All deficient orders will be corrected immediately. "DON, or designee, will notify Hospice agencies to conduct Medication Reviews weekly for two weeks, then monthly, on any patients being followed by their agency in the facility to ensure orders are in compliance. Any deficiencies will be reported to the Medical Director. "Results will be shared with QAPI team and action plans will be revised as needed to address any continued concerns with maintaining regulatory compliance with orders for PRN antipsychotics.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495287	A. BUILDING _____ B. WING _____	C 03/28/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 758	Continued From page 27	F 758	People Responsible □ DON, Clinical Manager, RN Supervisors, Pharmacy team, Staff Educator	
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility document review, the facility staff failed secure the narcotic box on unit 2 and on the back hall nursing cart on unit 1.	F 761	1.What corrective action will be accomplished for those residents found to be affected by the deficient practice? "Narcotic box in the Unit 2 medication room was corrected on 3/28/19.	5/24/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495287	A. BUILDING _____ B. WING _____	C 03/28/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 761	Continued From page 28 The findings included: The narcotic box in the unit 2 medication room was not permanently affixed and the narcotic box on the back hall medication cart on unit 1 was unlocked. On 03/27/19 at 10:25 a.m., the surveyor and LPN (licensed practical nurse) #2 checked the unit 1 back hall medication cart. The narcotic box on this cart was found to be unlocked during this observation. This narcotic box included the following controlled medications oxycodone, lyrica, and lorazepam. There were 15 medication cards in this narcotic box. The medication cart was located in the hall LPN #2 was observed to be down the hall when the surveyor approached the medication cart. On 03/27/19 at 10:34 a.m., the surveyor and RN (registered nurse) #2 checked the medication room on unit 2. This medication room included a locked refrigerator inside this refrigerator the surveyor observed a narcotic box. The surveyor was able to remove this narcotic box from the refrigerator. This narcotic box included 2-30 ml multiuse vials and 2-1 ml vials (2 mg) of lorazepam. RN #2 stated the box had been previous affixed but the refrigerator had been changed out about 3 months ago. The facility provided the surveyor with their policy titled storage of medications with a revision date of 02/15/18. This policy read in part, "...Schedule II-V controlled medication are stored separately from other medication in a locked drawer or compartment designated for that purpose..." During a meeting with the survey team on	F 761	Maintenance permanently affixed the narcotic box per regulatory requirement. "An adjustment of the 15 medication cards was needed in order to close the narcotic box on the medication cart on unit 1. Narcotic box was reorganized, which allowed the lock to close appropriately, and deficiency was corrected on 3/28/19. "Nurses will be educated on the importance of ensuring that narcotic box on unit 1 remains organized in order to make sure the box is able to close and lock at all times. "No resident was named in this deficient practice. 2. How will other residents having the potential to be affected by the same deficient practice be identified? "No residents were identified as having the potential to be affected by this deficient practice. 3. What measures will be put in place or what systemic changes will be made to ensure that the deficient practice does not reoccur? "Clinical Manager, or designee, will audit narcotic boxes (medication rooms and medication carts) with daily rounding for two weeks, then weekly thereafter, to ensure they remain secure per regulatory requirement. "Results of these rounds will be documented on new audit tool that will become part of the rounding process. Any deficiencies will be reported to Maintenance via work order for correction.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495287	A. BUILDING _____ B. WING _____	C 03/28/2019

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SENTARA NURSING CENTER HAMPTON	2230 EXECUTIVE DRIVE HAMPTON, VA 23666

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F 761	Continued From page 29 03/27/19 at 3:11 p.m., the administrator and DON (director of nursing) were notified of the above issues. Prior to the exit conference, the administrator verbalized to the surveyor that the narcotic box was now permanently affixed.	F 761	4. How will the corrective action be monitored to ensure the continued effectiveness of the system changes? "Clinical Manager, in conjunction with Maintenance, will audit all narcotic boxes on the medication carts and the medication rooms weekly as part of medication room and medication cart auditing process to ensure they remain secure as per the regulatory requirement. "Any deficiencies will be reported to Administrator and DON immediately for immediate correction and follow up. "Any results will be shared with QAPI team and action plans will be revised as needed to address any continued concerns with narcotic box security. People Responsible □ Administrator, DON, Clinical Manager, Maintenance, Staff Educator	
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility	F 842		5/24/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495287	A. BUILDING _____ B. WING _____	C 03/28/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SENTARA NURSING CENTER HAMPTON	2230 EXECUTIVE DRIVE HAMPTON, VA 23666

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F 842	Continued From page 30 must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law.	F 842		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495287	A. BUILDING _____ B. WING _____	C 03/28/2019

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F 842	Continued From page 31 §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to maintain a complete and accurate clinical record for 1 of 24 Residents, Resident #23. The findings included: The facility staff failed to determine the Resident DNR (do not resuscitate) status. The clinical record review revealed that Resident #23 had been admitted to the facility 07/18/18. Diagnoses included, but were not limited to, stage III pressure ulcer to sacrum, dementia, degenerative disease of nervous system, essential tremor, spondylosis, and cerebrovascular disease. Section C (cognitive patterns) of the Residents significant change in status MDS (minimum data set) assessment with an ARD (assessment reference date) of 02/12/19 had been coded 1/1/2 to indicate the Resident had problems with long and short term memory and was moderately impaired in cognitive skills for daily decision	F 842	1.What corrective action will be accomplished for those residents found to be affected by the deficient practice? "Resident #23 DNR status was corrected. Medical record now matches to indicate that flag on the medical record and physician orders indicate the resident is a DNR. Correction done on 3/27/19. 2. How will other residents having the potential to be affected by the same deficient practice be identified? "All residents with orders for DNR have the potential to be affected and their medical records will be 100% of medical records will be audited by Social Worker to ensure DNR accuracy. 3. What measures will be put in place or what systemic changes will be made to ensure that the deficient practice does not reoccur? "DON, or designee, in conjunction with social services, will audit all new admissions daily to verify code status and	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495287	A. BUILDING _____ B. WING _____	C 03/28/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SENTARA NURSING CENTER HAMPTON	2230 EXECUTIVE DRIVE HAMPTON, VA 23666

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F 842	Continued From page 32 making. The clinical record included a face sheet that listed the Resident as being a full code. Under the title of "Advance Directive" on the Residents comprehensive care plan the facility staff had documented that the Resident was a full code. However, the clinical record included a DDNR (durable do not resuscitate order) dated 11/01/18 that indicated the Resident was a DNR. The physician and the patients authorized representative had signed this DDNR . During a meeting with the DON (director of nursing) and administrator on 03/27/19 at 3:11 p.m., the DON verbalized that the Resident was a DNR. No further information regarding this issue was provided to the survey team prior to the exit conference.	F 842	ensure all residents with DNR have appropriate documentation and orders in the medical record. "Staff education will be done to instruct staff on the importance of ensuring that DNR orders AND medical chart ribbon are the same to ensure the resident receives the appropriate response to emergency care, if needed, during admission. 4. How will the corrective action be monitored to ensure the continued effectiveness of the system changes? "Social services, in conjunction with Clinical Manager and Supervisors, will conduct weekly audits on all newly admitted residents to verify their code status. If DNR, orders and chart ribbon will be checked for correctness and completion. "Any deficiencies in these audits will be reported to the Administrator and/or DON for immediate follow up. "Results of audits will be shared with QAPI team and action plans will be revised as needed to address any continued concerns with DNR accuracy. People Responsible □ Administrator, DON, Clinical Manager, Social Worker, RN Supervisors, Staff Educator	
F 868 SS=F	QAA Committee CFR(s): 483.75(g)(1)(i)-(iii)(2)(i) §483.75(g) Quality assessment and assurance. §483.75(g)(1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of:	F 868		5/24/19

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F 868	Continued From page 33 (i) The director of nursing services; (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; §483.75(g)(2) The quality assessment and assurance committee must: (i) Meet at least quarterly and as needed to identifying issues with respect to which quality assessment and assurance activities are necessary. This REQUIREMENT is not met as evidenced by: The facility failed to comply with regulations requiring the participation of the medical director at quarterly QAA meetings. Findings: The facility failed to comply with regulations requiring the participation of the medical director at quarterly QAA meetings. The administrator and DON were interviewed regarding the QAA committee on 3/28/19 at 2:45 PM. The facility administrator was asked how often the QAA committee held meetings. She stated the committee meet for quarterly meetings. The administrator provided the quarterly sign-up sheet for the committee members. The medical director had not signed the sheets for 12/18/18 or 3/19/19. The surveyor asked if anyone was designated to take the medical director's place on the two dates in question. The administrator said, no one had been designated to take his place but they sent	F 868	1.What corrective action will be accomplished for those residents found to be affected by the deficient practice? "Medical Director will be secured for facility to correct deficient practice. 2. How will other residents having the potential to be affected by the same deficient practice be identified? "All residents having the potential to be affected will be identified via review of the current census. 3. What measures will be put in place or what systemic changes will be made to ensure that the deficient practice does not reoccur? "New Medical Director will be onboarding during the month of April 2019. "MD will be educated on the importance of compliance with QAPI attendance and the frequency of the meetings.	

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F 868	Continued From page 34 the committee minutes to him after each meeting. The facility had no additional information to offer prior to the survey team's exit.	F 868	4. How will the corrective action be monitored to ensure the continued effectiveness of the system changes? "Corrective action will be monitored by Administrator and DON by ensuring that MD attendance is verified via quarterly sign in sheets at each meeting. People Responsible □ Administrator, DON	

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 495287	MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	DATE SURVEY COMPLETE: 3/28/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SENTARA NURSING CENTER HAMPTON	**2230 EXECUTIVE DRIVE HAMPTON, VA**

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 625	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to offer a bed hold for 1 of 24 Residents, Resident #64. The findings included: The facility failed to offer the Resident a bed hold when they were discharged to a local hospital. The clinical record review, revealed that Resident #64 had been admitted to the facility 06/15/18. Diagnoses included, but were not limited to, fracture of the right femur, pain, muscle weakness, vitamin deficiency, Alzheimer's disease, and history of urinary tract infection. Section C (cognitive patterns) of the Residents admission MDS (minimum data set) assessment with an ARD (assessment reference date) of 06/22/18 included a BIMS (brief interview for mental status) summary score of 3 out of a possible 15 points. Resident #64 had been transferred to a local hospital on 06/21/18. The surveyor was unable to locate any information in the Residents clinical record to indicate a bed hold had been offered. On 03/28/19 at 12:20 p.m., the DON (director of nursing) verbalized to the surveyor that a bed hold was not offered to this Resident the SW (social worker) stated it had been missed. No further information regarding this issue was provided to the survey team prior to the exit conference.