State of Virginia

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	VA0217	A. BUILDING: _____ B. WING _____	C 05/01/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SENTARA NURSING CENTER PORTSMOUTH	4201 GREENWOOD DRIVE PORTSMOUTH, VA 23701

(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 04/28/19 through 05/01/19. The facility was not in compliance with the Virginia Rules and Regulations for the Licensure of Nursing Facilities. Six complaints were investigated during the survey. The census in this 124 licensed bed facility was 74 at the time of the survey. The survey sample consisted of 35 current Resident reviews and 7 closed record reviews.	F 000		
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 Nursing facility was not in compliance with the following Virginia Rules and Regulations for Nursing Facilities: 12 VAC 5-371-150 (A) (B) (1) (C) (D) (I). Resident Rights. Cross Reference to F550, F-573,F-582, F584 F600 and F609. 12 VAC 5-371-170 (B) (1). Quality Assurance and Performance Improvement. Cross Reference to F868. 12VAC5-371-180. Infection Control cross references to F880. 12 VAC 5-371 - 220 A. Nursing Services. Cross Reference to F686 and F-698. 12VAC5-371-250, (G) (C), (F). Resident Assessment and Care Planning cross references to F-656 and F-657.	F 001		

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

Administrator — 5/20/2019

State of Virginia

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

State of Virginia

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F 001	Continued From page 1 12 VAC 5-371 - 300 B. Pharmaceutical Services. Cross reference to F755 and F756.	F 001		

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RESIDENT RIGHTS CROSS REFERENCE TO:

F550 – Resident Rights

1. Residents #33, #20, #2, #7 and #58 have been receiving a dignified dining experience for all meals by timely delivery of meals and serving all residents sitting at a table together during the meal periods.
2. All facility residents are at risk for facility failing to provide dignified dining experience.
3. Director of Nursing (DON), Clinical Manager, Dining Director or designee will educate facility staff on standards of practice for a dignified dining experience.
4. Clinical Manager, Dining Director or designee will round on 25% of residents 5 times x 4 weeks, then weekly x 4 weeks to ensure a residents are receiving a dignified dining experience. Variances identified will be corrected and staff re-educated as necessary. Results of the audits will be reviewed for patterns and/or trends and reported to QAPI for 2 months.
5. Date of Compliance: June 10, 2019

F573 – Right to Purchase Records

1. Resident #330 was provided a copy of the requested medical records on 12/18/18.
2. All resident, patients or resident representatives are at risk for delays in receiving medical records within required regulation timeframe(s).
3. Administrator or designee will educate staff on regulation related to medical records release.
4. Medical Records Clerk will audit 100% of medical record requests for 4 weeks, then 50% of medical records request x 4 weeks. Variances identified will be corrected and results of audits will be reviewed for patterns and/or trends. Findings will be reported to QAPI x 2 months.
5. Date of Compliance: June 10, 2019

F582 – Medicare/Medicaid Coverage (ABN)

1. An Advanced Beneficiary Notice (ABN) was issued to Resident #68 on May 20, 2019
2. All skilled residents who transition to long term care are at risk for of not receiving ABNs timely.
3. Director Social Services or designee will educate staff on the process/regulation for issuing ABNs for residents.
4. Director of Social Work or designee will audit 100% of skilled residents admitted since April 1, 2019 to ensure ABN notices were issued. Then audit 50% skilled residents admitted to ensure ABN letters are issued for

residents transitioning to long term care x 4 weeks. Variances will be reviewed for patterns and/or trends and reported to QAPI.

5. Date of Compliance: June 10, 2019

F584 – Safe/Clean/Comfortable/Homelike Environment

1. The situation regarding providing residents with a homelike dining environment could not be remedied for Residents eating meals on 4/28/19 and 4/30/19 due to the past date of incident cited on CMS Form - 2567 from the survey ending May 1, 2019. CNA #2 received 1:1 education on standards of practice for creating a homelike dining experience.
2. All facility residents are at risk for not being provided a homelike dining experience.
3. Director of Nursing (DON), Clinical Manager, Dining Director or designee will educate facility staff on standards of practice for a creating a homelike dining experience.
4. Clinical Manager, Dining Director or designee will round on 25% of residents 3 times per week x 4 weeks, then weekly x 4 weeks to ensure a residents are receiving a homelike dining experience. Variances identified will be corrected and staff re-educated as necessary. Results of the audits will be reviewed for patterns and/or trends and reported to QAPI for 2 months.
5. Date of Compliance: June 10, 2019

F600 – Free from Abuse / Neglect

1. Resident #329 expired in the facility on 9/26/18. Facility staff were educated on Abuse and Neglect by the Ombudsman on 8/29/18 and 8/30/18. Employees #50, #51 and #25 were terminated. Employee #26 and the unit secretary were suspended and upon return received 1:1 education regarding responding to falls, compassion/empathy, abuse/neglect and responding to accidents/incidents. The Unit Secretary interviewed on 5/1/19 will received 1:1 re-education on abuse, neglect, empathy/compassion sensitivity and providing care for high risk residents training on 5/24/19.
2. All resident living in the facility are at risk for potential abuse and neglect.
3. Administrator, Clinical Manager or designee will educate facility staff on preventing, identifying, reporting abuse and neglect. The Ombudsman will meet with the facility staff to education again on resident's rights and abuse/neglect. The Facility Risk Reporting System "STARS" reports will be reviewed daily by the Administrator or designee x 4 weeks. Allegations of neglect will be investigated and resolved as appropriate by the administrator or DON. The Infection Control Preventionist will educate staff on appropriate Infection Control practices for caring for residents with infectious diseases.
4. Administrator, DON or designee will audit 100% of reported abuse/neglects "STARs" reports and grievance logs x 4 weeks to assure compliance and appropriate follow-up for allegations of abuse/neglect. Results of the audits will be reviewed for patterns and/or trends and reported to QAPI.
5. Date of Compliance: June 10, 2019

F609 – Reporting Alleged Violations (FRI)

1. Resident #329 expired on 9/16/18 in the facility. Employees # 50, #51 and #25 were terminated. Employee #26 and the unit secretary were suspended and upon return received 1:1 education regarding responding to falls, compassion/empathy, abuse/neglect and responding to accidents/incidents on 9/4/18.

2. All residents living in the facility are at risk for abuse/neglect.
3. Administrator or designee will educate staff on preventing, identifying and reporting abuse and neglect to include Facility Reported Incidences (FRI) and complete a 6 month retrospective review of all FRIs to ensure appropriate timeliness of FRI reporting.
4. Administrator or designee will review 50% of FRIs for timeliness in reporting of abuse and neglect (2 hours) and all others (24 hours from the time of the incident).
5. Date of Compliance: June 10, 2019

QUALITY ASSURANCE AND PEFORMANCE IMPROVEMENT Cross Reference

F868 – QAPI / QAA

1. The situation regarding missing signature sheets as proof of previous quarterly QAPI meetings could not be remedied due to dates cited on the CMS-2567 report.
2. The facility/residents are at risk for when proof of QAPI meeting isn't in place.
3. Administrator or designee will educate facility staff on the required attendance and documentation of QAPI meetings.
4. Administrator will audit the documentation of the QAPI meetings to ensure attendance of QAPI committee members is met x 2 quarters (6 months).
5. Date of Compliance: June 10, 2019

INFECTION CONTROL Cross Reference

F880 – Infection Control Program

1. Resident #229 was discharged from facility on 5/5/19. Resident #71 was discharged on 5/3/19. As soon as the issues was identified, the oxygen equipment for Resident #58 was dated and stored in a sanitary manner. The situations regarding the cleaning of glucose monitoring machines before and after use could not be remedied due to the date of the citations reported on the CMS-2567 report from survey ending 5/1/19.
2. All residents utilizing oxygen and/or glucose monitoring are at risk for not having an effective infection control program.
3. DON, Staff Educator, Infection Control Preventionist (ICP) or designee will educate licensed nursing staff on appropriate cleaning of glucose monitoring units, infection control practices when preforming glucose testing and appropriate hand hygiene. DON/Staff Educator/ICP or designee will educate staff on appropriate infection control practices for residents on isolation to include hand hygiene and/or use of alcohol based solutions (hand sanitizers). DON/ICP/Educator or designee will educate on sanitary storage and dating of oxygen equipment.
4. CM, Staff Educator or designee will complete 2 observations of glucose monitoring 3 times weekly x 4 weeks. The ICP/Educator or designee will complete 2 observations for infection control practices for residents on Isolation 3 times per week for 4 weeks and 2 observations for appropriate oxygen equipment storage. Variances

will be reviewed for patterns and/or trends, staff re-educated when deficient practice is identified and results reported to QAPI for input and guidance.

5. Date of Compliance: June 10, 2019

NURSING SERVICES. Cross Reference

F686 – Prevention of Pressure Injury

1. Resident # 44 received a wound assessment by the wound physician during survey and wound treatments were implemented on 4/30/19. Resident #44 was provided with a pressure relief mattress from 5/1/19 to 5/6/19, however, due to resident preference mattress was removed on 5/6/18
2. All residents are at risk for potential impaired skin integrity.
3. DON or designee will complete skin assessments on all residents living in facility by 6/1/19 and any skin concerns identified will be appropriately assessed, staged and practitioners will be notified for appropriate treatment plan. DON or designee will educate licensed nursing staff and validate competencies on identification, assessment, treatment, documentation and monitoring of pressure injury and other skin conditions. DON or designee will educate CNAs on prevention of impaired skin integrity and the facility's policy and practice for completion of weekly skin assessments and acquired pressure injuries will be logged into the facility risk management tool and will be reported in morning meeting and standards of care meetings for follow-up. Risk Assessments will be completed weekly x 4 weeks on new admissions, on readmissions, quarterly and with significant change. This information will be used to develop a person centered care plan to prevent and/or treat pressure injuries.
4. DON, or designee will complete 4 observations (rounding) per week x 4 weeks for residents who have been identified with pressure injuries that are ordered and care planned. Clinical Managers or designee will audit weekly skin assessments for completion and accuracy 25% x 4 weeks, then 10% x 2 weeks. Variances observed during treatment observations and audits will be investigated and feedback provided to the responsible staff member, corrections/clarification will be made as needed. The summary of above audits will be presented to the QAPI committee for additional oversight and recommendation.
5. Date of Compliance: June 10, 2019

F698 – Dialysis Communication

1. Resident #73 dialysis notes from November, 2018 to April, 2019 were requested from dialysis center on 4/30/19
2. All residents receiving dialysis that are living in facility are at risk missing notes
3. DON, Clinical Manager, Staff Educator, or designee will educate facility nursing staff and dialysis center on continuity of care between dialysis center and facility to include pre and post dialysis communication form completion. A request will be sent to dialysis regarding entering an order requiring dialysis staff to complete dialysis complete dialysis communication flow sheet to assure appropriate communication between facility and dialysis center.
4. The clinical manager, medical record clerk or designee will complete audits of all dialysis flow sheets to assure continuity and completeness of communication between facility and dialysis center 100% weekly x 4 weeks.

Results of audits will be reviewed for patterns and/or trends and reported findings to QAPI for input and guidance

5. Date of Compliance: June 10, 2019

RESIDENT ASSESSMENT AND CARE PLANNING Cross Reference

F656 – Development / Implement of Initial Care Plan

1. The comprehensive care plan for resident # 6 was revised to include the diagnosis of depression and the use of psychotropic medications 4/29/19
2. Resident with diagnosis of depression are at risk for inaccurate comprehensive care plans
3. DON, Clinical Manager or designee will educate the interdisciplinary team on strategies and accuracy for completion of person-centered comprehensive care planning. MDS Coordinator(s) or designee will review the care plans for all residents identified with a diagnosis of depression for person centered approaches and comprehensiveness.
4. DON, Clinical Manager, MDS Coordinators or designee will audit care plans for residents with diagnosis of depression to assure comprehensiveness and person center approaches are included in the care plan, 50% x 4 weeks then 25% x 2 weeks. Variances and results will be reviewed for patterns and/or trends and reported to QAPI for input and guidance.
5. Date of Compliance: June 10, 2019

F657 – Timely Revision of Care Plans

1. Resident Centered Care Plans were revised for the residents identified as follows:

   Resident # 71 was discharged on 5/3/19
   Resident # 58 for antibiotics and pneumonia on 5/20/19
   Resident #32 for pressure injury on 5/1/19
   Resident #6 for DTI on 4/29/19
   Resident #73 for IV antibiotics on 4/30/19
2. All residents are at risk for care plans not being revised or updated to reflect current care provided.
3. Resident centered care pans will be reviewed for completeness on all residents living in facility on 5/20/19 to reflect changes in the care and services provided or requested by resident. Administrator, DON, Staff Educator or designee will educate the interdisciplinary team on strategies for person centered, comprehensive care planning. Care plans for all residents living in facility on 5/20/19 will be reviewed by MDS Coordinators, Clinical Managers or designee for completeness.
4. Clinical Managers, DON, MDS Coordinators or designee will audit resident care plans to assure comprehensiveness and person centered approaches are included in care plans 25% x 4 weeks, then 10% x 2 weeks. Results of audits will be reviewed for patterns and/or trends and reported to QAPI for input and guidance.
5. Date of Compliance: June 10, 2019

PHARMACEUTICAL SERVICES Cross Reference

F755 – Pharmacy Services

1. The medication for Resident # 44 was received in the facility and treatment initiated on 4/24/19 at 2100. Resident # 44 care plan was updated to include the prescribed medication and treatment.
2. All residents are at risk for errors in medication
3. DON, CM or designee will educate nursing on protocol for notifying pharmacy when prescribed medication is not available.
4. DON, CM or designee will audit the 24 hour report to identify any missed medications 5x per week for 4 weeks. Variances will be reviewed for patterns and/or trends and reported to QAPI for input and guidance.
5. Date of Compliance: June 10, 2019 (Monday)

F756 – Drug Regimen Review

1. The diagnosis and end date for the use of Valtrex was updated in the EMR for Resident # 47 on 5/15/19.
2. All residents are at risk for inaccurate diagnosis coding and recommended end date for prescribed medication(s).
3. DON, CM, or designee will educate clinical staff on: order entry for medications to include appropriate diagnosis and end/stop dates; and on the Medication Regimen Review process and follow-up to ensure Medication Irregularities identified are addressed appropriately.
4. DON or designee will audit Pharmacy Medication Regimen Review reports x 2 months to ensure Pharmacy Medication Irregularities identified are completed and recommendations are documented. Variances will be reviewed for patterns and/or trends and reported to QAPI for input and guidance.
5. Date of Compliance: June 10, 2019